PRACTICAL MODIFICATIONS OF MASTERS' AND JOHNSON'S APPROACH TO THE TREATMENT OF SEXUAL DYSFUNCTION.

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Thesis presented at the University of Leicester in fulfilment of the requirements of the degree of Ph.D. by research : 1979.

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FOREWORD

"Since the publication of Human Sexual Inadequacy in 1970, there have been many attempts by other health care professionals to interpret and extend the original concepts of dual-sex psycho-therapy for the rapid treatment of sexual dysfunction. .....in 1958, as we began to make plans for a clinical research programme in the psychotherapy of human sexual dysfunction, we conducted a detailed review of existing methods and findings in the field. It was immediately apparent that the available research was fragmented and unsystematic, with a marked dichotomy between biological and behavioural data that reflected the scientific bias of the times. Clinical techniques were both time-consuming and unreliable, and there were many indications that these methods derived more from the therapists' personal involvement in the psychotherapeutic process than from an objective knowledge of sexual function or in practical application of behavioural principles..... we have briefly described the original principles of treatment that were the foundation of the new therapy techniques of sexual dysfunction. Of course, there has been both significant modification of these principles and expansion of concepts of treatment as the clinical therapy programme has been closely observed during its 18 years of existence, first at Washington University School of Medicine and since 1964, at the reproductive Biology Research Foundation.

Obviously, there have been further modifications of concept, format, and technique in various centres throughout the United States and abroad. Some have represented significant innovations and additions, others have been poorly conceived and casually conducted. All of these improvements, alterations, and even distortions, simply point to the immense public demand for adequate professional support in this hitherto ignored health care field. Now that surfaces have been scratched, it remains for those interested in effective treatment programmes to improve techniques, train personnel, and encourage both basic science and clinical investigation.

We all have such a long way to go".

(Masters and Johnson, 1976)

.....(who, after all, goes to St. Louis for a two-week vacation?)....

(Marmor, 1971)

Acknowledgements

The work presented here was made possible through the research grant support of the DHSS to the National Marriage Guidance Council for the purposes of this study.

Mr. Geoffrey Court, Surgeon, and Mr. Mervyn Reed, Obstetrician and Gynaecologist, not only conducted the extensive medical screening, described later, but acted as professional friends and colleagues to all members of the research programme in times of medical doubt about our clients. Dr. John Bancroft, at that time of the Department of Psychiatry at the University of Oxford, acted as a source of sound advice in experimental clinical method, and Dr. Muriel Jones, Consultant Psychiatrist in Rugby, gave monthly support case-discussion seminars in the second year of the programme.

The administrative aspects of the clinics were managed initially by Judy Upton-Kemp, and when she left to marry and take up residence in the U.S.A. after eighteen months, they were seen to completion by Madeleine Rogers.

The Chief Officer of the National Marriage Guidance Council, Nicholas Tyndall, the Head of Counselling, Miss Joan Sullivan, the Planning Officer, Mr. David Barkla and the Research Officer, Mrs. Jill Heisler, all gave support, advice and encouragement, as did Mrs. Joan Harris, who chaired an internal Steering Committee on behalf of the Counselling Advisory Board of NMGC.

In the best manner of a teacher, a passing comment by Professor Gwynne Jones in 1969 set the seed which led to my interest in Masters' and Johnson's work and the subsequent wish to investigate it further. Professor Martin Herbert of the University of Leicester has supervised the preparation of this work with a kindly eye, and Dr James Thompson of the Middlesex Hospital revealed the mysteries of the Statistical Packages of the Social Sciences in making computer facilities available, giving unstintingly of his time and reassurance. Mrs Stella Cottman has typed heroically.

Finally, thanks are due to the couples who came and trusted us and to those members of the medical profession who let their patients know of the clinic services that we offered.

ABSTRACT : PH.D THESIS : UNIVERSITY OF LEICESTER 1979

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PRACTICAL MODIFICATIONS OF MASTERS' AND JOHNSON'S APPROACH TO THE TREATMENT OF SEXUAL DYSFUNCTION

A study is reported in which Masters' and Johnson's rapid-treatment (14-day) programme for sexual difficulties was modified to once-a-week out-patient attendance; in which couples attending for treatment were allocated to treatment by two therapists of opposite sex (cotherapy), or one therapist of either sex (single therapy); and in which observations were made upon the therapeutic efficacy of marriage guidance counsellors in treating sexual problems, following appropriate training, in comparison with the outcome results of an experienced clinician.

