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Attitude Change of Spinal Cord Injured Males and Their Marital Partner Involved in a Sexual Therapy Program

Joan B. Scott

ATTITUDE CHANGE OF SPINAL CORD INJURED MALES · SCOTT

THE UNIVERSITY OF NEW MEXICO
ALBUQUERQUE, NEW MEXICO 87106

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ATTITUDE CHANGE OF SPINAL CORD INJURED MALES AND THEIR MARITAL PARTNER INVOLVED IN A SEXUAL THERAPY PROGRAM

Title

Joan B. Scott

Candidate

Guidance and Counseling

Department

John P. Zepper

Dean

August 19, 1974

Date

Committee

Wayne R. Mais

Chairman

Sidney Rosenbaum

Marvin Walter Shelton

STATEMENT BY AUTHOR

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ATTITUDE CHANGE OF SPINAL CORD INJURED MALES AND THEIR MARITAL PARTNERS INVOLVED IN A SEXUAL THERAPY PROGRAM

BY
JOAN B. SCOTT
B.A., The University of New Mexico, 1969
M.A., The University of New Mexico, 1971

DISSERTATION

Submitted in Partial Fulfillment of the
Requirements for the Degree of
Doctor of Philosophy
in the Graduate School of
The University of New Mexico
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J. B. S.

The University of New Mexico
1974

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ABSTRACT OF DISSERTATION

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Joan B. Scott, Ph.D.
Department of Guidance and Counseling
The University of New Mexico, 1974

The purpose of this investigation was to study the changes in attitude of a group of spinal cord injured males and their marital partners after a sexual therapy treatment program. The investigation utilized a two-group design. The experimental group consisted of five couples who had sought treatment of difficulties in the sexual aspect of their relationship and had indicated some degree of inadequacy in this area on the part of one or both partners. The control group consisted of five similar couples who agreed to wait or did not feel ready for the treatment program. In both groups the male partner had suffered a spinal cord lesion and the effects of the injury presented problems in the sexual sphere of the relationship with their partner.

Subjects were placed in groups on an expediency basis. Couples who were ready and able to participate in the treatment program were placed in the experimental group. Couples for whom time and/or distance problems hindered their participation in the treatment program were

placed in the control group. All subjects were volunteers and were unpaid.

The major instrument of this investigation was Q-technique which offers a statistically efficient method of studying attitude change over time. Couples in the control group were administered the Q-sort battery twice with a one month interval between the tests. This measurement established the test-retest reliability of the instrument and also its temporal stability. Couples in the experimental group took the Q-sort prior to entry into the Caplan and Caplan treatment program and immediately thereafter (one month later). This measurement attempted to demonstrate attitude change in the area of sexuality which took place due to the treatment program. Individuals in both groups were administered the Q-sort regarding <u>themselves</u> and a second sort regarding their view of <u>their partner</u> in the sexual area.

Significance of change was analyzed by the Fisher Z_r transformation applied to the experimental group's pre:post and post:post:post correlations. A one tail test of significance was applied to the normal deviate because the direction of change was implicit in the investigation (toward lower correlations for the experimental group).

The results of testing the null hypotheses in terms of group data were:

1. Participation by individuals in the treatment program

resulted in significant change in attitude toward themselves in the sexual area as measured by Q-sort.

2. Participation by individuals in the treatment program resulted in significant change in attitude toward their partner in the sexual area as measured by Q-sort.

The results of testing the null hypotheses for individuals were:

1. Participation by individuals in a treatment program resulted in significant change in attitude toward themselves in the sexual area as measured by Q-sort for three (of five) males and two (of five) females.
2. Participation by individuals in a treatment program resulted in significant change in attitude toward their partner in the sexual area as measured by Q-sort for three males and three females.

The results of testing the remaining hypotheses were:

1. Participation by individuals in a treatment program resulted in a significant difference between males and females with regard to change in attitude toward themselves in the sexual area.
2. Participation by individuals in a treatment program resulted in no significant difference between males and females with regard to change in attitude toward their partner in the sexual area.

3. Participation by individuals in a treatment program resulted in fewer individuals showing as significant change in attitude as was found in the Caplan (1973) investigation.

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CHAPTER I

THE PROBLEM AND DEFINITION OF TERMS USED

Purpose

The purpose of this investigation was to study the changes in attitude after a sexual therapy treatment program of a group of couples in which the male was spinal cord injured. It was also an attempt to ascertain whether the Caplan and Caplan treatment program was as effective in producing attitude change with this population as it was shown to be in the Caplan (1973) study with abled-bodied persons.

Assumptions

For this investigation, the following assumptions were made: (a) attitude(s) could be measured by the instruments used, and (b) changes which might be present at the end of the treatment program would be reflected in such measurement. These assumptions were based on the work of Rogers and Dymond (1954), Stephenson (1953), and Mowrer (1953), in that Q-sort technique provides a convenient means to measure changes in attitudes.

Importance of the Study

A statement made in an article by Ann Shearer (1972) emphasizes the importance of the problem under investigation:

> Of all the problems that disabled people come up against in their dealings with society, our attitudes

> toward their emotional and sexual needs are probably least discussed of all. We talk increasingly of offering physically handicapped people as "normal" a life as possible and as long as we stick to exhortations about community care or job opportunities, it's a good enough yardstick. But when it comes to offering opportunities for emotional and sexual expression we prefer to duck.

In the past decade those with spinal cord injuries have begun to insist that they are entitled to a satisfactory sex life, a respectable self image and the expectation of being treated like other people who have a need for emotional, sexual expression. Breslin (1971) found that many veterans mourned their lost sexual abilities more than any other functional loss. Six years previously the loss of ambulation was said to be the overriding concern of spinal cord injured veterans. However, recently sexual loss seams to have become increasingly important and for some regaining sexual performance is more important than regaining the ability to walk.

Hohmann (1972) states,

> In the past there has been a general feeling among some professional staff that the less said to injured patients regarding sexual functioning, the better; and that "repressive mechanisms" should be allowed to take their course in stifling thoughts and preoccupations about sexuality.
>
> [However], a substantial number of marriages between cord injured men and their wives have continued with a good relationship for more than a quarter of a century based on a sexual relationship that consists of a profound love, and affection and understanding combined with only the most casual petting and kissing and other expressions of tenderness. It should be clear from these

> experiences that those professionals who presume to tell their patients that their sexual lives are over . . . and advise against establishing a permanent sexual liaison not only show the gross ignorance of facts, but do serious harm to the patients who trust them.

A review of the literature concerning spinal cord injuries and sexual functioning leads to the following conclusions: (a) a considerable amount of medical knowledge has been amassed concerning the physical consequences of a spinal cord injury and possible sexual functioning, (b) very little knowledge of the psychological concomitants of disability and sexual functioning is known, and (c) very little information is available dealing with sexual therapy with the disabled.

The first method developed for treating sexual dysfunction was the Masters and Johnson (1970) model, developed to take place during a two-week period of time with a single, non-disabled couple. This model was based on a positive reinforcement strategy, with emphasis on: helping the couple relax, alleviation of pressure, elimination of demands for performance, getting in touch with the body by means of sensate focus, etc. Others, notably Hartman and Fithian of the Long Beach Institute of Marital Studies (1972) and Lazarus (1971, Ch. 7), have broadened the behavioral base in various ways.

> Caplan and Caplan (1973), whose program was utilized in this investigation, have adopted the therapy models of Masters and Johnson and of Hartman and Fithian and the unpublished

> teaching model of the National Sex Forum through the use of intensive ongoing individual and group psychotherapy, transactional analysis, gestalt therapy and multi-media materials. This program takes place over a three-day period of 25-30 hours of group therapy and individual couple sessions, employing two to four therapists in attendance with from four to eight couples. In addition to the weekend program, each couple is seen individually for three to six preparatory sessions and there are from three to four follow-up sessions.

The Caplan and Caplan model differs somewhat from other models primarily in the utilization of group process and in the goals for individuals and couples participating. Although sexual dysfunction is treated, the primary goals are: (a) each member of the couple leaves each sexually toned encounter feeling better about himself (herself) and about the partner, and (b) attitudes and freedom regarding sex will change as a result of the program. The Caplan and Caplan model and goals seemed highly appropriate for sexual therapy with couples in which the male partner was spinal cord injured.

Caplan (1973) found significant change in attitude in a group of physically normal, sexually inadequate couples who participated in the Caplan and Caplan program. This investiagation was primarily concerned with replicating this previous study using couples in which a physical disability (spinal cord injury) was a major factor in their emotional, sexual lifespace.

Hypotheses

For purposes of this investigation the following null hypotheses will be tested:

1. Participation by individuals in a treatment program results in no significant change in attitude toward themselves in the sexual area as measured by a Q-sort.

2. Participation by individuals in a treatment program results in no significant change in attitude toward their partner in the sexual area as measured by a Q-sort.

3. Participation by individuals in a treatment program results in no major differences between the males and females in the study with regard to change in attitudes toward themselves in the sexual area.

4. Participation by individuals in a treatment program results in no major differences between the males and females in the study with regard to change in attitude toward their partners in the sexual area.

5. The individuals in the experimental group will not show as significant a change in attitude as was shown by the individuals in the Caplan (1973) investigation.

Limitations of the Study

1. The couples who entered the treatment program

for the purpose of improving their sexual relationship were volunteers.

2. The investigator was part of the therapy team which might result in an experimenter bias.

3. The small sample size may not allow for generalization to other than the experimental group itself.

Definition of Terms

For the purpose of this investigation, the following definitions were made to clarify their use in this study.

Couple. Two individuals of the opposite sex involved in an ongoing, committed relationship to each other. In the majority of cases the committed relationship included a legal marriage. In all cases the male was spinal cord injured.

Treatment Program. The sexual therapy model as evolved by Caplan and Caplan. This model will be discussed in the chapter on methodology and described specifically in Appendix A.

Disability. A spinal cord lesion, complete or incomplete, resulting in the loss of ambulation.

CHAPTER II

REVIEW OF THE LITERATURE

Sexual Therapy

As early as 1896 Havelock Ellis argued that attitudes toward sex were individual and culturally determined. Ellis' series, Studies in the Psychology of Sex (1896-1926), presented a great departure from the traditionally held notion in Western civilization that claimed human sexuality to be the same in all people. This work is the keystone of all modern research in the area of human sexuality. Alfred C. Kinsey (1948, 1953) presented the first quantitative information dealing with actual sexual behavior and beliefs. With the two major Kinsey studies, the groundwork was laid for scientific research in the area of normal sexual functioning.

In 1954 Masters and Johnson began an eleven-year study of how the human body responds during sexual functioning. The results of their research are published in their first book, Human Sexual Response (1966). In 1958 Masters and Johnson began a second research project which included a clinical investigation of sexual dysfunction and also the development of a therapy program for the removal of symptoms of sexual inadequacy.

In the past traditional psychotherapy frequently assumed that if conflicts in other areas of a marriage were resolved, the sexual relationship would automatically improve, and therefore need not be discussed with clients by the therapist on any but the most superficial level. However, increasing numbers of practicing psychotherapists have become aware that this change in the sexual relationship does not necessarily follow improvement in other areas. According to Masters and Johnson (1970), "One out of every two marriages is a sexual disaster area."

