AN ANALYSIS OF THE EFFECTIVENESS OF TWO COMPONENTS IN THE TREATMENT OF ERECTILE DYSFUNCTION

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ABSTRACT

AN ANALYSIS OF THE EFFECTIVENESS OF TWO COMPONENTS IN THE TREATMENT OF ERECTILE DYSFUNCTION

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This study compared the effectiveness of two components, a ban on sexual intercourse and communication of sexual preferences, in the treatment of couples in which the male was experiencing erectile dysfunction. The treatment format was via written instructions presented once at the beginning of the treatment phase. Therapist contact was minimal. It was predicted that instructions to ban intercourse would be more effective than the communication instruction in improving the target symptom of erectile dysfunction, but both treatment components would improve general sexual and marital functioning. Sixteen couples underwent a one month baseline period of self-monitoring by means of a daily record-keeping form; a one month treatment period and a one month follow-up period. Male subjects also underwent an endocrinological examination at the start of the program to ascertain testosterone and related hormone levels. Couples were randomly assigned to one of two treatment conditions. The Ban-Communication Group was prohibited from engaging in intercourse (but not other forms of sexual interaction) and encouraged to communicate their sexual likes and dislikes to their spouses, for one month. The Communication-Only Group simply received the instruction to communicate their sexual

preferences for one month. Following the treatment period, couples were allowed to resume the love-making style of their choice. Treatment effectiveness was evaluated by means of paper and pencil tests of sexual and marital adjustment, and by subjects' record forms monitoring daily sexual behaviour patterns.

Contrary to prediction, both conditions were found to have significant positive effects on erectile dysfunction, as well as on selected general sexual and marital measures. The ban on intercourse did not add to the improvement produced by the instruction to practice communication, indicating that the former instruction was likely an inert treatment component. Measures from the daily record form did not reveal as many positive changes as did the test battery. Two pre-treatment measures, the Sexual Interaction Inventory and testosterone level, were found to predict treatment outcome with sufficient power, to permit selection of future patients who might benefit most from a minimal contact-minimal treatment program. The effectiveness of a treatment consisting of written instructions combined with minimal therapist contact on males with erectile dysfunction have important cost benefit implications.

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Table of Contents

	page
Abstract	i
Acknowledgements	iii
List of Tables	iv
List of Figures	vii
Introduction	1
Early Theories of Etiology and Related Treatment Approaches	2
Current Treatment Approaches	4
Role of Biogenic Factors: General	8
Role of Biogenic Factors: Endocrinological	10
Role of Personal Adjustment	14
Role of Marital Conflict	15
Outcome Studies	16
Criteria for Treatment Outcome	16
Components of Treatment Packages	19
Present Study	22
Method	25
Subjects	25
Experimental Design	26
Measures	30
Questionnaire Measures	30
Record-Keeping Form	34
Laboratory Examination	37
Procedure	37

page

Results 43

Sample Characteristics 43

Equivalence of Groups 43

Subjects' Record-keeping 44

Analysis of Variance Results 44

Test Measures 46

Sexual Functioning 46

Marital Functioning 58

Sexual Communication Ability 58

Ratings of Improvement 60

Record-keeping Form Data 63

Sexual Functioning 64

Non-sexual Affectional Behaviour and Feelings Toward Partner 71

Ratings of Improvement 71

Discriminant Analysis Results 75

Discussion 81

References Notes 95

References 96

Appendix A:

Consent Form (Male) 105

Consent Form (Female) 107

Appendix B:

Marital Adjustment Scale 109

Appendix C:

Sexual History Form 110

Appendix D:

Sexual Interaction Inventory 116

Appendix E: page

Sexual Behaviour Questionnaire 152

Appendix F:

Goals for Sex Therapy 154

Appendix G:

Erection Difficulty Questionnaire 157

Appendix H:

Improvement Questionnaire (male) 160

Improvement Questionnaire (female) 161

Appendix I:

Daily Record-keeping Form 162

Appendix J:

Interview Protocol 163

Appendix K:

Instructions for Ban-Communication Group 166

Appendix L:

Instructions for Communication-Only Group 169

Appendix M:

T-Test Comparisons between Groups on Sample Characteristics 172

Appendix N:

T-Test Comparisons between Groups on Test Variables at Pre-Treatment 1 176

T-Test Comparisons between Groups on Record Form Variables at Baseline 178

Appendix O:

ANOVA Summary Tables on Test and Record Form Variables 179

List of Tables

		page
Table 1:	Selected Characteristics of the Sample	27
Table 2:	Frequency of Sexual Activities by Percent of Sample	45
Table 3:	Mean Ratings of Erectile Functioning (Sexual History Form)	47
Table 4:	Mean Ratings of ERectile Functioning (Sexual Behaviour Questionnaire)	49
Table 5:	Mean Scores on Erection Difficulty Questionnaire and Goals for Sex Therapy	51
Table 6:	Mean Ratings of General Sexual Functioning (Sexual History Form)	53
Table 7:	Mean Ratings of Amount of Interfering Thoughts (Sexual Behaviour Questionnaire)	54
Table 8:	Mean Scores on Sexual Interaction Inventory	55
Table 9:	Mean Scores on Marital Adjustment Scale	59
Table 10:	Mean Ratings of Sexual Communication (Sexual Behaviour Questionnaire)	61
Table 11:	Mean Ratings of Improvement Questionnaire	62
Table 12:	Mean Scores of Erectile Functioning (Daily Record Forms)	65
Table 13:	Mean Ratings of General Sexual Functioning (Daily Record Forms)	67
Table 14:	Mean Ratings of Nonsexual Affectional Behaviour and Feelings for Partner (Daily Record Forms)	72
Table 15:	Group Means of Success:Experience Ratio (Daily Record Forms)	74
Table 16:	Comparison of Actual Group Membership with Predicted Group Membership	77
Table 17:	Summary of Stepwise Discriminant Analysis	78
Table 18:	Group Means and Standard Deviations of SII Summary Scale and Testosterone	80

page

Table O.1: Frequency of Difficulty Obtaining Erections: ANOVA Summary Table 180

Table O.2: Frequency of Difficulty Maintaining Erections: ANOVA Summary Table 181

Table O.3: Length of Time to Get Erection: ANOVA Summary Table 182

Table O.4: Quality of Erection at Ejaculation: ANOVA Summary Table 183

Table O.5: Erection Difficulty Questionnaire: ANOVA Summary Table 184

Table O.6: Goals for Sex Therapy: ANOVA Summary Table 185

Table O.7: Duration of Sexual Foreplay: ANOVA Summary Table 186

Table O.8: Satisfaction with Sexual Relationship: ANOVA Summary Table 187

Table O.9: Amount of Interfering Thoughts: ANOVA Summary Table 188

Table O.10: SII Sexual Frequency Satisfaction Scale: ANOVA Summary Table 189

Table O.11: SII Sexual Pleasure Mean Scale: ANOVA Summary Table 190

Table O.12: SII Perceptual Accuracy Scale: ANOVA Summary Scale 191

Table O.13: SII Self-Acceptance: ANOVA Summary Table 192

Table O.14: SII Mate-Acceptance: ANOVA Summary Table 193

Table O.15: SII Summary Scale: ANOVA Summary Table 194

Table O.16: Marital Adjustment Scale: ANOVA Summary Table .. 195

Table O.17: Knowledge of Partner's Sexual Likes/Dislikes: ANOVA Summary Table 196

Table O.18: Perception of Partner's Knowledge of Sexual Likes/Dislikes: ANOVA Summary Table 197

page

Table O.19: Sexual Communication Satisfaction; ANOVA Summary Table 198

Table O.20: Improvement in Erectile Ability: ANOVA Summary Table 199

Table O.21: Improvement in Sexual Self-Concept: ANOVA Summary Table 200

Table O.22: Improvement in General Self-Concept: ANOVA Summary Table 201

Table O.23: General Erection Quality: ANOVA Summary Table 202

Table O.24: Erection Quality in Intercourse: ANOVA Summary Table 203

Table O.25: Concern Regarding Erection: ANOVA Summary Table 204

Table O.26: Sexual Encounter Frequency: ANOVA with Simple Main Effects Summary Table 205

Table O.27: Noncoital Sexual Encounter Frequency: ANOVA Summary Table 206

Table O.28: Quality of Sexual Experience: ANOVA with Simple Main Effects Summary Table 207

Table O.29: Intercourse Frequency: ANOVA Summary Table 208

Table O.30: Masturbation Frequency: ANOVA Summary Table 209

Table O.31: Orgasmic Frequency: ANOVA Summary Table 210

Table O.32: Affection Satisfaction: ANOVA Summary Table 211

Table O.33: Feelings Toward Partner: ANOVA Summary Table 212

Table O.34: Success:Experience Ratio: ANOVA Summary Table .. 213

List of Figures

page

Figure 1: Mean T Score Profile on MMPI 29

Figure 2: Sexual Encounter Frequency 68

Figure 3: Quality of Sexual Experience 70

Introduction

The present study was designed to investigate the problem and treatment of erectile dysfunction in males. Erectile dysfunction is defined as the persistent inability to obtain or sustain an erection that is sufficient to allow intromission and pelvic thrusting during sexual intercourse (Masters & Johnson, 1970). The problem of erectile dysfunction does not represent a homogeneous grouping. Researchers and clinicians commonly classify erectile dysfunction as being primary (i.e., never having experienced successful intromission) or secondary (i.e., having had successful intromission at least once in one's life) (Masters & Johnson, 1970). The importance of differentiating subgroups of erectile dysfunction is suggested by one study that examined the clinical histories of 468 males presenting for treatment with erectile dysfunction (Graber & Kline-Graber, 1981). It was shown that patients with primary erectile failure have a sexual profile distinct from those with secondary erectile failure. The authors also suggested additional classifications with respect to the area of erectile dysfunction, based on data pertaining to the frequency of occurrence of the dysfunction, the quality of erections (e.g., full, partial or full then partial), and whether the disorder occurs in coital or noncoital activities. Graber and Kline-Graber believe that this specificity in reporting is critical, because differences in range and frequency of erectile dysfunction and quality of erection may be related to different etiologies and/or responses to treatment. Since subject availability and research costs make it difficult to achieve complete homogeneity

within a single problem category, it has also been suggested by several investigators (e.g., Kilmann & Auerbach, 1979; Reynolds, 1980) that future researchers in the area be specific in describing their subject samples.

The prevalence of erectile dysfunction or impotence in the general population has not been statistically established. However, in a study that investigated 100 married couples who had never sought help for marital or sexual problems (Frank, Anderson & Rubinstein, 1978), 16% reported difficulties with either obtaining or maintaining an erection. Welch and Kartub (1978) in reviewing the incidence of erectile dysfunction, stated that it may occur in men of all ages and is not affected by race or socioeconomic status. They also noted that in almost all cultures a great deal of male self-esteem is invested in erection capacity.

Masters and Johnson (1970) reported that erectile dysfunction was the presenting complaint for 245 of the 790 couples (31%) treated during the initial eleven years of their treatment program. The percentage of male patients who sought treatment for erectile difficulties was slightly greater than the percentage who sought treatment for premature ejaculation.

Early Theories of Etiology and Related Treatment Approaches

Erectile dysfunction, for a long time, was considered to be a manifestation of deep-seated psychological problems, treatable only in long-term individual psychotherapy (cf. Kilmann & Auerbach, 1979). Classical psychoanalytic theory held that erectile dysfunction was a result of sexual fear and guilt that could be traced to unresolved oepidal conflicts. Sexual excitement and behavior were believed to re-evoke both unconscious unresolved incestuous wishes, as well as the

castration anxiety and guilt feelings engendered by these wishes. Impotence developed as a defence against the emergence of these conflicting affects (Kaplan, 1974). Because of the defensive nature of the erectile failure, classical psychoanalytic theory maintained that the oedipal conflict must be brought into consciousness and resolved before any lasting improvement in the erectile symptom could occur.

Specific references to the use of psychoanalysis in treating impotence include those of Freud (1910/1953) and Stekel (1927). According to more recent authors (Bieber, 1974; O'Connor & Stern, 1972), the psychoanalytic treatment of erectile dysfunction was not appreciably different from psychoanalytic approaches to other problems. Indeed, Freud (1910/1953) proposed that "Anyone who is in any way abnormal, is invariably abnormal in his sexual life".

In his review of treatment studies conducted prior to 1971, Cooper (1971) lamented the lack of empirical data on the efficacy of various forms of psychoanalytically oriented treatments. Pronouncements concerning treatment efficacy and prognostic indicators were often based on single-case studies or relatively uncontrolled clinical observations. Cooper (1971) concluded that there did not exist any controlled research to support the efficacy of insight therapy for the treatment of erectile dysfunction. In fact, evidence began to accumulate which contradicted the assumptions made by the psychoanalysts. Several authors reported the successful treatment of large numbers of sexually dysfunctional males without any attempt at extensive personality reorganization or the resolution of unconscious conflict (Friedman & Lipsedge, 1971; Lazarus, 1961; Masters & Johnson, 1970; Semans, 1956; Wolpe, 1958).

Current Treatment Approaches

The general public as well as the professional community first became aware of the effectiveness of an alternative approach for the treatment of sexual dysfunction with the landmark publication of Masters and Johnson's "Human Sexual Inadequacy" (1970). This method involved brief, time-limited directive counseling of the couple focusing on the erection problem rather than on the attainment of insight or resolution of presumed unconscious conflicts.

Masters and Johnson conceptualized erectile dysfunction as having easily traceable etiological roots in the male's sexual learning history and/or in his ignorance of sexual physiology. They described their treatment for erectile dysfunction as a series of problem-centered procedures dealing with immediate causes such as performance anxiety, excessive self-observation, poor communication in the couple and/or misinformation about sexual matters. Four procedures in this approach appear to be important to treatment effectiveness; a) alleviation of performance concerns, b) facilitation of open verbal and non-verbal communication between partners on sexual issues, c) educative counseling to eradicate sexual myths and to modify sexual attitudes, and d) replacement of maladaptive sexual behavior patterns with more effective patterns through the use of graded, directed practice.

Masters and Johnson (1970) and Kaplan (1974) considered concern about erectile performance to be the most important immediate cause of erectile dysfunction. They state that performance concerns can transform a single episode of erectile difficulties into a chronic sexual dysfunction. Kaplan (1974) viewed erectile dysfunction as a

psychophysiological reaction to anxiety occurring in men with an excessive vulnerability to stress. Masters and Johnson (1970) postulated that performance concerns had two components; (1) an affective component, termed "performance anxiety", and (2) a cognitive component consisting of fear of erection loss and "spectatoring". They contended that the erectile dysfunction is usually maintained by the male's preoccupation with actively achieving or willing an erection. This preoccupation makes the male a spectator to his own sensual experience rather than a participant, thereby blocking his access to the physical and psychological stimulation which would normally elicit erection. Geer and Fuhr (1976) have demonstrated experimentally that cognitive distraction from psychosexual stimulus input results in reduced erectile responsiveness. Performance anxiety and spectatoring have been observed in cases of erectile failure by numerous clinicians (Annon, 1974; Cooper, 1969; Friedman, 1968; Zilbergeld, 1978).

An important strategy in the treatment of many sexual dysfunctions is the temporary banning of intercourse from the couple's sexual repertoire at the outset of therapy (LoPiccolo & LoPiccolo, 1978). The ban on intercourse is particularly important for the treatment of erectile dysfunction because it is presumed that pressure to perform successfully in that act is directly related to the maintenance of the dysfunction. The rationale for this technique is twofold. Firstly, by imposing a ban on intercourse the pressure to obtain an erection and the accompanying anxiety are removed. The individual gradually learns to respond to sexual sensations by engaging in other types of sexual activity that are less anxiety provoking, thereby reestablishing

the connection between sexual activity and pleasure. Through graduated exposures to sexual stimulation the individual begins to concentrate on and enjoy sexual feelings without concerns about performance. Once this response is stabilized intercourse is reintroduced at which time it is hoped that the accompanying anxiety has been extinguished and replaced with normal sexual responsivity. The individual is encouraged to continue with these other forms of sexual activity as a preparatory measure to intercourse, to ensure proper arousal levels. Secondly, banning intercourse encourages couples to engage in other forms of sexual activity, thereby broadening their sexual repertoire and increasing the probability that sex play will produce pleasurable feelings.

Though sex therapists have encouraged couples not to overevaluate intercourse and coital orgasm for sexual satisfaction, intercourse remains a valued and justifiable behavioural goal. The rationale for directing a couple to abstain from intercourse follows from formulations about how erectile dysfunction are maintained. However, the effectiveness of this single treatment element has not been empirically evaluated. Furthermore, the effects of this obtrusive intervention on a couple's broader interpersonal interactions are unknown.

Inadequate communication between sexual partners has been viewed as a contributing factor to sexual dysfunction (Kaplan, 1974; Masters & Johnson, 1970; Zilbergeld, 1978). In the case of erectile failure the male may be reluctant or unable to communicate verbally or non-verbally to his partner the form and amount of stimulation he requires. In other instances, he may also feel reluctant to inform his partner on the occasions when he prefers not to have intercourse. In the absence

of communication to the contrary, the female may interpret episodes of erectile failure as a rejection of her, thereby increasing tension during subsequent sexual encounters (Reynolds, 1980). Though lack of communication is not considered to be directly responsible for causing erectile dysfunction, it is viewed at least in part, to be responsible for its maintenance. For these reasons sexual communication training is often a component in erectile dysfunction treatment. LoPiccolo (1978) suggested that next to eliminating anxiety and performance demands, the most important component in treating erectile failure consists of insuring that the male is receiving a high level of sexual stimulation from his partner. Thus to ensure that sexual needs and preferences are well understood between partners, therapists discuss with impotent clients the need to communicate about sex in general, sexual feelings and sensations, specific sexual stimulation techniques and other sexual behaviours that they enjoy, and sexual behaviours that they dislike (Annon, 1974; Hartman & Fithian, 1972; Kaplan, 1974; Masters & Johnson, 1970). Masters and Johnson (1970) and Hartman and Fithian (1972) teach clients to use physical touch to communicate feelings, by having them guide their partners' hands during genital caressing, and emphasize the importance of clients giving feedback to their partners during sexual activity.

As mentioned, many individuals suffering from sexual dysfunction are ignorant of both basic biology and effective sexual techniques. A number of clinicians have noted that misinformation and lack of knowledge contribute to erectile difficulties (Kaplan, 1974; Zilbergeld, 1978). For example, many men are not aware of the normal changes in male sexuality that are associated with age. In particular, they are unaware that as men get

older they require an increasing amount of direct tactile stimulation of the genitals in order to elicit erection (Masters & Johnson, 1966). Other men may be unaware of the importance of clitoral stimulation for female arousal or may believe that female satisfaction is associated with penis size, the rigidity of the erection, or the depth and number of pelvic thrusts (Reynolds, 1980). Thus, sex education is another component in most treatment programs. During treatment couples are given information on sexual anatomy, physiology and "normality", correcting misconceptions, and instruction in sexual technique. While information alone is probably not sufficient to produce symptom remission, therapists believe it is necessary for treatment to succeed, though this too has never been empirically tested.

Role of Biogenic Factors: General

In the early 1970's there was a general consensus amongst medical practitioners and psychologists that impotence was predominantly psychogenic. Masters and Johnson (1970) stated that physiological factors had only a minor influence. The American Medical Association Committee on Human Sexuality (1972) held a similar view. However, recent evidence has encouraged reconsideration of this belief.

Schumacher and Lloyd (1981) conducted a study on possible organic contributions to erectile dysfunction. One hundred and two impotent men who sought sex therapy were compared to 67 potent men who presented for sex therapy because their partners were experiencing sexual dysfunctions. Complete psychosexual and medical histories were obtained on the sample. Laboratory examination included hemotological examination, urinalysis, measures of cholesterol and triglycerides and endocrine examination. Results revealed that a significantly higher

proportion of the impotent men, compared to the sexually functional men, had organic disease (73% versus 12% respectively). With the exception of four men, all the impotent men had "selective" or "periodic" impotence—previously thought to be evidence of a psychogenic origin. Medical abnormalities fell into five general categories; 1) cardio-vascular-respiratory disease (34%); 2) endocrine disease (22%); 3) metabolic disease (22%); 4) neurological disease (7%); 5) urogenital disease (15%). Eighty-three of the 102 impotent males received sex therapy with their wives for 10 sessions. The effectiveness of treatment was evaluated in two areas; the effect on the overall relationship, and the effect on the specific sexual dysfunction. Only two categories of therapeutic outcome were used; improvement and no change. Results collected six months after the termination of treatment revealed that the improvement rate in men with organic disease was significantly higher for changes in overall relationship issues than for changes in sexual behavior. In contrast, in the impotent men without organic disease, improvement rates were higher for both relationship adjustment and sexual behaviour.

These data contradict previous conceptions of the origins of the majority of impotence cases. Several reasons can be postulated to account for the failure of investigators in the past to recognize possible organic factors in erectile dysfunction. Firstly, the training and orientation of many sex therapists has led to an emphasis on psychological over physiological variables, rather than equal consideration of both. Second, in the evaluation of results of therapy, criteria for success or failure are often not defined clearly (Kilmann & Auerbach, 1979; Reynolds, 1977). Therefore, investigators may

confuse positive changes in global sexual interaction (e.g., frequency of sexual activity, enjoyment of sexual activity, etc.) with changes in specific erectile functioning. It appears that further studies on the physical status of impotent patients, previously thought to be free of organic problems, is warranted.

Role of Biogenic Factors: Endocrinological

A number of studies have examined the contribution of sex hormone deficiencies to erectile failure. The hypothalamic-pituitary-gonadal axis is the major hormonal system responsible for the development and maintenance of erectile adequacy (Schiavi & White, 1976). The entire axis exists as an endocrine negative feedback loop. Dysfunction at any locus in this axis may lead to erectile failure. The term androgen refers to any compound that has masculinizing activity. Testosterone is the most potent androgen and is synthesized by the Leydig cells of the testes under the influence of luteinizing hormone (LH) and follicle stimulating hormone (FSH). Prolactin, a pituitary hormone, has recently been found to also influence the secretion of testosterone (Franks, Jacobs, Martin & Nabarro, 1978; Reckless & Geiger, 1978).

Since testosterone is the major gonadal steroid responsible for maintenance of potency, any investigation of hormonal dysfunction in an impotent patient would logically begin with the determination of his testosterone level. Between 1965 and 1975 several studies were published evaluating the role of testosterone in impotent men. Apostolakis and Schmidt (1968) measured testosterone excretion in 20 patients suffering from erectile disorder and lack of sexual drive. In 17 cases the testosterone values were within normal limits. Another study (Racey, Ansari, Rowe, & Glover, 1973) divided impotent males into

three groups based on their sexual and medical histories: (1) acute impotence of obvious psychogenic origin, (2) chronic impotence of psychogenic origin, and (3) chronic impotence of unknown etiology. The mean plasma testosterone concentration of the total group did not differ significantly from a control group of seven men free from sexual disorders. Furthermore, there were no significant differences among the three subgroups of impotent men. In contrast to these findings, Legros and colleagues (Legros, Palem, Servais, Margoulies, & Franchmont, 1973) also found that the testosterone levels of a group of 84 impotent men were within the normal range. However, when compared to a group of sexually functional males, mean testosterone levels in the impotent group were lower and LH levels slightly higher. In another study hormonal analyses were performed on 25 patients who had been referred for psychotherapeutic treatment of impotence (Cooper, Ismail, Smith & Loraine, 1970). Urinary testosterone levels were found to be abnormally low in 16 of these patients who were therefore rediagnosed as having "constitutional impotence". A later study found lower mean testosterone levels in a group of 45 married patients complaining of erectile difficulties between the ages of 36 and 55, than in a control group of comparable age (Raboch, Mellan & Starka, 1975). However, the differences were significant only in the subgroups of men between 36 and 45 years.

Adding to the confusion are studies involving the administration of exogenous testosterone as a treatment for erectile dysfunction. A few studies (Miller, 1968; Jakobovits, 1970) reported increased potency for some dysfunctional males who were not hormonally deficient. Generally, however, the effects of such treatment have not been found

to be superior to those of placebo administrations (Benkert, Horn, Pickardt & Schmid, 1976; Cooper 1968).

To summarize, the early findings on testosterone levels in impotent men free from obvious organic disease furnished inconsistent evidence. Methodological differences in measuring testosterone and inadequate matching of control groups may account from some of the discrepancies in the findings.

Recent studies have not provided more definitive answers. Pirke and his associates (Pirke, Kockott, Aldenhoft, Besinger & Feil, 1979) measured LH, total testosterone and free testosterone levels of 16 impotent men, 16 men with premature ejaculation, and 16 normal men, matched for age. No significant difference was found in hormonal levels between patients and normal controls or between the two problem groups. Another study (Schwartz, Kolodny & Masters, 1980) examined the plasma testosterone levels of a group of 341 men with mixed sexual dysfunction compared to those in 199 men with normal sexual function. With respect to the subsample of erectile dysfunction cases, it was found that the circulating levels of testosterone in normal males were not significantly different from testosterone values in males with erectile dysfunction. However, males with primary impotence had significantly higher testosterone levels than males with secondary impotence. There were no significant differences in testosterone levels between males whose dysfunction was or was not subsequently reversed in sex therapy, although it was noted that for every case of erectile dysfunction the failures had a lower mean testosterone level.

In contrast to the finding that there is no relationship between impotence and hormonal levels, a recent study (Spark, White & Connolly,

1980) found that of 105 impotent patients, 36 of them (34%) had abnormal serum testosterone levels. The screening of serum testosterone levels initiated further endocrine investigation. All of the 36 men were subsequently found to have previously unsuspected disorders of the hypothalamic-pituitary-gonadal axis. Only one patient, with normal testosterone levels, was found to have an organic disorder. Once the specific defects were defined, appropriate hormonal therapy was instituted and potency was restored in 33 patients. The authors concluded that the screening of serum testosterone levels is a useful technique in identifying hormonal dysfunction in men with impotence. In another study, (Franks et al, 1978) it was shown that nearly the whole sample of impotent males had clinical evidence of hyperprolactinaemia and lowered testosterone concentrations.

Two studies (Brown, Monti & Corriveau, 1978; Persky, Lief, Strauss, Miller & O'Brien, 1978) investigated the relationship between testosterone and sexual behaviour in normal males. Both studies found no correlation between testosterone levels and intercourse frequency, orgasmic frequency, masturbation frequency, sexual initiation frequency and sexual responsivity. These results demonstrated that variations among men in testosterone levels within the normal range were neither a determinant nor a result of individual differences in sexual behaviour.

Workers in the field readily acknowledge that the findings on the role of testosterone and related hormones in sexual behaviour and particularly in erectile functioning are discrepant, and therefore, stress the importance of further investigation in this area (Schwartz et al, 1980; Spark et al, 1980).

Role of Personal Adjustment

There is recent empirical evidence to suggest that personality factors are related to sexual adjustment. Schumacher and Lloyd (1981) found that 22% of their impotent males had definable psychiatric disorders, with a total of 78% reporting mild to moderate psychological distress. There were, however, no significant differences in improvement rates between impotent men with mild to moderate psychological distress and those with psychiatric disorders.

In a recent study (Munjack, Oziel, Kanna, Whipple & Leonard, 1981) males with the primary complaint of erectile failure were compared to a group of psychiatric patients not selected for sexual dysfunction, and to a sexually "normal" control group. Using a battery of personality instruments it was found that the two clinical groups showed more psychopathology than sexually normal males.

Derogatis and his colleagues (Derogatis, Meyer & King, 1981) reported on the psychiatric status of 325 patients who sought treatment for sexual disorders. Using his SCL-90-R to assess psychological symptom status, Derogatis found that approximately one-third of the 199 males and one-half of the 126 females were assigned psychiatric diagnoses. Of particular interest to this review, of 137 men with erectile problems, 37% showed psychological distress with particular elevation on the depression dimension and secondary peaks on anxiety and phobic anxiety dimensions. Impotent men, overall, showed a psychological symptom profile 1.4 standard deviations above the norms established on a nonclinical sample.

One study attempted to investigate whether symptom removal as a result of sex therapy also lead to a stabilization of affected

personality areas (Clement & Pfafflin, 1980). Pretherapy data on two personality measures, The Gissen Test and the Freiburg Personality Inventory, and the Sexual Attitude Scale, confirmed that the 92 sexually dysfunctional patients differed from normal controls in the same direction as are typically found in psychosomatic and psychoneurotic patients. In 80% of males treated successfully for erectile dysfunction, test scores collected one year after treatment indicated that changes in positive self-perception, including being less depressed, less aggressive and less inhibited, accompanied symptom removal. In addition, the men described themselves as being less sex-role stereotyped. Female partners of males with erection disturbances were found to go through almost the same positive changes as their partners. The authors concluded that general emotional lability connected with the sexual symptom is also reduced following sex therapy.