By way of introduction, a survey of the literature prior to the publication of Masters' and Johnson's "Human Sexual Inadequacy" in 1970 identifies four main strands of therapeutic practice and development which potentiated the uptake of Masters' and Johnson's ideas. These four strands - the psychoanalytic, the sociological, the cultural and the behavioural - are related to the period of questioning about professional knowledge of sexual function that Masters' and Johnson's "Human Sexual Response" of 1967 provoked.

The marriage guidance counsellor training group is described in detail by reference to personality characteristics, as defined by the 16PF test, and sexual knowledge, as assessed by the Sexual Knowledge Inventory (SKI). Results are compared with a population of marriage guidance counsellors. The effects of training are demonstrated by changes in the acquisition of sexual knowledge in the training group and by improvement in diagnostic skills over the period of training.

Under the two conditions of cotherapy and single therapy, it is demonstrated that there are significant differences in favour of cotherapy, on the basis of an analysis of variance of questionnaires completed independently by therapists, by client couples, and by an external assessor. Therapists recorded their judgements before and after treatment, whilst client couples and an external assessor made judgements at the conclusion of treatment only. Analysis of the questionnaire results suggested however that treatment produced greater effects upon the general and sexual relationships of presenting couples than upon their sexual function, though all treatment procedures produced some change in all three aspects. It was concluded that further work might isolate in more specific detail the differential effects of treatment upon sexual function as distinct from appreciation of the sexual relationship and the general relationship.

In modifying the time structure of treatment from a daily to a weekly procedure, it was observed that treatment typically took 12 sessions over 17 weeks but that there wide variations both between and within specific disorders. Marriage guidance counsellors were shown to establish treatment results that were of the same order of success as an experienced clinician.

Final observations made proposals for modifying the diagnostic schema proposed by Masters and Johnson, and reflected upon the nature of cotherapy.

Paul T Brown

Introduction

When, in 1970, Masters and Johnson published Human Sexual Inadequacy, they made three resoundingly simple observations about sexual function which had, until that time, passed clinicians by almost completely. The first was that sex tends to happen between two people, and so both partners to a sexual relationship were best seen together in therapy. The second was that a male therapist can never fully understand a woman's sexual experience, or vice versa, and so it might be productive to have a male and a female therapist present with the male and female couple presenting for help. The third one was that sexual arousal and response is a normal physiological function, and the natural property of a physically mature human being. In consequence difficulties of function (dysfunctions) could be approached through the processes of education rather than psychopathology.

The effect of such simplicity has been startling, as Section 3 below details. It is, however, in Masters' and Johnson's assumption of the need for two therapists (the dual-sex therapy team) that there appears to be the least a priori justification for their practices, yet this assumption contains in their writing an unquestioned acceptance of its rightness.

In the introductory pages of Human Sexual Inadequacy, they observe:

> "... this report will be of little value unless concept and content are reinforced in the future by the success of a large number

of dual-sex therapy teams in a variety of geographic areas throughout the world." (page V)

They were also conscious of the limitations of their clinical work:

" ... this clinical text has myriad shortcomings in concept and content - statistically limited and motivationally biased population, imperfect five-year patient follow-up, improved alterations of basic concepts of psycho-therapy, and inability to describe precisely subtleties so vital to effective treatment return are some examples." (page V)

This mix of dogma, awareness, simplicity and, as will appear later, powerful therapeutic results, left the present author, at first meeting Masters' and Johnson's clinical writing in early 1971, tremendously stimulated and equally frustrated - a combination which could hardly fail to stimulate experimental ardour. As Masters and Johnson had failed (most beneficially) to ally themselves with any then-current school of psychological thought or therapy, and so avoided being elected into either of the then-generally-opposed camps of learning theorists or psychodynamicists, early professional discussion of their work centred upon its actual content and the outcome of treatments recorded, and was not sidetracked by the kinds of allegiance that clinicians of opposing theoretical schools are wont

to impose upon members they can claim as their own or otherwise reject. Masters' and Johnson's work thus had an independence of position which was remarkably reinforced by the fact that they had not published any tentative findings prior to the single volume in 1970 recording both their methods and results.

Yet their unsupported insistence on the concept of the dual-sex therapy team, which was such an innovation in clinical concept and practice in the sexual function field,[1] and which was presented as a sine qua non of their method and results, nagged at the experimental impulse. It created an assumption which, it was felt, might continue to underlie all future assessments of the efficacy of any treatment for sexual difficulties if the centrality of the dual-sex therapy model was not first questioned. It was in consequence around this issue that the work presented here was first formulated.