The sexual therapy model developed by Masters and Johnson was the first in the area of the treatment of sexual problems which worked in a couple relationship and on a short term basis. In their second book, Human Sexual Inadequacy (1970) the authors present a detailed statistical analysis of their successes and failures in treatment. The study included 510 married couples and 57 single people. The total dysfunctional individuals treated was 790. The overall success rate after a period of five years' follow-up was 74.5 percent. "This success rate has never been approached by other forms of therapy" (Belliveau & Richter, 1970).

The concepts underlying the Masters and Johnson treatment program were:

a. Attitudes and ignorance, rather than any mental or physical illness, are responsible for most sexual problems.

b. The relationship between the partners is the patient. There is no such thing as an uninvolved partner in any marriage in which there is some form of sexual inadequacy.

The goal of this treatment program was the elimination of sexual dysfunction and the restoration of adequate sexual functioning within the couple. Masters and Johnson considered the primary presenting symptoms of sexual inadequqcy to be: lack of orgasm, primary and secondary impotence, prematurity, ejaculatory incompetence and vaginismus or painful intercourse. A detailed account of the behavioral techniques utilized to treat these problems was presented in Human Sexual Inadequacy (1970).

Classical behavior therapy is defined as "the use of experimentally established principles of learning for the purpose of changing unadaptive behavior" (Wolpe, 1968). However, the Masters and Johnson behavioral model is more closely aligned to the view taken by Lazarus (1958).

> Where necessary, the behaviorist or objective psychotherapist employs all the usual psychotherapeutic techniques, such as support, guidance, insight, catharsis, interpretation, environmental manipulation, etc, but in addition . . . the behavior therapist applies objective techniques which are designed to inhibit specific neurotic patterns.

In his recent book, Behavior Therapy and Beyond (1971), Lazarus stated,

> Effective psychotherapy frequently necessitates an appreciation of the subtle interplay between biological, psychological and sociological factors. Nowhere is this more fundamental than in the treatment of sexual problems. To consider sexual

> intercourse merely an expression of a "drive" or "need" is to ignore the network of social values, cultural taboos and personal attitudes that permeate every aspect of this frenetic embrace. Very few sexual problems stem entirely from structural, hormonal, or neurotic deficiencies. The overwhelming majority of sexual problems stem from psychological (attitudinal) determinants (p. 141).

Hartman and Fithian of the Center for Marital and Sexual Studies, Long Beach, follow this model closely.

> We have a bio-psycho-social approach to the treatment of human sexual dysfunction. We believe the physical background and current physical status should be examined; someone with a physical problem should be referred for medical care. This is the biological aspect of our program. We agree with Freud that the image one has about one's self stems from the basic biological image; therefore, it is important that the basic biology be dealt with before the program moves on to consideration of feelings concerning one's self. Self-concept, along with psychological testing forms the psychological portion of the program. It is important that this be done before one is put in touch with someone else--this is the sociological step in the program. This process is an interdisciplinary approach to the resolution of sexual dysfunction (1972).

The Hartman and Fithian program includes a series of steps, activities and exercises moving the individual and couple toward becoming more intimately in touch with their own feelings and the feelings of the significant other. They regard their program as action oriented rather than "talk" psychotherapy. Treatment of Sexual Dysfunction (1972) outlines the Hartman and Fithian model, discusses their client population and research, and describes their adaptation of a behaviorally based sexual treatment program.

Until recently the research reported on attitude change with sexual therapy has utilized verbal self report as the only measurement tool. Caplan (1973) studied the changes in attitude of a group of sexually inadequate couples after a sexual treatment program. The investigation utilized Q technique which offers a mechanically efficient method of studying measurable aspects of the self over a period of time. The results of the Caplan investigation were that participation by couples in a treatment program results in significant change in attitude towards themselves and their partners in the sexual area as measured by Q-sort.

Previous Research on Sexuality in Spinal Cord Injured Subjects

A large body of literature exists on the subject of sexual functioning in spinal cord injured subjects. This literature is largely restricted to considerations of the mechanical and biologic aspects of conventional sexual behavior in males, particularly erection, ejaculation and orgasm.

Griffith, Tomko and Timms (1973) summarized nine major studies in this area in which all information had been gathered by interview or questionnaire. The combined populations of male spinal cord injured subjects exceeded 2,000. Erection occurred in 54 to 87 percent of subjects. Ejaculation occurred in 3 to 20 percent of subjects; that

is much less frequently than did erection. Orgasm was reported as occurring even less frequently than ejaculation. When intercourse was attempted, there was greater than 50 percent probability of success. The matter of libido (defined by Griffith from "interest in sexual intercourse" to "broad psychosexual desire") was considered in several of the summarized studies and depending on definition was found in 50 to 100 percent of spinal cord injured subjects.

Griffith et al. (1973) suggested that one area of study requiring further elaboration was that of the attitudes and feelings of both sexual partners toward their relationship and its physical expression.

At the 17th V.A. Spinal Cord Injury Conference Talbot stated,

> Sexuality comprises three major factors--psychic, gonadal and neuromuscular. Confusion has existed in evaluating the first of these because it has not always been distinguished from perception of somatic stimuli. Loss of the latter is frequent but, in the vast majority of patients, psychosexual content remains substantially normal in spite of its divorce from the soma. Allowing for the distractions of illness, discomfort, and fear, which are antagonistic to libidinous impulses in neurologically intact individuals as well, those patients retain the same erotic interests they exhibited before injury.

Money (1960) interviewed fourteen men and seven women, who were cord injured, with special reference to their "cognitional eroticism" and dream eroticism. Although this author concluded that in general patients did not have the subjective feelings of sexual urge and gratification they formerly experienced, he found that it is possible for vivid orgasm imagery to

occur in dreams of paraplegics, despite total lack of somesthetic sensation from, and paralysis of the genito-pelvic area. "'Cognitional eroticism' is a variable of sex that may be entirely independent of genitopelvic sensation and action" (Money, 1960).

Although some authors in the field, notably Fox (1971) do not feel that sex education and therapy are desirable for the severely physically handicapped, the trend toward exploring this area is expanding. Hohmann (1972) attributes this trend to what he terms the "now" generation who have been raised with many less inhibitions and less emphasis on repression of sexual thoughts and feelings.

In a comprehensive survey of psychosocial rehabilitation programs in the V.A. cord centers Morgan, Hohmann and Davis (1971) found an overwhelming demand on the part of veterans for counseling and instruction in altered sexual functioning which was unmet by the staff. A few patients who had been fortunate enough to receive good advice and counseling found this was probably the most helpful service that they had received at the Cord Injury Center.

George W. Hohmann (1972) in an attempt to answer this need published a brief paper listing suggestions on: who should talk about sex, what is to be told, what kinds of sexual activities are open to the cord injured, what

are the sexual rewards and some precautions. He states,

> Generally speaking, cord injured people should be inclined to engage in whatever types of sexual activities are physiologically possible and which are pleasing, esthetic, gratifying and acceptable to both the cord injured person and his partner. The counselor should begin by assuming that some genital functioning is possible until experience, time and careful neurological examination demonstrate this not to be so. Too many professionals approach the patient with the assumption that "sex is a dead issue."

The University of Minnesota Medical School has adopted the National Sex and Drug Forum educational format in a training program required for its medical students. The program uses speakers and films of explicit sexual activity together with trained professional leaders for small group discussion. It deals directly with sexual attitudes by means of demythologizing sexual behavior and desensitizing students to hasty or emotional overreactions to sexual stimuli. At the same time, a resensitization toward gentle, humanistic and professional understanding is attempted. A major area dealt with in the medical student training course is sexual function in physical disability (Chilgren, 1971).

Cole, Chilgren and Rosenberg (1972) used the medical school model to develop a unique program for paraplegic and quadraplegic men and women. An intensive two-day program was developed for both spinal cord injured and able bodied persons to deal with sexual attitudes and activities.

Fifty-five participants ranging in age from 16 to 59 took part in the first workshop. The first ten hours in the workshop were spent in desensitizing participants to explicit sexual material so they could deal with their own sexual feelings more easily during the remainder of the workshop. Presentations and movies explained or graphically described conventional and controversial aspects of human sexuality. Pertinent literature was recast for ready understanding by people with no medical background. Essential to the process were small group discussions with twelve to fourteen people per group. These were led by experienced group leaders whose task was to facilitate conversation about feelings in the group.

A comparison of the small group interaction between medical students and spinal cord injured members revealed some interesting differences. For the spinal cord injured: (1) There was a lack of interest in the topic of masturbation. Conversation focused on one person masturbating another. (b) Disabled groups more quickly came to grips with meaningful discussion. They were ready and able to discuss their sexual concerns much more openly and less defensively than the able bodied groups. (c) Oral-genital sex was much more acceptable and the role of fantasy was very strong. The ability to substitute satisfaction of one's partner for personal physical satisfaction and to use the partner's sensory experience to stimulate

one's own sexual fantasy became evident. (d) At the conclusion of the program, discussions in the disabled groups had testimonials of greater warmth and feeling than did discussions by the able bodied.

At the conclusion of the workshop participants were asked, "Are you glad you attended the workshop on sexual function in the spinal cord injured?" One hundred percent of the participants reported they were glad or very glad. It should be remembered, however, that the participants were personally invited to attend and therefore would be expected to react favorably. A second measure of the workshop was investigated by asking, "Has the workshop in sexual function in spinal cord injury been helpful or harmful to you?" Ninety-eight percent of the participants indicated that it had been helpful. Two percent indicated it had "no effect." No one indicated that it had been a harmful experience. Ninety-eight percent of the participants felt that a deliberate program dealing with human sexuality should be offered on a voluntary basis to all spinal cord injured adults. Two percent did not answer the question. Finally, a large majority felt that such a deliberate program should be offered during the first hospitalization or certainly during the first six months after injury.

Several authors have looked at the personality coorelates and emotional consequences of spinal cord injury. Gunther (1969) stated,

> For a majority of instances spinal cord injuries tend to occur to individuals with certain personality and social characteristics, i.e., young adult males between the ages of 15 and 40 who earn their living in some active or outdoor vocation. Many of them are passive-aggressive characters with a strong tendency to express in a direct way the aggressive side of their ambivalent emotional conflicts. Generally in personality and emotional make-up they resemble adolescents. The injury almost completely limits the discharge of aggressive energy, imposes a severe restriction on activity and requires the patient to rely on verbal channels for relating to others and for expressing feelings. These people of action rather than contemplation usually have few inner emotional resources for gratification and frequently lack the capacity for fantasy as a means of discharging their impulses. The injury itself prevents previous modes of behavior and confronts patients with painful unacceptable impulses, to which they frequently respond with verbal provocation and disturbed behavior. Ironically, these individuals who are least well endowed to cope with such blows are the ones who most frequently incur them.