It is important to realize that though these studies have shown an association between erectile disorder and psychological maladjustment, they have not demonstrated causality. It cannot be said that the psychological distress in these patients caused their sexual dysfunction or the reverse.

Role of Marital Conflict

Marital conflict may prevent patients from solving sexual problems and often causes the couple to perceive the problem in a distorted manner (Hogan, 1978). For example, wives of men suffering from erectile failure may believe the erectile problems indicate that their husbands do not love them (Zilbergeld, 1978). Masters and Johnson (1970) believed secondary erectile failure was associated with

marital problems, in that it often originated from a pattern of premature ejaculation combined with the wife's complaints about her husband's inadequacy. Kaplan (1974), in treating erectile dysfunction, uses her therapy sessions as well, to alter those interactional difficulties that interfere with sexual expression, e.g., the wife undermining her partner's progress by demanding a sexual performance.

Outcome studies

The results of controlled outcome studies generally indicate that the behavioural techniques used to treat erectile dysfunction are effective in alleviating the target symptom (cf. Fordney-Settlage, 1975; Kilmann & Auerbach, 1979; Reynolds, 1977). However, though the methodological standards of outcome studies in the treatment of erectile dysfunction have improved in recent years, major weaknesses are still evident in two areas; 1) the use of vague and limited criteria for treatment outcome, and 2) the use of treatment packages comprised of a large variety of therapeutic components.

Criteria for Treatment Outcome: Many studies in the field of sex research suffer from vague and poorly specified criteria of successful outcome. Most researchers merely report their results in terms of global categories such as "improved", "cured", or "successful", without providing operational definitions for these judgements. Insofar as these criteria are not tied to an empirical base, such judgements may be unreliable.

For example, criteria for the effectiveness of treatment of erectile failure, such as "return to coital competence" (Jones, 1973), "ability to have intercourse which was satisfying to both partners without erectile or ejaculatory problems" (Friedman, 1968), or

"maintaining erection for at least one minute after intromission with intravaginal ejaculation" (Kockott, Dittmar, & Nusselt, 1975) may appear specific. However, such criteria cannot differentiate men who are able to function adequately on a single occasion from men who are consistently functional.

Ansari (1976) conducted a study involving 65 males with erectile failure. She used three outcome criteria of "recovered", "improved", or "no change". Though she did attempt to define these categories, they were hardly specific enough to allow for replication in another setting.

A few recent studies have attempted to resolve the problem of imprecise outcome criteria by employing standardized sexual behaviour inventories (Lobitz & Baker, 1979; LoPiccolo & Steger, 1974; Price, Reynolds, Cohen, Anderson & Schochet, 1981). Though objective questionnaire data reflect an improvement over subjective data, problems remain. Most researchers simply report total scores on these inventories (Reynolds, Note 1). The meaning of total scores is often ambiguous because these measures are usually comprised of a mixture of items on sexual attitudes, sexual behaviours and sexual satisfaction. Though cross-study comparisons and replication studies are in these cases possible, again it is difficult to interpret the kinds of changes which occur.

Studies by Price and his associates (Price, et al, 1981) and Lobitz and Baker (1979) are two examples of research that utilized standardized measures with specific outcome criteria. These studies both evaluated the effectiveness of group treatment in single males experiencing erectile failure. In the Price study, 22 men with

secondary erectile dysfunction were randomly assigned to one of two men's treatment groups or to a waiting list control condition. The content of the treatment package consisted of didactic presentations, audiovisual aids, homework exercises, and group discussions. The didactic presentations and group discussions focused on such topics as male and female anatomy and physiology, myths about male and female sexuality, and the importance of communicating with partners about sexual difficulties and sexual preferences. Bibliotherapy, in the form of readings related to these topics was also incorporated into the program. Sexual intercourse was banned at the beginning of the treatment program. Results indicated that treatment groups improved significantly more than waiting-list controls on a variety of measures concerning sexual attitudes and satisfaction. However, the treatment groups and waiting-list participants did not differ significantly in their reported frequency of erection difficulties both before intercourse and during intercourse. Only nonsignificant declines from pretest to posttest in the frequency of erection difficulties were reported by both treatment groups. The authors concluded that their group treatment approach was effective in producing changes in general sexual functioning, but less effective in producing specific changes in the frequency of erection difficulties.

Lobitz and Baker (1979) in their study, also used multiple standardized measures to evaluate outcome. On one of their measures "Goals for Sex Therapy" overall improvement at the termination of treatment was found. The authors subsequently examined the individual items of this test measure and found that items pertaining to specific skills for coping with erectile failure demonstrated the greatest changes.

These two studies illustrate the importance of assessing outcome in terms of specific erectile behaviour, broader sexual behaviour and the overall interaction within the couple.

Components of Treatment Packages: In reviewing the state of the literature on sex therapy effectiveness, LoPiccolo wrote "At this point, the "active ingredients" and "inert fillers" in the direct therapy package cannot be distinguished, and the explanations offered for the effectiveness of the approach are simply speculations rather than data-based interpretations" (LoPiccolo, 1978, p.2). It is reasonable to conceptualize direct sex therapy procedures as complex and multifaceted packages containing many different components. Some packages for the treatment of erectile dysfunction have included such procedures as systematic desensitization (Obler, 1973), other anxiety-reduction techniques, including a ban on intercourse (Price et al, 1981), hypnosis (Hartmann & Fithian, 1972), arousal reconditioning (LoPiccolo, Stewart & Watkins, 1972), thought stopping (Wish, 1975). biofeedback training (Reynolds, Note 1), attitude restructuring (Zilbergeld, 1978), assertive training (Dengrove, 1971), information giving (Roen, 1965), communication training (Kaplan, 1974), cognitive techniques (Ellis, 1980), and masturbation therapy (Annon, 1974). We have not yet isolated the essential versus the inactive treatment ingredients necessary to promote erectile functioning.

Isolating the effects of treatment components is of both theoretical and clinical interest. From a theoretical perspective knowledge of the independent effects of individual components would help to clarify the nature of the underlying mechanisms involved in sexual dysfunctions. From a clinical standpoint, this type of analysis

would lead to more efficient, cost-effective treatment services.

In general, programs patterned after the Masters and Johnson approach achieve 60 - 90% success rates for the treatment of erectile failure (cf. Cooper, 1971; Kilmann & Auerbach, 1979; Reynolds, 1977; Reynolds, 1980). The focus has now shifted from the question of whether or not sex therapy packages work to the question of which components of the package contribute to its effectiveness (Hogan, 1978). Reviews of the relevant literature have all concluded that no firm knowledge exists on the effectiveness of commonly used therapy components (Annon, 1974; Franks & Wilson, 1974; Kaplan, 1974; Kilmann & Auerbach, 1979; Reynolds, 1980).

Only one outcome study in the treatment of erectile dysfunction, has been carried out that provides a good model of component analysis research. This study (Auerbach & Kilmann, 1977) was designed to demonstrate that a hierarchy of anxiety-provoking sexual behaviours was a vital ingredient of imaginal systematic desensitization (SD) treatment for erectile dysfunction. The sample consisted of 16 males with secondary erectile failure who were unsuccessful in their coital encounters on at least 15% of occasions. Subjects were divided into two groups which were matched on a number of demographic and symptom-related variables. The experimental group, consisting of relaxation training and the hierarchy component received imaginal SD in a group setting for 15 sessions, the attention-placebo control group received 15 sessions of relaxation exercises only. Outcome measures included two inventories measuring satisfaction with sexual and non-sexual areas of the relationship and a success: experience ratio which is composed of the number of successful sexual experiences (achieves and

maintains full intromission) divided by the total number of attempts at coitus. The results revealed a highly significant interaction in favour of the experimental group on the success: experience ratio. The experimental group showed an improvement rate of over 40%, while the control subjects showed a 3% improvement rate. The experimental group also maintained this improvement over a three-month follow-up period. A significant difference in favour of the experimental group was also found on the sexual and non-sexual relationship inventories. The findings were further bolstered by the female partner's confirmation of the male's self-reports and by concurrent changes in other aspects of the relationship (sexual and non-sexual).. The authors were able to conclude that the hierarchy component of the experimental procedure was the critical variable which fostered the differential findings.

Other component analysis studies, evaluating effectiveness of treatment for various sexual dysfunctions, have dealt with practical, economic issues. For example, the effectiveness of 1) one versus two therapists (Mathews, Bancroft, Whitehead, Hackmann, Julier, Bancroft, Goth, & Shaw, 1976; Crowne, Gillian & Golombok, Note 2); 2) weekly versus monthly therapy sessions (LoPiccolo, 1979; Carney, Bancroft & Mathews, 1978; Mathews, 1981); 3) couple versus group treatment (Lobitz & Baker, 1979; Price et al, 1981); and 4) minimal versus intensive therapist contact (Lowe & Mikulas, 1975; Zeiss, 1978) have been investigated. The results of such studies have provided valuable treatment delivery guidelines. For example, the results showed; 1) two therapists are not much better than one, 2) infrequent sessions are as effective as intensive treatment, 3) group therapy sessions are

worthwhile, especially for individuals where partners are not available, and 4) self-administered treatment, in conjunction with minimal therapist contact, is effective in treating premature ejaculation.

Present Study:

The aim of the present study was to examine the effectiveness of a specific treatment component--banning of intercourse, in relation to a second treatment component--communication of sexual preferences, in a sample of couples in which the males' complaint was erectile dysfunction. To accomplish this objective, couples in one group were told to make an effort to communicate their sexual likes and dislikes to their partners during sexual activity. Couples in the second group were also given this communication instruction. However, in addition, they were told to abstain from intercourse and to engage instead in other, noncoital sexual activities. It was predicted that the ban on intercourse combined with the communication instruction, would serve to redirect the male's attention from sexual performance to sensual pleasure, and increase communication of preferences leading to increased arousal and improved erectile functioning. The ban on intercourse component would appear to be a more powerful tactic in improving erectile functioning than the sexual communication technique, because it eliminates performance anxiety, postulated as being primarily responsible for causing the dysfunction. The communication instruction, however, is likely to affect broader sexual and marital functioning. In that both groups received the identical communication instruction, any differences between the two groups could be attributed to the additional instruction to ban intercourse. Should there be no differences between the two groups one would have to conclude

that the ban on intercourse added nothing to treatment effectiveness.

Given the evidence for the role played by personal and marital adjustment on erectile functioning, the current study utilized standardized questionnaires, measuring functioning in the areas of marital, emotional and sexual adjustment specific to the target symptom and in the overall sexual relationship. In addition, daily subject record-keeping forms which furnished quantitative, concurrent performance data were employed to enable specificity in describing the sample.

It was hypothesized that (1) the ban on intercourse plus communication condition would result in improvement in the target symptom of erectile functioning as well as in general sexual functioning and in non-sexual aspects of adjustment; (2) the communication only condition would improve the couples' general sexual and marital relationship, but have little or no effect on the males' erectile functioning.

Due to the increasing controversy regarding the origins of impotence, that is, whether the majority of cases are biogenic or psychogenic in origin, the current study also investigated the physiological status of men with erectile failure. The sample of impotent men was given a complete medical examination as a screening technique to rule out obvious organic causes to the disorder. In addition, the general incidence of organic problems in the sample was recorded.

In an attempt to shed further light on the role of hormonal factors in erectile problems, endocrinological data was collected on male subjects. Hormone levels were also employed along with sexual,

marital and personality variables in the prediction of outcome of the treatment procedures.

Method

Subjects

The sample consisted of 16 married couples. In order to be included in this investigation the couples were required to meet the following criteria :

(1) Male partner experienced erectile dysfunction which was defined as a failure to obtain and/or to sustain an erection in more than 25% of occasions of interpersonal sexual contact, and for which there were no obvious organic causes that could be identified (based on medical consultation).

(2) Female partner had no sexual difficulties which would interfere with her ability to engage in sexual intercourse, (e.g., vaginismus, dyspareunia, extreme phobic avoidance of intercourse, etc.).

(3) Couples were engaging in some form of sexual contact at least twice per month within the last three months.

(4) Duration of the problem was at least six months.

(5) Individual partners displayed no marked psychopathology as measured by the MMPI (i.e., 2 SD's above the norm on any scale; King-Ellison Godd & Brantner, 1974). Couples were excluded if either spouse was currently receiving help from a professional person for an emotional problem.

(6) Couples convincingly stated mutual commitment to the continuation of their marriage and regarded their problems as basically sexual rather than marital.

(7) Couples had been married or cohabiting for at least one year.

(8) Male partner was between the ages of 20 – 60 years.

(9) Couples were competent in reading English.

(10) Couples were willing to sign a consent form explaining the treatment approach, its rationale and the requirements of the project (e.g., questionnaire and record-keeping demands). Appendix A presents a copy of the Male and Female Consent Forms.

In all, 29 couples volunteered to participate in this study. Ten couples failed to meet the selection criteria and were therefore excluded after the initial clinical interview. Three additional couples dropped out of the study after one month because of marital or medical complications.

Of the 29 couples, 22 of them had responded to newspaper advertisements, five had been referred by private physicians, and two were on the waiting list of the Jewish General Hospital Sexual Dysfunction Service. Table 1 presents selected demographic, hormonal and problem-related variables of the 32 remaining participants (16 couples). Figure 1 presents the MMPI profiles for the sample of males and females.

Of the sample of 16 couples, all the men were experiencing secondary erectile failure, (i.e., having experienced successful intromission at least once). All 16 men reported having difficulty maintaining an erection during intercourse. Of these, 11 also reported having difficulty achieving an erection before intercourse began. In five men the dysfunction was always a problem, in the remaining 11, the erection difficulties occurred periodically.

Experimental Design

A 2 x 4 factorial design with repeated measures was used. The two groups: Ban-Communication Group and Communication-Only Group completed the questionnaire materials at four time periods, spaced

Table 1

Selected Characteristics of the Sample
(N = 16 couples)

Variables		Male	Female	Couple
Age	M	48.4	45.8	
	SD	7.9	7.8	
Education	M	11.8	12.8	
	SD	2.8	2.4	
Duration of Relationship	M			20
	SD			10.6
Combined Income	M			$41,250.00
	SD			$24,324.00
Marital Adjustment Scale	M	103.2	104.5	
	SD	22.9	18.6	
Problem Duration (years)	M			4.2
	SD			5.4
Frequency of Sexual Activity (times per month)	M			6.4
	SD			4.3
Occurrence of Erection Difficulties (% of encounters unsuccessful)	M	68%		
	SD	28%		
Testosterone (ng/dl)	M	594.8		
	SD	218.2		
Prolactin (ng/ml)	M	9.4		
	SD	3.5		

Table 1 (Continued)

Variables		Male	Female	Couple
Follicle Stimulating Hormone (FSH) (miu/ml)	M	24.1		
	SD	12.9		
Luteinizing Hormone (LH) (ng/ml)	M	11.9		
	SD	5.5		
Occupation				
	Business	4 (25%)	-	
	Professional	1 (6%)	4 (25%)	
	Skilled Labor	7 (44%)	-	
	Sales	4 (25%)	1 (6%)	
	Secretarial	-	6 (38%)	
	Homemaker	-	5 (31%)	

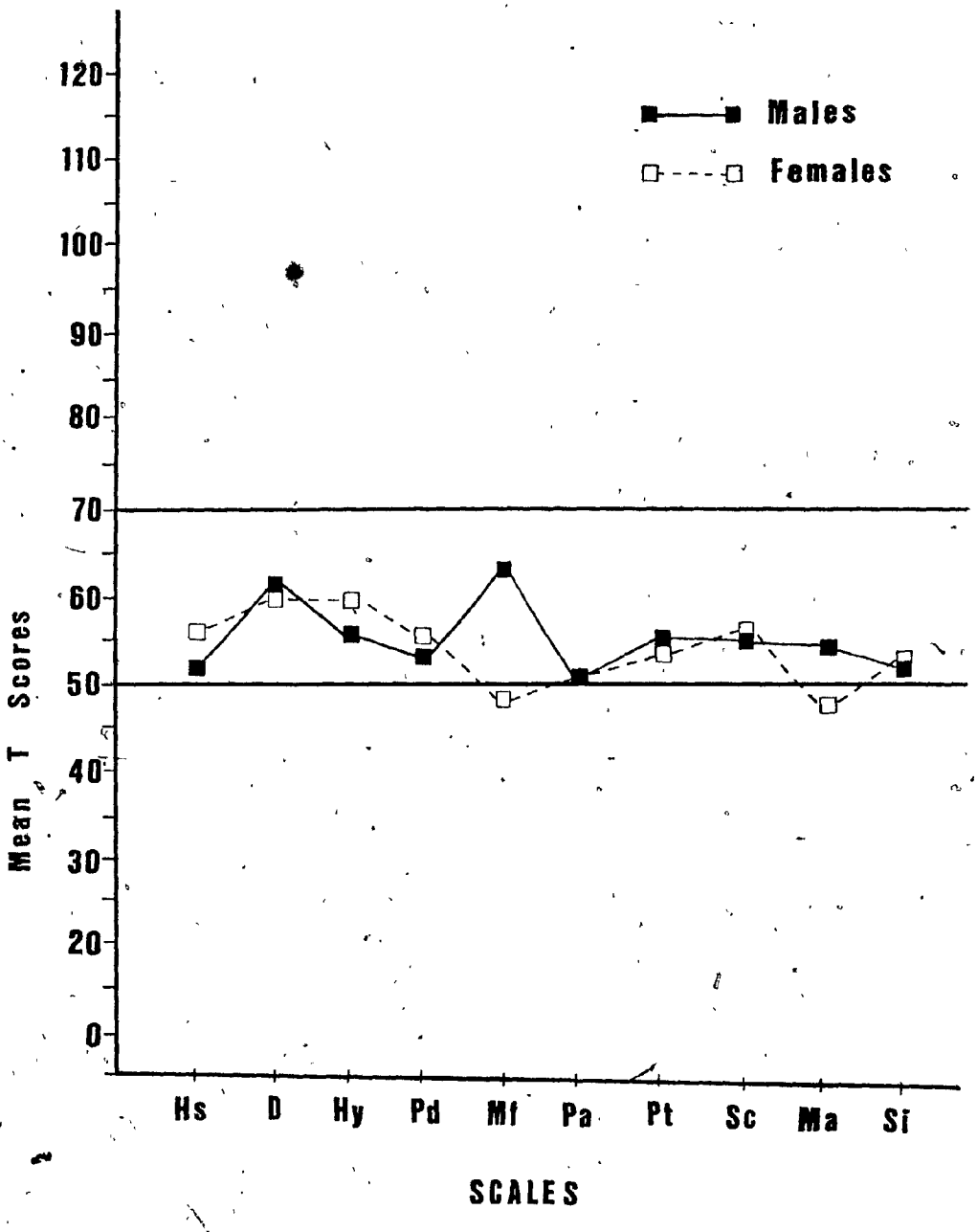

FIGURE 1: Mean T Score Profile on MMPI

one month apart; pre-treatment 1, pre-treatment 2, post-treatment and one month following treatment. The daily record-keeping forms were filled out by subjects throughout the program and were summed and analyzed at three time periods; baseline, treatment and follow-up (2 x 3 design).

Descriptive statistics to portray couples' general patterns of sexual behavior prior to treatment, were based on the first month of the daily, self-administered record-keeping forms.

An Analysis of Variance with repeated measures was computed on various sexual and marital dependent variables to test for group, time and interaction effects. Differential effects of the two treatments could be attributable to the ban component of the Ban-Communication condition or a ban-communication combination since both groups received the identical communication instruction.

A Stepwise Discriminant Analysis was performed to determine the constellation of pre-treatment sexual, marital, personality and hormonal measures that best predicted success or failure in symptom remission one month following treatment.

Measures

Questionnaire Measures

Eight paper and pencil, self-report test instruments were administered to all subjects, individually, in the following sequence:

(1) Minnesota Multiphasic Personality Inventory-Form R (MMPI) (Hathaway & McKinley, 1967). This test was included in the battery to objectively assess major personality characteristics that affect personal and social adjustment. The data which has been reported on the reliability and validity of the MMPI appear to be quite satisfactory

(Hathaway & McKinley, 1967).

(2) Marital Adjustment Scale-Short Form (MAS) (Locke & Wallace, 1959). This widely used test consists of 15 bipolar items. It provides a measure of marital adjustment including marital compatibility and marital satisfaction. Scores can range from two to 158, with higher scores indicating greater marital adjustment, a score of 100 being the norm. A copy of the MAS appears in Appendix B. The MAS has a reported reliability of .90 computed by the split-half technique. Locke and Wallace (1959) reported as evidence of validity that their instrument was able to discriminate between well-adjusted and maladjusted couples with minimal overlap in the two groups.

(3) Sexual History Form (SHF) (Nowinski & LoPiccolo, 1979). This 28-item questionnaire is designed to obtain basic data on sexual functioning. Four of the 28 questions were selected for analysis because of their particular relevance to the interest of this study. These include frequency of difficulty obtaining an erection, frequency of difficulty maintaining an erection, duration of sexual foreplay, and overall satisfaction with the sexual relationship. A copy of this questionnaire is presented in Appendix C.

(4) Sexual Interaction Inventory (SII) (LoPiccolo & Steger, 1974). This instrument consists of a list of 17 heterosexual behaviours. For each behaviour, couples answer six questions using a 6-point scale. The totals from each spouse are used to derive an 11 scale profile. The scales assess for each spouse (a) Frequency Satisfaction; derived by totaling across all 17 items, the differences between ratings of current frequency for each activity and the desired frequency for each activity. A high score indicates dissatisfaction with the range and/or

frequency of sexual activities; (b) Self-Acceptance; derived by totaling differences between ratings of current pleasure obtained from each activity and pleasure desired from each activity. A high score indicates dissatisfaction with the degree of pleasure currently obtained from sexual activity; (c) Pleasure Mean; derived by summing ratings of pleasure obtained from each activity and dividing by the number of sexual activities practiced. A low score indicates low enjoyment of sexual activities; (d) Perceptual Accuracy; derived by summing differences in partner's self-report of pleasure and spouses ratings of their partner's pleasure in those sex acts practiced by the couple. High scores indicate that the partners do not effectively communicate their sexual tastes and preferences; (e) Partner Acceptance; derived by summing differences in the perception of partner's responsiveness and desired partner responsiveness. A high score indicates dissatisfaction with partner's perceived responsiveness; (f) The last scale is an overall summary scale. It is derived by totaling all of the raw difference scores of the other scales for each spouse (excluding Pleasure Mean). This score is a measure of the total disharmony and dissatisfaction in the sexual relationship. Appendix D presents a copy of this questionnaire.

Norms for the Sexual Interaction Inventory were based on the scores obtained from two samples totaling 124 couples free from sexual dysfunction (LoPiccolo & Steger, 1974). The test-retest reliability, computed using a sample of 15 sexually dysfunctional couples, ranged in values from .67 to .90 for the 11 scales. Cronbach's alpha coefficient for measuring internal consistency ranged from .80 to .93. Convergent validity was evaluated by correlating each scale score with

couples' simple self-reports of sexual satisfaction. All correlations were in the predicted direction and nine out of 11 were significant at the .05 level or better. The SII discriminated between 28 couples suffering from sexual dysfunction and sexually satisfied couples. In addition, comparison of the pre- and post-treatment scores indicated that all 11 of the scales were sensitive to treatment effects.

(5) Sexual Behaviour Questionnaire (SBQ). This questionnaire was developed for the present study and examines the following areas: satisfaction with sexual communication between partners, amount of interfering thoughts, erectile functioning, and arousal in the female during sexual activity. No data on the psychometric properties of this questionnaire are available. A copy of this questionnaire appears in Appendix E.

(6) Goals for Sex Therapy (Goals) (Lobitz & Baker, Jr., 1979). This instrument was administered to males only. This 15-item questionnaire was developed specifically to assess changes in the male's evaluation of his erectile functioning as a result of treatment. Total scores range from 15-105. A copy of this test appears in Appendix F. Though test reliability has not been reported, the authors found this measure to be sensitive to changes in response to group treatment for single men experiencing erectile difficulties. In addition, Price and his colleagues (Price et al, 1981) found that this instrument discriminated between men who received group treatment and men who were on a waiting list.

(7) Erection Difficulty Questionnaire (EDQ) (Reynolds, Note 3). This test was also administered to males only. It includes 24 items on the frequency of occurrence of erection difficulties and attitudinal and behavioural reactions to this disorder. Scores range from 24 (good

functioning) to 120 (poor functioning). A copy of the EDQ is presented in Appendix G.

Though no reliability information has been reported, this instrument has demonstrated convergent validity (Price et al, 1981). Significant correlations were found between pre- and post-treatment change scores on the EDQ and client reports of both global improvement in erectile functioning and frequency of erection difficulties before and during intercourse. Significant correlations were also found between laboratory erectile response measures following treatment and pre- to post-treatment change scores on the EDQ. The EDQ also showed appropriate changes in subjects who received biofeedback training for erectile failure (Reynolds, Note 1).

(8) Improvement Questionnaire (Reynolds, Note 3). This instrument consists of three questions developed by Reynolds to accompany the Erection Difficulty Questionnaire. Subjects are asked to rate their degree of improvement in erection ability, sexual self-concept and overall self-concept. A copy of the Improvement Questionnaire appears in Appendix H.

This battery of eight test instruments were administered to evaluate functioning in three distinct domains; marital, sexual and personality functioning.

Record Keeping Form

Subjects were required to complete structured, diary-like record forms detailing their sexual activities over the past 24 hours. These self-administered forms include items on frequency and enjoyment of a variety of sexual activities, satisfaction with partner and affectional behaviour, number of orgasms, and drug and alcohol consumption rates.

In addition, males rated the quality and number of erections obtained during each sexual activity and overall concern about erection ability during sexual activity. A copy of the record-keeping form appears in Appendix I.

Eleven variables from the record forms were selected apriori for analysis. These included:

(1) Sexual Encounter Frequency: This score was derived by summing the number of sexual encounters engaged in over the total number of days. A sexual encounter was defined as at least one of the activities from k to r in question 1 of the record-keeping form. (Appendix I)

(2) Masturbation Frequency. This scale is the number of times masturbation (activity c) was engaged in over the total number of days.

(3) Intercourse Frequency. This score is the number of times intercourse (activity r) was engaged in over the total number of days.

(4) Quality of Sexual Experience. This score was derived by summing the responses to question 3 each time a sexual encounter occurred and dividing it by the number of encounters. Question 3 pertains to feelings about ongoing sexual experiences.

(5) Orgasmic Frequency. This score is the number of orgasms experienced divided by the number of sexual encounters.

(6) Affection Satisfaction. This score was derived by summing the responses to question 6 and dividing by number of days. Question 6 refers to the level of satisfaction with affectional behaviour.

(7) Feelings Toward Partner. This score was derived by summing the responses to question 7 and dividing by number of days. Question 7 pertains to spouses' feelings toward their partners.

(8) General Erection Quality. This score was derived by summing the

highest rating for question 8 associated with each sexual encounter (i.e., maximum erection obtained) and dividing by the number of encounters. Question 8 pertains to the quality of erection achieved for each sexual activity and ranges from 1 (no erection at all) to 7 (full erection).

(9) Erection Quality in Intercourse. This score was derived by summing the rating of question 8 for intercourse and dividing by the number of times intercourse occurred.

(10) Concern Regarding Erection. This score was derived by summing the ratings for question 9 and dividing by the number of sexual encounters. Question 9 pertains to males' overall concern with erection getting while engaging in sexual activity.

(11) Success:Experience Ratio. This score represents the percentage of successful sexual encounters that occurred in all sexual interactions. It was computed by dividing the number of successful sexual encounters, i.e., attained and maintained a satisfactory erection (a rating of 6 or 7 on question 8) until orgasm, by the total number of sexual encounters, for each male subject. This score was computed at the end of the baseline phase and at the end of the follow-up phase. A judgement of success or failure in the treatment program was subsequently made based on the success:experience ratio. A subject was judged a success in treatment when at follow-up the success:experience ratio equaled or was greater than 75% indicating the subject was successful on at least 75% of the occasions in which sexual encounters occurred. Subjects who were not experiencing successful sexual encounters at least 75% of the time were categorized as failures. Auerbach and Kilmann (1977) found the reliability of this ratio was verified by independent records by the

sexual partner. The success:experience ratio has been shown to be sensitive to treatment and post-treatment changes (Obler, 1973; Reynolds, Note 1).