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1 In Marital Tensions (1967), H. V. Dicks described the use of two therapists in psychotherapy with marital couples in what he called "four-person joint therapy" in the exploration of the dyadic relationship of marriage. He is not however insistent upon it.

This thesis pivots on the question -

> "Is the dual-sex therapy team necessary for effective treatment outcome?" or, to state it in practical terms, "Does one therapist produce treatment results that are as good or as poor as two therapists working together?"

The time basis of the treatment procedure as described (fourteen consecutive days of treatment involvement, see Section 2 below) and its specific setting (within the context of a vacation, see Section 2 below) were also questioned in preparing the study. Both were considered inappropriate to the patterns of health care commonly accepted in the UK, where the greater proportion of the population does not seek private treatment, or, during it, live at a considerable distance from home in a well-appointed hotel. In consequence, the study also set out to define the time structure of treatment within a UK setting, by establishing a pattern of weekly out-patient attendance and observing the consequences for the duration of treatment. The specific question that the study sought to answer was -

> "How long does treatment take when established on a regular out-patient basis?"

For terminating treatment it was decided to use clinical judgement

(which inevitably involved detailed discussion with the patients concerned about their readiness to end), or de facto endings such as patient couples not attending. Thus the treatment procedure was to be kept constant across couples, modifications of Masters' and Johnson's procedures having been made, and then observations made upon duration of treatment by reference to weeks in treatment and numbers of sessions to termination.

As is recorded in Section 5 below, the study also took place within the setting of a training programme in the treatment of sexual difficulties for experienced marriage guidance counsellors, the training being established by the author for the purposes of this study. As there was no literature of any kind on whether or not marriage guidance counsellors might be expected to make good sex therapists, observations were also made upon the therapeutic efficacy of the counsellors in comparison with the author, a clinical psychologist of some thirteen years practice at the time of the study.

The question -

> "Do counsellors establish as effective treatment results as a clinician?" 1

was therefore also examined.

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1 It should perhaps be observed, in the context of a thesis, that the questions which form the focus of the research work have been framed in operational rather than null-hypothesis terms, it being a predilection (or limitation) of the author to do so.

As is described in detail below (Sections 1 and 5), the study took place in a counselling service setting, and whilst established within an experimental framework, sought to answer operational questions. It was felt in this setting that a good deal of attention ought to be paid to the competence of counsellors as sexual function therapists, and in consequence, Sections 5.1.4 and 6.1 below present the evidence which suggests that counsellors established skills of a kind that might reasonably be supposed to have reference to competence as sexual function therapists.

In summary, then, this study set out to question the dual-sex therapy context of treatment, and in doing so, modify and observe upon the duration phenomena of a modified time base of treatment; looking also at the effectiveness of marriage guidance counsellors in treating sexual difficulties.

1. BACKGROUND TO THE STUDY

In 1966 W.H. Masters and Virginia Johnson of the Reproductive Biology Research Foundation at St. Louis, Missouri, reported the results of 12 years experimental and investigative work into the anatomy and physiology of human sexual response. The volume containing their work, Human Sexual Response, detailed the laboratory-based results of direct visual and psychophysiological observations of the human sexual response cycle on 694 adult volunteer subjects (382 women; 312 men) in the age ranges 21 - 90.

The significance of Human Sexual Response is twofold. In the first place, it is the first systematic study of human sexual response based upon direct laboratory observation. In this it is distinguished from the classic texts regarding human sexual function (e.g., Freud, 1905; 1920; 1933; Havelock Ellis, 1933), none of which are based upon systematic direct observation and all of which take abnormal or disturbed behaviour as their starting point. In the second place, Human Sexual Response provides the background body of knowledge upon which a second published volume Human Sexual Inadequacy depends. It is this second published volume which is the immediate progenitor of the work reported here.

In describing the phenomenon of sexual response, Masters and Johnson elucidated the physiological processes (if not all the mechanisms) underlying the observable behaviours attaching to sexual arousal and orgasmic release and demonstrated, within the confines of an

experimental population, that the vasocongestive and myotonic processes of sexual arousal and response in both male and female are essentially similar.