Johnson (1974) reported that the sequence of emotions following spinal cord injury is:

1. Denial possibly combined with anger,
2. Depression,
3. Aggression and anger,
4. Acceptance.

These four phases which at times overlap or recur cyclicly were frequently reported in the literature.

The effects of spinal cord lesions on experienced emotional feelings were studied by Hohmann (1966). In structured interviews 25 adult males with spinal lesions at varying levels were asked to compare certain of their emotional feelings before and after injury. The investigator,

himself a paraplegic, knew all subjects well. The major findings were:

1. Significant decreases in experienced feelings of anger, sexual excitement, fear and an over-all estimate of change were found.
2. Although spinal cord lesions decrease some emotional feelings, overt emotional behavior may continue to be displayed.
3. A trend was noted which suggests that the more extensive the destruction, the greater the decrease in emotional feeling.
4. A significant increase in the feeling of sentimentality was noted.

Most studies on the rehabilitation of spinal cord injured subjects deal specifically with physical and/or vocational rehabilitation. A limited amount of research is available regarding the social and psychological rehabilitation of these subjects. Comarr(1962) and Guttmann (1964) broached the issue by looking at the marriage and divorce rates of spinal cord injured males in the United States and England respectively. Because that literature had only indirect bearing on this investigation, it was not reported in detail here. Rusk (1967) pointed out the need to give the injured patient's spouse as much information, counseling and outside help as possible in order to maintain the relationship.

Two studies were found concerning the use of group therapy in the rehabilitation of spinal cord injured and amputees. Mann, Godfrey and Dowd (1973) reported the use of on-going groups based on a self-concept approach with hospitalized, disabled patients. Although no measurement instrument was employed, observational measures demonstrated that self-concept did improve through the group process.

In another study eight lower limb amputees discussed self-image, inadequacy, dependency, morbidity, deprivation, separation and pain in a group setting. The goals of the therapy were to assist in development of motivation, to provide group support, to reduce feelings of isolation, and to provide opportunity to discuss problems. It was demonstrated that group therapy can be a useful technique in rehabilitation of amputees (Richards, 1966).

Summary

The theoretical background of sexual therapy was presented with particular attention to the program and research of Masters and Johnson. The behavioral basis for the treatment program utilized in this investigation was clarified. Pertinent literature dealing with the sexual functioning of spinal cord injured subjects was presented. The Minnesota program dealing with sexual therapy for paraplegics and quadraplegics was reported in

detail. Points of view held by several authors working with spinal cord injured patients were presented with an emphasis on the necessity for broadening the definition of sexual functioning and the need for expanded research and techniques in this area. The limited amount of information dealing with psychosocial rehabilitation and emotional consequences with a spinal cord injury was highlighted.

CHAPTER III

METHODOLOGY AND PROCEDURES

Design

The methodology and design in this investigation was primarily a replication of the Caplan (1973) study. The investigation utilized a two-group design. The experimental group consisted of five couples who expressed interest in the treatment of difficulties in the sexual aspects of their relationship and had indicated some degree of inadequacy in this area on the part of one or both partners. The experimental group is hereafter designated as Group A.

The control group (Group B) consisted of five couples who had expressed interest in participating in a treatment program but who agreed to wait or did not feel ready to enter the one investigated here. In both groups the male partner had suffered a partial or complete spinal cord lesion. All of the female partners were able-bodied. In each couple the male's physical disability had presented problems in the emotional-sexual sphere of their relationship. All participants volunteered to take part in the investigation.

The Caplan (1973) investigation utilized a second

control group (Group C) consisting of couples who indicated satisfactory and adequate sexual functioning on the part of both parnters. This control group was not used in this investigation for the following reasons:

1. The Caplan study showed no significant difference in the results of the testing (Q-sort correlations) between Group B and Group C.

2. Couples who met the requirements for Group C and in which the male partner was disabled were either inaccessible or not identifiable during this investigation.

Client Description

The two groups were chosen on an expediency basis. Couples who volunteered to participate in the program were placed in Group A. Couples who were not ready or who could not participate in the two treatment weekends were placed in Group B. For the most part Group B consisted of couples from out of Albuquerque who expressed an interest in treatment but time and distance problems prevented them from taking part in these particular workshops. Only two couples were not accepted for participation in this study. One was an elderly couple who presented special problems with aging and one male's physical disability was such that the required intensive three-day workshop was impossible.

The couples in the two groups were roughly matched

with respect to age, education, years of commitment and years of disability. For this matching, see Table 1, page 24. The code numbers given to each couple in this table were used for identification purposes throughout the experiment. The letters "M" and "F" were used to identify the male and female partners.

Instrumentation

Q-sort Technique

The instrument used in this investigation was the Q-sort or Q-technique which measures correlations within persons. Instead of giving a few tests to many persons, Q-technique gives many tests or demands many responses from one person. Correlation is between individuals over time instead of r between tests. William Stephenson (1953) who originated this technique was interested in the investigation of subjective as well as objective behavior. Norms based on large numbers are not prerequisites of Q methodology. The technique seemed appropriate for this investigation which utilized a small sample and which was interested in looking at subjective data, namely attitude change.

The individual being tested with Q methodology is forced to sort the responses into a normal distribution. This forced normal distribution results in an equalization of all means and standard deviations for each sort or test

TABLE 1

DESCRIPTION OF SUBJECTS

Group	Code Number	Age	Education in Years	Years of Commitment	Years of Disability
A	1M	28	17	2	9
	1F	32	13	2	-
	2M	30	21	2	1
	2F	24	19	2	-
	3M	23	14	1	3
	3F	21	15	1	-
	4M	47	13	7	5
	4F	46	15	7	-
	5M	53	9	27	9
	5F	48	12	27	-
Median, Group A		31	14.5	5	5
B	1M	31	17	3	8
	1F	23	13	3	-
	2M	50	15	31	5
	2F	50	13	31	-
	3M	28	13	2	4
	3F	37	15	2	-
	4M	27	12	1	3
	4F	25	16	1	-
	5M	36	13	2	5
	5F	33	16	2	-
Median, Group B		32	14	3	5

and is therefore efficient in terms of statistical manipulation. A segment of the personality, self, attitude or thinking behavior is represented statistically in a Q sort.

This investigation was concerned with looking at attitude change in the area of sexuality in a group of individuals (couples in which the male was spinal cord injured) over a period of time. Individuals in the control group were administered the Q sort battery twice with a one month interval between the pre- and posttest. The mean correlation for the pre- to posttest of the individuals in the control group established the test-retest reliability of the instrument and also the temporal stability of the Q sort.

The individuals in the experimental group were administered the first (pre) Q sort battery prior to their entry into the Caplan and Caplan treatment program (the independent variable in this investigation). At the end of the treatment program the individuals again were administered the Q sort battery. The correlation for each individual provided the measurement of the amount of change which took place for each participant (the dependent variable in this investigation).

A third administration of the Q sort was given to individuals in the experimental group one month following the posttest. This was done in an attempt to ascertain

the holding power of attitudinal change found on the pre- to posttest.

Item Selection

Q technique is a method in which an individual's attitude about a situation is expressed by ordering a set of cards bearing statements which are pertinent to the object of the research. The selection of the statements or items becomes particularly important in that conclusions drawn from the sort are limited by the items in the sort. Stephenson (1953) makes the following suggestion regarding item selection:

> . . . in Q, <u>any</u> sample of statements put together theoretically is, in principle, as acceptable as any other for the same design, but care is taken about such matters as conciseness, clarity, representativeness and the like. It is essential . . . to achieve a certain homogeneity in the sample: so that no item in it is picked out for special regard on any extraneous or incidental grounds (p. 76).

Cronbach (1953) has also listed three criteria which he regards as important in item selection:

> (a) . . . while logically bearing on the same domain, should represent a large number of continua. . . .
> (b) . . . statements being compared should have about the same average degree of desirability, over the entire population. . . .
> (c) . . . each statement should have substantial variance, in that different persons put it in different piles (p. 380).

This investigation utilized the Q sort developed for the Caplan (1973) study. Caplan (1973) stated:

> The items were selected in light of Cronbach's criteria. The fifty statements used in this

> investigation were selected from a universe of items gathered from records, history-taking interviews, and therapy sessions of over one hundred clients indicating couple/sexual problems. Some of the items were reworded for clarity. The items which were chosen were those which seemed to bear most closely on couple sexual adjustment and therefore were the most relevant for the purpose of this investigation. The item population in no way purported to represent all possible phases of personality, the self, or general adjustment, but was confined to a sample of a wide range of couple sexual adjustment which was deemed to be the legitimate concern within a sexual therapy treatment program.

The items are presented in Table 2, page 28.

Q-technique: The Forced Sort

It was noted previously that in Q-technique the sorter is forced to sort the cards into a normal distribution. The sorter is free to place any statement in any pile, but a designated number of statements must be placed in each pile. The statistical advantage of this forcing has already been mentioned. The forced choice also requires less time, gives more reliable ordering of items and saves the sorter from making many difficult decisions as compared with rank ordering. The problem which arises with free choice sorting which makes accurate comparisons difficult is also eliminated.

Traditionally Q-sorts have used 7, 9, or 11 piles. Eleven piles are normally used with a fifty-item sort as was utilized in this investigation. Table 3 below presents the frequency distribution used.

TABLE 2

THE FIFTY DESCRIPTIVE PHRASES USED IN THIS STUDY

1. Feel good about myself after sex
2. Feel good about my partner after sex
3. My sex life is O.K.
4. My partner is attractive to me
5. Seldom ask for what I want sexually from my partner
6. Often comfortable being nude with my partner
7. Comfortable with my own sexuality
8. Seldom have doubts about my masculinity/femininity
9. Usually feel satisfied after contact with my partner
10. Often find sex fun
11. Have few hang-ups or limitations about sexual activity
12. Often feel pressure from my partner
13. Feel free talking about sex with my partner
14. Often disappointed in myself
15. Often try to please or pleasure my partner
16. Feel uncertain about approaching my partner
17. Seldom feel guilty about sexual activities
18. Often find sex dirty or sinful
19. Am satisfied with my body
20. Frequently masturbate without guilt
21. Often tell my partner what pleases me
22. Often suggest variety in sex
23. Feel controlled or used in the sexual relationship
24. Usually enjoy staying close with my partner after sex
25. Usually feel tense during or after sexual activity
26. Often restrict or limit my own responses
27. Touch and pleasure my own body freely
28. Get satisfaction from giving to my partner
29. Have many doubts about myself
30. Seldom have oral sex
31. Find sex smelly or messy
32. Enjoy initiating sexual activity
33. My partner is satisfied with me sexually
34. Seldom have sexual problems
35. Feel driven for sexual activity
36. Reach climax most of the time
37. Seldom get enough foreplay before intercourse
38. Being seductive is O.K.
39. Enjoy being seduced by my partner
40. Feel better the next day after sex
41. Enjoy touching others
42. Argue about sex
43. Often disinterested in sex
44. Need more sex than my partner does
45. Look forward to sexual activity
46. Often have sexual dreams or fantasies
47. Am self-conscious or embarrassed easily
48. Seldom refuse my partner's request
49. Often feel my sexual advances will be rejected
50. Like myself in and out of bed

TABLE 3

FREQUENCY DISTRIBUTION FOR THE Q SORTS:

N = 50

	Least Like									Most Like
Pile no.	1	2	3	4	5	6	7	8	9	10	11
No. of items	1	2	4	7	7	8	7	7	4	2	1

Q-technique: Computation

The standard kind of coefficient of correlation and the one most commonly computed is Pearson's product-moment coefficient. This statistic was therefore chosen for use in this investigation. The same distribution was used for all sorts in the study and the formula was applied to each individual's sorts.