Laboratory Examination

The endocrinological examination carried out on all male subjects consisted of the measurement of serum testosterone (normal, between 300-1200 ng/dl); serum luteinizing hormone (LH) (normal, less than 20 miu/ml); prolactin (normal, less than 25 ng/ml); and follicle stimulating hormone (FSH) (normal, between 5-20 miu/ml) levels.

Procedure

Three recruitment strategies were employed to obtain subjects. These were carried out with the cooperation of the Sexual Dysfunction Service at the Jewish General Hospital in Montreal.

(1) Sexual Dysfunction Service: Appropriate couples already on the waiting list of the Sexual Dysfunction Service were informed that in addition to its normal treatment program, the service was participating in a study evaluating short-term sex therapy techniques. Couples were given the option of remaining on the waiting list until a staff therapist was available, or of participating in this study, for a period of approximately four and one half months which might also serve to improve their sexual functioning. Subjects were informed that while taking part in the study, they would retain their position on the waiting list and thereby could begin regular therapy through the Service shortly after completion of the study, if they so desired.

(2) Media Advertisements: Advertisements were placed periodically in four local newspapers describing the purpose of the study and the problem under investigation. In addition, announcements appeared on

community bulletin radio broadcasts.

(3) Solicitations from Medical Community: Letters were sent to urologists, gynecologists and general practitioners in the Montreal area requesting referrals. In addition, printed cards describing the study were left in the waiting room of cooperating doctors.

Subjects who were obtained by one of these recruitment strategies, but who did not meet the screening criteria, were referred to the hospital sex therapy service of their choice for appropriate treatment.

Subjects were screened initially on the telephone, by the investigator, to ensure that major selection criteria were met. Appropriate couples were asked to come to the hospital and complete the MMPI and the Locke-Wallace Marital Adjustment Scale. These questionnaires were administered by the Service secretary and formed part of its regular assessment battery. Appointments were then arranged with couples whose scores on these tests indicated appropriateness for participation. The initial meeting between the couple and the investigator consisted of a 30-minute interview which completed the screening process and enabled the collection of more detailed information on the couple's sexual functioning. A copy of the interview protocol appears in Appendix J.

The objectives and requirements of the study were explained at this time. Couples were informed that the project was designed to evaluate the effectiveness of two treatment techniques commonly used in sex therapy. They were told that they would receive one of two therapeutic instructions aimed at improving their sexual functioning. Complete confidentiality was guaranteed to all participants. Couples were also told that no fee was required, but in order to maximize their motivation for completing the program, consenting couples were required

to furnish a refundable penality deposit of $50.00. This deposit would be refunded if they withdrew within 15 days of starting the program or when they completed the program. In addition, in cases where special circumstances arose which interfered with the couples' continued participation, the deposit would be refunded, e.g., medical or marital complications. Individual spouses were free to contact the investigator if problems occurred during the course of the program. In cases where a question developed concerning the advisability of a couple continuing in the project, the investigator consulted with a Service therapist. The final decision as to whether a couple should remain in the project rested with the Service staff. This procedure provided a safeguard against experimenter bias. In cases where it was judged inadvisable for a couple to continue, appropriate referrals were arranged. A total of 3 participants were actually counselled to withdraw from the study.

As each couple entered the study they were randomly assigned to one of two experimental groups. In two meetings, one week apart, the paper and pencil self-report test instruments, measuring sexual and marital adjustment, were administered. All questionnaires were filled out individually, without collaboration between partners. In addition, the male subjects underwent an endocrinological and physical examination for purposes of the study. This examination, carried out within two weeks of the first interview by one of the two endocrinologists available, was designed to screen out medical complications that might be contributing to the erectile dysfunction and to obtain information on hormone levels in the sample.

Following completion of the questionnaires, each subject was given 28 self-administered record-keeping forms with four stamped, self-

addressed envelopes. Couples were required to independently monitor their sexual behaviour daily and to mail the forms in on a weekly basis. Instruction on how to fill out these forms was thorough and detailed. It was explained to each couple that the record form was necessary to obtain current information on their daily sexual functioning before therapeutic intervention took place. At this time, an appointment was arranged for one month later.

At the end of the one month baseline phase, couples again filled out the battery of questionnaires in two visits. The Improvement Questionnaire was added to the test battery examining any change in couples' sexual or personal life over the preceding four weeks. At the end of the second visit, one week later, couples were interviewed to ensure that problems had not arisen that would make continuation with the program inadvisable. During these interviews, discussions concerning sexual attitudes, or more general sexual feelings were avoided. Subjects completed the test battery before the clinical interview to avoid any clinician influence which might develop as a result of the interview. At the end of the interview, each subject was given a written copy of their experimental instructions which they read in the office. Questions pertaining to the instructions were answered at this time.

The Ban-Communication Group was instructed to refrain from engaging in or attempting to engage in intercourse for a period of one month. They were advised instead to engage in forms of sexual activity other than intercourse. It should be noted that because some couples were not actively engaging in intercourse at the time they began treatment, the instruction to ban intercourse included the restriction from even

attempting to engage in intercourse. In addition, this group was instructed to work on communicating their sexual likes and dislikes to their partners during non-coital sexual activity. The written instructions also provided a rationale for this exercise. (The instructions for the Ban-Communication Group appear in Appendix K).

The Communication-Only Group received instructions to work on communicating their sexual likes and dislikes to their partners during sexual activity for a period of one month. The merits of this recommendation were also presented. No instruction prohibiting sexual intercourse was given to this group. In addition, background information on sexual problems in general was provided, to equate the length of the written instructions in each group. The communication instructions were identical for each group. Both groups were given the expectation that they would improve. (See Appendix L for a copy of the instructions given to the Communication-Only Group).

Couples in each group were provided with a written copy of the instructions for review at home.

During the treatment phase each subject was again provided with 28 record-keeping forms and four stamped, self-addressed envelopes. They were required to continue filling them out daily and mail them back weekly. Subjects were told that this would allow the investigator to follow their progress on a continuous basis. At this time an appointment was arranged for one month later.

Following the treatment phase, subjects again completed the battery of questionnaires in two sessions, one week apart. During the second appointment, couples were again interviewed regarding critical problems that might have arisen over the past month. At this time they were told

that they could now resume their normal style of love-making. The ban on intercourse with emphasis on other sexual activities and the communication exercise were no longer necessary if they so chose. Couples were required to continue monitoring their sexual activities for two more weeks, using the record-keeping forms. Self-monitoring was only required for the first two weeks of the four week follow-up period, so that couples would be free from any intervention by the end of the program.

After a one month follow-up period, couples once again completed the test battery. At this time their $50.00 deposit was returned and options regarding continuation of treatment were discussed.. Appropriate arrangements were subsequently instituted. Couples not continuing with sex therapy were given a self-help book entitled: "Male Sexuality" by B. Zilbergeld (1978), on completion of the project. Couples were encouraged to call the investigator if they encountered difficulties in the future.

Throughout the course of the study, the record-keeping forms provided information on couple's daily pattern of sexual behaviours and served as a compliance check for the Ban-Communication Group.

Laboratory Examination: The endocrine examination was carried out on all male subjects by an endocrinologist. Blood samples were taken between 7:30 and 2:30 by venipuncture. The samples were immediately centrifuged and serum was frozen until assayed. All samples were measured by radioimmunoassay with each sample being determined in duplicate. Testosterone was measured by a specific double antibody radioimmunoassay following organic solvent extraction, within one week of sample collection. Internal standards were used to monitor recovery.

Results

Sample Characteristics

Equivalence of groups. T-test comparisons of the means of the demographic variables showed no significant differences between the Ban-Communication and Communication-Only Group in a) ages of spouses, b) educational level of spouses, c) duration of relationships, and d) combined annual income. T-test comparisons also yielded no significant differences between the two groups on problem-related and relationship variables associated with the selection criteria. These included: a) problem duration, b) sexual activity frequency, and c) spouse scores on the Marital Adjustment Scale (MAS). T-test comparisons of the group means by gender, on each of the psychological scales of the MMPI revealed no significant differences. No significant differences were found between groups on any of the hormonal measures which included levels of: a) testosterone, b) prolactin, c) luteinizing hormone (LH), and d) follicle stimulating hormone (FSH). Appendix M presents the means, standard deviations and t-test results for each of the demographic, relationship, MMPI, and hormonal variables.

Results of the medical examination showed that seven males were free from any detectable organic abnormalities (four in the Ban-Communication Group; three in the Communication-Only Group). Of the remaining nine men, two were hypertensive, three had one abnormal testicle, three displayed a hormonal pattern suggestive of early primary testicular failure (i.e., low normal testosterone levels and slightly elevated FSH levels), and one male had mild diabetes mellitus. However, in no cases did the endocrinologists judge that an individual's physical

condition was able to account for the erectile disorder.

Subjects' Record-Keeping. The record keeping forms provided descriptive information on the sample's baseline sexual behaviour patterns. This information was obtained from the first question of the males' daily records, accumulated during the one-month baseline phase. (A copy of the record-keeping form appears in Appendix I). Table 2 describes the percentage of the sample that engaged in various sexual activities and the average frequency with which these activities were undertaken. It can be seen, for example, that less than half the males engaged in masturbation and of those who did, the mean frequency was less than once per week. Three-quarters of the males, at baseline, were engaging in sexual intercourse approximately once per week. The majority of males engaged in manual or oral stimulation and erotic fantasizing. Half the sample took part in activities involving reading or viewing erotica. The high standard deviations for each of these mean frequencies, indicate that there was great variability in the sample in terms of their average frequency of engaging in these activities.

Analysis of Variance Results

Overview. The various sexual and marital dependent variables were analyzed using a Balanova program for a mixed model Analysis of Variance (ANOVA) with repeated measures. Mean scores on the test measures for the two treatment groups were compared at four periods separated by one month: Pre-treatment 1, Pre-treatment 2, Post-treatment and Follow-up. Means scores calculated from the record-keeping forms for each group were analyzed at three time periods, each of which represented 14 days of self-monitoring: Baseline, Treatment, and Follow-up. There were

Table 2

Frequency of Sexual Activities

by Percent of Sample

Activity	Sample Percentage (n = 16)	Frequency (per month)	
Intercourse	n = 12 (75%)	M	6.25
		SD	4.5
Manual Stimulation	n = 16 (100%)	M	5.81
		SD	4.2
Oral Stimulation	n = 9 (56.25%)	M	3.78
		SD	3.0
Masturbation	n = 6 (37.5%)	M	3.67
		SD	3.4
Erotic Fantansy	n = 9 (56.25%)	M	7.11
		SD	10.1
Erotica (reading/seeing)	n = 8 (50%)	M	2.63
		SD	3.3

therefore, three main factors in the design: treatment group (A), time (B), and subjects (S). Subjects were nested in treatment group and crossed with time.

Where the results of the ANOVA showed significant effects for the time factor, post-hoc comparisons were performed using the Tukey HSD test to explore the source of the effects (Tukey, 1949). In the case of significant interaction effects, simple main effects tests were performed to examine the source of the interaction, followed by Tukey tests where appropriate.

Male and female data were analyzed separately. Only the results for the male subjects will be reported. T-tests comparisons between groups were performed on all the dependent variables at Pre-treatment 1. No significant differences between the groups on any of the variables were found. Appendix N presents these T-test comparisons for all the test and record form variables. It was concluded that any initial differences observed between the groups were due to random error, and therefore, not meaningful with respect to post-test results.

Test Measures

a) Sexual Functioning

Erectile Ability. Separate ANOVA comparisons were carried out on four variables that assessed changed in erectile behaviour. These included two questions from the Sexual History Form (SHF): frequency of difficulty obtaining erections and frequency of difficulty maintaining erections, and two questions from the Sexual Behaviour Questionnaire (SBQ): the length of time to erection and the quality of erection at ejaculation.

Table 3 presents the group means at the four time periods for the

Table 3

Mean Patings of Erectile Functioning (Sexual History From)

Group (n = 8)	Time Periods			
	Pre-Treatment 1	Pre-Treatment 2	Post-Treatment	Follow-up
	Difficulty Obtaining Erections[1]			
Ban-Communication Group	3.88	3.63	2.75	2.88
Communication-Only Group	4.13	3.75	3.25	3.38
	Difficulty Maintaining Erections[1]			
Ban-Communication Group	5.13	4.12	3.38	2.75
Communication-Only Group	4.98	4.25	3.00	2.88

1. Scale ranges from 6 (occurs "nearly always") to 1 ("never" occurs)

two frequency of erection difficulty questions. Results of the first ANOVA showed a significant time effect in frequency of difficulty obtaining erections, $F(3,42) = 4.795$, $p < .01$ (Appendix O, Table O.1). Post-hoc comparisons using Tukey tests revealed a significant decrease in difficulties between pre-treatment 1 and post-treatment, $Q(4,42) = 4.64$, $p < .05$, and between pre-treatment 1 and follow-up, $Q(4,42) = 4.06$, $p < .05$.

Similarily, a significant time effect was obtained in frequency of difficulty maintaining erections, $F(3,42) = 15.717$, $p < .001$ (Table O.2). Tukey tests indicated a significant decrease between pre-treatment 1 and post-treatment scores, $Q(4,42) = 7.62$, $p < .01$, pre-treatment 1 and follow-up scores, $Q(4,42) = 8.76$, $p < .01$, and between pre-treatment 2 and post-treatment scores, $Q(4,42) = 4.0$, $p < .05$, and pre-treatment 2 and follow-up scores, $Q(4,42) = 5.51$, $p < .01$.

Table 4 presents the group means at the four testing periods for the two questions from the Sexual Behaviour Questionnaire. Results of the ANOVA on the length of time to erection showed no significant group, time or interaction effects. (Table O.3).

With respect to quality of erection at ejaculation, a significant time effect was obtained, $F(3,42) = 15.508$, $p < .001$ (Table O.4). Tukey tests showed significant improvement occurred between pre-treatment 1 and post-treatment, $Q(4,42) = 5.40$, $p < .01$, pre-treatment 1 and follow-up, $Q(4,42) = 9.0$, $p < .01$; and between pre-treatment 2 and follow-up, $Q(4,42) = 6.90$, $p < .01$. The means for the quality of erection at ejaculation indicate that both groups were ejaculating with partial erection at baseline (a rating of 4), but by follow-up, ejaculation occurred with almost full erections (a rating of 6).

Table 4

Mean Ratings of Erectile Functioning (Sexual Behavior Questionnaire)

Group (n = 8)	Time Periods			
	Pre-Treatment 1	Pre-Treatment 2	Post-Treatment	Follow-up
	Quality of Erection at Ejaculation[1]			
Ban-Communication Group	4.25	4.88	5.88	6.50
Communication-Only Group	4.63	4.88	5.25	6.13
	Time to Obtain Erection[2]			
Ban-Communication Group	2.63	3.00	2.38	2.13
Communication-Only Group	3.25	2.88	2.88	2.67

1. Scale ranges from 1 (flaccid) to 7 (full erection)

2. Scale ranges from 1 (0 - 2 minutes) to 5 (11 minutes or longer)

Two questionnaires, the Erection Difficulty Questionnaire (EDQ) and Goals for Sex Therapy (Goals) assessed degree of improvement both in frequency of behaviours associated with erectile functioning and in attitudinal and evaluative reactions to the disorder. The group means for these two questionnaires appear in Table 5.

The EDQ revealed a significant time effect, $F(3,42) = 23.557$, $p < .001$ (Table 0.5). Tukey tests indicated that a decrease in frequency of negative attitudes and problem perception occurred in the treatment phase and was maintained at follow-up. Specifically, pre-treatment 1 scores were found to be significantly different from those at post-treatment, $Q(4,42) = 7.71$, $p < .01$, and from those at follow-up, $Q(4,42) = 10.99$, $p < .01$; and pre-treatment 2 scores were significantly different from those at post-treatment, $Q(4,42) = 4.4$, $p < .05$, and from those at follow-up, $Q(4,42) = 7.68$, $p < .01$.

Goals for Sex Therapy measured satisfaction with a number of behaviours associated with erectile ability and general sexual functioning. ANOVA results, again, revealed significnat improvement over time in both groups, $F(3,42) = 14.34$, $p < .001$ (Table 0.6). Consistent with the other measures, post-hoc comparisons showed a significant difference between pre-treatment 1 and post-treatment, $Q(4\ 42) = 5.27$, $p < .01$, pre-treatment 1 and follow-up, $Q(4,42) = 7.84$, $p < .01$, and between pre-treatment 2 and post-treatment, $Q(4,42) = 4.74$, $p < .01$, and pre-treatment 2 and follow-up, $Q(4,42) = 7.31$, $p < .01$. These changes signify that both groups showed improvement in satisfaction level at treatment and maintained this level at follow-up.

In summary, the changes on these tests indicate improvement from pre-treatment to post-treatment in specific erectile abilities and in

Table 5

Mean Scores on Erection Difficulty Questionnaire and Goals for Sex Therapy

Group (n = 8)	Time Periods			
	Pre-Treatment 1	Pre-Treatment 2	Post-Treatment	Follow-up
	Erection Difficulty Questionnaire[1]			
Ban-Communication Group	74.50	68.88	60.00	52.50
Communication-Only Group	66.75	60.13	52.75	48.13
	Goals for Sex Therapy[2]			
Ban-Communication Group	46.63	48.13	67.38	78.63
Communication-Only Group	51.00	52.63	61.00	64.75

1. Scale ranges from 120 (poor functioning) to 24 (good functioning)

2. Scale ranges from 15 (much less than satisfied) to 105 (much more than satisfied)

attitudes and satisfaction levels associated with erectile functioning.

2) General Sexual Functioning. Two items on the Sexual History Form measured duration of sexual foreplay and satisfaction with the sexual relationship. Table 6 presents the group means at the four time periods for these two questions. The results of the ANOVA did not show any significant group, time or interaction effects in the length of time couples spent in sexual foreplay. (Table O.7). ANOVA findings for the question regarding overall satisfaction with the sexual relationship showed a significant time effect, $F(3,42) = 4.314$, $p < .01$ (Table O.8). Tukey tests revealed a significant increase between pre-treatment 1 and post-treatment, $Q(4,42) = 4.84$, $p < .01$. However, the other time periods were not found to be significantly different from each other. One question on the Sexual Behaviour Questionnaire concerned the occurrence of thoughts that could disrupt sexual activity. Group means for this variable appear in Table 7. The ANOVA on interfering thoughts produced a significant time effect, $F(3,42) = 3.049$, $p < .05$ (Table O.9). Tukey tests showed that a decrease occurred between pre-treatment 2 and follow-up, $Q(4,42) = 4.20$, $p < .05$. The group means in Table 7 suggest that both groups actually increased slightly in the amount of distressing thoughts experienced between the pre-treatment periods, and subsequently decreased at the end of treatment and at follow-up.

The Sexual Interaction Inventory (SII) is divided into five subscales for the males and includes an overall summary scale that measures disharmony in the sexual relationship. This summary scale is derived by summing the subscales of both spouses. Group means for the SII scale appear in Table 8. The first subscale measuring satisfaction

Table 6

Mean Ratings of General Sexual Functioning (Sexual History Form)

Group (n = 8)	Time Periods			
	Pre-Treatment 1	Pre-Treatment 2	Post-Treatment	Follow-up
	Duration of Sexual Foreplay[1]			
Ban-Communication Group	3.88	4.13	4.13	4.00
Communication-Only Group	4.13	4.88	4.75	4.88
	Satisfaction with Sexual Relationship[2]			
Ban-Communication Group	2.63	3.63	3.75	3.88
Communication-Only Group	3.38	4.63	5.25	4.25

1. Scale ranges from 1 (less than one minute) to 7 (30 minutes to one hour)
2. Scale ranges from 1 (extremely unsatisfactory) to 6 (extremely satisfactory)

Table 7

Mean Ratings of Amount of Interfering Thoughts (Sexual Behaviour Questionnaire)

Group (n = 8)	Time Periods			
	Pre-Treatment 1	Pre-Treatment 2	Post-Treatment	Follow-up
	Amount of Interfering Thoughts[1]			
Ban-Communication Group	3.60	4.50	3.25	2.25
Communication-Only Group	2.88	3.75	3.50	3.38

1. Scale ranges from 1 (none) to 7 (many)

Table 8

Mean Scores on Sexual Interaction Inventory

Group (n = 8)	Time Periods			
	Pre-Treatment 1	Pre-Treatment 2	Post-Treatment	Follow-up
	Sexual Frequency Satisfaction[1]			
Ban-Communication Group	27.25	24.13	24.75	20.00
Communication-Only Group	21.00	27.00	21.63	18.75
	Self-Acceptance[2]			
Ban-Communication Group	6.13	4.38	4.25	2.50
Communication-Only Group	7.13	6.88	9.25	8.63
	Sexual Pleasure Mean[3]			
Ban-Communication Group	5.49	5.51	5.56	5.63
Communication-Only Group	4.99	5.24	5.09	5.09
	Perceptual Accuracy[4]			
Ban-Communication Group	12.25	12.75	9.63	10.38
Communication-Only Group	13.00	15.13	11.25	10.75

Table 8 (Cont'd)

Mean Scores on Sexual Interaction Inventory

Group (n = 8)	Time Periods			
	Pre-Treatment 1	Pre-Treatment 2	Post-Treatment	Follow-up
	Mate Acceptance[5]			
Ban-Communication Group	17.00	17.25	12.50	13.88
Communication-Only Group	7.25	9.50	9.38	11.00
	Summary Scale[6]			
Ban-Communication Group	117.13	101.13	92.75	88.50
Communication-Only Group	102.75	104.13	99.38	89.13

1. Scale ranges from 46 (poor functioning) to 0 (good functioning)
2. Scale ranges from 24 (poor functioning) to 0 (good functioning)
3. Scale ranges from 23 (poor functioning) to 6.0 (good functioning)
4. Scale ranges from 41 (poor functioning) to 5 (good functioning)
5. Scale ranges from 45 (poor functioning) to 0 (good functioning)
6. Scale ranges from 217 (poor functioning) to 0 (good functioning)

with frequency of sex was found to be significant with respect to time, $F(3,42) = 3.296$, $p < .05$ (Table 0.10). Post-hoc Tukey tests revealed a significant decrease in dissatisfaction between pre-treatment 2 and follow-up, $Q(4,42) = 4.25$, $p < .05$. Examination of group means in Table 8 suggests that the major decrease in dissatisfaction with frequency of sexual activities occurred in the follow-up period, for both groups.

Results of the ANOVA on the Pleasure Mean subscale showed a significant group effect in favour of the Ban-Communication Group $F(1,14) = 4.54$, $p < .05$ (Table 0.11). Examination of the group means for the Please scale, indicate that the Ban-Communication Group derived greater pleasure from sexual activity than the Communication-Only Group at all four time periods. However, the means for both groups fell within one standard deviation of the norms provided for this scale.

The Perceptual Accuracy subscale of the SII measures males' knowledge of their spouses sexual preferences. This scale was found to be significant with respect to time, $F(3,42) = 4.16$, $p < .05$ (Table 0.12). Tukey tests showed that the pre-treatment 2 scores were significantly different from those at post-treatment, $Q(4,42) = 4.21$, $p < .05$, and follow-up $Q(4,42) = 4.06$, $p < .05$.

No significant group, time or interaction effects were found on the remaining subscales of Self-Acceptance (Table 0.13) and Mate Acceptance of sexual responsiveness (Table 0.14).

The Summary Scale of the SII measuring couple disagreement showed only a signficant time effect, $F(3,42) = 4.876$, $p < .01$ (Table 0.15). Tukey tests indicated a significant decrease in disagreements between

pre-treatment 1 and follow-up, $Q(4,42) = 5.17$, $p < .01$. The group means presented in Table 8 for this variable suggest a gradual improvement at each testing period, which reached significance by the time of follow-up.

In summary, both groups made gains with respect to thoughts that disrupted sexual activity, in overall satisfaction with the sexual relationship, and in overall disagreement between spouses about their sexual relationship, specifically in the areas of sexual frequency satisfaction and knowledge of sexual preferences.

b) Marital Functioning

Table 9 presents the group means for the Marital Adjustment Scale (MAS). Results of the ANOVA conducted on the MAS showed a significant time effect, $F(3,42) = 4.333$, $p < .01$ (Table O.16). Tukey test procedures performed on combined group means found a significant difference between pre-treatment 1 and follow-up scores, $Q(4,42) = 4.74$, $p < .01$, and between pre-treatment 2 and follow-up scores, $Q(4,42) = 3.99$, $p < .05$. As can be seen from the means on Table 9, subjects made the most gains in marital adjustment in the follow-up period.

c) Sexual Communication Ability

Sexual communication was evaluated separately because of its importance in both treatment instructions. Three questions in the Sexual Behaviour Questionnaire measured communication effectiveness. The first question pertained to the male's awareness of his partner's sexual likes and dislikes; the second concerned the male's perception of his partner's knowledge of his sexual tastes and preferences. The final question, inquired into the male's satisfaction with couple

Table 9

Mean Scores on Marital Adjustment Scale

Group (n = 8)	Time Periods			
	Pre-Treatment 1	Pre-Treatment 2	Post-Treatment	Follow-up
	Marital Adjustment Scale[1]			
Ban-Communication Group	110.38	113.88	115.88	122.88
Communication-Only Group	96.00	95.63	97.88	103.38

1. Scale ranges from 2 (maritally disturbed) to 158 (maritally adjusted)

sexual communication techniques. Group means for these communication questions appear in Table 10.

ANOVA results showed no significant group, time or interaction effects on any of these variables. (Tables 0.17, 0.18, 0.19). As can be seen from the group means, males rated communication skills at above the mid-point of the scale from the start of the program and maintained this rating throughout the course of the program. Therefore, the only measure of sexual communication that was found to improve significantly over time was the SII Perceptual Accuracy subscale, reported earlier, that pertained to males' accuracy in estimating partners' enjoyment of a variety of sexual activities.

d) Ratings of Improvement

The Improvement Questionnaire measured gains in three areas: a) erectile ability, b) sexual self-concept, and c) personal self-concept. This questionnaire was administered at three testing periods only: pre-treatment 2, post-treatment and follow-up. Group means for the Improvement Questionnaire are presented in Table 11. At follow-up testing, 14 of the 16 males felt their erectile ability had improved somewhat. Of these, 11 rated their improvement as considerable or complete. One subject felt 'no change' had occurred, and another felt he was 'worse' off than before the program began. The ANOVA computed on ratings of improvement in erection ability showed there was no significant group, time or interaction effects. (Table 0.20). Examination of the group means in Table 11, indicates that both groups initially reported mild improvement (a rating of 1) at pre-treatment 2 and maintained this level at follow-up.

On the question evaluating improvement in sexual self-concept, at

Table 10

Mean Ratings of Sexual Communication (Sexual Behaviour Questionnaire)

Group (n = 8)	Time Periods			
	Pre-Treatment 1	Pre-Treatment 2	Post-Treatment	Follow-up
	Knowledge of Sexual Likes and Dislikes[1]			
Ban-Communication Group	5.38	5.50	5.63	5.88
Communication-Only Group	5.88	6.38	5.75	6.00
	Perception of Partner's Knowledge of Sexual Likes and Dislikes[1]			
Ban-Communication Group	5.00	5.13	4.88	5.50
Communication-Only Group	5.25	4.88	5.13	4.88
	Satisfaction with Sexual Communication[2]			
Ban-Communication Group	4.63	4.63	4.88	5.38
Communication-Only Group	4.50	4.38	4.38	4.75

1. Scale ranges from 1 (do not know them at all) to 7 (know them very well)
2. Scale ranges from 1 (not satisfied at all) to 7 (very satisfied)

Table 11

Mean Ratings on Improvement Questionnaire

Group (n = 8)	Time Periods		
	Pre-Treatment 2	Post-Treatment	Follow-up
	Improvement in Erectile Ability[1]		
Ban-Communication Group	.88	1.75	1.63
Communication-Only Group	1.00	1.25	1.38
	Improvement in Sexual Self-Concept[1]		
Ban-Communication Group	.75	1.50	1.50
Communication-Only Group	.75	1.25	1.37
	Improvement in Self-Concept[1]		
Ban-Communication Group	1.00	1.12	1.37
Communication-Only Group	.38	1.00	.75

1. Scale ranges from +3 (complete improvement) to 0 (no change) to -1 (worse than before)

follow-up, the same 14 males felt they had made some improvement. Eleven of these reported their improvement rate as considerable or complete. The same one subject felt he had made no improvement, and the other felt he had regressed from when he had started the program. ANOVA results on the sexual self-concept variable found a significant effect over time for both groups, $F(2,28) = 4.246$, $p < .05$ (Table O.21). Tukey tests found a significant increase in judgements of improvement between pre-treatment and follow-up, $Q(3,28) = 3.73$, $p < .05$.