> "The basic physiological responses of the human body to sexual stimulation are twofold in character. The primary reaction to sexual stimuli is widespread vasocongestion, and the secondary response is a generalised increase in muscle tension. ... (our) Attempts to answer the challenge inherent in the question, "what do men and women do in response to effective sexual stimulation?" have emphasized the similarities, not the differences, in the anatomy and physiology of human sexual response."
>
> (Human Sexual Response,pp.8-9) [1]

Masters' and Johnson's observations of the normal sexual response cycle led to a description of four phases constituting the full

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1 Unless preceded by the abbreviation HSR (for Human Sexual Response) all page references in the text recording quotations from Masters and Johnson are page references to Human Sexual Inadequacy.

cycle. These four phases - called, in sequence, excitement, plateau, orgasm and resolution - are established by reference to the discrete anatomical and physiological changes which take place as effective sexual stimulation is established and maintained in any particular individual. Failure to establish one of the first three phases in the presence of effective sexual stimulation results in a sexual dysfunction.[2] It is the remedy of sexual dysfunction that is the core of Human Sexual Inadequacy, which was itself, in 1970, the result of eleven years of clinical research, carried out in parallel to the physiological work reported in Human Sexual Response.

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2 Detail concerning the sexual dysfunctions follows below (p. 35 et seq).

It should be noted in passing, however, that, paradoxically, one category of dysfunction, namely premature ejaculation, arises not from the absence of an orgasmic response, but from establishing the response too rapidly. It is thus a different type of disorder than disorders which are response failures. The problem of classification is considered further below (p. 226).

The underlying concept of normal human sexual response, as Masters and Johnson developed their views, is that it is the property of a biologically intact mature human to be able to respond sexually, and therefore lack of response must be the consequence of inhibitory (higher centre) processes. In stating a strong case for a physiological view of sexual function, they also state a strong case for the psychological origins of those inhibitions of sexual function which result in classifiable dysfunctions.

In developing procedures for the treatment of sexual dysfunctions, Masters and Johnson established an intensive, 14-day rapid treatment programme during which a presenting couple were treated by a male and female cotherapist couple. As will be shown in more detail below, this work not only described a treatment programme for sexual difficulties that were not previously very responsive to treatment, but also clarified diagnostic terminology; made considerable claims for the therapeutic efficacy of the procedures described; and set the context of the treatment of sexual difficulties firmly in the context of the presenting relationship. The work has generated a rapidly developing literature, whose mass is fed from the popular writings of the sexual education and feminist movements as well as the clinical literature. Sections 2.1 to 2.3 below detail Masters' and Johnson's procedures.

This study questions the need for two therapists, modifies the 14-day programme to a once-a-week attendance basis, and establishes marriage guidance counsellors as sexual function therapists.

In the local context a number of trends and events (none in themselves of marked significance but accumulating towards a direction) combined to produce a climate in which the work reported here took place. Section 4 below describes the derivation of the experimental and operational questions.

On a visit to the headquarters of the National Marriage Guidance Council in late 1971, Professor David Mace of the U.S.A. showed some of the sexually explicit film material which was beginning to be developed by the (then) National Sex and Drug Forum of the United States for educational and research purposes (now the National Sex Forum), and in the following year, he published a small book which set the concepts for the direct treatment of sexual difficulties in a Marriage Guidance Council context (Mace 1972). In so doing, he provoked thinking inside the NMGC[1] about developments of role and function. The NMGC itself, after a period of re-structuring, moving its headquarters physically from London to the Midlands, and the more extensive development of its selection and training procedures, was ready to look at the extension of its role and the extending of its counsellors' skills. An article had appeared in the NMGC Newsletter describing an attempt by two counsellors to use some of Masters' and Johnson's ideas in a Council setting (Harris and Usborne 1972). At the instigation of Coventry Marriage Guidance Council, this author, then as principal clinical psychologist in Coventry, conducted four teaching sessions in the Spring of 1972 on the work of Masters and Johnson. Bancroft (1972a) had drawn attention to the

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[1] National Marriage Guidance Council

treatment of sexual difficulties, post-Masters and Johnson, in general practice, and Bancroft (1972b) and Brown and Kolaszynska-Carr (1972) had read papers on the uptake of Masters' and Johnson's work in this country, of which the latter was taken up by the Head of Counselling at NMGC on the instigation of Dr. J.R.T. Finlayson, then psychiatric consultant to the Coventry MGC.

In 1972 the uptake of Masters' and Johnson's work in an NHS context was still very limited. Apart from the two papers to which reference has just been made, there were no systematic clinical services in the country using Masters' and Johnson's work beyond those beginning to be established at Warneford Hospital, Oxford, under the direction of Dr. Bancroft; at Sheffield, under the direction of the late Dr. J. Lawton Tonge, and at Walsgrave Hospital, Coventry under the direction of Brown.