Correlation was measured by the formula

$$r = 1 - \frac{d^2}{2\ n\sigma^2}$$

in which r is the product moment correlation between the scores on a given statement for two sorts, N is the number of items in the sample (50 in this study), σ is the standard deviation of the forced distribution, and d^2 is the squared difference between the pile number of an item in two sorts. For example, if a particular item is placed in pile 7 in

one sort and pile 9 in another, the d^2 is 4. Correlations were made between the first and second (pre and post) administrations of the test battery for all groups and between the second and third (post and post-post) administrations for Group A (see Chapter IV, Statistical Findings).

Questionnaire

All Group A couples were asked to complete a questionnaire at the end of the three-day intensive workshop. Because this study was original research in the area of sexual treatment of couples with physical disability, it was deemed important to note which facets of the Caplan and Caplan treatment program were most helpful to the participants. The questionnaire investigated the helpfulness of the different segments of the entire program, the principles underlying the program and participants' evaluation of changes in their sexual attitudes and behavior. The results of the questionnaire are presented in Chapter IV. The questionnaire itself is presented in Appendix B.

Verbal Self Report

During the three-day intensive workshop and the follow-up period each therapist kept a record of the statements made by Group A participants. These statements included the changes in attitude, feelings and behavior

perceived by individuals and couples. Although this investigation was not primarily concerned with behavioral changes, it was deemed important to report these in order to further the knowledge in this area of research. Therefore, both the attitudinal and behavioral changes as reported verbally to individual therapists are presented in Chapter IV.

Procedure

1. Following the selection of cases and the Q-sort items, the data collection began. As each couple volunteered to participate in the program, the test battery was administered. The control couples were tested again exactly one month following their initial Q-sort.

2. Each statement (50) in the Q-sort was typed on a separate card in order to allow the sorter to easily place the statement in the desired pile. Large cards which indicated the number of statements which could be placed in a given pile were set in front of each individual. These large cards were also marked at each end as "Most Like" and "Least Like" to prevent confusion. Each individual was given the following instructions:

"The results of this experiment will remain confidential. Your names, once the information has been recorded, will be coded to avoid identification. Please sort these cards to describe how you feel about yourself

now, from those that are least like you to those most like you. Place the same number of cards in each pile as it says on the card marking that pile. It may help you make your decisions to make a preliminary division of the cards into four piles varying from least to most like you. Please do not discuss the items or your placement of them with anyone, especially your partner, between now and the end of the project." The last statement was made in order to avoid possible contamination of the results and in an effort to eliminate possible disagreements between couples regarding the items or their perceptions of themselves and/or each other. Additional information was given individually as needed to explain the forced sort procedure.

3. When an individual completed the "self" sort and the data were collected, a second set of the same 50 statements was given to him with the following instructions:

"Sort the cards again in the same way in terms of how you view your partner now. Please be certain to sort them as you feel about your partner, not as you think your partner would sort them."

4. The control couples repeated this procedure a month later.

5. Following the initial Q-sort experimental couples were interviewed by a member of the therapy team.

During this interview an effort was made to assess the couple's commitment to each other and the problems they were experiencing within the relationship. The therapist also attempted to ascertain what changes each individual would like to see occur in the sexual-emotional aspect of the relationship.

6. Couples were then separated in the therapy process and seen individually by a therapist of the same sex. Normally these preliminary interviews were on a one hour per week basis for from three to six interviews. In the individual sessions a sex history was taken, and an effort was made to enable each client to feel more comfortable talking about sexuality. The female participants received specific instruction and homework assignments which allowed them to become more comfortable with their own sexuality. Male participants were requested to work primarily with body-image and masculinity issues. Both partners were asked to begin establishing a "courting," "romantic" attitude toward each other.

7. At all points in the program the therapist was supportive, positive and as assuring of success as possible.

8. Explicit explanations of the three-day intensive workshop were provided so that unrealistic anxieties could be avoided and participants knew what to expect.

9. Arrangements were made with a local motel to

provide a meeting room and specially designed rooms and accommodations for those participants in wheelchairs.

10. The three-day workshop itself was conducted in a group meeting room of a local motel. Two experimental couples participated in a workshop with six able-bodied couples. Three weeks later the other three experimental couples participated in a workshop with five able-bodied couples.

11. Briefly, the treatment program consisted of

> . . . group sessions which included didactic material, viewing of slides and films, instructions covering the individual couple sessions, and exchange of feelings, progress or lack of it and regular group therapy sessions. Group sessions lasted approximately one hour and were followed by individual practice sessions by each couple in their own rooms, also approximately one hour. The time schedule was flexible and was changed at various times to meet the needs of the participants. Any individual or couple was free to request assistance from one or more members of the therapeutic team at any time and several did so.
>
> The instructions prior to the practice sessions were given on a graduated basis, with emotional safety and support emphasized at all times. The group therapy sessions and exchange of feelings between participants followed each practice session and were an integral part of the treatment program. A complete outline of the three-day workshop program is presented in detail in Appendix A (Caplan, 1973).

12. Immediately following the completion of the three-day treatment workshop, the Q-sort items were administered to Group A in the same manner as at the previous session approximately one month earlier. The questionnaire was administered immediately following the the Q-sort.

13. Three one-hour follow-up group therapy sessions were conducted one, three and five weeks following the workshop for Group A to reinforce the treatment program, to discuss progress and problems involved in carrying on the process in the normal home/work atmosphere, and to support the individual and couple commitments.

14. One month after the three-day treatment program Group A was again administered the Q-sort items in the same manner as previously. This was the post-post testing for the purpose of measurement of the holding power of any attitude changes made from the pre- to posttesting results.

CHAPTER IV

ANALYSIS OF THE DATA

Analysis of the Q-Sort Data:

Study of Items

Prior to the analysis of the Q-sort results it was important to determine whether: (a) items selected for the sorts had met the criterion of having substantial range of variation (i.e., the items were placed in widely different piles by different individuals), and (b) the sorts could be termed reliable.

Item Variation

For the purpose of answering the first question, Table 4, page 37, was prepared. Care was taken in the development of each item so that its meaning was clear and well defined. This was necessary in order to ensure the discriminatory power of each item. Those items with the widest span of placement (1 to 11) would be the best items, since they appeared to have the greatest discriminating power. For the sorts regarding the self 57 percent and for the sorts regarding the partner 80 percent of the items varied six or more categories in placement. In neither self nor partner sorts did any item have less than a three-pile

TABLE 4

ITEM VARIATION

Range	Self Frequency	Per Cent of Items
9	1	2
8	8	16
7	9	19
6	10	20
5	11	21
4	5	10
3	6	12

Range	Partner Frequency	Per Cent of Items
10	1	2
9	4	8
8	13	26
7	7	14
6	15	30
5	7	14
4	0	0
3	3	6

range. The Caplan (1973) study showed considerably more item variability and range. In that investigation for the sorting regarding self, 72 percent and for the sorting regarding partner, 90 percent of the items varied 9 or more categories. In neither self nor partner sorts did any item have less than a six-place range. These data are presented in Table 5, page 39.

It was, therefore, concluded that the sample population in the present study was far more homogeneous than the sample used in the original investigation. The minimal item variation also indicated that the sort did not have a substantial range of variation for this population and thus the ability to generalize the results beyond this sample population was reduced. (See Chapter V for a discussion of the measurement instrument.)

Reliability of Items

Reliability of such Q-sorts has been reported by Stephenson (1953, p. 304) to be ". . . at least on the order of 0.80." The Caplan (1973) study obtained a test-retest reliability of .72 as the mean reliability for both control groups. This was not appreciably different from the test-retest reliability of .67 obtained from the control group in the present study. The correlations (r) obtained for Group B (self) had a mean r of .69 and for partner a mean r of .65. Since these reliability determinations were made on the basis of a month's interval

TABLE 5

ITEM VARIATION: CAPLAN (1973) INVESTIGATION

Range	Self Frequency	Per Cent of Items
10	10	20
9	13	26
8	13	26
7	10	20
6	4	8

Range	Partner Frequency	Per Cent of Items
10	8	16
9	17	34
8	20	40
7	4	8
6	1	2

rather than the traditional week's interval, they seemed sufficiently high for purposes of the study

General Analysis

The results from the Q sorts are presented in Table 6, page 41. These results are stated in terms of correlation coefficients expressing the relationship between the self-self and partner-partner sorts for each individual at the two sorting periods. The range of correlation coefficients for the control group was from -.02 to .89. The range for the experimental group was from -.69 to .80.

The data presented in Table 6 demonstrate the correlations found on the pre- to posttest for the experimental group tend to be lower than those found in the control group. These data indicate that for the experimental group change in the expected direction (toward lower correlations) did occur.

For purposes of this investigation analysis of the data testing whether or not change was significant was conducted in two fashions. The data were grouped and the null hypotheses tested for the total group and subgroups thereof.

In addition a test for significant change was computed for each individual for both self and partner in the experimental group. Normally, in using Q-technique

TABLE 6

SELF AND PARTNER CORRELATIONS

Group A			Group B		
Code Number	Self/ Partner	Pre:Post r	Code Number	Self/ Partner	Pre:Post r
1M	S	.77	1M	S	.69
1M	P	.70	1M	P	.68
1F	S	.54	1f	S	.81
1F	P	.68	1F	P	.82
2M	S	-.69	2M	S	.71
2M	P	.42	2M	P	.53
2F	S	.80	2F	S	.62
2F	P	-.27	2F	P	.33
3M	S	.36	3M	S	.60
3M	P	.52	3M	P	—.02
3F	S	-.04	3F	S	,84
3F	P	.40	3F	P	.74
4M	S	.48	4M	S	.57
4M	P	.43	4M	P	.63
4F	S	.47	4F	S	.58
4F	P	-.22	4F	P	.76
5M	S	-.05	5M	S	.68
5M	P	.19	5M	P	.89
5F	S	.19	5F	S	.69
5F	P	.48	5F	P	.67

significance is not based on group data but is tested for each individual in the sample.

Analysis of Changes in the Experimental Group

The major null hypothesis of this study was that the Caplan and Caplan treatment program would result in no significant change in attitude on the part of participants in the sexual area as measured by Q-sort. Data bearing on this hypothesis are presented in Table 7, page 43. The correlation coefficients expressing the relationship between group and subgroup "self" and "partner" concepts for the pre- to posttesting are expressed in terms of mean Fisher $\bar{z}$ scores for both Group A and B.