On the question regarding improvement in general self-concept, 11 of the 16 men, at follow-up, rated themselves as having improved somewhat. Only six of these, felt this improvement was considerable. Results of the ANOVA found no significant group, time or interaction effects (Table O.22).

Record-Keeping Form Data

Overview. ANOVA's computed on variables monitored on the record-keeping form evaluated change at three time periods: baseline, treatment and follow-up. Because subjects were only required no monitor their sexual activities for the first two weeks in the follow-up period, ratings from the baseline and treatment phases were calculated on only the first two weeks of each respective time period. Duration of monitoring was thereby equated. Only the success: experience ratio was computed using the full 28 days of the baseline period. This variable was analyzed at baseline and follow-up only. One subject from the Communication-Only Group did not fill out the forms in two of the time periods, therefore the maximum number of subjects included in these analyses was 15. In addition, the number of subjects varied for some items because of the inappropriateness of the

question for a particular subject's situation, e.g., erection quality in intercourse could not be computed for subjects who did not engage in intercourse over one of the two-week periods. The record-keeping forms during the treatment phase for the Ban-Communication Group indicated that no couple engaged in intercourse, thereby verifying that the group complied with the ban on intercourse portion of the instructions.

a) Sexual Function

1) Erectile Ability: Three variables specifically related to erectile functioning were computed from males' daily ratings of their sexual activities. These included; general mean erection quality when engaging in sexual activity (unspecified), mean erection quality when engaging specifically in intercourse, and mean level of concern about erections when engaging in sexual activity. Table 12 presents these group means.

ANOVA results showed there were no significant group, time or interaction effects on the two erection quality variables (Tables 0.23, 0.24). It should be noted that because the Ban-Communication Group was abstaining from intercourse during the treatment phase, the mean erection in intercourse variable was analyzed comparing differences at the baseline and follow-up periods only. It can be seen from the means in Table 12 that males reported obtaining only partial erections (a rating of four) during their sexual encounters at baseline and did not make any significant gains by the end of the program. Furthermore, males reported having almost full erections when engaging in intercourse at baseline which did not change at follow-up. It would seem that males attempted intercourse only when they had almost full

Table 12

Mean Scores of Erectile Functioning (Daily Record Forms)

Group	n	Time Periods		
		Baseline	Treatment	Follow-up
		General Erection Quality [1]		
Ban-Communication Group	7	4.54	4.46	5.12
Communication-Only Group	7	4.15	4.35	5.20
		Erection Quality in Intercourse [1]		
Ban-Communication Group	6	6.00	-	6.25
Communication-Only Group	5	5.13	-	5.80
		Concern Regarding Erection [2]		
Ban-Communication Group	7	3.72	3.46	1.98
Communication-Only Group	7	2.75	2.24	1.90

1. Scale ranges from 1 (no erection at all) to 7 (full erection)

2. Scale ranges from 1 (not at all concerned) to 7 (very concerned)

erections.

The only variable that did undergo change was the question pertaining to the concern males felt about getting erections during sexual activity. The ANOVA demonstrated that both groups' concern level showed an effect of time, $F(2,24) = 4.267$, $p < .05$ (Table O.25). Tukey tests comparing the three time periods, found a significant decrease between baseline and follow-up ratings, $Q(3,24) = 4.02$, $p < .05$. In summary, erection quality as measured by daily, self-monitoring was not found to have improved for either treatment group. However, both groups showed a decrease in degree of concern about obtaining erections.

2) General Sexual Functioning: Table 13 presents the group means for the general sexual functioning variables of the record forms. Results of the ANOVA indicated a significant group X time interaction effect on frequency of sexual encounters, $F(2,26) = 3.770$, $p < .05$. Simple main effects tests showed that the Communication-Only Group underwent an increase over the three time periods, $F(2,26) = 3.218$, $p < .06$, whereas the Ban-Communication group did not change (Table O.26). Subsequent Tukey tests, to find the time periods at which the Communication-Only group increased its frequency of sexual encounters, did not reveal any signficant comparisons, probably because the simple main effects test was only marginally significant. However, the graph of the group means for the sexual encounter frequency variable (Figure 2) illustrates that the Communication-Only Group almost doubled their frequency in the treatment phase, compared to the baseline period, and subsequently returned to baseline frequency at follow-up.

Table 13

Mean Ratings of General Sexual Functioning (Daily Record Forms)

Group	n	Time Periods		
		Baseline	Treatment	Follow-up
		Sexual Encounter Frequency[1]		
Ban-Communication Group	8	5.38	4.13	5.75
Communication-Only Group	7	4.29	7.43	4.86
		Noncoital Sexual Encounter Frequency[1]		
Ban-Communication Group	8	5.38	4.13	5.75
Communication-Only Group	7	4.29	4.86	4.86
		Intercourse Frequency[1]		
Ban-Communication Group	8	1.88	-	1.88
Communication-Only Group	7	2.14	-	2.29
		Masturbation Frequency[1]		
Ban-Communication Group	8	.125	1.125	2.625
Communication-Only Group	7	.714	.714	1.143
		Orgasmic Frequency		
Ban-Communication Group	8	.365	.415	.444
Communication-Only Group	7	.323	.369	.529
		Quality of Sexual Experience[2]		
Ban-Communication Group	7	1.009	1.383	.781
Communication-Only Group	6	1.103	.488	1.002

1. Frequency of activity for 14 days

2. Scale ranges from -2 (very negative) to +2 (very positive)

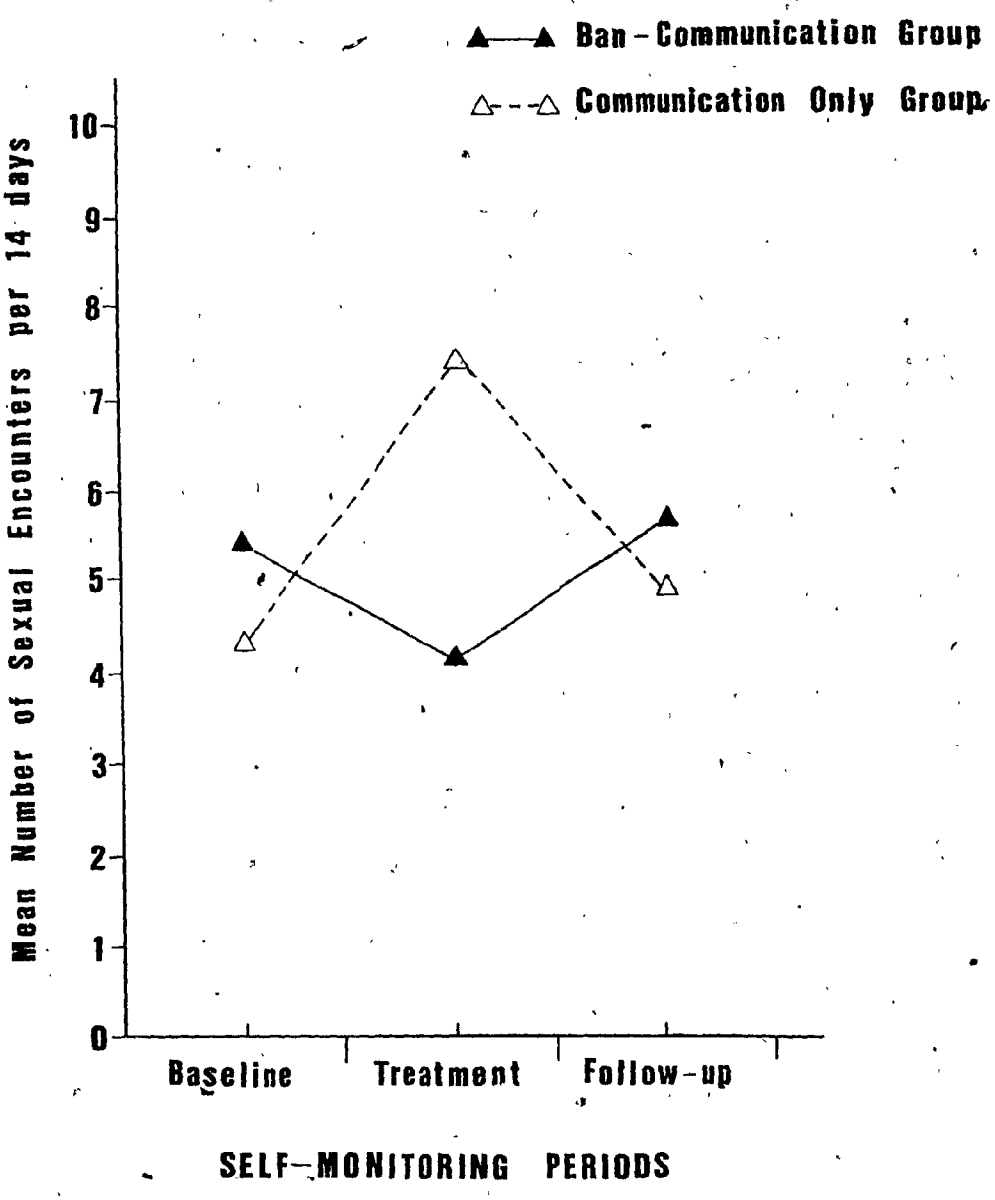

FIGURE 2: Sexual Encounter Frequency

In order to equate the groups for type of sexual activity engaged in (i.e., the Ban-Communication Group was prohibited from engaging in intercourse during the treatment phase), an additional measure was computed. For this variable, the number of times intercourse was engaged in was subtracted from the total number of sexual encounters engaged in during the treatment phase, for the Communication-Only Group. Thus, the two groups were equated for noncoital sexual encounters during the treatment phase. An ANOVA computed on this variable found no significant group, time or interaction effects (Table O.27). The group means in Table 13 reveal that when intercourse was omitted from the treatment period of the Communication-Only Group, their noncoital sexual encounters did not increase in frequency over time, nor did it differ from the frequency reported by the Ban-Communication Group.

ANOVA results also revealed a significant interaction on the measure of how males felt about their ongoing sexual experiences, $F(2,22) = 5.295$, $p < .05$. Simple main effects tests showed there was a significant difference between the two groups' mean ratings at the treatment phase, $F(1,18) = 4.32$, $p < .05$ (Table O.28). Specifically, the Ban-Communication Group rated their sexual experiences as significantly more positive than the Communication-Only Group. The graph of these data (Figure 3) illustrates that the Ban-Communication Group increased slightly in positive feelings, while the Communication-Only Group decreased in positive feelings from baseline to treatment. Both groups returned to baseline levels in the follow-up period.

The results of the ANOVA's showed no significant group, time or interaction effects for intercourse frequency (computed only at

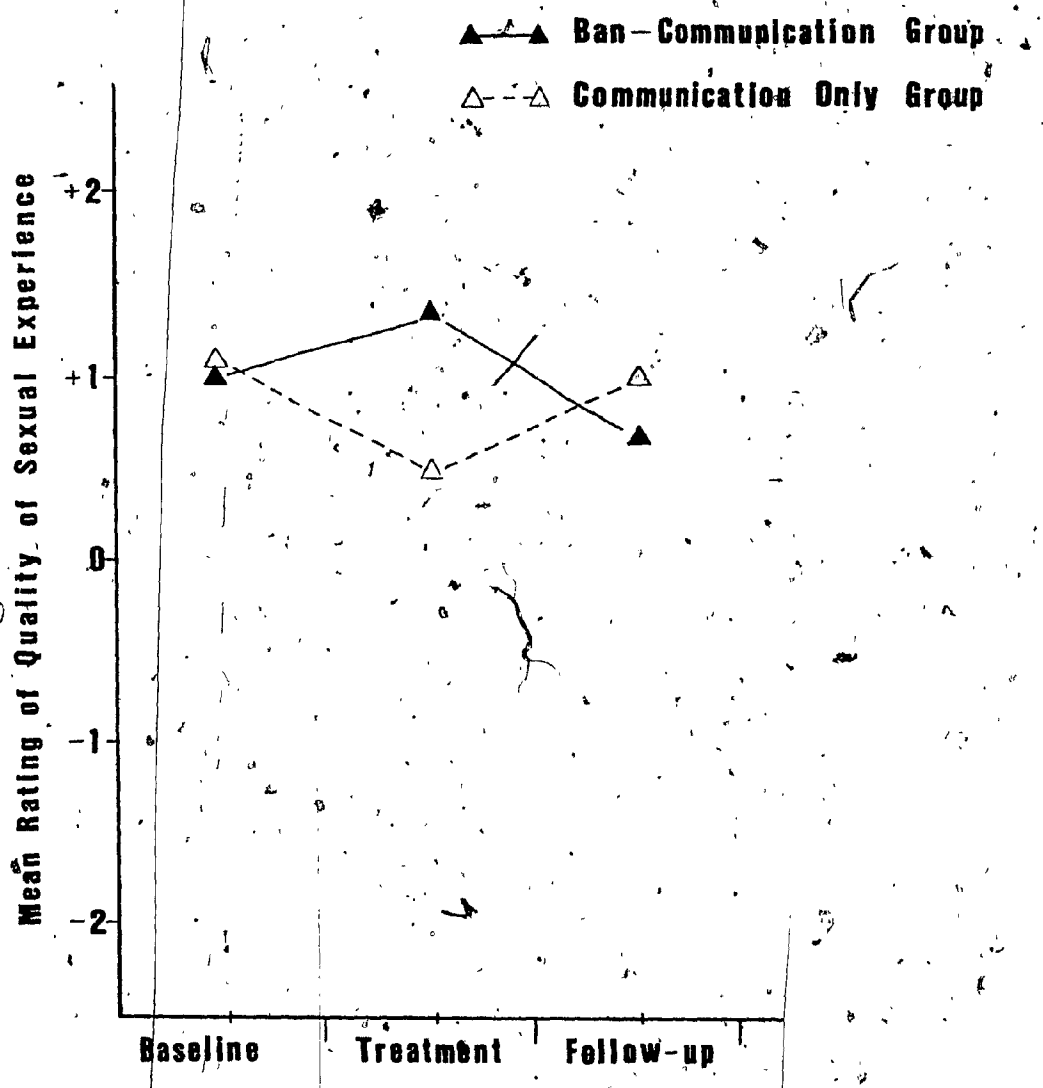

FIGURE 3: Quality of Sexual Experience

baseline and follow-up), masturbation frequency, and orgasmic frequency (Tables 0.29, 0.30, 0.31).

In summary, no improvement in self-monitored rates of intercourse, masturbation or orgasmic frequencies were found for either group. However, significant group X time interaction effects were found in frequency of unspecified sexual encounters and in quality of sexual experience.

b) Nonsexual Affectional Behaviour and Feelings Toward Partner

Males also self-monitored their satisfaction with the daily amount of physical affection occurring and daily feelings toward their partner. Group means for these two variables are presented in Table 14. The ANOVA showed a significant effect of time for both groups on affection satisfaction, $F(2,26) = 6.818$, $p < .005$ (Table 0.32). Tukey tests of the combined group means found a significant increase in satisfaction with affectional behaviour, between baseline and follow-up, $Q(3,26) = 5.20$, $p < .01$. No significant group, time or interaction effects were found for the feelings toward partner variable (Table 0.33).

In summary, only one of the two nonsexual relationship variables, satisfaction with affectional behaviour, improved for both groups. Males' feelings toward their partners did not change significantly over the course of the program.

c) Ratings of Improvement

The success:experience ratio was derived by summing the number of successful sexual encounters (i.e., obtaining and maintaining a full erection to ejaculation), over the total number of sexual encounters engaged in for each male subject. This measure was calculated over the

Table 14

Mean Ratings of Nonsexual Affectional Behaviour and Feelings for Partner (Daily Record Forms)

Group	n	Time Periods		
		Baseline	Treatment	Follow-up
		Affection Satisfaction[1]		
Ban-Communication Group	8	.751	.748	.919
Communication-Only Group	7	.593	.993	1.093
		Feelings Toward Partner[2]		
Ban-Communication Group	8	.789	.693	.878
Communication-Only Group	6	.725	.938	.840

1. Scale ranges from -2 (very dissatisfied) to +2 (very satisfied)
2. Scale ranges from -2 (very negative) to +2 (very positive)

28 days of the baseline period and over the 14 days of the follow-up period. Group means on the success:experience ratio appear in Table 15. A 2 by 2 ANOVA was performed, which indicated that both groups underwent changes over time in the percentage of occasions they experienced successful sexual encounters, $F(1,13) = 7.08$, $p < .05$ (Table 0.34). Examination of the group means on Table 15 indicates that at baseline both groups were successful on only 32% of their total sexual encounters. At follow-up, the Ban-Communication Group was successful approximately 68% of the time, a 36% improvement rate. The Communication-Only Group was successful 55% of the time at follow-up, a 23% improvement rate. Overall, for the entire sample, a 30% mean improvement rate was observed.

As discussed in the measures section at follow-up, subjects were judged as a success or a failure using the success:experience ratio as the criterion measure. Those males who attained a criterion of at least 75% were categorized a success; those achieving less than 75% success rates were considered a failure. Of the sample of 15 males, by the above criterion, eight were judged as successes (four men from each treatment group), and seven failures (four from the Ban-Communication Group, three from the Communication-Only Group). With respect to subjects' medical status, of the eight successes, six had been previously diagnosed in the medical examination as having organic problems. Of the seven failures, three were found to have organic problems. The successful subjects' success:experience ratio at baseline was 36%; at follow-up it increased to a rate of 94%. Failing subjects, on the other hand, initially were experiencing successful encounters 28% of the time. At follow-up this rate

Table 15

Group Means of Success:Experience Ratio (Daily Record Forms)

Group	n	Time Periods	
		Baseline	Follow-up
Ban-Communication Group	8	32.4%	67.8%
Communication-Only Group	7	32.0%	55.4%
Combined Groups	15	32.2%	62.0%

decreased to 25%. Thus, the failures displayed virtually no change in their ability to obtain and maintain sufficient erections to orgasm during sexual activity.

In summary, with respect to successful sexual encounters there was an overall improvement rate of 30% for both treatment groups. Half the subjects in each group were judged as successes, the rest as failures. Successful subjects at follow-up, were almost 100% successful in their sexual activities, the failures showed no improvement from baseline rates.

Discriminant Analysis Results

A stepwise Discriminant Analysis (Klecka, 1970) was conducted to assess whether subjects' pre-treatment test data, could distinguish between the eight successfully treated and seven unsuccessfully treated subjects based on the success:experience ratio criterion calculated at follow-up. The test measures that assessed initial sexual, marital and personality (MMPI) functioning and hormone levels were used as the discriminating variables.

The stepwise Discriminant Analysis employed subjects pooled scores to determine if the data enabled differentiation of subjects into their prior success or failure categories. This technique produced a predicted group membership for each subject. Wilks Lambda, a measure of group discrimination, was used to select the variables for entry into the stepwise analysis on the basis of their discriminating power. This statistical technique uses the overall multivariate F ratio for testing differences in the group centroids. The variable which maximizes the F ratio will also minimize Wilks Lambda. Because there were far more variables entered into the analysis than

there were subjects, the stepwise Discriminant Analysis was programmed to select only the two best discriminating variables in order to make the findings meaningful. A rule of thumb recommends that there should be approximately 10 times the subjects as there are variables (Huberty 1975). When the predicted group membership was compared with actual group membership, it was found that 13 of 15 subjects or 86.67% were correctly classified on the basis of information from two of the 33 variables, Wilks = .4705 (equivalent $F(2,12) = 6.75$) $p < .01$. That is, the stepwise Discriminant Analysis demonstrated that initial subject data on two measures (collected at pre-treatment 1) were able to predict, with 87% accuracy, those who succeeded or failed at follow-up. For the number of subjects correctly classified within each group see Table 16. Table 17 presents the two measures that separated the groups in descending order of discriminating power.

Examination of Table 17 indicates that the Sexual Interaction Inventory (SII) Summary Scale (couples' ratings of satisfaction with the frequency of sexual activities, enjoyment of sexual activities, sexual responsiveness, and knowledge of partner's preferred sexual activities) was found to be the single best discriminating variable. Testosterone was then selected in combination with the SII Summary Scale as the next best discriminating variable. In order to assess the relative discriminating power of the SII Summary Scale scores and testosterone levels, Pearson Product-Moment Correlation coefficients were calculated between the discriminant function score (which included both variables) and each of the two variables (SII Summary Scale and testosterone). A correlation coefficient of .82 was found between the SII Summary Scale scores and the discriminant function

Table 16

Comparison of Actual Group Membership with Predicted Group Membership

		Predicted Group	
Actual Group	n	Successes	Failures
Successes	8	7	1
Failures	7	1	6

Table 17

Summary of Stepwise Discriminant Analysis

Step	Variables Entered	Wilks Lambda
1.	SII Summary Scale	.646*
2.	Testosterone	.470**

* $p < .05$

** $p < .01$

($p < .001$). A coefficient of .70 was found between testosterone levels and the discriminant function ($p < .005$). However, there was no relationship between testosterone levels and the SII Summary Scale scores, $r(13) = .16$, $p > .50$. These findings indicate that both the SII Summary Scale score and testosterone levels are important discriminators, separately and in combination with each other. Furthermore, each variable contributes unique information to the power of the discriminant function.

T-tests were subsequently carried out comparing "Success" and "Failure" group mean scores on the SII Summary Scale and on testosterone levels. The Success group was found to have significantly better (lower) scores on SII Summary Scale, a measure of couple's sexual disharmony, than the Failure group at pre-treatment 1, $t(13) = 2.64$, $p < .05$. In addition, the difference in testosterone levels between the success and failure groups was marginally significant, $t(13) = 2.14$, $p < .06$. Table 18 presents the means and standard deviations on both these variables. It is particularly noteworthy that both group's mean levels of testosterone fall within what endocrinologists consider the normal range (i.e., 300-1200 ng/dl).

In summary, the results of the Discriminant Analysis indicate that males with a profile of lower (better) scores on the SII Summary Scale and higher testosterone levels, are more likely to succeed in this type of treatment program, than males with a profile consisting of higher scores on the SII Summary Scale and lower levels of testosterone.

Table 18

Group Means and Standard Deviations of

SII Summary Scale and Testosterone

Variables		Group	
		Success Group (n = 8)	Failure Group (n = 7)
SII Summary Scale	M	90.0	133.0
	SD	28.74	34.33
Testosterone (ng/dl)	M	700.13	476.86
	SD	200.77	202.38

Discussion

The results of the present study support the first hypothesis that the ban on intercourse plus communication condition would result in improvement in the target symptom of erectile functioning, as well as improvement in general sexual and marital functioning. However, the results do not support the second hypothesis which predicted that the communication instruction alone would improve males' general sexual and marital functioning, but not their erectile ability. In fact, the Communication-Only condition not only produced positive changes in general sexual and marital functioning, but it proved to be just as effective as the instruction to practise communication combined with the ban on intercourse, in improving erectile functioning. That is, on all measures of erectile functioning, no between group differences were found. It appears that the instruction to ban intercourse did not add to the improvement produced by the instruction to practice communication, indicating that the former instruction was likely an inert component of the Ban-Communication condition.

Six measures evaluated changes in behaviours, attitudes, and satisfaction levels related to erectile functioning. On all six measures both groups were found to improve from the pre-treatment testing periods to the post-treatment testing period, and maintained these improvement levels at follow-up testing. Because differences between groups were not found on any of these test measures it might be concluded that the communication instruction was responsible for this positive outcome. However, the design of the present study does not permit this conclusion to be drawn with certainty. Because this study did not employ an

attention-placebo control group, the effect of this component cannot be ignored in the observed outcome. Another uncontrolled variable might also account for the improvement in both groups. As mentioned in the Introduction, wrong or inadequate information can contribute to erectile difficulties. Perhaps an educative component was involved in bringing about the observed changes. For example, filling out the extensive questionnaires may have given couples some instruction about sexual functioning in general, e.g., the Sexual Interaction Inventory provides pictures illustrating various sexual positions. The questionnaire material may also have served to "give permission" for the performance of certain sexual activities which are perhaps less socially acceptable (e.g., masturbation, oral sex, and other non-coital sex acts), and thus freed couples to attempt them with some benefit. Simply being informed that a research project on impotence was being conducted may have provided males with information about incidence, which served to make them feel less abnormal. As well, the interviews, in some cases, may have been the first occasion that couples openly discussed their sexual difficulties, revealing sufficient information of value to each spouse to initiate gains.

Finally, the couples' self-monitoring of their sexual activities could have been reactive. Monitoring one's sexual activities and corresponding feelings may increase the occurrence of positive behaviours and feelings. Self-monitoring has been shown to be reactive in this manner in the treatment of other problems, e.g., obesity and smoking (Mahoney, 1977). However, evidence for effects of self-monitoring in this study is equivocal. No significant differences were found between the two testing periods occurring prior to treatment on any of the

dependent variables. It was in the interval between these two testing periods that all couples began to self-monitor their daily sexual activities. If self-monitoring did indeed have an effect on their behaviour, one would have expected a significant change to occur from pre-treatment 1 to pre-treatment 2 on the measures. This was not found. On the other hand, on some variables (e.g., frequency of difficulty obtaining erection, quality of erection at ejaculation) significant improvement between pre-treatment 1 and post-treatment were found, but no significant differences between pre-treatment 2 and post-treatment were found. In these cases, one might speculate that slight improvement occurred in the self-monitoring phase, but not enough to make pre-treatment 2 scores significantly better than those at pre-treatment 1, but enough so that pre-treatment 2 scores were not significantly lower than post-treatment scores.

In order to rule out the majority of uncontrolled variables previously mentioned, future component analysis research on erectile dysfunction therapy should include two more groups. In addition to the Ban-Communication Group and Communication-Only Group employed in the present study, a third ban-on-intercourse-only group should be added. Based on the results of this study, it would be predicted that no change would occur in this group. However, it is important to empirically evaluate this prediction. The fourth group, a self-monitoring only group, would control for the effects of self-monitoring, testing, expectation of gain and educational elements in the assessment process. This four-group design would shed further light on active ingredients in the treatment package. In the present study it was not possible to follow this design because of the limits on subject availability.

The design of the present study permits the conclusion that the communication instruction was primarily responsible for the changes observed. This assertion is supported by two major findings: 1) Both treatment groups achieved similar gains suggesting that the intercourse ban did not contribute an effect additional to communication instructions. 2) Significant change on the majority of the test variables was found between the testing periods, pre-treatment 1 and post-treatment (in some cases pre-treatment 2 was also significantly different from post-treatment). As well, in no instance were follow-up scores significantly different from post-treatment scores. Changes coincided with the month that subjects followed their respective treatment instruction. Had factors such as self-monitoring, compliance with the experimenter, education, or positive expectation, been responsible for the greater part of the improvements, differences might also have been found between the two pre-treatment periods, or between post-treatment and follow-up. This was not found.

Turning now to a closer examination of treatment effects, it is of interest that decreases in frequency of difficulty, both in obtaining and maintaining an erection were found in this study. In the Price study (Price et al, 1981) discussed earlier, no significant decreases from pretest to posttest on these measures were found. Price's study was multi-faceted, including among other techniques, a ban on intercourse and sexual communication training. Males were seen weekly in two-hour treatment sessions for eight weeks. Subjects in Price's study appear to be similar to the present sample, although he did not provide a detailed description of subject characteristics.

The major difference between the two studies is that Price used

single males while this study involved males and their partners. It is not clear why the present study, employing minimal intervention and minimal therapist contact, was able to bring about decreases in frequency of erectile difficulties, while Price's more intensive program did not. A possible explanation is provided by several studies which found that one of the predictors of a better outcome in the treatment of impotence is the willingness and ability of the female to cooperate fully in the treatment program (Kilmann & Auerbach, 1979). This finding could explain why the communication instruction was effective in producing positive change in this study, but similar techniques were not effective in the Price study. There could be no assurance even if the males developed communication skills, that their less committed partners would respond positively to the contents of the communication. In the present study the importance of effective sexual communication and its relationship to good sexual functioning was emphasized to both spouses.

The results of three questions on sexual communication in the present study do not show that males perceived themselves as improving in this area from pre- to post-treatment. In fact, in pre-treatment testing, males rated their sexual communication skills and satisfaction with communication as above average. It appears that they perceived themselves and their partners from the start of the program as good communicators about their sexual interaction. However, the Perceptual Accuracy Scale of the Sexual Interaction Inventory revealed that males in both groups became more accurate in estimating their wives' enjoyment of a variety of sexual activities from pre-treatment to post-treatment and maintained this knowledge at follow-up. This finding is of particular interest because it suggests that wives, husbands or both did comply with

the communication portion of their therapeutic instructions. The findings also suggest that males' ratings with repsect to communication do not reflect the improvements implied by the increase in perceptual accuracy of partners' preferred sexual activities.