The data indicate that:

1. There was a change in attitude toward <u>self</u> in the sexual area as measured by Q-sort for the experimental group compared to the control group significant at the .01 level of confidence.
2. There was a change in attitude toward <u>partners</u> in the sexual area as measured by Q-sort for the experimental group compared to the control group significant at the .05 level of confidence.
3. The combined total change in attitude of the experimental group compared to the control group in the sexual area as measured by the Q-sort was significant at the .05 level.

TABLE 7

GROUP A AND B: MEAN CORRELATIONS BETWEEN PRE AND POSTTESTING

	Group A	Group B	Normal Deviate
Self	.343	.848	2.45*
Partner	.383	.775	1.90**
Total	.354	.811	2.21**
Male M Self	.121	.775	3.12*
Male M Partner	.510	.725	1.04
Female F Self	.448	.908	2.23**
Female F Partner	.255	.848	2.87*

* $p < .01 : z \geq 2.326$
** $p < .05 : z \geq 1.645$
*** $p < .10 : z \geq 1.282$

Level of significance for a one-tail test.

The first two null hypotheses which predicted no change in attitude for either self or partner correlations were therefore rejected in terms of group data.

The breakdown of the group data to subgroups indicates specifically where the maximal change occurred. These data demonstrate that,

1. Change in attitude towards self for the males in the experimental group compared to males in the control group was significant at the .01 level.
2. Change in attitude towards their partner for males in the experimental group was not significant as compared with the control group.
3. Change in attitude toward self for females in the experimental group compared to females in the control group was significant at the .05 level.
4. Change in attitude toward their partner for the females in the experimental group as compared with females in the control group was significant at the .01 level of confidence.

It was concluded that the major changes within the experimental group took place in terms of how the males viewed themselves and how the females viewed self and partner.

Analysis of Changes for Individuals in the Experimental Group

The population in Q-technique is the number of

items in the Q-sort rather than the number of persons in the sample. Therefore, significance is normally not based on group data but is tested for each individual. Testing for significance for each individual poses a difficult problem. Caplan (1973) in discussing this problem stated:

> The hypothesis of "no-change," i.e. the null hypothesis assumed that the correlation between the salient variables in the hypothetical parent population is equal to +1.0. All samples drawn from such a population must also yield correlations of +1.0, since the constitution of the population allows no sampling error whatsoever. For this reason it is meaningless to consider the significance of the amount by which a correlation differs from unity since <u>any</u> difference, no matter how slight, demonstrates that the sample cannot have been drawn from the hypothetical population. In order to circumvent this dilemma, the empirically-obtained reliability coefficient (Group B, mean correlation) [must] be substituted for the hypothetical value of +1.0 as the appropriate representation of a "no-change" condition.

The empirically obtained reliability coefficient (Group B, mean correlation) in this investigation was .67. Table 8, page 46, presents the correlations of the pre- to posttesting for self and partner of Group A compared with the mean correlation of Group B, .67. This table and all the computations analyzing the Q-sort data utilized the Fisher $\bar{z}$ transformation.

"This variable has two very great advantages. Its distribution is approximately normal even for small samples in which ρ is near 1, and its standard error does not depend on the unknown population value but only

TABLE 8

GROUP A: SELF AND PARTNER CORRELATIONS BETWEEN PRE- AND POSTTESTING

Code Number	Self/ Partner	Pre:Post r_1	Post Post:Post r_n	z_{r_1}	z_{r_n}	Normal Deviate
1M	S	.77	.67	1.02	.76	1.262#
1M	P	.70	.67	.87	.76	.53
1F	S	.54	.67	.60	.76	.78
1F	P	.66	.67	.83	.76	.34
2M	S	-.69	.67	-.85	.76	7.92*
2M	P	.42	.67	.45	.76	1.51***
2F	S	.80	.67	1.10	.76	1.65#
2F	P	-.27	.67	-.28	.76	5.05*
3M	S	.36	.67	.38	.76	1.84**
3M	P	.52	.67	.58	.76	.87
3F	S	-.04	.67	-.04	.76	3.88*
3F	P	.40	.67	.42	.76	1.65**
4M	S	.48	.67	.52	.76	1.16
4M	P	.43	.67	.46	.76	1.46***
4F	S	.47	.67	.51	.76	1.21
4F	P	-.22	.67	-.22	.76	4.76*
5M	S	-.05	.67	-.05	.76	3.93*
5M	P	.19	.67	.19	.76	2.77*
5F	S	.19	.67	.19	.76	2.77*
5F	P	.48	.67	.52	.76	1.16

* $p < .01$: $z \geq 2.326$
** $p < .05$: $z \geq 1.645$
*** $p < .10$: $z \geq 1.282$
\# less change than predicted by chance

Level of Significance for a one-tail test

only on the size of the sample" (Walker & Lev, 1953).

In Table 8 r_1 indicates the relationship between the self-self and partner-partner sorts for the individuals in Group A at the two sorting periods (i.e., the correlations). The r_n represents the mean of the "no change" condition, namely the mean correlation of Group B (.67). The Fisher $\not{z}_r$ transformation of r_1 is indicated under the column $\not{z}_{r_1}$. The column $\not{z}_{r_n}$ indicates the Fisher $\not{z}$ transformation of the r_n (or "no change") condition. The "Normal Deviate" contains the difference between $\not{z}_{r_1}$ and $\not{z}_{r_n}$ expressed as a $\not{z}$ or normalized score expressed in units of standard deviations (Walker & Lev, 1953). A one tail test of significance was applied to the normal deviate because the direction of change (toward lower correlations) is implied in the study.

In this investigation three (of five) males and two (of five) females demonstrated significant change in attitude toward self as measured by the pre- to posttest. Significance was at the .01 level for four of these individuals and at the .05 level for one male. The null hypothesis was rejected for these individuals. The two remaining males and three females did not show a significant change in attitude toward self and for these individuals the null hypothesis was not rejected.

Three males and three females showed a significant change in attitude toward their partner as measured by the

pre- to posttest. Significance was at the .01 level for three individuals, at the .05 level for one individual and at the .10 level for the two other participants. The second null hypothesis was rejected for these individuals. The two remaining males and two females did not show significant change in attitude toward their partner and in these cases the null hypothesis was not rejected. The possible complications presented by the measurement instrument (the Q-sort) in reducing measurement of change will be discussed in Chapter V.

Analysis of Change between Males and Females in the Experimental Group

The third and fourth hypotheses in this study were that participation by couples in a treatment program results in no major difference between the males and females in the study with regard to changes in attitude toward themselves and their partners in the sexual area. In order to test these hypotheses, mean correlations were computed for each group (Male and Female) on both dimensions (self and partner). The data bearing on these hypotheses are presented in Table 9, page 49. The mean correlation for males on the pre- and posttest self-rating was .12, that for females was .42. The mean for males on the pre- and posttest partner rating was .47, that for females was .25.

TABLE 9

GROUP A AND B: SELF AND PARTNER CORRELATIONS BETWEEN MALES AND FEMALES

	Group A			Group B
	Pre/ Post	Post: Postpost		Pre-Post
$\bar{r}$ self	.33	.59		.69
$\bar{r}$ partner	.36	.51		.65
$\bar{r}$ total	.34	.56		.67
$\bar{r}$ male self	.12	.56		.65
$\bar{r}$ male partner	.47	.57		.62
$\bar{r}$ female self	.42	.62		.72
$\bar{r}$ female partner	.25	.45		.69

$\bar{r}$ = mean correlation

The difference between the male self sort (.12) and the female self sort (.42) is significant at the .01 level. Therefore, the third hypothesis was rejected.

The difference between the female partner sort and the male partner sort approaches significance. However, because the difference is not statistically significant, it was necessary to accept the fourth hyptothesis.

The extremely low mean self-correlation for the males again emphasizes a significant change in attitude towards themselves as was indicated in Table 7. The low mean partner-correlations for the females indicated that there was a trend toward change in their view of their partner.

The Caplan study found no significant difference between males and females. In the present study no singificant difference was found between male and female self or partner sorts for Group B. However, significant differences were found between the males and females in this investigation for the experimental group.

Summary of the Null Hypotheses for Individuals

Null Hypothesis 1

Participation by couples in a treatment program results in no significant change in attitude toward

themselves in the sexual area as measured by Q-sort. Two males and three females did not show significant change in attitude toward themselves. Therefore, this hypothesis was not rejected for these individuals. This hypothesis was rejected for three males and two females in which significant change did occur.

Null Hypothesis 2

Participation by couples in a treatment program results in no significant change in attitude toward their partner in the sexual area as measured by Q-sort. Two males and two females did not show significant change in attitude toward their partner. Thus, hypothesis 2 was not rejected for these individuals. Hypothesis 2 was rejected for the three males and three females in which significant change occurred.

Null Hypothesis 3

Participation by couples in a treatment program results in no major differences between the males and females with regard to change in attitude toward themselves in the sexual area. This hypothesis was rejected since a significant difference was found as measured by the mean correlations between the two groups.

Null Hypothesis 4

Participation by couples in a treatment program results in no major differences between the males and

females in the study with regard to change in attitude toward their partner in the sexual area. Although a trend toward difference was noted between male and female view of their partner, this hypothesis was not rejected because the difference did not reach statistical significance.

Null Hypothesis 5

The individuals in the experimental group will not show as significant a change in attitude as was shown by the couples in the Caplan (1973) investigation. Hypothesis 5 could not be rejected since all participants in the Caplan study showed sginificant change at the .01 level as measured by the pre- and posttest administrations of the Q-sort battery while approximately half the individuals in the present study showed significant change.

Analysis of Changes during the Pre:Post and Post:Post:Posttest Period of the Experimental Group For Individuals

The Q-sort battery was administered a third time to the experimental group one month following the three-day intensive workshop to determine the extent of the holding power of the changes in attitude of the participants towards themselves and their partner in the sexual area.

These data are presented in Table 10, page 54. The data show Fisher Z_r transformation applied to the pre-post and post:post:posttest correlations. A one tail test of significance was applied to the normal deviate because the null hypothesis predicts the direction of change, namely, toward lower correlations. Of the twenty correlations for Group A, five showed a holding power over a month's period of time significant at the 1 percent level, two at the 5 percent level and one at the 10 percent level. The remaining twelve correlations showed no significant degree of holding power.

It was concluded that a maintenance in attitude change was present for less than half the participants.

Caplan (1973) found much higher maintenance of the attitude changes in that of twenty correlations, thirteen showed a holding power over a month's period of time significant at the 1 percent level, 3 at the 5 percent level, and 1 at the ten percent level. A discussion of the differing results on the two studies will be presented in Chapter V.