It was predicted that a ban on intercourse would have a marked positive impact on the erectile symptom because of etiological formulations which postulate that performance anxiety is the primary cause of impotence. One might argue that the failure of the ban on coitus to contribute to treatment effects casts doubt on the performance anxiety model of impotence. However, it is possible that the communication instruction also served to remove performance anxiety. Effective communication of sexual tastes and preferences between partners might alleviate the pressure to perform for the male, for example, by giving him permission to express the desire to engage in non-coital activities or to request from his partner longer and more direct stimulation. Since the underlying mechanisms of erectile dysfunction were not directly investigated in this study it is not possible on the basis of the present findings to reject the performance anxiety formulation of erectile dysfunction.

The findings of the present study are significant from a cost-benefit perspective. They demonstrate that males can improve in erectile and general sexual and marital functioning, without participating in an intensive treatment program, involving weekly contact with a therapist over a prolonged period of time, though the short duration of the follow-up period limits conclusion about the stability of gains. These findings are consistent, however, with other treatment outcome studies on couples with different sexual dysfunctions. In these studies positive

changes were also obtained with minimal therapist contact combined with a self-administered treatment program (e.g., Mathews, 1981; Zeiss, 1978).

An inherent weakness in sex research is that for ethical and practical reasons, one cannot directly observe behavioural change and, therefore, investigators must rely on a variety of self-report measures. However, no standardized valid measures of erectile functioning are available to investigators working in this area. Researchers under these circumstances tend to resort to multiple measures of various aspects of penile erection, accepting the fact that the findings will occasionally conflict. In the present study the results of the daily record forms did not closely match those obtained from periodically administered questionnaires and scales. For example, no improvement over time was found on general erection quality and erection quality in intercourse as measured on the daily self-monitoring forms. On the other hand the success: experience ratio, a measure calculated from daily records of erectile functioning, yielded results consistent with the questionnaire items on erectile ability. At present there is little basis for ascribing greater validity to one measure relative to another. As yet, no other erectile dysfunction outcome studies have employed daily, self-monitoring forms as an assessment tool. However, the very fact that the daily record forms produced somewhat different results from those of more commonly used test measures should encourage their use in future treatment outcome studies. It may be that clinicians have overestimated the power of their treatment techniques because of their reliance on a narrow range of assessment measures. A future research endeavor would be to investigate the relative accuracy

of self-monitoring and questionnaire data by correlating them with physiological evidence e.g., penile-plethysmography.

Only two measures showed significant group X time interaction effects. Both of these were from the daily record forms. They dealt with frequency of sexual encounters and a rating of the quality of the sexual experience. The findings on these variables constitute the only evidence that there were differential effects as a result of the treatment conditions. It will be recalled that the Communication-Only Group almost doubled their sexual encounter frequency during the treatment phase. Subsequent analysis suggested that this change involved an increase in the amount of times intercourse was engaged in, rather than other sexual activities. It was also found that the Communication-Only Group rated the quality of their sexual experiences, in this period, as significantly more negative than at other times, and also as more negative than the ratings by the Ban-Communication Group. Thus it appears that as a result of the instruction to emphasize communication during sex, the Communication-Only Group increased their frequency of intercourse which somehow produced more negative feelings about these sexual experiences. This process could not occur in the Ban-Communication Group due to the prohibition on intercourse. Despite this suspected advantage for the Ban-Communication Group it did not generate evidence of differential benefits on other measures employed in this study.

The success:experience ratio, derived from the daily self-monitoring record, was calculated differently in this investigation than in other studies. Auerbach and Kilmann (1977), for example, defined their success: experience ratio as the number of successful

coital experiences divided by the total number of attempts at intercourse. In the present study, successful encounters (maintained a complete or almost complete erection until ejaculation during any sexual activity) were divided by total number of unspecified sexual encounters, which could include intercourse or non-coital sexual activites. This definition is, perhaps, more consistent with what many sex therapists attempt to communicate to their clients, namely, one can have an enjoyable sexual experience without always having to proceed to intercourse. Furthermore, it seemed inappropriate to encourage the Ban-Communication Group to value non-coital sexual activities and then to ignore this form of love-making in the method of evaluating improvement at follow-up.

Male subjects in this study were categorized as having either succeeded or failed in reversing their symptom as another way of evaluating the effects of the treatment program. Evaluating therapeutic outcome by only these two categories has the disadvantage of discounting the gains in erectile functioning made by those men who improved over the course of the program, but did not reach the criterion of "being successful in at least 75% of their sexual encounters." However, dichotomizing the sample in such a manner, allows for subsequent and more detailed study of group differences. In the present study half of the subjects were judged as "successes" in the treatment program, the rest as "failures." For the success subjects, it appeared that the target symptom of erectile dysfunction was almost completely reversed, that is, these subjects were successful in nearly 100% of their sexual encounters. For the failures, they were experiencing difficulties in approximately three of every four sexual

episodes, which represented no change from their baseline rates. Therefore, though overall, the results of this study indicate that the treatment program resulted in improved erectile functioning for both experimental groups, subsequent examination demonstrated that only half of the subjects in each group could be considered as "cured." This pattern of findings argues for the presentation of individual subject results in addition to group means to provide a complete picture of the gains in a therapy outcome study.

The Discriminant Analysis served to explain the key differences between men whose dysfunction was or was not successfully reversed under the same treatment instructions. The results of the Discriminant Analysis and subsequent t-tests revealed that failures began the treatment program at a disadvantage. That is, they were found to have poorer scores than successes at pre-treatment on the Sexual Interaction Inventory (SII) Summary Scale (level of satisfaction with the frequency of sexual activities, enjoyment of sexual activities, and knowledge of partner's preferred sexual activities). In addition, they were also found to have lower levels of testosterone than did successes at pre-treatment. Furthermore these two variables were found to be good predictors of treatment outcome. This finding represents a first step towards answering a critical question in outcome research, namely, what subjects are best suited to what type of therapy. The findings of this study imply that impotent males with a profile of poor SII Summary Scale scores and low normal testosterone levels may be less able to benefit from a minimal contact-minimal treatment intervention package. Therapists opting for this type of treatment paradigm in the future, might want to screen couples on these

two measures before considering them for treatment.

It is interesting that the pre-treatment SII Summary Scale, a global measure of sexual disharmony in a couple, was the single most powerful predictor of improved erectile functioning, as opposed to erection-related variables. This result suggests that broader issues in a couple's sexual relationship may need to be evaluated and perhaps remediated in certain couples in which the male presents erectile problems.

The finding that males with lower testosterone levels were less likely to benefit from the treatment, conforms with the results of the Schwartz, Kolodny and Masters' study (1980) which found a tendency for males who failed to reverse their erectile dysfunction in therapy, to have had a lower mean testosternone level than those who were successful in symptom reversal. A worthwhile future investigation might assess the effectivness of a combined sex-testosterone therapy program for impotent males with low normal testosterone levels. Other studies as well have found that testosterone is implicated in erectile dysfunction (e.g., Franks et al, 1978; Raboch et al, 1975). While it is risky to infer underlying mechanisms in erectile dysfunction from predictors of successful outcome one might speculate from the present findings that testosterone level, as well as level of general sexual conflict, play a role in this disorder.

The results of the medical examination found that 56% of the males had some type of organic problem. This is a somewhat lower rate than Schumacher and Lloyd (1981) who found that 73% of their impotent cases had organic disease. However, the latter study showed that males with organic disease, who underwent therapy, made significantly

less gains in erectile functioning than impotent men free from organic disease. In the present study the majority of successes, defined here as improvement in erectile ability, had been previously found to have medical problems. The majority of failures, on the other hand, were made up of men with no evidence of organic disease. Therefore these findings do not support Schumacher and Lloyd's assumption that the origins of the majority of impotence cases are biologically based. Had this been the case, it is unlikely that six of the nine impotent men with organic problems would have achieved success from a psychologically-based therapy approach.

Also in contrast to Schumacher and Lloyd's findings and those of other studies (e.g., Derogatis et al, 1981; Munjack et al, 1981), the present study's sample of impotent men did not present definable psychiatric disorders as measured by the MMPI. Though, in fact, subjects with gross psychopathology would have been eliminated from participation in the study, only one of the 29 males who originally volunteered for the study, was screened out because of his psychological profile on the MMPI. It is notable, however, that on the average males displayed an elevated Depression scale on the MMPI (i.e., one SD above the norm). When each subject's MMPI scale scores were entered as discriminating variables in the Discriminant Analysis, none of these psychological scales was found to discriminate between those who succeeded or failed in therapy. Personality factors in this study were not related to treatment outcome.

Two final points of caution regarding the results of this study should be mentioned. Firstly, the present results should be interpreted cautiously because the large number of questionnaire items that

were tested increases the possibility that some significant findings may have been due to chance differences.

Secondly, the issue of the representativeness of this clinical sample deserves mention. That is, because of the manner in which the subject sample was recruited, the generalizability of the findings to other clinical samples may be limited. The majority of the couples in the present study, responded to a newspaper advertisement and volunteered to participate in a treatment research project. They did not seek out treatment on their own initiative, prompted by problem distress. It is difficult to speculate whether the present sample would have eventually sought out professional help had they not been prompted by an advertisement soliciting couples with their specific problems; nor can it be determined whether this sample is distinguishable from other clinical samples by virtue of this recruitment factor. However, the sample's problem description (e.g., nature of problem, frequency of problem occurrence, and duration of problem) appears no more or less severe than those described in other studies. For example, males in the Price study (Price et al, 1981) were all experiencing secondary erectile dysfunction in approximately 64% of their sexual encounters. In the Auerbach and Kilmann study (1977) the mean problem duration for the secondary erectile dysfunction sample was 5.38 years. Males were unsuccessful in their coital attempts 70% of the time. These rates compare closely to the present sample in which all the males were also secondary erectile failures. The average problem duration was 4.2 years. Males were unsuccessful in 68% of their total sexual encounters.

The challenge for future research in the area of erectile

dysfunction lies in the study of the relative contribution of additional treatment components, determining which interventions are most effective for particular clients, and specifying the cost effectiveness of alternative procedures.

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Appendix A'

CONSENT FORM (Yale)

1. I am informed that this study is an attempt to evaluate the effectiveness of various procedures currently available for the treatment of male erectile difficulty.

2. I understand that by participating in this study I may benefit by receiving help for my problem. Also my participation may be helpful to the improvement of treatment in general for couples where the male experiences similar problems.

3. As I have been advised previously, I am aware that I have every right to receive treatment regardless of whether I partake in this study or not.

4. I understand that by participating in this study, I will be assigned to one of two home-based treatment programs involving a three month time period. I understand that the treatment instructions which I will receive are designed to assist in correcting my sexual difficulty. As my first task I will be asked to observe and record my sexual behaviour in the privacy of my home, for a period of one month, prior to receiving the treatment instructions, in order to provide detailed information on my sexual behaviour patterns.

5. I am willing to take the psychological tests and questionnaires, at four different time periods, that are designed to assess my overall psychological functioning, my marital adjustment and my sexual functioning.

6. I understand that my partner will also be requested to complete the evaluation procedures. She must also be informed about the procedures and agree to cooperate with the therapy program.

7. I am willing to receive a medical examination by an endocrinologist at the Jewish General Hospital which will be paid through medicare, to evaluate the possible role of any physical factors related to my problem.

8. I understand that I am free to ask any questions concerning the procedure used in this study at any time. If for any reason I experience discomfort or concern during participation in this project, I understand I am free to discuss this with the project coordinator and request appropriate recommendations or referrals.

9. I am aware that this is a short-term (3 months) therapy program, and that no fee is required to participate. I am informed that should I desire additional therapy once I have completed the program, I can obtain information from the project coordinator about the availability of other services and their costs.

10. I understand that if results of this study are published, my part in the study will be completely anonymous and my privacy will be completely protected.

11. I understand that each participating couple will be required to furnish a deposit of $50.00. This sum will be refunded if I withdraw within 15 days of beginning the program, or when I have completed the program and all the evaluation measures. I understand the $50.00 will not be refunded if I withdraw after 15 days or if on completion of the program I fail to complete the measures. Unrefunded money will be donated to the Women's Auxiliary of the Jewish General Hospital.

12. On the basis of this information I _____ willingly consent to participate as a subject in this study conducted at the Sexual Dysfunction Service of the Jewish General Hospital.

Date Participant

Date Project Coordinator

Date Witness

Appendix A

CONSENT FORM (Female)

1. I am informed that this study is an attempt to evaluate the effectiveness of various procedures currently available for the treatment of male erectile difficulty.

2. I understand that by participating in this study we may benefit by receiving help for the problem of erectile difficulty. Also my participation may be helpful to the improvement of treatment in general for couples where the male experiences similar problems.

3. As I have been advised previously, I am aware that we have every right to receive treatment regardless of whether I partake in this study or not.

4. I understand that by participating in this study, we will be assigned to one of two home-based treatment programs involving a three month time period. I understand that the treatment instructions which we will receive are designed to assist in correcting my partner's sexual difficulty. As my first task I will be asked to observe and record my sexual behaviour in the privacy of my home, for a period of one month, prior to receiving the treatment instructions, in order to provide detailed information on my sexual behaviour patterns.

5. I am willing to take the psychological tests and questionnaires, at four different time periods, that are designed to assess my overall psychological functioning, my marital adjustment and my sexual functioning.

6. I understand that my partner will also be requested to complete the evaluation procedures. He must also be informed about the procedure and agree to cooperate with the therapy program.

7. I understand that I am free to ask any questions concerning the procedure used in this study at any time. If for any reason I experience discomfort or concern during participation in this project, I understand I am free to discuss this with the project coordinator and request appropriate recommendations or referrals.

8. I am aware that this is a short-term (3 months) therapy program, and that no fee is required to participate. I am informed that should I desire addtional therapy once I have completed the program, I can obtain information from the project coordinator about the availability of other services and their costs.

9. I understand that if results of this study are published, my part in the study will be completely anonymous and my privacy will be completely protected.

10. I understand that each participating couple will be required to furnish a deposit of $50.00. This sum will be refunded if I withdraw within 15 days of beginning the program, or when I have completed the program and all the evaluation measures. I understand the $50.00 will not be refunded if I withdraw after 15 days or if on completion of the program I fail to complete the measures. Unrefunded money will be donated to the Women's Auxiliary of the Jewish General Hospital.

11. On the basis of this information I _____ willingly consent to participate as a subject in this study conducted at the Sexual Dysfunction Service of the Jewish General Hospital.

Date Participant

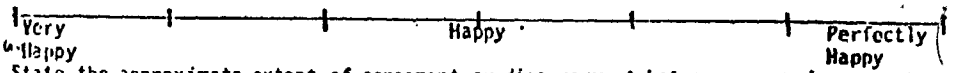
Date Project Coordinator

Date Witness

Appendix B

Marital Adjustment Scale

1. Check the point on the scale 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.



State the approximate extent of agreement or disagreement between you and your mate on the following items. Please check the ONE most appropriate column for each item.

	Always Agree	Almost Always Agree	Occasionally Disagree	Frequently Disagree	Almost Always Disagree	Always Disagree
2. Handling family finances						
3. Matters of recreation						
4. Demonstrations of affection						
5. Friends						
6. Sex relations						
7. Coventionality (right, good, or proper conduct)						
8. Philosophy of life						
9. Ways of dealing with in-laws						

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 mate 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 mate 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 mate? Almost never ___ Rarely ___ In most things ___ [illegible] ___

Appendix C - SEXUAL HISTORY FORM

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

1. How frequently do you and your mate have sexual intercourse or activity?
   1) more than once a day
   2) once a day
   3) 3 or 4 times a week
   4) twice a week
   5) once a week
   6) once every two weeks
   7) once a month
   8) less than once a month
   9) not at all

2. How frequently would you like to have sexual intercourse or activity?
   1) more than once a day
   2) once a day
   3) 3 or 4 times a week
   4) twice a week
   5) once a week
   6) once every two weeks
   7) once a month
   8) less than once a month
   9) not at all

3. Who usually initiates having sexual intercourse or activity?
   1) I always do
   2) I usually do
   3) my mate and I each initiate about equally often
   4) my mate usually does
   5) my mate always does

4. Who would you like to have initiate sexual intercourse or activity?
   1) myself, always
   2) myself, usually
   3) my mate and I equally often
   4) my mate, usually
   5) my mate, always

5. How often do you masturbate?
   1) more than once a day
   2) once a day
   3) 3 or 4 times a week
   4) twice a week
   5) once a week
   6) once every two weeks
   7) once a month
   8) less than once a month
   9) not at all

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ALL THE REMAINING QUESTIONS ARE TO BE ANSWERED BY BOTH MEN AND WOMEN

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

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

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

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

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

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

25. Do you feel pain in your genitals during sexual intercourse?

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

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

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

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

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

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

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

Appendix D

SEXUAL INTERACTION INVENTORY

This booklet describes a number of sexual activities. For example, "The male and female kissing for one minute continuously". There is also a picture of a couple engaged in each activity on each page. For each sexual activity, you will be asked to answer the same six questions. Answer the questions by marking on the attached answer sheet. Do not mark on this booklet itself. Please check that the number of the question you are answering matches the space on the answer sheet, from No. 1 to 102.

In answering each question, read the description of the sexual behavior, then answer each question as it currently applies to you. Please be sure to answer every question even if you have never experienced some of the activities. Do not leave any blanks and do not mark more than one answer to any question. If you have not experienced some of the activities, try to imagine how you would feel if you were to perform this activity at the present time.

The first question on each page asks whether or not the particular activity usually occurs when you and your spouse engage in sexual activity. You are asked to specify whether this particular activity is "always", "usually", "fairly often", "occasionally", "rarely", or "never" part of your sexual acrivity. We are not asking whether it occurs once a day or once a week or once a month, but rather how regularly this particular activity forms part of your sexual relationship.

The second question on each page asks how pleasant or unpleasant this activity is for you at the present time. If you have never experienced this activity or are not experiencing it now, please try to image how pleasant or how you would find it to be if you did engage in the activity today.

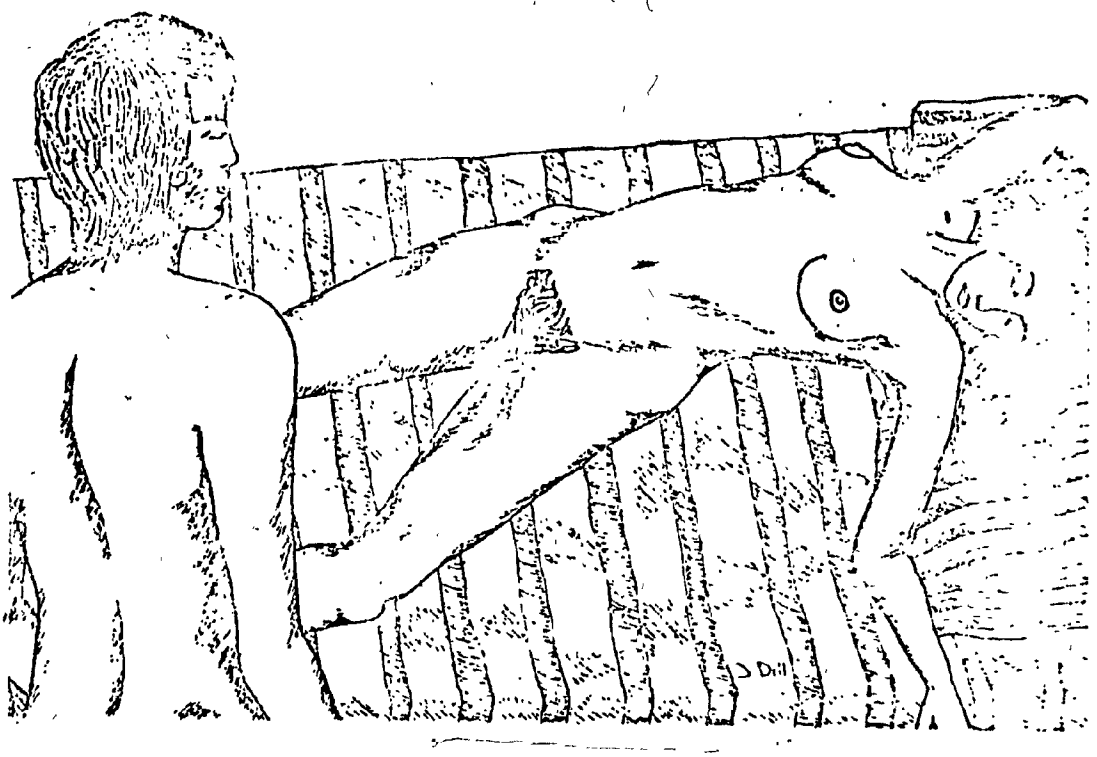
The third question on each page asks how pleasant you would like this activity to be for you at this time.

The fourth question on each page simply asks how regularly you would like this particular activity to be part of your sexual relationship.

The fifth question on each page asks you to estimate how pleasant your spouse finds the particular activity.

The last question on each page asks you how much you would like your spouse to enjoy the particular activity at this time.

Please mark your answers on the answer sheet without discussing any of the questions with your spouse. When you have finished filling out the form, you may if you wish, discuss the questions with your spouse. In order for us to obtain valid information, itis crucial for you to answer every question honestly and without discussing the questions with your spouse.



A. ACTIVITY: THE MALE SEEING THE FEMALE WHEN SHE IS NUDE.

When you and your mate engage in sexual behavior, does this particular activity usually occur? How often would you like this activity to occur? ("Sexual behavior" refers to any type of physical contact which is intended to be sexual by either you or your mate.)

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

4. 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 mate finds this activity to be?

2. I find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

5. I think my mate finds this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

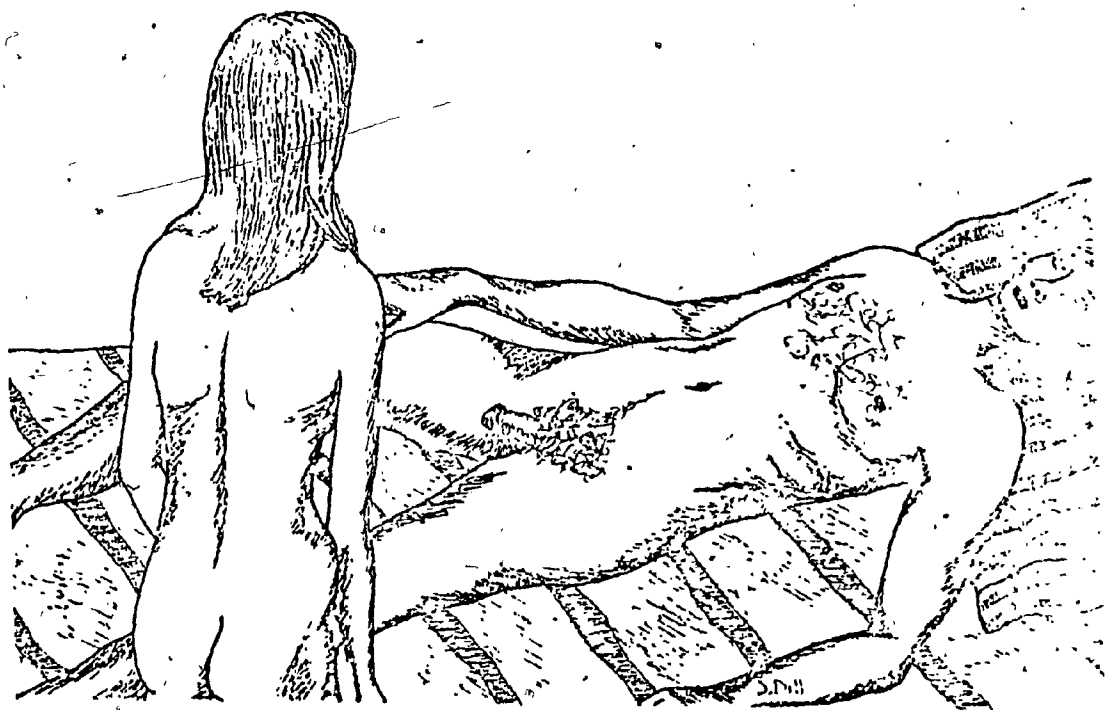
How would you like to respond to this activity? How would you like your mate to respond? (In other words, how pleasant do you think this activity <u>ideally should be</u> for you and your mate?)

3. 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 mate to find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant



B. ACTIVITY: THE FEMALE SEEING THE MALE WHEN HE IS NUDE.

When you and your mate engage in sexual behavior, does this particular activity usually occur? How often would you like this activity to occur? ("Sexual behavior" refers to any type of physical contact which is intended to be sexual by either you or your mate.)

7. 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

10. 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 mate finds this activity to be?

8. I find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

11. I think my mate finds this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

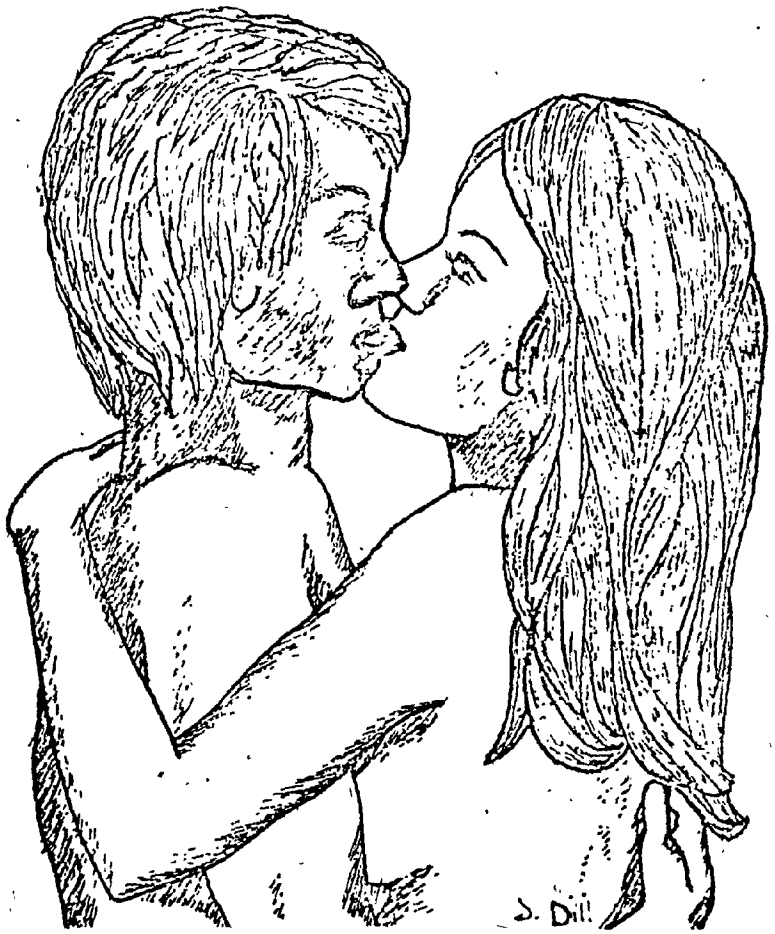
How would you like to respond to this activity? How would you like your mate to respond? (In other words, how pleasant do you think this activity <u>ideally should be</u> for you and for your mate?)

9. 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

12. I would like my mate to find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant



C. ACTIVITY: THE MALE AND THE FEMALE KISSING FOR ONE MINUTE CONTINUOUSLY.

When you and your mate engage in sexual behavior, does this particular activity usually occur? How often would you like this activity to occur? ("Sexual behavior" refers to any type of physical contact which is intended to be sexual by either you or your mate.)

13. 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

16. 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 mate finds this activity to be?

14. I find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

17. I think my mate finds this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

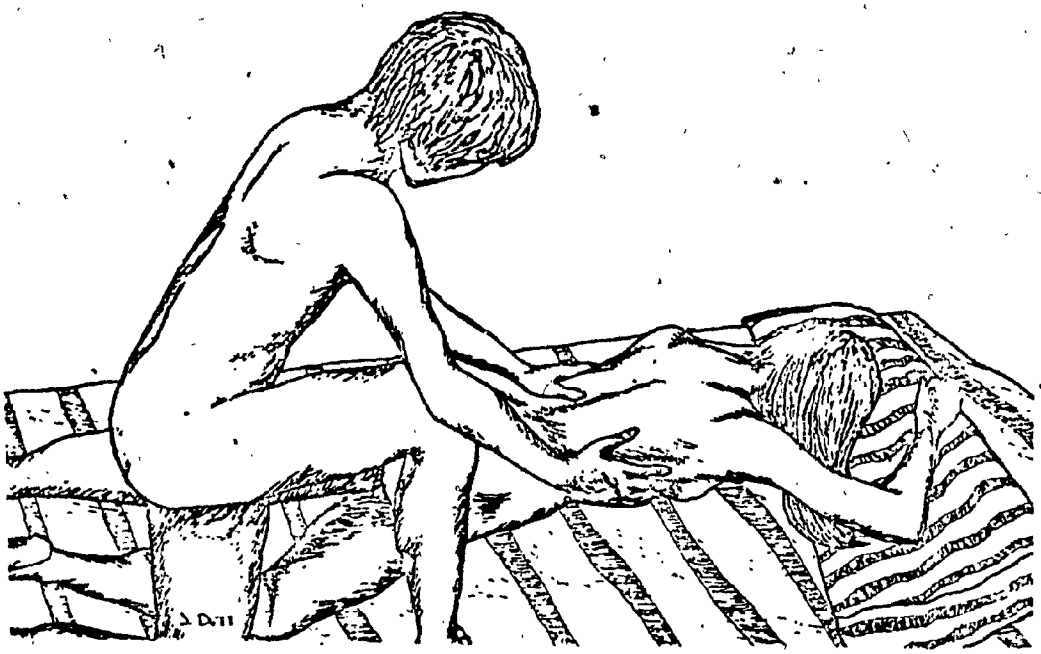
How would you like to respond to this activity? How would you like your mate to respond? (In other words, how pleasant do you think this activity <u>ideally should be</u> for you and for your mate?)

15. 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

18. I would like my mate to find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant



D. ACTIVITY: THE MALE GIVING THE FEMALE A BODY MASSAGE, NOT TOUCHING HER BREASTS OR GENITALS.

When you and your mate engage in sexual behavior, does this particular activity usually occur? How often would you like this activity to occur? ("Sexual behavior" refers to any type of physical contact which is intended to be sexual by either you or your mate.)

19. 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

22. 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 mate finds this activity to be?

20. I find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

23. I think my mate finds this activity:

1) Extremely unpleasant
2) Moderately 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 mate to respond? (In other words, how pleasant do you think this activity <u>ideally should be</u> for you and for your mate?)

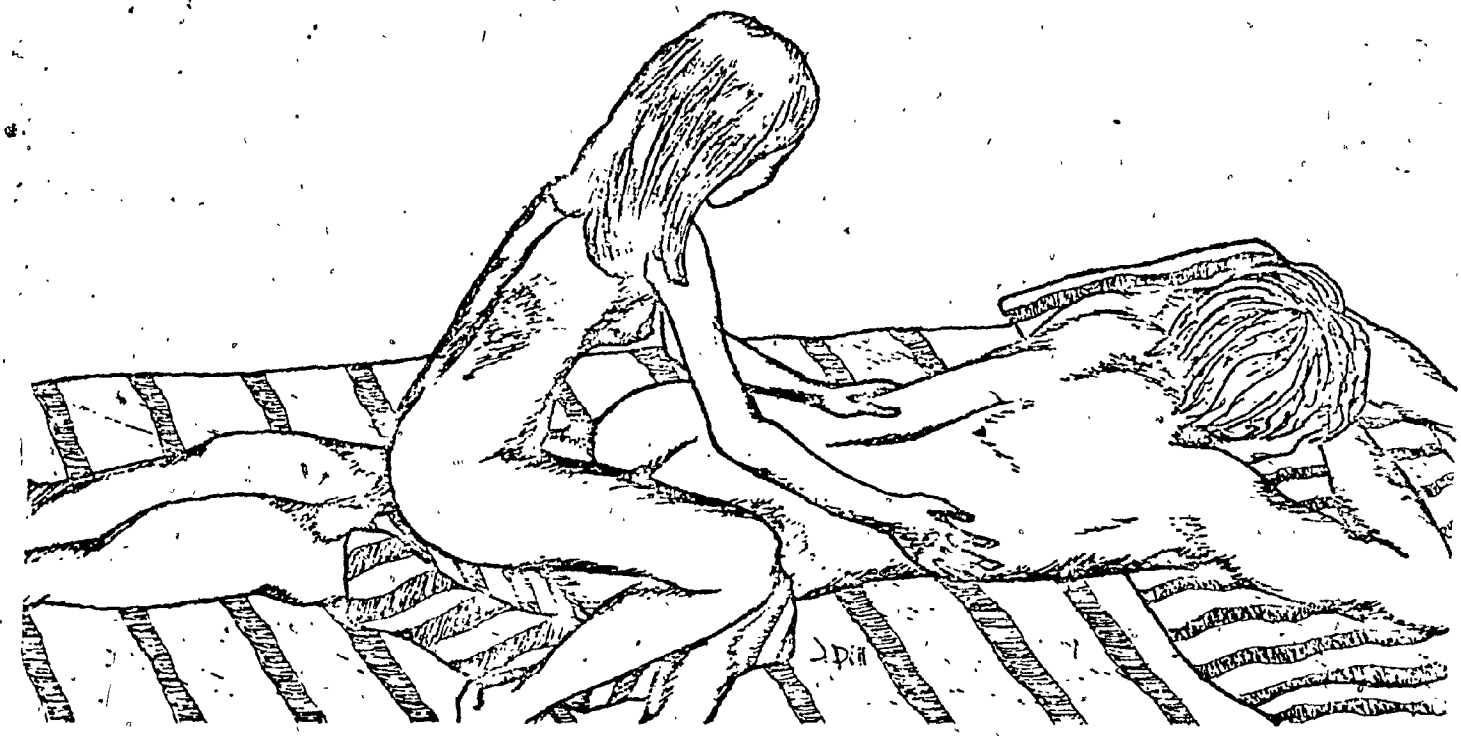
21. I would like to find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

24. I would like my mate to find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

PART TWO



E. ACTIVITY: THE FEMALE GIVING THE MALE A BODY MASSAGE, NOT TOUCHING HIS GENITALS.

When you and your mate engage in sexual behavior, does this particular activity usually occur? How often would you like this activity to occur? ("Sexual behavior" refers to any type of physical contact which is intended to be sexual by either you or your mate.)

25. 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

28. 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 mate finds this activity to be?

26. I find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

29. I think my mate finds this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

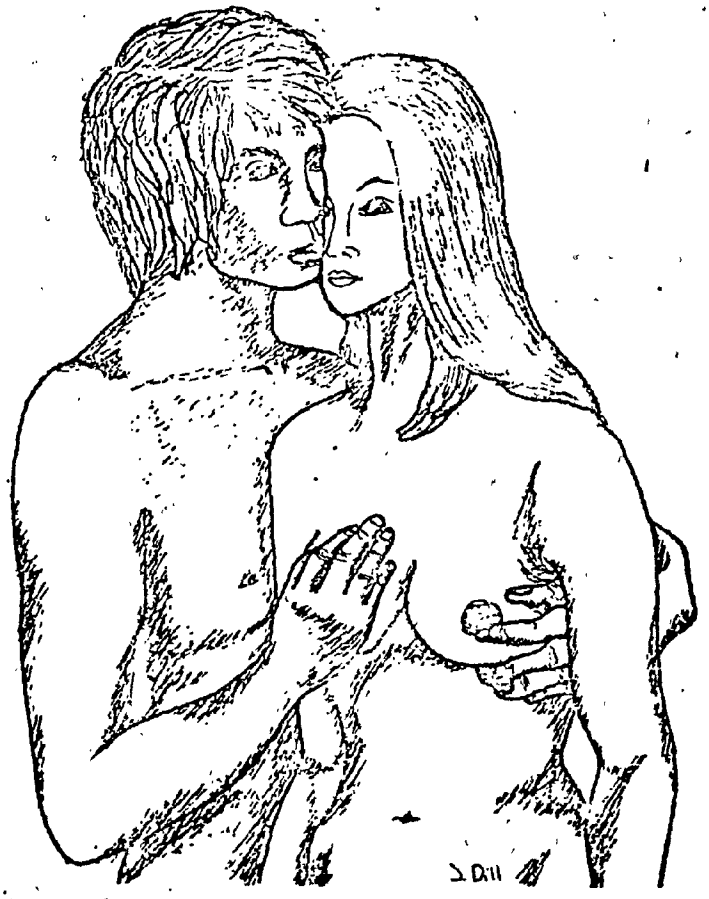
How would you like to respond to this activity? How would you like your mate to respond? (In other words, how pleasant do you think this activity <u>ideally should be</u> for you and for your mate?)

27. 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

30. I would like my mate to find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant



F. ACTIVITY: THE MALE CARESSING THE FEMALE'S BREASTS WITH HIS HANDS.

When you and your mate engage in sexual behavior, does this particular activity usually occur? How often would you like this activity to occur? ("Sexual behavior" refers to any type of physical contact which is intended to be sexual by either you or your mate.)

31. 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

34. 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 mate finds this activity to be?

32. I find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

35. I think my mate finds this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

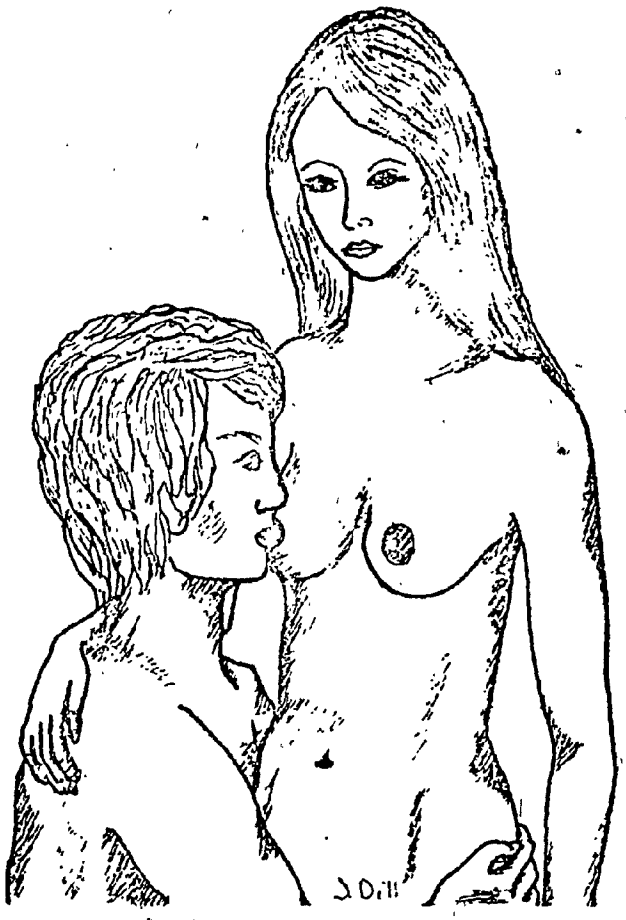
How would you like to respond to this activity? How would you like your mate to respond? (In other words, how pleasant do you think this activity <u>ideally should be</u> for you and for your mate?)

33. 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

36. I would like my mate to find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant



G. ACTIVITY: THE MALE CARESSING THE FEMALE'S BREASTS WITH HIS MOUTH (LIPS OR TONGUE).

When you and your mate engage in sexual behavior, does this particular activity usually occur? How often would you like this activity to occur? ("Sexual behavior" refers to any type of physical contact which is intended to be sexual by either you or your mate.)

37. 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

40. 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 mate finds this activity to be?

38. I find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

41. I think my mate finds this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

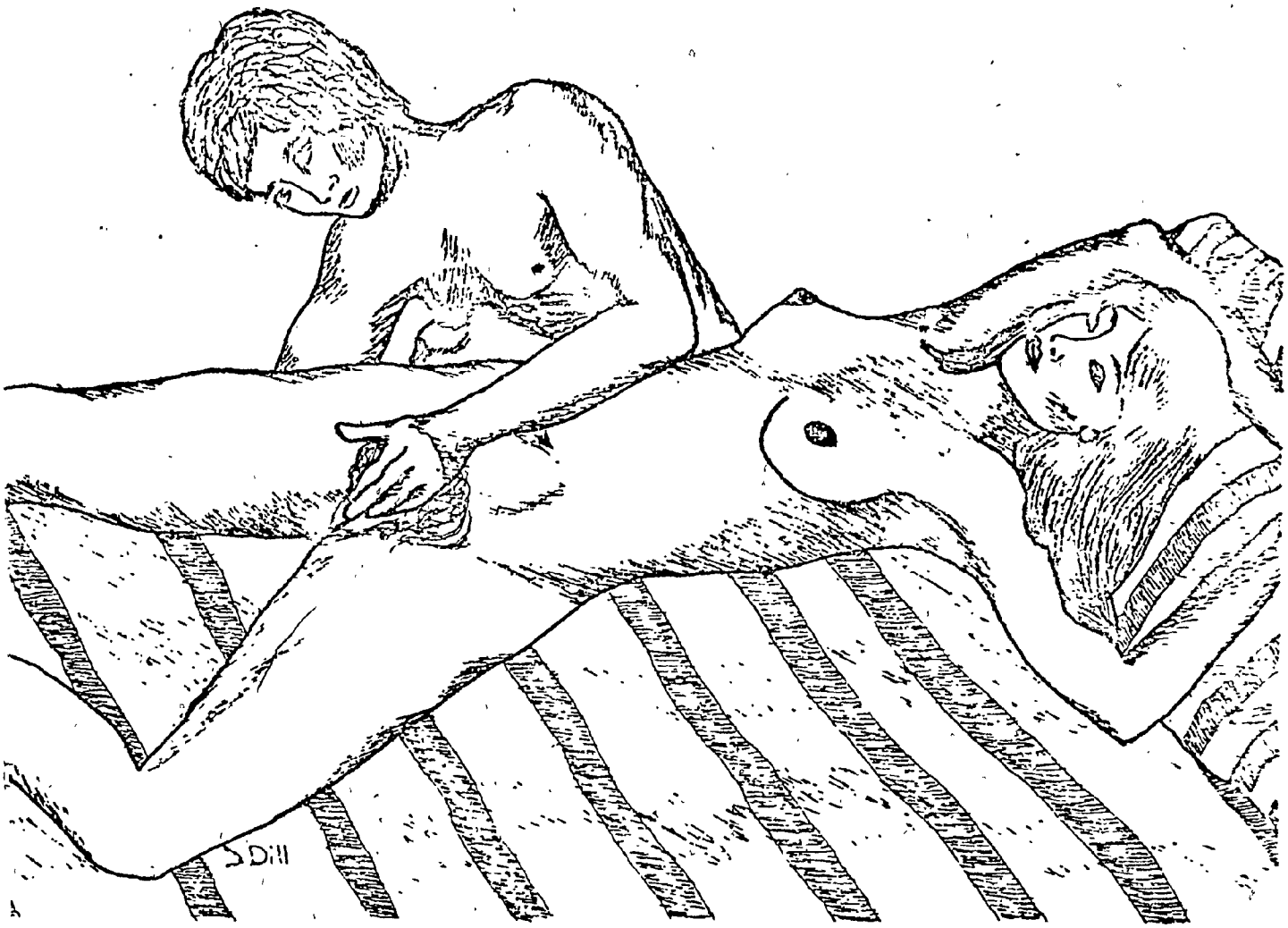
How would you like to respond to this activity? How would you like your mate to respond? (In other words, how pleasant do you think this activity <u>ideally should be</u> for you and for your mate?)

39. 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

42. I would like my mate to find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant



H. ACTIVITY: THE MALE CARESSING THE FEMALE'S GENITALS WITH HIS HANDS.

When you and your mate engage in sexual behavior, does this particular activity usually occur? How often would you like this activity to occur? ("Sexual behavior" refers to any type of physical contact which is intended to be sexual by either you or your mate.)

43. 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

46. 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 mate finds this activity to be?

44. I find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

47. I think my mate finds this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

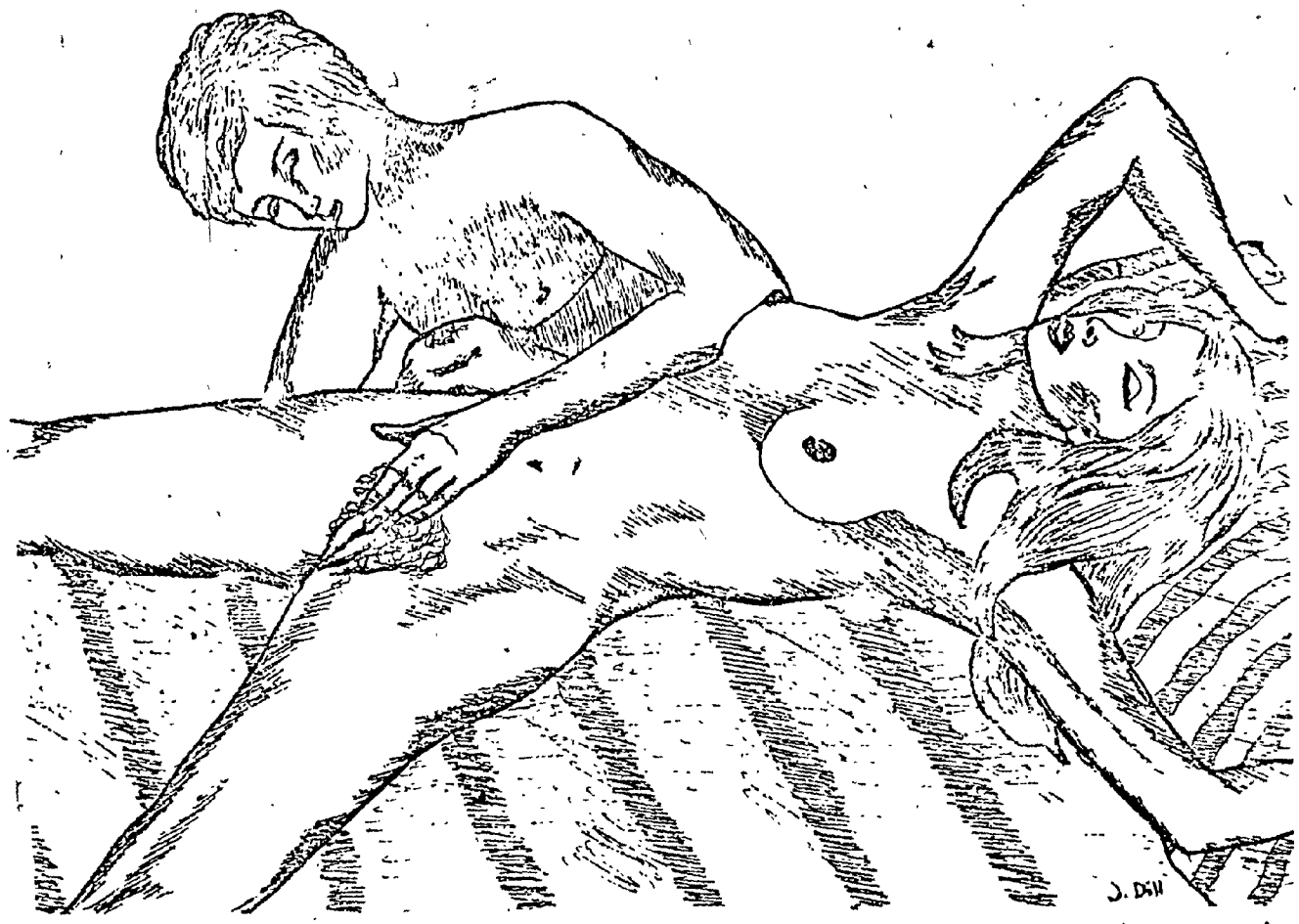
How would you like to respond to this activity? How would you like your mate to respond? (In other words, how pleasant do you think this activity <u>ideally should be</u> for you and for your mate?)

45. 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

48. I would like my mate to find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant



I. ACTIVITY: THE MALE CARESSING THE FEMALE'S GENITALS WITH HIS HANDS UNTIL SHE REACHES ORGASM (CLIMAX).

When you and your mate engage in sexual behavior, does this particular activity usually occur? How often would you like this activity to occur? ("Sexual behavior" refers to any type of physical contact which is intended to be sexual by either you or your mate.)

49. 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

52. 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 mate finds this activity to be?

50. I find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

53. I think my mate finds this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

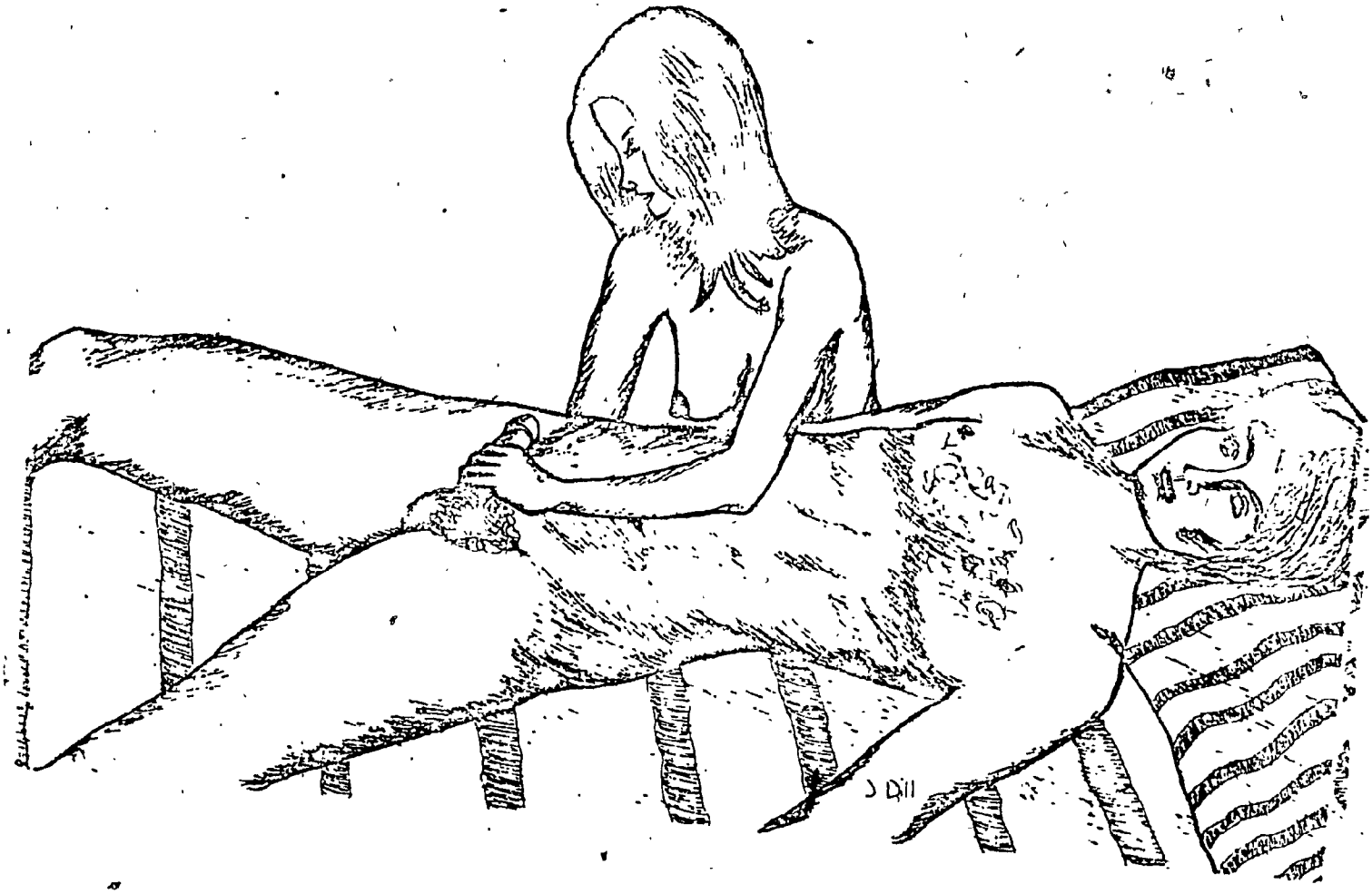
How would you like to respond to this activity? How would you like your mate to respond? (In other words, how pleasant do you think this activity ideally should be for you and for your mate?)

51. 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

54. I would like my mate to find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant



J. ACTIVITY: THE FEMALE CARESSING THE MALE'S GENITALS WITH HER HANDS.

When you and your mate engage in sexual behavior, does this particular activity usually occur? How often would you like this activity to occur? ("Sexual behavior" refers to any type of physical contact which is intended to be sexual by either you or your mate.)

55. 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

58. 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 mate finds this activity to be?

56. I find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

59. I think my mate finds this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

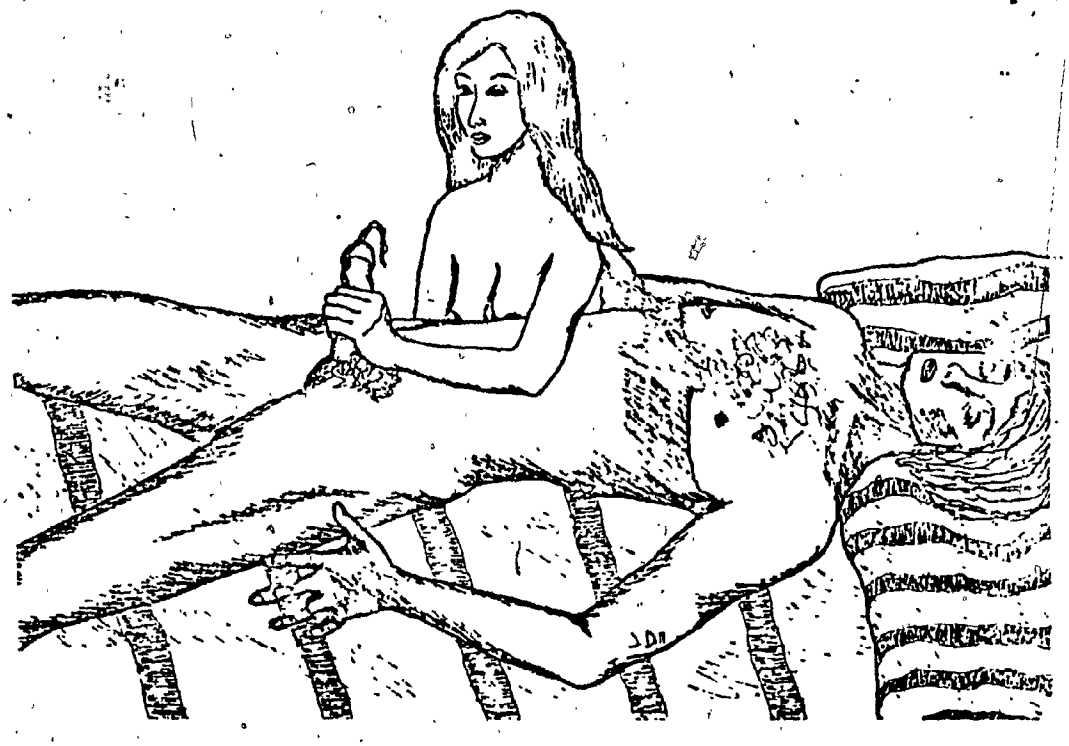
How would you like to respond to this activity? How would you like your mate to respond? (In other words, how pleasant do you think this activity <u>ideally should be</u> for you and for your mate?)

57. 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

60. I would like my mate to find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant



K. ACTIVITY: THE FEMALE CARESSING THE MALE'S GENITALS WITH HER HANDS UNTIL HE EJACULATES (HAS A CLIMAX).

When you and your mate engage in sexual behavior, does this particular activity usually occur? How often would you like this activity to occur? ("Sexual behavior" refers to any type of physical contact which is intended to be sexual by either you or your mate.)

61. 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

64. 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 mate finds this activity to be?

62. I find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

65. I think my mate finds this activity:

1) Extremely unpleasant
2) Moderately 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 mate to respond? (In other words, how pleasant do you think this activity <u>ideally should be</u> for you and for your mate?)

63. 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

66. I would like my mate to find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

L. ACTIVITY: THE MALE CARESSING THE FEMALE'S GENITALS WITH HIS MOUTH (LIPS OR TONGUE).

When you and your mate engage in sexual behavior, does this particular activity usually occur? How often would you like this activity to occur? ("Sexual behavior" refers to any type of physical contact which is intended to be sexual by either you or your mate.)

67. 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

70. 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 mate finds this activity to be?