The Questionnaire

The results of the questionnaire which investigated the helpfulness of each segment of the Caplan and Caplan program, the principles underlying the program and the participants' evaluation of change in their sexual behavior and attitude were tabulated for both males and

TABLE 10

GROUP A: SELF AND PARTNER CORRELATIONS BETWEEN PRE:POST AND POST:POST:POSTTEST

Code Number	Self/ Partner	Pre:Post r_1	Post Post:Post r_2	z_{r_1}	z_{r_2}	Normal Deviate
1M	S	.77	.75	1.02	.97	.24
1M	P	.70	.50	.87	.66	1.55***
1F	S	.54	.74	.60	.95	1.70**
1F	P	.68	.72	.83	.91	.39
2M	S	-.69	-.30	-.85	.31	5.63*
2M	P	.42	.74	.45	.95	2.43*
2F	S	.80	.86	1.10	1.29	.92
2F	P	-.27	-.18	-.28	.18	2.23#
3M	S	.36	.77	.38	1.02	3.11*
3M	P	.52	.78	.58	1.04	2.23**
3F	S	-.04	-.01	-.04	.01	.24
3F	P	.40	.45	.42	.48	.29
4M	S	.48	.56	.52	.63	.53
4M	P	.43	.47	.46	.51	.24
4F	S	.47	.48	.51	.52	.05
4F	P	-.22	-.25	-.22	.26	2.33*
5M	S	-.05	.21	-.05	.21	1.26
5M	P	.19	.20	.19	.20	.05
5F	S	.19	.71	.19	.89	3.40*
5F	P	.48	.51	.52	.56	.19

*p $<$ .01: $z \geq$ 2.326
**p $<$ .05: $z \geq$ 1.645
***p $<$ .10: $z \geq$ 1.282

Level of Significance for a one-tail test

less change than predicted by chance.

females. The N does not equal 10 for each item because some subjects did not respond to every item. The results are presented in Table 11, pages 56 through 59.

Due to the small number of participants no definite conclusions were attached to the results of the questionnaire. The data were analyzed in a preliminary attempt to discover focal areas of the program which possibly need expansion or elimination for this particular population. In general the results are unclear, but several trends were noted. Four of five females stated that the preliminary interviews were very helpful. All five females reported that the principles of "no demand sexual activity" and "taking 'time-outs' when needed" were very helpful. Four of the males also agreed that the "time out" principle was very helpful. All five males stated that the principle of "saying 'yes' rather than 'no'" was very helpful. Four of five females reported that the principles of "quality vs. quantity sex" and "sex is fun and adult play" were also very helpful to them.

The evaluation of sexual behavior and attitude change showed that all participants, both male and female, felt that their sexual behavior was improved as a result of the treatment program. All of the male participants (5) reported that they felt their sexual attitudes had improved. These data tend to support the contention that change in sexual attitudes and behavior did take place as

TABLE 11

TABULATION OF QUESTIONNAIRE RESULTS FOR
MALE AND FEMALE PARTICIPANTS

Parts of the Intimacy Program	(a) very helpful	(b) helpful	(c) not helpful
1. Preliminary interviews, sex history and preliminary assignments to the intimacy workshop.	M. 2 F. 4	M. 2 F. 0	M. 1 F. 1
2. Kegal exercises for women .	M. 1 F. 1	M. 0 F. 2	M. 1 F. 0
3. Slide and film presentations.	M. 3 F. 1	M. 1 F. 4	M. 0 F. 0
4. Lecture and discussion sessions.	M. 2 F. 2	M. 3 F. 3	M. 0 F. 0
5. Massage instruction.	M. 1 F. 3	M. 4 F. 2	M. 0 F. 0
6. Making up and sharing "turn on" lists	(a) very helpful M. 3 F. 3	(c) helpful M. 2 F. 2	(c) not helpful M. 0 F. 0

continued

TABLE 11
(continued)

7. Making up and using alternate lists

(a) very helpful	(b) helpful	(c) not helpful
M. 2	M. 3	M. 0
F. 1	F. 4	F. 0

8. Pleasuring sessions with your partner

(a) very helpful	(b) helpful	(c) not helpful
M. 2	M. 3	M. 0
F. 3	F. 2	F. 0

Evaluation of behavioral and attitude change

1. I feel my sexual behavior is

(a) improved	(b) poorer	(c) no different
M. 5	M. 0	M. 0
F. 5	F. 0	F. 0

2. I feel my sexual attitudes are

(a) improved	(b) poorer	(c) no different
M. 5	M. 0	M. 0
F. 2	F. 0	F. 3

Principles of the Caplan and Caplan Program

1. Awareness of generalization about the opposite sex and not making these about your partner.

(a) very helpful	(b) helpful	(c) not helpful
M. 0	M. 3	M. 2
F. 2	F. 3	F. 0

continued

TABLE 11
(continued)

2. No demand sexual activity

(a) very helpful	(b) helpful	(c) not helpful
M. 2	M. 2	M. 1
F. 5	F. 0	F. 0

3. No performance criterion for sexual activities

(a) very helpful	(b) helpful	(c) not helpful
M. 2	M. 3	M. 0
F. 3	F. 2	F. 0

4. "Give to get"

(a) very helpful	(b) helpful	(c) not helpful
M. 3	M. 1	M. 1
F. 4	F. 1	F. 0

5. It is "OK" for either partner to take "time outs" when needed.

(a) very helpful	(b) helpful	(c) not helpful
M. 4	M. 1	M. 0
F. 5	F. 0	F. 0

6. Give alternates to your partner

(a) very helpful	(b) helpful	(c) not helpful
M. 3	M. 2	M. 0
F. 2	F. 2	F. 0

7. Say "yes" instead of "no."

(a) very helpful	(b) helpful	(c) not helpful
M. 5	M. 0	M. 0
F. 2	F. 2	F. 0

continued

TABLE 11
(continued)

8. Sensuality and sexuality are part of the same continuum.

(a) very helpful	(b) helpful	(c) not helpful
M. 1	M. 2	M. 1
F. 1	F. 3	F. 1

9. Work towards quality rather than quantity sex

(a) very helpful	(b) helpful	(c) not helpful
M. 2	M. 2	M. 1
F. 4	F. 1	F. 0

10. The goal of every sexual encounter is an increased sense of self worth.

(a) very helpful	(b) helpful	(c) not helpful
M. 3	M. 2	M. 0
F. 2	F. 3	F. 0

11. Sex is fun and adult play

(a) very helpful	(b) helpful	(c) not helpful
M. 3	M. 1	M. 1
F. 4	F. 1	F. 0

experienced by the participants although the change did not reach a level of significance as measured by the Q-sort in all cases. Suggestions for further research in this area are presented in Chapter V.

Self Reports

During the three-day intensive workshop and the follow-up period verbal self-reports were collected by the therapy team. These statements were unsolicited and spontaneous on the part of the participants. Both members of one couple confided at different times to different therapists, "This program may have saved our marriage." These statements seemed rather dramatic in that there had been no indication that the marriage was at all disrupted. One male, injured nine years before had achieved erection only sporadically during that time period. During the three-day intensive workshop and for two months following both he and his wife reported regular erective capacity with both indirect and direct stimulation. The female in this couple asked for and received instructions to help her overcome her fear towards oral sex. Two weeks later she reported, "I can't believe it's [oral sex] so easy and that I even enjoy it."

Another couple reported, "This has been much more than a workshop on sex for us. What we learned has extended to all parts of our marriage especially communication."

The male stated at the end of the workshop, "It [the workshop] has made everything 'new' for us again. I didn't believe that could happen." His wife later told her therapist that "the tension level between us has dropped because I don't feel he is after me for sex all the time."

The couple who had not made love in the three years previous to the workshop report regular lovemaking as a part of their lives now. The female had stated in preliminary interviews that she did not like the "female superior" position which they both felt was necessary for intercourse due to his disability. At his suggestion they developed several alternate positions which are comfortable to both of them. This was the first time in years that he had taken the initiative in their sexual activity and his wife said, "I really feel both_____ and I have made progress now."

The last of the five couples has not kept in contact with the therapy team. At the end of the workshop he stated that it had been a "valuable" experience. She felt that their sex life was "satisfactory" to both of them and that they each experienced far less anxiety about their sexual relationship than before the beginning of treatment.

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

This study was concerned with the changes in attitude in a group of spinal cord injured men and their marital partners after a sexual treatment program. The investigation utilized a two-group design. The experimental group consisted of five couples who expressed interest in the treatment of difficulties in the sexual aspects of their relationship and had indicated some degree of inadequacy in this area on the part of one or both partners. The control group consisted of five couples who had expressed interest in participating in a treatment program but who agreed to wait or did not feel ready to enter the one under investigation here. In both groups the male partner had suffered a partial or complete spinal cord lesion which had resulted in difficulties in the emotional-sexual area of the relationship with the partner. All participants in the study were volunteers.

Each individual was administered a Q-sort battery designed to measure changes in attitude towards themselves and their partner in the sexual area at the time they

volunteered. Those participants in the control group re-sorted the cards one month after their initial sort. Individuals in the experimental group participated in the Caplan and Caplan program for the treatment of sexual problems. At the end of the program (approximately one month later) the experimental group again took the Q-sort battery. One month following, the experimental group re-sorted the Q-sort cards in order to determine the holding power of any attitude change found on the pre- to posttest. All sorts were studied by Q-sort methodology. The experimental group responded to a questionnaire which attempted to discern which aspects of the Caplan and Caplan program were most beneficial to them. Verbal self-reports concerning attitude and behavior change were also obtained.

Group Analysis

1. The first two null hypotheses were rejected in terms of an analysis of the group data which indicated that in comparison with the control group the participants' attitudes towards themselves in the sexual area as measured by Q-sort changed significantly at the .01 level. The group data also indicated that the participants' attitudes toward their partner changed significantly at the .05 level of confidence.

Individual Analysis

2. Three (of five) males and two (of five) females showed a significant change in attitude toward self in the sexual area from the beginning of the treatment program to the end of the three-day intensive workshop. The nyll hypothesis for these individuals was rejected. The null hypothesis was accepted for the two remaining males and three females who did not show significant change in attitude during that time period.

3. Three males and three females showed a significant change in attitude toward their partner in the sexual area from the beginning of the treatment program to the end of the three-day intensive workshop. The null hypothesis was rejected for these individuals. The null hypothesis was accepted for the two males and two females who did not show significant change in attitude during that time period.

4. During the month's follow-up period eight of the participants indicated a holding power in attitude change. This holding power was significant at the .01 level for five participants, at the .05 level for two participants and at the .10 level for one participant.

General Analysis

5. A significant difference was found between the males and females in their attitude toward self in

the sexual area as evidenced by the pre- and posttest correlations for the two groups. This difference was significant at the .01 level.

6. There was a trend towards difference between the males and females in their attitude toward their partner in the sexual area as measured by the pre- and post mean correlations for the two groups. However, this difference did not reach a significant level.

7. All the participants in this study did not show as significant change in attitude toward themselves and their partners in the sexual area as was found in the Caplan (1973) investigation which utilized couples in which both partners were able-bodied.

Conclusions and Discussion

1. The Caplan and Caplan treatment program for assisting sexually inadequate couples by use of a variety of therapeutic techniques within a group therapy setting produced attitude change within three males and two females regarding self and three males and three females regarding partner in the experimental group of spinal cord injured males and their partners. However, fewer individuals demonstrated change than was found with individuals in whom no physical disability was present.

2. In the sample population the major tendency towards change was noted in how the males viewed themselves and how the females viewed their partner.