68. I find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

71. I think my mate finds this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

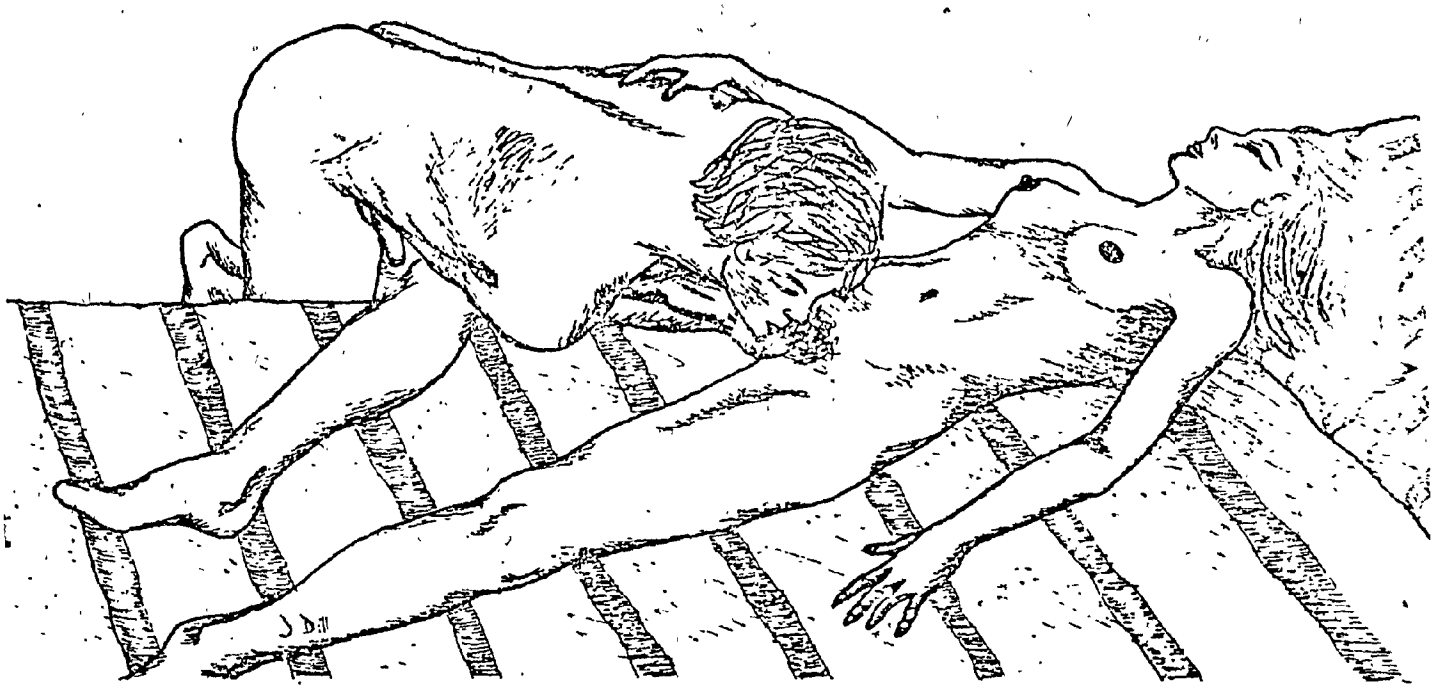
How would you like to respond to this activity? How would you like your mate to respond? (In other words, how pleasant do you think this activity <u>ideally should be</u> for you and for your mate?)

69. 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

72. I would like my mate to find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant



M. ACTIVITY: THE MALE CARESSING THE FEMALE'S GENITALS WITH HIS MOUTH UNTIL SHE REACHES ORGASM (CLIMAX).

When you and your mate engage in sexual behavior, does this particular activity usually occur? How often would you like this activity to occur? ("Sexual behavior" refers to any type of physical contact which is intended to be sexual by either you or your mate.)

73. 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

76. 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 mate finds this activity to be?

74. I find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

77. I think my mate finds this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

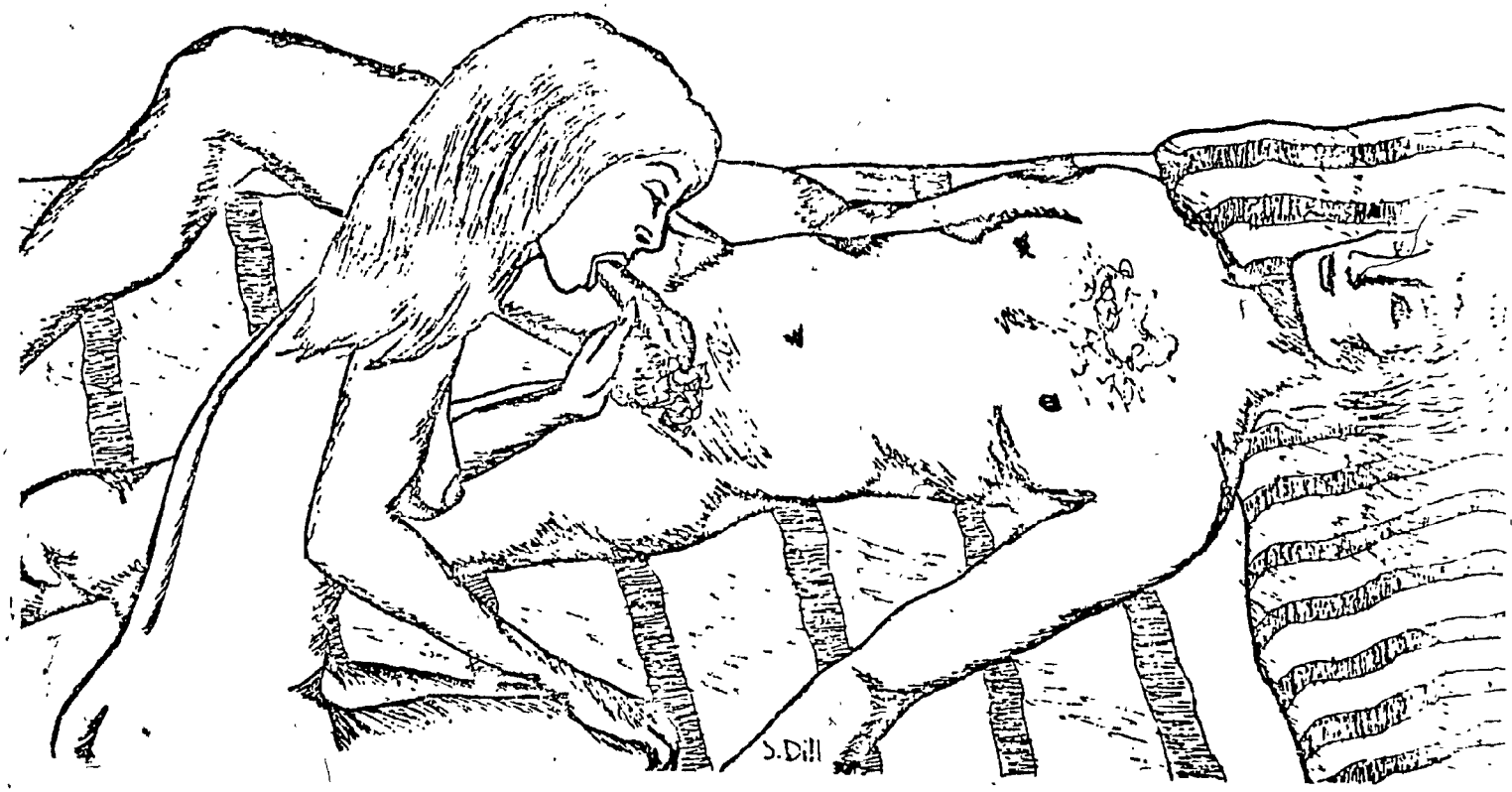
How would you like to respond to this activity? How would you like your mate to respond? (In other words, how pleasant do you think this activity <u>ideally should be</u> for you and for your mate?)

75. 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

78. I would like my mate to find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant



N. ACTIVITY: THE FEMALE CARESSING THE MALE'S GENITALS WITH HER MOUTH (LIPS OR TONGUE).

When you and your mate engage in sexual behavior, does this particular activity usually occur? How often would you like this activity to occur? ("Sexual behavior" refers to any type of physical contact which is intended to be sexual by either you or your mate.)

79. 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

82. 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 mate finds this activity to be?

80. I find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

83. I think my mate finds this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

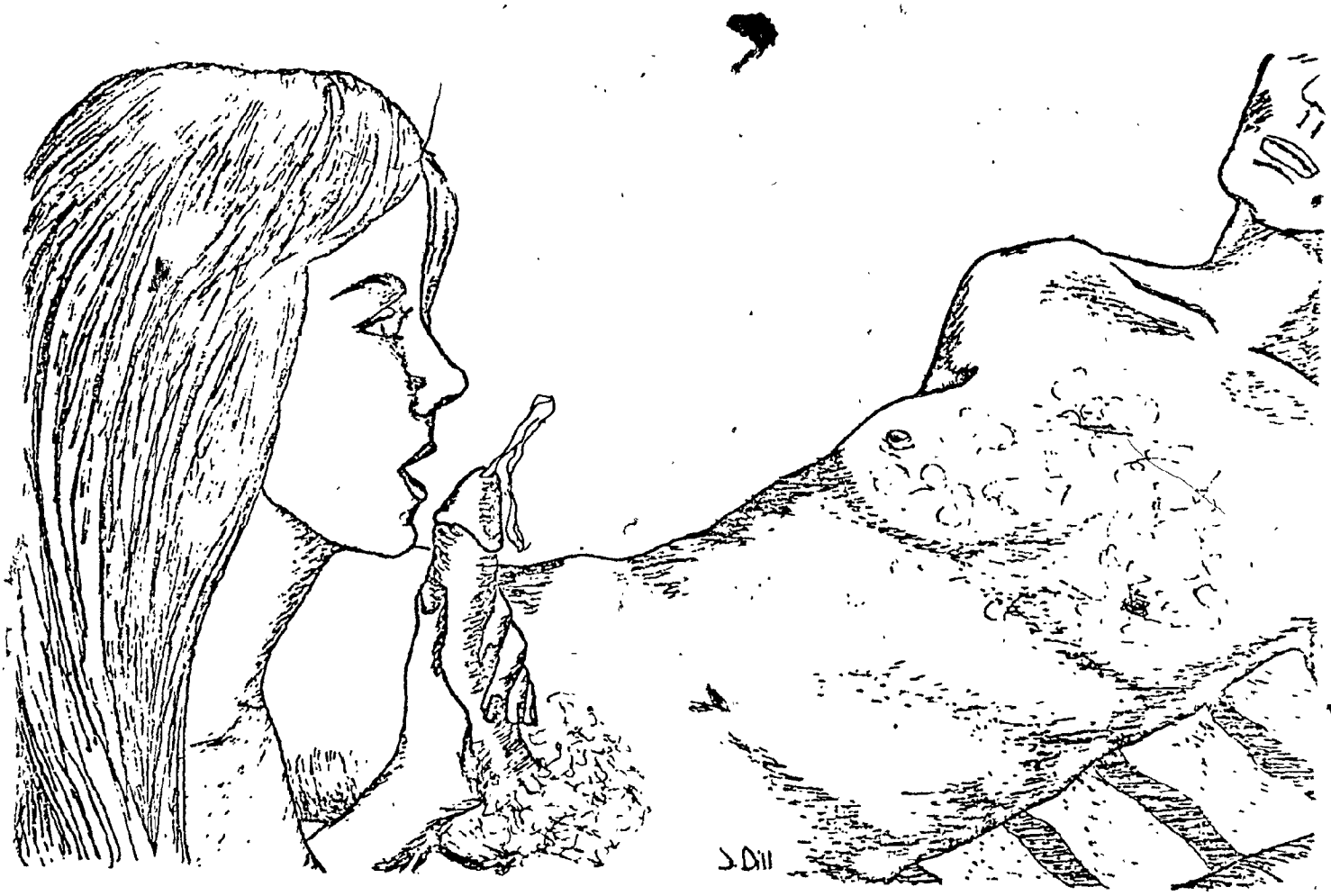
How would you like to respond to this activity? How would you like your mate to respond? (In other words, how pleasant do you think this activity ideally should be for you and for your mate?)

81. 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

84. I would like my mate to find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant



O. ACTIVITY: THE FEMALE CARESSING THE MALE'S GENITALS WITH HER MOUTH UNTIL HE EJACULATES (HAS A CLIMAX).

When you and your mate engage in sexual behavior, does this particular activity usually occur? How often would you like this activity to occur? ("Sexual behavior" refers to any type of physical contact which is intended to be sexual by either you or your mate.)

85. 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

88. 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 mate finds this activity to be?

86. I find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

89. I think my mate finds this activity:

1) Extremely unpleasant
2) Moderately 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 mate to respond? (In other words, how pleasant do you think this activity <u>ideally should be</u> for you and for your mate?)

87. 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

90. I would like my mate to find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

P. ACTIVITY: THE MALE AND FEMALE HAVING INTERCOURSE.

When you and your mate engage in sexual behavior, does this particular activity usually occur? How often would you like this activity to occur? ("Sexual behavior" refers to any type of physical contact which is intended to be sexual by either you or your mate.)

91. 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

94. 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 mate finds this activity to be?

92. I find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

95. I think my mate finds this activity:

1) Extremely unpleasant
2) Moderately 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 mate to respond? (In other words, how pleasant do you think this activity <u>ideally should be</u> for you and for your mate?)

93. 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

96. I would like my mate to find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

Q. ACTIVITY: THE MALE AND FEMALE HAVING INTERCOURSE WITH BOTH OF THEM HAVING AN ORGASM (CLIMAX).

When you and your mate engage in sexual behavior, does this particular activity usually occur? How often would you like this activity to occur? ("Sexual behavior" refers to any type of physical contact which is intended to be sexual by either you or your mate.)

97. 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

100. 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 mate finds this activity to be?

98. I find this activity:

1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

101. I think my mate finds this activity:

1) Extremely unpleasant
2) Moderately 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 mate to respond? (In other words, how pleasant do you think this activity <u>ideally should be</u> for you and for your mate?)

99. I would like to find this activity:

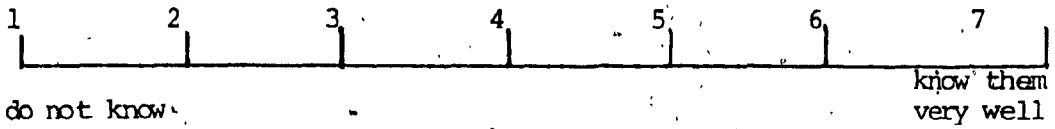
1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

102. I would like my mate to find this activity:

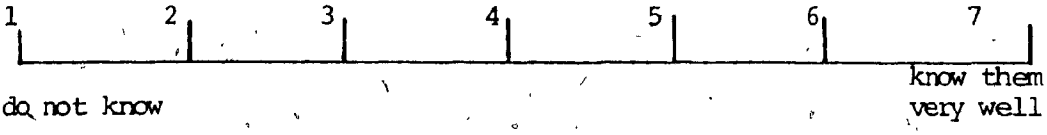
1) Extremely unpleasant
2) Moderately unpleasant
3) Slightly unpleasant
4) Slightly pleasant
5) Moderately pleasant
6) Extremely pleasant

Appendix E - Sexual Behaviour Questionnaire

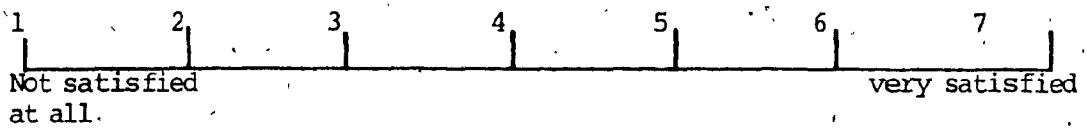
1. How well do you think you know your partner's sexual likes and dislikes?



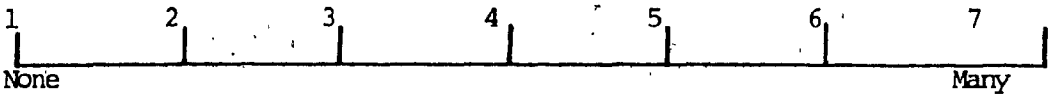
2. How well do you think your partner knows your sexual likes and dislikes?



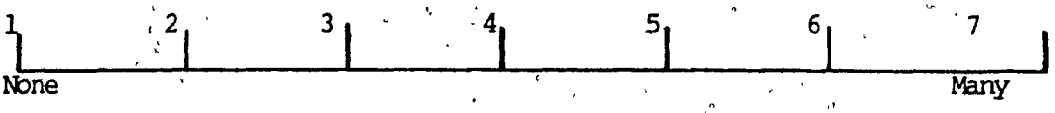
3. How satisfied are you with the ways in which you and your partner talk about sex in order to develop better ways of pleasing each other?



4. Do you have any thoughts or ideas which you think interfere with your sexual functioning?



5. Do you think your partner has any thoughts or ideas which interfere with his/her sexual functioning?



The following two questions are to be answered by the FEMALES ONLY

1. What is the extent of your vaginal lubrication during sexual activity?

2. Do you use any supplementary genital lubrication during sexual activity? e.g., Vaseline, Baby Oil, etc.

Yes_____

No _____

The following three questions are to be answered by the MALES ONLY

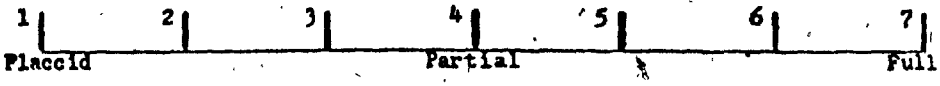
1. Select the phrase that best describes the pattern of your erection during sexual activity.

a) Do not obtain an erection at all.
b) Obtain an erection then lose it.
c) Obtain an erection, lose it, then regain it.

2. If you are experiencing erections, overall, estimate the length of time it takes you to get an erection during sexual activty?

a) 0 - 2 minutes
b) 3 - 5 minutes
c) 6 - 8 minutes
d) 9 - 11 minutes
e) 11 minutes or longer

3. Overall, what is the quality of your erection at ejaculation?



Appendix F

Goals for Sex Therapy

Name_____ Date_____

The following scales are intended to estimate your current satisfaction in each of the 15 goals listed.

You are to CIRCLE one of the numbers (1 - 7) beside each area. Numbers toward the left end of the scale indicate some degree of dissatisfaction and numbers toward the right end of the scale reflect varying degrees of satisfaction.

Ask yourself this question as you rate each goal area:- "HOW SATISPIED AM I PRESENTLY WITH MY ABILITY TO ACCOMPLISH THE PARTICULAR GOAL ITEM?"

In other words, state according to the numerical scale (1 - 7) exactly how satisfied you feel today. Try not to allow one item to interfere with your ratings of the other items.

(1) Being able to anticipate (think about) having intercourse without fear of anxiety

1 2 3 4 5 6 7

Much less than satisfied — Satisfied — Much more than satisfied

(2) Being able to get an erection by stimulating myself when I am alone

1 2 3 4 5 6 7

Much less than satisfied — Satisfied — Much more than satisfied

(3) Being able to get an erection during foreplay with a woman while both of us are clothed

1 2 3 4 5 6 7

Much less than satisfied — Satisfied — Much more than satisfied

(4)Being able to get an erection during foreplay while both of us are nude

1 2 3 4 5 6 7

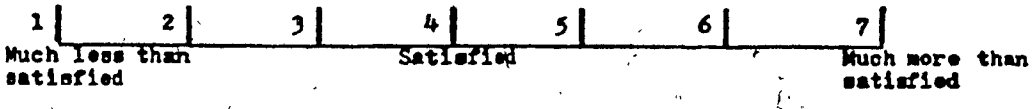
Much less than satisfied — Satisfied — Much more than satisfied

(5) Being able to regain an erection if I lose it during foreplay

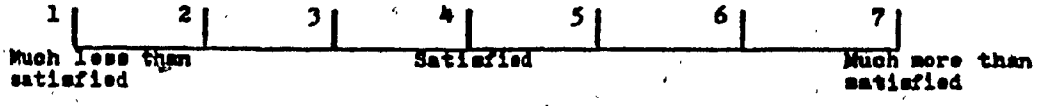
1 2 3 4 5 6 7

Much less than satisfied — Satisfied — Much more than satisfied

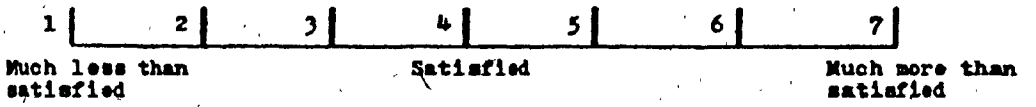
(6) Being able to get an erection sufficient to begin intercourse



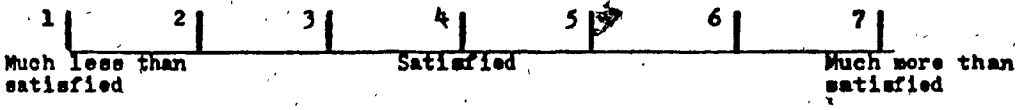
(7) Being able to keep an erection during intercourse until I ejaculate



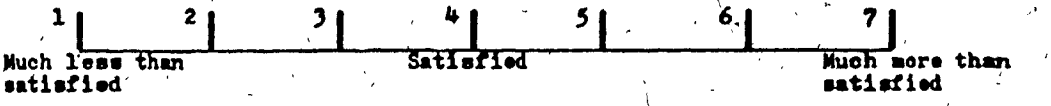
(8) Being able to regain an erection if I lose it during intercourse



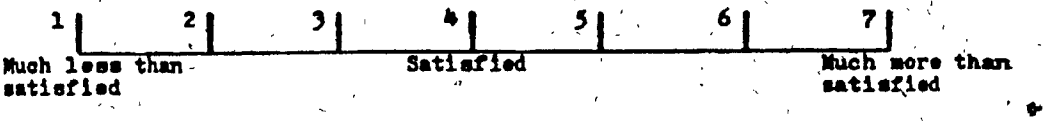
(9) Being able to get an erection sufficient for intercourse within a reasonable period of time



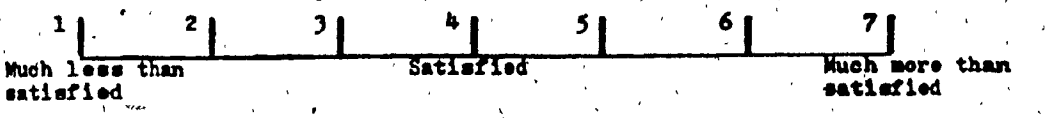
(10) Being able to engage in intercourse for as long as I like without ejaculating



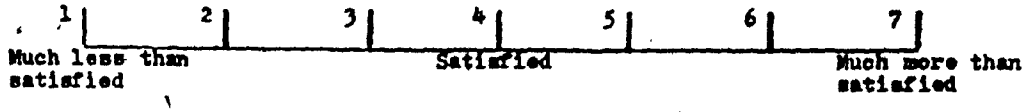
(11) Being able to stimulate my partner to orgasm by means other than intercourse



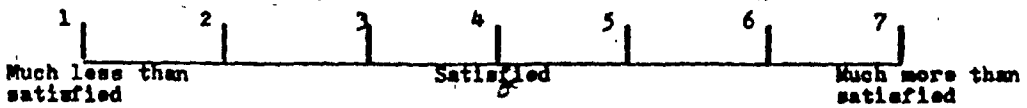
(12) Feeling like I am sexually desirable to my partner



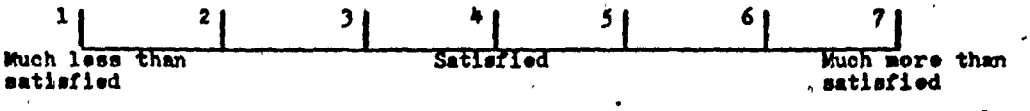
(13) Feeling comfortable about my own sexuality



(14) Being able to enjoy a sexual encounter without having intercourse



(15) Being able to anticipate a sexual encounter without feeling I should have intercourse



Appendix G

NAME _____

ERECTION DIFFICULTY QUESTIONNAIRE

Instructions: This questionnaire is designed to provide information about various aspects of the erection problems which a man and his partner may experience.

For each question, check (✓) the response which best fits your answer from the list of alternative responses.

1. During sex I worry about what my partner is thinking or feeling about my performance, especially if I am having (would have) erection difficulty.

____Always ____Usually ____Sometimes ____Rarely ____Never

2. Even though I admit to myself that I have an erection problem, I tell my partner(s) that "I've had too much to drink," "I guess I'm just tired," or something else so they may not know about my problem.

____Always ____Usually ____Sometimes ____Rarely ____Never

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

____Always ____Usually ____Sometimes ____Rarely ____Never

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

____Always ____Usually ____Sometimes ____Rarely ____Never

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

____Always ____Usually ____Sometimes ____Rarely ____Never

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

____Always ____Usually ____Sometimes ____Rarely ____Never

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

____Always ____Usually ____Sometimes ____Rarely ____Never

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

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

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

___Always ___Usually ___Sometimes ___Rarely ___Never

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

___Always ___Usually ___Sometimes ___Rarely ___Never

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

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

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

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

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

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

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

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

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

___Always ___Usually ___Sometimes ___Rarely ___Never

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

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

Erection Difficulty Questionnaire 3

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

____Always ____Usually ____Sometimes ____Rarely ____Never

18. Because of my erection problem, I do not attempt sexual intercourse (entering my partner and moving until orgasm) even if I am engaging in other sexual activities with my partner.

____Always attempt ____Usually attempt ____Sometimes attempt ____Rarely attempt ____Never attempt

19. My penis remains hard enough for me to stay inside of my partner until I ejaculate (reach orgasm).

____Always ____Usually ____Sometimes ____Rarely ____Never

20. I am dissatisfied with my sexual functioning.

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

21. If I (would) have difficulty getting or keeping an erection during sex, I (would) feel uncomfortable about telling my partner what types or amounts of sexual stimulation I want or need.

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

22. I would rather avoid sex altogether than to experience erection problems again.

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

23. I know how I could help myself if I had an erection problem again.

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

24. I feel (would feel) anger or resentment if I have (would have) erection difficulty during sexual activities with a partner.

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

Appendix H - Improvement Questionnaire (males)

1. Generally speaking, has your level of satisfaction with your ability to get and/or maintain an erection changed since the beginning of treatment?

___improved completely ___improved considerably ___improved slightly ___no change ___worse

2. Generally speaking, have your feelings about yourself as a sexual person changed since the beginning of treatment?

___improved completely ___improved considerably ___improved slightly ___no change ___worse

3. In general, have your feelings about yourself (how you feel about yourself as a person) changed since the beginning of treatment?

___improved completely ___improved considerably ___improved slightly ___no change ___worse

Appendix H - Improvement Questionnaire (female)

1. Generally speaking, has your level of satisfaction with your partner's ability to get and/or maintain an erection changed since the beginning of treatment?

___improved completely ___improved considerably ___improved slightly ___no change ___worse

2. Generally speaking, have your feelings about yourself as a sexual person changed since the beginning of treatment?

___improved completely ___improved considerably ___improved slightly ___no change ___worse

3. In general, have your feelings about yourself (how you feel about yourself as a person), changed since the beginning of treatment?

___improved completely ___improved considerably ___improved slightly ___no change ___worse

Appendix I

NAME_____

DATE_____

DAILY RECORD KEEPING SHEET
(Please fill out alone)

(1) Sexual activities (please check in column 1 if the activity occurred)

Individual Activities	1	2	3
a) fantasies (daydreams)	___	___	___
b) dreams	___	___	___
c) masturbation	___	___	___
d) reading erotica	___	___	___
e) seeing erotica	___	___	___
f) other (specify below)	___	___	___
Interpersonal activities			
g) kissing	___	___	___
h) caressing-non genital (giving)	___	___	___

i) caressing
j) breast ca
k) genital t
l) genital t
m) oral stim
n) oral stim
o) anal stim
p) anal stim
q) mutual ma
r) intercour
s) other (sp

(2) Please look at Scale A on the right and then rate each activity noted above in terms of how it compared with the last time you engaged in that activity. Write in the rating in the second blank above.

SCALE A

very much less enjoyable			much less enjoyable			slightly less enjoyable			no change	slight more enjoya	
-10	-9	-8	-7	-6	-5	-4	-3	-2	-1	0	+1	+2	+3

(3) How did you feel about your sexual experience today? very negative somewhat negative

(4) Did you experience any orgasm(s)?
If yes, during which activity? _____

(5) What medication, alcohol or dru

(6) How satisfied are you with the amount of affection you received today? very dissatisfied somewhat dissatisfied mixed som

(7) In general how did you feel about your partner today? very negative somewhat negative

The following two questions are intended for only the husbands.

(8) Please look at Scale B on the right and then rate the quality of erection you obtained for each activity noted above. Write in the rating in the third blank above.

Scale B

(9) Circle the point on Scale C that describes your overall concern with having an erection while you were engaging in any sexual activity.