3. Due to the minimal item variability found on the Q-sorts, it was concluded that this sample population was more homogeneous than the sample population of physically normal couples who participated in the Caplan (1973) investigation.

4. The holding power of the attitude change was also found to be less reliable than that found in the Caplan (1973) investigation.

5. The Q-sort battery used in this investigation was originally developed for use in the Caplan (1973) study. The universe of statements from which the items were chosen came primarily (although not totally) from persons in whom no physical disability was present. It may be that a different Q-sort specifically designed with and for couples in whom the male is spinal cord injured would be necessary for accurate measurement of attitudinal change.

6. It was this investigator's contention that in the population either a "denial" mechanism or an unrealistic view of "good" body image and "adequate" sexual functioning resulted in inaccurate reports on the first (pre) Q-sort. In many instances individuals placed an item in a "Most Like" pile on the initial sort, only to report during the preliminary interviews that this view of themselves was entirely inaccurate. For example, one person placed the item "Feel good about myself after sex"

"Most Like" pile. The therapist later found that this couple had had no sexual activity other than a good night kiss in over three years. It was concluded that couples in this investigation were not as accurate or as reliable in their self and partner evaluations in terms of reality as those couples in the Caplan study. With inaccurate pre-treatment reports, the possibility of significant change may have been diminished.

7. For future investigations it seems important to note that in preliminary interviews it was found that imbalance in sexual drive level was the primary problem within the experimental couples. In most instances the females reported feeling overwhelmed by their husband's sexual demands and the males reported an uncomfortable "drive" toward sexual activity.

Implications

1. In light of the conclusions and complications found in this investigation, it seems necessary that research regarding both body image and sexual self- and partner-concepts be conducted. It would appear valuable to compare persons prior to and following a spinal cord trauma. This research would result in knowledge of what changes in body and sexual image actually do occur following this type of trauma.
2. It seems highly relevant to investigate the possibility

of a "denial" mechanism or a tendency towards unrealistic sexual concepts among spinal cord injured men and their partners because of the discrepancies found in this study between Q-sort information and interview material. If a "denial" process is indeed found to be operational, future researchers need to be aware of the possible inaccurate pre-test measurements due to this mechanism. Techniques to "partial out" this denial mechanism need to be developed in measurement instruments; possibly techniques for therapeutic intervention need to be established.

3. It is further suggested that research in the area of personality variables, the need structures and the sexual expectations of women who marry spinal cord injured men would be valuable. During the course of this investigation it was noted that many female partners of spinal cord injured men were totally unwilling to participate in any type of sexual therapy program while the male partners were exceedingly eager for treatment.
4. A replication of this study using instrumentation designed specifically for the population might yield more significant results and seems valuable.
5. A replication of this study in which couples actively sought help with the sexual aspects of their relationship (as opposed to simply volunteering to participate)

and in which the couples made a personal financial investment is recommended. These two conditions would more nearly replicate the Caplan (1973) investigation.

6. It is possible that special adaptations of the Caplan and Caplan (1973) program and specific techniques for dealing with the spinal cord injured population need to be developed. Further research in this area is desperately needed.
7. The study suggested that this sexual treatment program is a useful method for assisting some spinal cord injured males and their partners. It would seem advantageous to seek ways of broadening the concept of sexual therapy to sex education which could be included in high school and college programs on human sexuality, family living, etc. This type of adaptation would be recommended in terms of educative processes aimed at prevention of inadequate sexual behavior for students on a personal, social and perhaps professional level.
8. Further clinical impressions are presented in Appendix C.

APPENDIX A

THE CAPLAN AND CAPLAN TREATMENT PROGRAM

APPENDIX A

THE CAPLAN AND CAPLAN TREATMENT PROGRAM (Caplan, 1973)

This section is included in order to make replication of the original experiment possible. The actual techniques utilized and the principles involved are very similar to those used by Masters and Johnson (1970) and by Hartman and Fithian (1972, p. xiv). They are also outlined in the program for medical students of the University of Minnesota (Maddock & Dickman, 1972, Book 1).

1. Referrals are accepted to the sexual treatment program from physicians, clergymen and lawyers. A relatively small number of individuals also come as a result of hearing about the technique from friends who have been through the program, but a medical referral is required in all cases.

2. The couple is always treated as a unit.

3. The initial interview is designed to determine whether the couple is committed to each other (whether married or unmarried). The couple is always treated by a male and female therapy team.

4. A sexual history is taken emphasizing early experiences which includes myths and stories about the individual's birth, nudity in the home, early information and experiences with masturbation, knowledge of the opposite sex and bodies, pregnancy, birth, intercourse, early homosexual

experimentation, and heterosexual experiences prior to the time of entry into the program. These histories are taken by the member of the therapy team of the same sex and are then compared.

5. A series of three to six hourly interviews is conducted in which the couple is prepared for the treatment procedures. Effort is made to help the couple talk more easily about sex. Each member of the treatment couple is seen by the therapy team member of the same sex but the other member of the treatment team often enters the interview and takes part in it. An atmosphere that success is likely to occur is generated, and confidence in the therapist appears to be as essential to this treatment procedure as to any other.

6. Extensive history taking and individual interviews are conducted in order to gain mutual understanding and to create a comfortable atmosphere.

7. A medical examination is required (if the male is dysfunctional with a urologist and if the female is dysfunctional, with a gynecologist with emphasis in the latter case on determination of possible tearing, scarring, resiliency of the pubococcygeus muscle, freeing of clitoral adhesions, etc.). Referral to endocrinologists and other specialists is made as required during this period and checks for conditions that might be detrimental to the program (such as diabetes) are made. In cases in which a

physical disability is present, consultations are made with appropriate physicians in an attempt to ascertain activities which are medically safe and/or possible. These are reviewed with the consulting psychiatrist who is seen by the treatment team every two weeks. Effort is made in these early interviews to assist the couple to become more comfortable with their own bodies and to begin to talk about sex with each other and a series of "warm-up" exercises is suggested for getting close without any pressure for performance or intercourse being made. The treatment couple is studied extensively in terms of their life style.

8. "Sensate focus" exercises, which we term "pleasuring," are given in which the couple learns to feel and respond pleasurably to simple touching and stroking of non-genital areas, first of their own body and then of their partner's and to communicate what sensory experiences are pleasurable.

9. Women are taught the "Kegel" exercises for tightening the internal muscles (Hartman & Fithian, 1972, pp. 83-87).

10. Studies of early sexual trauma are made and attempts to do traditional therapeutic work in such areas as body imagery, extensive sexual involvement with a family member, etc., are worked through and detraumatized.

11. Procedures for couples regardless of the initial condition of referral are made in the same way, particularly

where prematurity, ejaculatory incompetence, impotence, and orgasmic dysfunction are concerned. Only a few cases of vaginismus and dyspareunia have been seen at this point. Approximately 150 couples have completed the program until now. The weekend procedure is explained to the couple, including the group approach and any fears or fantasies they may have about the weekend are desensitized through conjoint discussion.

12. The weekend is held from 9 a.m. to 9 p.m. on Friday, Saturday from 12:30 p.m. to 9 p.m., and on Sunday from 9 a.m. to 1 p.m. Three follow-up sessions at one, two, and three week intervals were made in this investigation. Extensive long term follow-up is possible and encouraged through phone and direct consultation with therapists.

13. The procedure of the weekend takes place in the manner outlined below. Departures from the procedures do occur, however, and the therapy team remains flexible and sensitive to the individual and couple needs of the participants and adjusts the outlined procedure accordingly.

The principles of the program are didactically explained to the couples in a group while erotic slides are shown as a desensitization device. These principles are as follows: (a) no one should give in to sex as a duty to the partner, (b) no performance criteria for sexual performance is allowed, (c) pressure is taken off either partner to perform at any level, (d) effort is made to

transfer love-making from "getting for themselves" to "giving to their partner" (the principle of pleasuring is introduced at this point), (e) a goal for the program is stated over and over again as: each member of the couple leave each sexual experience feeling an increasing sense of self-worth about himself/herself and about his/her partner (attention is directed away from orgasms, ejaculations, erections, etc.), (f) partners are encouraged to give each other a great deal of verbal and non-verbal encouragement throughout the program, (g) partners are encouraged to tell their opposite member what feels good rather than what doesn't feel good. We call this the principle of saying "Yes" rather than "No." Couples are encouraged to suggest an alternate when one makes an offer of something that the other partner is not ready to accept. For example, if one partner says, "I would like to make love," and the other partner is not ready, he/she is encouraged to come back with, "I'd like a back rub." The original partner may say, "Gee, that doesn't sound so great to me but I'd sure enjoy just lying close for awhile" until they make an agreement that both find acceptable. In other words, a compromise must be reached. Partners are cautioned that fights and tensions may take place during the weekend and arrangements are made for a therapist to be available at all times.

At this point a practice session is given in which

each couple goes to their room privately and are encouraged to discuss the principles to be sure they understand them the same way and to discuss where and how they originally obtained their sexual information. This is done in the nude with no touching. Intercourse is prohibited for the first day and most of the second day.

Following that session (about 45 minutes) couples return to the group and are shown several humorous desensitization films which cause laughter, lessening the tension and general relaxation. Common sexual myths, such as penis size, are discussed. Body images are discussed and couples are given another practice session of about the same length in their rooms during which time they are allowed to touch their partner in any way that the partner finds pleasurable, using the time out, no demand, no performance criteria, but are requested to avoid genital and breast touching.

Couples come back together again the next session when male and female erotic fantasy films are shown. Couples are encouraged to discuss this in detail. Males and females are then separated for a brief discussion (males with a male therapist, females with a female therapist). The therapists exchange groups during the approximately half-hour discussion session in order to determine where the clients are in the program and what difficulties are occurring. This check-up of difficulties takes place after each practice session.

The next practice session concerns standing in front of a mirror together nude, examining their own and their partner's body from head to toe and talking freely and openly with their partner about what they like and don't like about their own body, but are requested to give only positive feedback about their partner's body. Again, the positive reinforcement principle is present throughout the program.

After return to the group room the couples review what has happened so far. Couples are encouraged to go as slowly as the slowest partner and not to get in competition with each other or with other couples. This seems to generate a great deal of relaxation. The next film appears to be a crucial point in the program as it is a film of a female who became orgasmic through masturbation. This leads to a general discussion of masturbation followed by a long private practice session, again with no genital or breast touching. Couples are then allowed to dine together but separate from the other couples and have a quiet time together.

Following the dinner, couples return to the group room and are shown a film on the Semans' squeeze technique, basically used for impotence and prematurity, but which is taught to all couples as a way of putting the female in control, as well as providing an aid in aging and illness and another technique for an alternate to intercourse. The

technique of "stuffing" a limp penis demonstrated in this film offers an important alternate for couples in which the male is physically unable to achieve an erection and intercourse is desired. The evening session is concluded with a brief demonstration of massage technique using a foot or hand massage. Couples are requested to sleep as late as they wish the next morning, have a practice session either evening or morning, to separate and have some alone time, and then return to the group room after lunch on Saturday.

At this point, a review of the progress of each individual and couple is made and the second Semans' film is shown. Couples are requested to practice the technique shown in the film and genital touching is now allowed. A practice session involving massage and genital touching but no intercourse is conducted.

Following this practice session, another one-half hour male-female separation group therapy session is conducted. Next, two special technique films are shown, one of which illustrates the principle of alternates in which a male makes love to a female, but the love-making ends with masturbation to orgasm rather than intercourse (again, illustrating that there is more than one way to end a sexual encounter). This seems to take the pressure off both males and females to have intercourse every time they have a sexually-oriented activity. Couples are taught to

lie close together and breathe together in sequence and are taught about sexual caressing. Various oils, perfumes, and bubble bath, etc., are provided and a discussion of sensuality is followed by a long practice session.

After this long practice session, a technique film of whole body massage is viewed, and another long practice break is conducted. At this point, the couples then meet together at a local restaurant for a "celebration" type feast. This is a relaxing, informal fun session which enables the couples to become better acquainted in a different setting. Returning to the group room, couples are shown two films of adequate sexual functioning. One of the films portrays a quadraplegic male and his partner making love, again making the point that penile-vaginal intercourse is not a requisite of successful love-making. Couples are encouraged <u>at all points</u> of the program to go back to earlier steps whenever they feel uncertain at any time during or following the program as an essential ingredient to success.

The non-demand pleasuring technique schedule is continued throughout on Sunday morning, the third adequate functioning film is shown and several practice sessions are conducted. Considerable time in group sessions is spent on "locking-in" the procedure and about how to take these techniques home and to integrate them into the lifestyle of daily living. A male-female separation therapy session

is conducted and the workshop concludes with instructions to each couple on how to proceed when they return home.

Following this, three one-hour group sessions of discussion, encouragement, and reinforcement are conducted. (Couples will be followed up to two years to check on whether our results hold.) Romance and play-functions of sex are emphasized, as is the conclusion of every sexual encounter with a long afterglow pleasuring session which is a recommitment to the couple relationship. At the end of the program, couples are again reminded of all the principles involved and the necessity for good communication which is the essential ingredient of the program. For this investigation, the third Q-sort battery was administered at the conclusion of the last follow-up session. Couples will be followed up to check on whether the results hold.

Films and slides may be secured through Multi-Media Center, National Sex Forum.

APPENDIX B

The following is the questionnaire completed by Group A at the completion of the three-day intensive sexual treatment program.

APPENDIX B

Name_____

The following are parts of the intimacy program. Please circle the appropriate statement regarding how important they were to changes in you and your relationship with your partner.

1. Preliminary interviews, sex history and preliminary assignments to the weekend workshop.

   (a) very helpful (b) helpful (c) not helpful

2. Kegal exercises for women.

   (a) very helpful (b) helpful (c) not helpful

3. Slide and film presentations at the workshop.

   (a) very helpful (b) helpful (c) not helpful

4. Lecture and discussion sessions at the workshop.

   (a) very helpful (b) helpful (c) not helpful

5. Massage instruction.

   (a) very helpful (b) helpful (c) not helpful

6. Making up and sharing "turn on" lists.

   (a) very helpful (b) helpful (c) not helpful

7. Making up and using alternate lists.

   (a) very helpful (b) helpful (c) not helpful

8. Pleasuring sessions with your partner.

   (a) very helpful (b) helpful (c) not helpful

PART II

9. I feel my sexual behavior is

   (a) improved (b) poorer (c) no different

10. I feel my sexual attitudes are

(a) improved (b) poorer (c) no different

PART III

The following are the basic principles of the intimacy workshop. Please circle the appropriate statement regarding how each of these principles affect you and your partner.

1. Be aware of your own generalizations about the opposite sex and don't make these assumptions about your partner.

(a) very helpful (b) helpful (c) not helpful

2. No demand sexual activity.

(a) very helpful (b) helpful (c) not helpful

3. No performance criteria for sexual activities.

(a) very helpful (b) helpful (c) not helpful

4. "Give to get."

(a) very helpful (b) helpful (c) not helpful

5. It is "OK" for either partner to take "time outs" when needed.

(a) very helpful (b) helpful (c) not helpful

6. Give alternates to your partner.

(a) very helpful (b) helpful (c) not helpful

7. Say "yes" instead of "no."

(a) very helpful (b) helpful (c) not helpful

8. Sensuality and sexuality are part of the same continuum.

(a) very helpful (b) helpful (c) not helpful

9. Work toward <u>quality</u> sex as opposed to quantity sex.

(a) very helpful (b) helpful (c) not helpful

10. The goal of every sexual encounter is an increased sense of self worth.

    (a) very helpful (b) helpful (c) not helpful

11. Sex is fun and adult play.

    (a) very helpful (b) helpful (c) not helpful

APPENDIX C

CLINICAL IMPRESSIONS

CLINICAL IMPRESSIONS

During the course of this investigation the therapy team working with this population of spinal cord injured males and their partners made clinical observations which seem important to report.

1. For approximately eighteen months before the actual beginning of the investigation members of the therapy team had spoken to a variety of groups and individuals about their previous work in this area and this particular research project. Support and enthusiasm were almost unanimous from individuals who expressed interest in participating in the study themselves to professionals and agencies who stated they had clients whom they would like to refer for treatment. When the investigation was initiated, a majority of these sources became "too busy," "unavailable" etc. To say that actually dealing with sexuality is still "taboo" in this society or community seems unlikely because a high percentage of the able-bodied clientele who enter sex therapy come from precisely these same sources. The comments in Chapter II which expressed the feeling that this society does not yet feel comfortable with dealing with sexuality in persons with a physical disability may provide a

partial explanation for the phenomenon which occurred.

2. During the course of this investigation which ran about two years, the therapy team estimated that they were contacted by from thirty to forty spinal cord injured men who expressed a desire for treatment. In almost every case the male reported later that his female partner was opposed to any form of treatment. Casual observation suggested three plausible hypotheses for this occurrence:

   A. If a couple had been married before the injury and had made a satisfactory adjustment to the trauma situation, it is possible that doing anything which might "rock the boat" and upset the established stability of the relationship was far too frightening for the female partner.

   B. Women who marry spinal cord injured males may intentionally or subconsciously be looking for a spouse who they expect will be sexually non-demanding and thus would be unwilling to do anything that they expect might possibly increase sexual activity.

   C. The males may state overtly that they would like help in improving their sexual relationship but may also covertly fear looking at what is already an emotionally laden area for them. They may in fact, covertly "sabotage" themselves and their

partners into not seeking the help they express they would like. All three of these mechanisms may be active in various combinations, and of course many others may be operational also.

3. The possibility of a "denial mechanism" was briefly mentioned in Chapter 5. This process was seen repeatedly in interviews with this population. Quite often there was complete denial of any "body image" problems on the part of both partners. Later the fact would emerge that the male was quite disturbed about the change in body image he had experienced. Still later the problem would again be denied. Although it is typical in therapy to meet this type of resistance, the intensity found in this population seemed far more difficult to work with therapeutically than with able-bodied clients and even clients with other physical disabilities.

4. Most spinal cord injured males seen by the therapy team expressed an extremely high drive for sexual activity. These reports have been substantiated by their partners. An oversimplified explanation which was deemed correct by several subjects is that sexual activity is seen as one of the few ways in which a spinal cord injured male can exert or "prove" his "masculinity." A common complaint among this population

was that they did not see their lives as providing enough avenues for improving their self-concept, "feeding their egos" or simply feeling like a "man."

5. Many of the relationships seen in this investigation seemed to be based on a "Parent-Child" model. For the most part the wife played "Parent," telling her husband constantly what he should and should not do. Occasionally, a role reversal would take place with the husband playing harsh parent. Superficially it is easy to see that a man in a wheelchair <u>is</u> dependent for some things and very much in a "child" position. This "game" was probably the most difficult to treat therapeutically and sexual therapy is impossible in this situation. A flowing, warm sexual relationship takes place for the most part between two equal partners.

6. It is George Bach's contention in <u>The Intimate Enemy</u> that a couple who can fight well can usually establish a good sexual relationship. When a fight between a couple has truly been resolved and the air is cleared of underlying tension, there is a good chance for emotional closeness. However, many couples in this investigation felt they "could not" or did not know how to fight with each other effectively. The female point of view was "How can I get angry at this poor man?" The male point of view seemed to be "I'm afraid

to get mad at her. . . . I'm too dependent on her for everything I need."

7. Many males who are spinal cord injured receive some sort of financial compensation which allows them not to work. (Of course, finding a job for many spinal cord injured males is difficult anyway.) By not working the male is often deprived of traditional methods of defining his masculinity which play into the issue raised previously. He is also deprived of many social experiences which many people "need" to feel good about themselves. Wives often felt frustrated at watching their husbands be totally unproductive in any way that they can <u>see</u>. This cycle, of course, seemed to lead to tension, anger and resentment.

8. A large part of the Caplan and Caplan therapy program centers around having a couple put more "courting," "romance" and "fun" into their marriage. This normally includes activities outside the home such as dining out, movies, visiting friends, etc. However, the males were often reluctant to go out of the home because they felt self-conscious in a wheelchair. (This is directly related to body image problems discussed previously.) At the same time wives were going "stir crazy" at home or having to socialize with other people, behaviors which often resulted in more resentment from both

parties. It is a fact that many public buildings are not designed to accommodate wheelchairs and this simply aggravates the problem.

9. Finally this investigator would like to emphasize the point made several times in Chapter II concerning professionals dealing with the disabled. Practically all the males interviewed by the therapy team had been told at the time of the injury either verbally or non-verbally that their sex lives were virtually over. This message caused many couples to "give up" and not explore alternatives which were available to them and in some cases never to find out that complete sexual functioning still existed. Attempting to break down a belief which has been maintained for years is difficult for both therapist and client. It is this investigator's firm recommendation that counseling concerning sexuality begin within several days or weeks after the injury is incurred and no later. It is also necessary to involve the partner if one is available in this counseling as a key therapeutic agent.

These nine points are in no way meant to be purported as true for all couples in which the male is spinal cord injured. They are mentioned briefly in this Appendix in the hope that research investigating these observations will be done in an attempt to clarify the

entire area. It is also hoped that if some of these observations are found to hold true for a large percentage of this population, specific techniques for intervention will be developed for use both in sexual treatment programs and other forms of counseling and/or therapy.

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CURRICULUM VITAE

Joan B. Scott was born November 30, 1947 to David and Virginia McGiboney, Jr. She attended private and public schools in Albuquerque, New Mexico and graduated from Manzano High School in Albuquerque. She attended the University of New Mexico where she received her Bachelor of Arts degree in Psychology in 1969. She continued her education at the University of New Mexico where she received her master's degree in Counseling in 1971.

She married Gary B. Scott in 1967. Mr. Scott is currently a student at the University of New Mexico.

She was employed from 1969 to 1970 as a counselor at the Girls' Welfare Home in Albuquerque. In 1968 and again in 1971 she worked part-time as a Spanish teacher in a private school in Albuquerque. Since receiving her master's degree, she has been employed by Stanley W. Caplan, Ed.D. (P.C.) as a counselor and group co-therapist.