Scale C

1 of

Appendix I

DAILY RECORD KEEPING SHEET
(Please fill out alone)

Individual Activities	1	2	3
a) fantasies (daydreams)	___	___	___
b) dreams	___	___	___
c) masturbation	___	___	___
d) reading erotica	___	___	___
e) seeing erotica	___	___	___
f) other (specify below)	___	___	___
Interpersonal activities			
g) kissing	___	___	___
h) caressing-non genital (giving)	___	___	___
i) caressing--non genital (receiving)	___	___	___
j) breast caressing	___	___	___
k) genital touching (giving)	___	___	___
l) genital touching (receiving)	___	___	___
m) oral stimulation (giving)	___	___	___
n) oral stimulation (receiving)	___	___	___
o) anal stimulation (giving)	___	___	___
p) anal stimulation (receiving)	___	___	___
q) mutual masturbation	___	___	___
r) intercourse	___	___	___
s) other (specify below)	___	___	___

s (please
the

cale A on the
ach activity
of how it
t time you
ity. Write
second

SCALE A

very much less enjoyable			much less enjoyable			slightly less enjoyable			no change	slightly more enjoyable			much more enjoyable			very much more enjoyable		
-10	-0	-8	-7	-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6	+7	+8	+9	+10

about your sexual experience today? very negative somewhat negative neutral somewhat positive very positive
ce any orgasm(s)?
hich activity? _____ (5) What medication, alcohol or drugs did you take today? _____

e you with the amount of
ceived today? very dissatisfied somewhat dissatisfied mixed somewhat satisfied very satisfied
id you feel about your partner today? very negative somewhat negative neutral somewhat positive very positive

o questions are intended for only the husbands.

cale B on the
ate the quality
obtained for each
ove. Write
the third blank

Scale B

1 no erection at all — 2 — 3 — 4 partial erection — 5 — 6 — 7 Full erection

on Scale C that
erall concern
ection while
in any

Scale C

1 not at all concerned — 2 — 3 — 4 mildly concerned — 5 — 6 — 7 very concerned

Appendix J

Interview Protocol

I Demographic

Name (M)_____ Name (F)_____

* Age (M)_____ Age (F)_____

Occupation (M)_____ Occupation (F)_____

* Education level (M)_____ Education level (F)_____

* Ability to read English (M)_____ (F)_____

Address_____ Phone #_____

Years Married_____ How referred_____

Income (M)_____ Income (F)_____

II General Information

(1) Have either of you ever received professional help for an emotional, marital, sexual or fertility problem? If yes, describe for what, when and for how long.

_____
_____
_____

(2) Do either of you have any medical problems that might interfere with sexual functioning? Describe.

_____
_____

(3) Other than your sexual difficulty, are there any other difficulties with your marital relationship? Describe.

_____
_____

(4) Have you had a recent check-up with a urologist/gynecologist? When? Any complications?

_____
_____

(5) What is your rate of drug and alcohol consumption? (Male only)

_____
_____

(6) Are you currently taking any medication? Describe. (Male only)

_____
_____

III Sexual Activity

(1) What is your current frequency of engaging in any type of sexual activity?

_____

(2) What types of sexual activities do you most often engage in?

_____

_____

*(3) What is the frequency in which you engage in or attempt to engage in sexual intercourse per month?

_____

(4) What is your masturbation frequency? (M & F)

_____

IV Problem (ask male have wife corroborate)

*(1) Describe your sexual problem.

_____

_____

_____

_____

*(2) How long have you had this problem?

_____

(3) Was the onset of the problem sudden or gradual over time?

_____

(4) Do you think the onset of the problem was associated with a significant event? Describe.

_____

(5) Describe your sexual functioning before this problem occurred?

_____

_____

(6) Are you able to obtain erections in any particular situations? e.g., in the morning? when reading pornography? when dreaming? etc.

_____

_____

(7) When you engage in sexual intercourse, what percentage of the time is it totally successful?

_____

(8) When you engage in intercourse, describe the quality of your erections? e.g., partial, full than lose, etc.

_____

(9) When you engage in intercourse, what is the quality of your erection at ejaculation?

_____

V Wife's functioning (ask wife have husband corroborate)

(1) Considering your own sexual functioning, does your sexual life have any problems?
e.g. Are you satisfied with your ability to achieve orgasm?
Do you ever experience pain or discomfort during intercourse?
Do you lack desire to engage in sexual activity?
Do you have any extreme inhibitions toward sex?
Do you have difficulty lubricating?
Did these problems predate your husband's problem?

_____

_____

_____

_____

_____

Appendix K - Instructions for Ban-Communication Group

This is a short-term training program of one month's duration which will consist of carrying out 2 procedures that we believe may help to improve your sexual functioning. Firstly, for the next month you are both to refrain from engaging in or even attempting to engage in sexual intercourse. Please note that I am talking about only abstaining from intercourse, not other forms of sexual activities. Let me explain the reasons why a period of abstinence from intercourse could have positive results on your sexual performance. Sexual problems often arise because we become, over time, too focussed on the act of sexual intercourse to the exclusion of enjoying the pleasures of caressing and being touched. Instead of allowing yourself to enjoy the sexual excitement produced by the sight and feel of each other's bodies, you become worried or anxious about sexual arousal and having an erection for intercourse. This anxiety itself often disrupts your ability to get an erection. By banning intercourse, the intention is to get rid of any worries about your being able to have erections and open the door to enjoying sex. Once you have relearned to enjoy sex play, this often leads to regaining the ability to have erections. Most people can enjoy forms of love making other than intercourse. Some of these activities might include: gently massaging and caressing the body, kissing or orally stimulating one's partner's body, exploring and discovering where certain types of touch make you feel particularly responsive, and touching the genitals. It is important to simply enjoy the feelings and the sense of learning and exploration. If an erection occurs simply accept it and enjoy the sensation, but do not, at this time, proceed to have intercourse. You need to have some time to relax and enjoy the pleasures your body can bring without the pressure of having to engage in intercourse.

Secondly, during any sexual encounter you have together in this month you are to communicate with your partner about your sexual likes and dislikes. You are to focus on using verbal and non-verbal communication to help guide your partner in sexual activity. For example, you can let each other know with words what you would like him/her to do for you sexually. Tell each other what kind of touch is best for you, what feels good or what should change about the way you are caressing one another. You can say things like "A little lighter would feel better", or "Mmm...that feels great". Verbal communication should be given in a gentle, positive manner. What is said and the tone of your voice should indicate whether you like what is being done, and if not, what your partner could do differently. As well, at times, rather than speaking, you might try non-verbal communication. For example, you could place your hand over your partner's hand and guide it to indicate the kind of stroke you like so that you are being touched in the way that feels most pleasant. Let me explain why this procedure may help to enhance your sexual relationship. Communicating your reactions, whatever they may be, will help your partner to better understand your sexual needs and preferences. There is a lot of pressure on men and women, particularly men, to be experts at sex. Many men believe that they are supposed to be good lovers without being told the right thing to do to please their partner. This kind of situation only increases worries and tension which interfere with really enjoying yourself sexually. In addition, communicating your specific likes and dislikes gives your partner vital information on how you are feeling during sexual activity - information that only you can provide. Communication of sexual preferences can enhance your sexual relationship by guiding and teaching your partner the location and the kinds of touch to

which you are responsive.

In summary, as explained, we are asking you for one month, to a) Refrain absolutely from attempting or engaging in intercourse, whether you obtain an erection or not. You are only to engage in pleasurable sexual activities other than intercourse, and b) To communicate and explain carefully your sexual likes and dislikes to each other, both verbally and non-verbally, during these sexual encounters.

Appendix L - Instructions for Communication-Only Group

In our experience couples with sexual difficulties derive benefit from a little background information on this area of human functioning. Although sexuality comes in many cultural wrappings, members of different societies have always been concerned with the problems engendered by their sex lives. For instance, there is recorded as early as 1400 B.C. a prescription of massive doses of tiger testicles for the treatment of impotence. While no society is devoid of sexual problems, historically however, Western society has been reluctant to acknowledge this fact. Sex therapy as a specialty was virtually unknown in the first half of this century and was practised largely by psychoanalysts who saw their patients' problems as only surface expressions of childhood conflicts. Thus traditionally sexual concerns, if acknowledged at all, were not directly treated. Eventually, however, these assumptio were challenged. The first sex researchers to challenge this point of view publicly were Masters and Johnson. Not only did they claim that sexual problems were widespread (they estimated that more than 50% of married couples experience sexual problems at one time or another), but Masters and Johnson advocated the stance of taking the sexual problem at face value. And through the use of prescribed "homework" assignments, they supplied evidence of treatment effectiveness. Although some features of their original format have been modified by other sex researchers and therapists the basic assumption that sexual problems can be treated directly remains a hallmark.

There is often uncertainty in people's minds as to the meaning of the term "impotence". Occasionally it is confused with two other male sexual problems, namely the inability to conceive children or the lack of control over the ejaculatory response. We currently rely on a specific definition of impotence furnished by Masters and Johnson. In our usage of

the term, impotence refers only to erectile difficulties, specifically, the persistent inability to obtain or maintain an erection sufficient for intercourse. This program in which you are now involved has been designed to help couples to overcome the problem of male erectile difficulty.

This is a short term training program of one month's duration which will consist of carrying out a procedure that we believe may help to improve your sexual functioning. For the next month, during any sexual encounter you have together, you are to communicate with your partner about your sexual likes and dislikes. Please note I am not asking that you restrict the type or frequency of sexual activity you currently engage in. However, when engaging in any sexual encounters, including intercourse, you are to focus on using verbal and non-verbal communication to help guide your partner in making love to you. For example, you can let each other know with words what you would like him/her to do for you sexually. Tell each other what kind of touch is best for you, what feels good or what should change about the way you are caressing one another. You can say things like "A little lighter would feel better", or "Mmm... that feels great". Verbal communication should be given in a gentle, positive manner. What is said and the tone of your voice should indicate whether you like what is being done, and if not, what your partner could do differently. As well, at times, rather than speaking, you might try non-verbal communication. For example, you could place your hand over your partner's hand and guide it to indicate the kind of stroke you like so that you are being touched in the way that feels most pleasant. Let me explain why this procedure may help to enhance your sexual relationship. Communicating your reactions, whatever they may be, will help your partner to better understand your sexual needs and preferences. There is a lot of pressure on men and women, particularly men, to be experts at sex. Many men believe that they are supposed to be good lovers without

being told the right thing to do to please their partner. This kind of situation only increases worries and tension which interfere with really enjoying yourself sexually. In addition, communicating your specific likes and dislikes gives your partner vital information on how you are feeling during sexual activity - information that only you can provide. Communication of sexual preferences can enhance your sexual relationship by guiding and teaching your partner the location and the kinds of touch to which you are responsive.

In summary, as explained, we are asking you for one month to communicate and explain carefully your sexual likes and dislikes to each other, both verbally and non-verbally, during any sexual encounter.

Appendix M

T-test Comparisons between Groups on Sample Characteristics

Variable		Ban-Communication	Communication-Only	df	t[a]
Age (males)	M	48.5	48.4	14	.02
	SD	5.67	10.21		
Age (females)	M	45.8	45.8	14	.03
	SD	5.5	10.0		
Education (males)	M	11.75	11.75	14	0
	SD	2.8	3.0		
Education (females)	M	12.8	12.8	14	0
	SD	2.3	2.7		
Duration of Relationship	M	21.4	18.6	14	.56
	SD	9.0	12.4		
Combined Annual Income	M	43,125	39,375	14	.30
	SD	24,630	25,560		
Problem Duration	M	2.2	6.2	14	1.55
	SD	1.4	7.2		
Sexual Activity	M	6.1	6.4	14	.11
	SD	4.4	4.9		
Marital Adjustment Scale (males)	M	110.4	96.0	14	.22
	SD	26.6	17.4		
Marital Adjustment Scale (females)	M	109.1	99.9	14	.34
	SD	19.0	18.2		

[a] all t values N.S., $p > .05$.

Variable		Ban-Communication	Communication-Only	df	t[a]
Testosterone	M	574.6	615.1	14	.72
	SD	223.1	226.5		
Prolactin	M	8.1	10.8	14	.14
	SD	2.7	3.9		
LH	M	12.1	11.6	14	.85
	SD	6.9	4.0		
FSH	M	20.1	28.0	14	.23
	SD	14.9	10.0		
MMPI Scale 1 (HS) (males)	M	48.8	55.6	14	.07
	SD	7.5	6.3		
MMPI Scale 1 (HS) (females)	M	55.0	57.0	14	.72
	SD	7.2	13.8		
MMPI Scale 2 (D) (males)	M	63.4	62.0	14	.75
	SD	7.6	8.9		
MMPI Scale 2 (D) (females)	M	62.8	57.4	14	.42
	SD	11.9	13.9		
MMPI Scale 3 (Hy) (males)	M	54.6	57.6	14	.48
	SD	6.6	9.7		
MMPI Scale 3 (Hy) (females)	M	62.8	58.1	14	.44
	SD	10.8	12.2		

[a] all t values N.S., $p > .05$

Variable		Ban-Communication	Communication-Only	df	t[a]
MMPI Scale 4 (Pd) (males)	M	50.1	57.6	14	.08
	SD	8.1	8.0		
MMPI Scale 4 (Pd) (females)	M	56.5	55.5	14	.81
	SD	9.4	6.2		
MMPI Scale 5 (Mf) (males)	M	64.5	64.1	14	.94
	SD	11.0	8.4		
MMPI Scale 5 (Mf) (females)	M	51.0	45.1	14	.25
	SD	9.5	9.8		
MMPI Scale 6 (Pa) (males)	M	52.6	51.0	14	.64
	SD	7.6	6.1		
MMPI Scale 6 (Pa) (females)	M	52.8	50.8	14	.66
	SD	9.6	8.4		
MMPI Scale 7 (Pt) (males)	M	53.3	59.5	14	.11
	SD	5.3	9.0		
MMPI Scale 7 (Pt) (females)	M	55.5	52.9	14	.64
	SD	11.2	10.6		
MMPI Scale 8 (Sc) (males)	M	53.6	59.4	14	.17
	SD	8.9	7.0		
MMPI Scale 8 (Sc) (females)	M	56.1	58.1	14	.69
	SD	4.5	13.1		

[a] all t values N.S., $p > .05$.

Variable		Ban-Communication	Communication-Only	df	t[a]
MMPI Scale 9 (Ma) Males)	M	52.6	58.6	14	.18
	SD	10.7	5.1		
MMPI Scale 9 (Ma) (females)	M	46.6	49.4	14	.63
	SD	11.5	11.1		
MMPI Scale 10 (Si) (males)	M	53.6	53.3	14	.95
	SD	13.2	12.2		
MMPI Scale 10 (Si) (females)	M	56.0	53.0	14	.54
	SD	7.5	11.1		

[a] all t values N.S., $p > .05$.

Appendix N

T-Test Comparisons between Groups on Test Variables at Pre-Treatment 1

Variable		Ban-Communication	Communication-Only	df	t[a]
Duration of Sexual Foreplay (SHF)	M	3.9	4.1	14	.68
	SD	1.1	1.2		
(SHF) Satisfaction with Sexual Relationship	M	2.6	3.4	14	.47
	SD	1.8	2.1		
Difficulty Obtaining Erection (SHF)	M	3.9	4.1	14	.78
	SD	1.7	1.8		
Difficulty Maintaining Erection (SHF)	M	5.1	4.9	14	.66
	SD	0.8	1.4		
Frequency Satisfaction (SII)	M	27.3	21.0	14	1.12
	SD	14.4	6.6		
Self-Acceptance (SII)	M	6.1	7.1	14	.40
	SD	2.9	6.5		
Pleasure Mean (SII)	M	5.5	5.0	14	1.92
	SD	0.2	.71		
Perceptual Accuracy (SII)	M	12.3	13.0	14	.33
	SD	5.7	3.1		
Mate-Acceptance (SII)	M	17.0	7.3	14	1.40
	SD	18.9	5.8		

[a] all t values N.S., $p > .05$.

Variable		Ban-Communication	Communication-Only	df	t[a]
Total Summary Scale (SII)	M	117.1	102.8	14	.45
	SD	42.3	30.7		
Knowledge of Sexual Likes/ Dislikes (SBQ)	M	5.4	5.9	14	.46
	SD	1.5	1.1		
Partners' Knowledge of Sexual Likes/ Dislikes (SBQ)	M	5.0	5.3	14	.74
	SD	1.4	1.5		
Satisfaction with Sexual Communication (SBQ)	M	4.6	4.5	14	.89
	SD	1.8	1.6		
Amount of Interfering Thoughts (SBQ)	M	3.6	2.9	14	.39
	SD	1.4	2.0		
Quality of Erection at Ejacualtion (SBQ)	M	4.3	4.6	14	.64
	SD	1.3	1.8		
Time to Obtain Erection (SBQ)	M	2.6	3.3	14	.42
	SD	1.4	1.6		
Goals for Sex Therapy	M	46.6	51.0	14	.60
	SD	20.2	11.5		
Erection Difficulty Questionnaire	M	74.5	66.8	14	.25
	SD	15.1	9.9		

[a] all t values N.S., $p > .05$.

T-Test Comparisons between Groups on Record Form Variables at Baseline

Variable		Ban-Communication	Communication-Only	df	t[a]
Sexual Encounter Frequency	M	5.4	4.3	13	.61
	SD	4.4	3.5		
Masturbation Frequency	M	0.1	0.7	13	.30
	SD	0.4	1.5		
Intercourse Frequency	M	1.9	2.1	13	.82
	SD	1.9	2.5		
Quality of Sexual Experience	M	1.0	1.1	12	.81
	SD	0.8	0.8		
Orgasmic Frequency	M	0.4	0.3	13	.81
	SD	0.3	0.4		
Affection Satisfaction	M	0.8	0.6	13	.65
	SD	0.8	0.4		
Feelings Toward Partner	M	0.8	0.7	13	.84
	SD	0.8	0.3		
General Erection Quality	M	4.5	4.2	12	.67
	SD	1.6	1.7		
Erection Quality in Intercourse	M	6.0	5.1	9	.41
	SD	1.3	2.0		
Concern Regarding Erection	M	3.7	2.7	12	.28
	SD	1.5	1.7		
Success: Experience Ratio	M	32.4	32.0	13	.03
	SD	0.3	0.3		

[a]all t values N.S., $p > .05$.

Appendix O

ANOVA Summary Tables for Test and Record Form Variables

Table O.2

Frequency of Difficulty Maintaining Erections: ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	.141	1	.141	.038
S (Subjects)	52.469	14	3.748	
B (Time)	47.047	3	15.682	15.717*
A X B	.797	3	.266	.266
S X B	41.906	42	.998	

*$p < .001$.

Table 0.1

Frequency of Difficulty Obtaining Erections: Anova Summary Table

Source	SS	df	MS	F
A (Group)	1.890	1	1.890	.241
S (Subjects)	109.719	14	7.837	
B (Time)	10.672	3	3.557	4.795*
A X B	.422	3	.141	.190
S X B	31.156	42	.742	

*$p < .01$.

Table 0.3

Length of Time to Get Erection: ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	1.266	1	1.266	.251
S (Subjects)	70.594	14	5.042	
B (Time)	6.047	3	2.016	2.183
A X B	1.422	3	.474	.513
S X B	38.781	42	.923	

Table 0.4

Quality of Erection at Ejaculation: ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	.391	1	.391	.077
S (Subjects)	71.219	14	5.087	
B (Time)	32.297	3	10.766	15.508*
A X B	2.297	3	.766	1.103
S X B	29.156	42	.694	

* $p < .001$.

Table C.5

Erection Difficulty Questionnaire: ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	791.016	1	791.016	1.655
S (Subjects)	6692.590	14	478.042	
B (Time)	3828.920	3	1276.310	23.357*
A X B	42.297	3	14.100	.258
S X B	2295.030	42	54.644	

* $p < .001$.

Table 0.6

Goals for Sex Therapy: ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	129.391	1	129.391	.169
S (Subjects)	10721.300	14	765.810	
B (Time)	5853.420	3	1951.140	14.340*
A X B	960.797	3	320.266	2.354
S X B	5714.530	42	136.060	

* $p < .001$.

Table 0.7

Duration of Sexual Foreplay: ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	6.250	1	6.250	1.156
S (Subjects)	75.688	14	5.407	
B (Time)	2.563	3	.854	2.746
A X B	.875	3	.292	.938
S X B	13.063	42	.311	

Table O.8

Satisfaction with Sexual Relationship: ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	13.141	1	13.141	1.765
S (Subjects)	104.219	14	7.444	
B (Time)	19.922	3	6.641	4.314*
A X B	2.672	3	.891	.579
S X B	64.656	42	1.540	

* $p < .01$.

Table O.10

SII Sexual Frequency Satisfaction Scale: ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	60.063	1	60.063	.093
S (Subjects)	9046.690	14	646.192	
B (Time)	335.875	3	111.958	3.296*
A X B	174.563	3	58.188	1.713
S X B	1426.560	42	33.966	

* $p < .05$.

Table 0.9

Amount of Interfering Thoughts: ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	.016	1	.016	.003
S (Subjects)	85.469	14	6.105	
B (Time)	14.297	3	4.766	3.049*
A X B	9.797	3	3.266	2.089
S X B	65.656	42	1.563	

* $p < .05$.

Table O.11

SII Sexual Pleasure Mean Scale: ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	3.195	1	3.195	4.54*
S (Subjects)	9.857	14	.704	
B (Time)	.178	3	.059	.959
A X B	.165	3	.055	.891
S X B	2.599	42	.062	

* $p < .05$.

Table O.13

SII Self-Acceptance: ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	213.891	1	213.891	1.894
S (Subjects)	1581.09	14	112.935	
B (Time)	19.297	3	6.432	.527
A X B	65.172	3	21.724	1.781
S X B	512.281	42	12.197	

Table 0.12

SII Perceptual Accuracy Scale: ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	26.266	1	26.266	.392
S (Subjects)	937.219	14	66.944	
B (Time)	137.672	3	45.891	4.16*
A X B	9.672	3	3.224	.292
S X B	463.406	42	11.034	

* $p < .05$

Table O.14

SII Mate-Acceptance: ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	552.250	1	552.250	.834
S (Subjects)	9269.69	14	662.121	
B (Time)	48.563	3	I6.188	.811
A X B	140.375	3	46.792	2.345
S X B	838.063	42	19.954	

Table O.16

Marital Adjustment Scale: ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	4917.520	1	4917.520	2.968
S (Subjects)	23197.700	14	1656.980	
B (Time)	914.047	3	304.682	4.333*
A X B	58.297	3	19.432	.276
S X B	2953.410	42	70.319	

* $P < .01$.

Table 0.15

SII Summary Scale: ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	17.016	1	17.016	.003
S (Subjects)	77639.000	14	5545.640	
B (Time)	3914.670	3	1304.890	4.876*
A X B	1022.670	3	340.891	1.274
S X B	11239.400	42	267.605	

* $p < .01$.

Table O.17

Knowledge of Partner's Sexual Likes/Dislikes: ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	2.641	1	2.641	.556
S (Subjects)	66.469	14	4.748	
B (Time)	1.297	3	.432	.986
A X B	1.547	3	.516	1.18
S X B	18.406	42	.438	

Table O.18

Perception of Partner's Knowledge of Sexual Likes/Dislikes:

ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	.141	1	.141	.028
S (Subjects)	70.719	14	5.051	
B (Time)	.422	3	.141	.308
A X B	2.172	3	.724	1.587
S X B	19.156	42	.456	

Table 0.19

Sexual Communication Satisfaction: ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	2.250	1	2.250	.244
S (Subjects)	129.00	14	9.214	
B (Time)	3.125	3	1.042	1.522
A X B	.625	3	.208	.304
S X B	28.750	42	.685	

Table O.20

Improvement in Erectile Ability: ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	.521	1	.521	.482
S (Subjects)	15.125	14	1.080	
B (Time)	3.375	2	1.688	2.864
A X B	.792	2	.396	.672
S X B	16.500	28	.589	

Table O.21

Improvement in Sexual Self-Concept: ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	.188	1	.188	.137
S (Subjects)	19.125	14	1.366	
B (Time)	4.625	2	2.313	4.246*
A X B	.125	2	.063	.115
S X B	15.250	28	.545	

* $p < .05$.

Table 0.22

Improvement in General Self-Concept: ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	2.521	1	2.521	1.862
S (Subjects)	18.958	14	1.354	
B (Time)	1.500	2	.750	1.881
A X B	.667	2	.333	.836
S X B	11.167	28	.399	

Table 0.27

Noncoital Sexual Encounter Frequency: ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	1.944	1	1.944	.059
S (Subjects)	427.833	13	32.901	
B (Time)	5.644	2	2.822	.511
A X B	7.463	2	3.731	.676
S X B	143.560	26	5.522	

Table O.26

Sexual Encounter Frequency:

ANOVA with Simple Main Effects Summary Table

Source	SS	df	MS	F
A (Group)	2.173	1	2.173	.059
S (Subjects)	477.738	13	36.750	
B (Time)	4.844	2	2.422	.397
A X B	45.977	2	22.989	3.771*
S X B	158.512	26	6.097	
$B(A_1)$ (Time for Ban-Communication Group)	11.58	2	5.79	.950
$B(A_2)$ (Time for Communication-Only Group)	39.24	2	19.62	3.218**
$A(B_1)$ (Group at baseline)	4.43	1	4.43	.272
$A(B_2)$ (Group at treatment)	40.74	1	40.74	2.492
$A(B_3)$ (Group at follow-up)	2.98	1	2.98	.183
Pooled Error	-	21	16.314	

* $p < .05$.

** $p < .06$.

Table 0.24

Erection Quality in Intercourse: ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	2.362	1	2.362	.832
S (Subjects)	25.536	9	2.837	
B (Time)	1.060	1	1.060	1.281
A X B	.236	1	.236	.285
S X B	7.448	9	.828	

Table 0.23

General Erection Quality: ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	.200	1	.200	.028
S (Subjects)	85.118	12	7.093	
B (Time)	5.798	2	2.899	2.533
A X B	.404	2	.202	.177
S X B	27.461	24	1.144	

Table 0.25

Concern Regarding Erection: ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	6.034	1	6.034	1.323
S (Subjects)	54.753	12	4.563	
B (Time)	12.396	2	6.198	4.267*
A X B	2.536	2	1.268	.873
S X B	34.862	24	1.453	

* $p < .05$.

Table 0.28

Quality of Sexual Experience:

ANOVA with Simple Main Effects Summary Table

Source	SS	df	MS	F
A (Group)	.362	1	.362	.255
S (Subjects)	15.600	11	1.418	
B (Time)	.186	2	.093	.409
A X B	2.409	2	1.205	5.30*
S X B	5.005	22	.227	
$B(A_1)$ (Time for Ban-Communication Group)	1.295	2	.648	2.852
$B(A_2)$ (Time for Communication-Only Group)	.804	2	.402	1.771
$A(B_1)$ (Group at baseline)	.029	1	.029	.046
$A(B_2)$ (Group at treatment)	2.698	1	2.698	4.324*
$A(B_3)$ (Group at follow-up)	.147	1	.147	.236
Pooled Error	-	18	.624	

* $p < .05$.

Table O.30

Masturbation Frequency: ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	2.115	1	2.115	.192
S (Subjects)	142.863	13	10.990	
B (Time)	18.178	2	9.089	2.262
A X B	8.013	2	4.006	.997
S X B	104.476	26	4.018	

Table 0.29

Intercourse Frequency: ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	.860	1	.860	.201
S (Subjects)	55.607	13	4.277	
B (Time)	.033	1	.033	.013
A X B	.038	1	.038	.014
S X B	34.429	13	2.648	

Table 0.31

Orgasmic Frequency: ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	.000	1	.000	.000
S (Subjects)	2.938	13	.226	
B (Time)	.147	2	.074	.995
A X B	.042	2	.021	.280
S X B	1.925	26	.074	

Table 0.32

Affection Satisfaction: ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	.085	1	.085	.089
S (Subjects)	12.402	13	.954	
B (Time)	.786	2	.393	6.818*
A X B	.347	2	.173	3.007
S X B	1.500	26	.058	

* $p < .005$.

Table 0.33

Feelings Toward Partner: ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	.024	1	.024	.024
S (Subjects)	11.853	12	.988	
B (Time)	.072	2	.036	.305
A X B	.202	2	.101	.858
S X B	2.826	24	.118	

Table O.34

Success:Experience Ratio: ANOVA Summary Table

Source	SS	df	MS	F
A (Group)	.030	1	.030	.187
S (Subjects)	2.107	13	.162	
B (Time)	.668	1	.668	7.08*
A X B	.027	1	.027	.285
S X B	.123	13	.009	

* $p < .05$.