The dates are recorded not only as matters of fact, but because in the context of recent clinical developments in the treatment of sexual difficulties, they set the study and its relevance in the period immediately following the first full English publication in 1970 of the clinical work undertaken by Masters and Johnson at St. Louis, Missouri.

Bancroft and Coles (1976) have reported on the experience of running a sexual clinic, and Bancroft and his research colleagues

have subsequently reported work which has investigated the efficacy of Masters' and Johnson's procedures in comparison with other behaviourally based techniques, and has also examined the single versus co-therapist effect, using qualified clinicians of some experience (Mathews, Bancroft et al, 1976); and Tonge and his associates made a preliminary report of their introduction of systematic training for members of the helping professions working in the sexual function field (Anderton et al, 1976). Duddle extended her long-standing interest in psychosexual problems by incorporating Masters' and Johnson's work into training (Duddle, 1975), and the psychosexual work of Haslam in York (Haslam, 1978) and Milne in Bradford developed similarly (Milne and Hardy, 1975). It appears, however, that the work reported here is the only work in England or America which has experimentally explored sexual function work with counselling personnel as the main source of therapeutic help.

A particular feature of the period of time since the research was conceived has been the rapid growth of interest in the development and application of Masters' and Johnson's work and its derivatives in a clinical setting, especially in the NHS. As a response to demand for information about resources during the conduct of the study reported here, Brown developed a list of those centres and resources country-wide which have made treatment facilities within a modified Masters and Johnson format available. From perhaps three identifiable centres in early 1973, the list identified 24 centres by 1976. As a further

response to demands for information, Brown also established an invited co-therapists' conference which started meeting on a quarterly basis in early 1975, and in the summer of 1976, formalised itself as the Association of Sexual and Marital Therapists. This body now (Spring 1978) has a membership of 80, and a mailing list of 150.

Masters' and Johnson's work was integrated with broad-spectrum psychological and medical knowledge of sexual difficulties, by Kaplan (1974). Annon (1974 and 1975) set Masters' and Johnson's ideas into a broader behavioural context. These influences are elaborated in the wider context of the literature in Section 3 below. None of the studies coming out of the U.S.A. pay particular attention, in an experimental sense, to the kind of research questions which are formulated by the present study and by the Oxford group. The major American derivatives of Masters and Johnson pay special attention to the development of therapeutic skills and depend upon the clinical experience of the various workers writing.

As additional influences on the development of the study, the late Autumn of 1973 coincidentally saw a radical restructuring of the organisation of the NHS, and in this process, considerable change took place in the role and function of the Family Planning Association. (F.P.A.) This body, constituted outside but in parallel to the NHS, had developed not only contraceptive services, but also specialist services for the treatment of psychosexual difficulties. These latter services were conceived largely within a brief psychotherapy

format, based upon the work of Balint as reported by Friedman (1961).

Whilst the services of the F.P.A. tended to attract a preponderance of women clients, they did nevertheless generate, outside the context of general psychiatry, a focus of concern about sexual difficulties. This concern was also expressed in the more recently developed Brooke Clinics. Together, the FPA and Brooke Clinics provided a service which was available not only upon medical referral but on self-referral too. However, upon the re-organisation of the NHS, the psychosexual services of the FPA were incorporated into the NHS, and in an already hard-pressed service had no special priority for development. In consequence, not only did the services for the treatment of psychosexual difficulties diminish after 1973, but, when psychosexual clinics were established in the NHS, medical referral became necessary. Thus, at the time that new approaches to the treatment of sexual difficulties were developing in the States, and beginning to be taken up in Britain, with an emphasis upon the searching/discovery/educational aspects of the sexual expression of sexuality, the main trend in Britain was to identify sexual difficulties in an illness/medical context more clearly than had been the case in recent previous years. This identification was, in part, furthered by the establishing, in 1973, of the Institute of Psychosexual Medicine, which offered membership to medical practitioners only who had completed a supervised training within the Balint model. This Institute aimed to carry on the training work of the FPA, but,

perhaps inadvertently, might be seen to have encouraged a limiting of the concepts relevant to the treatment of sexual difficulties at a time when they were beginning to broaden.

These, then, are the sources of influence in the background of this study. Above all, it is a study undertaken in co-operation with a national voluntary counselling organisation, heavily reliant on central funding, wishing to proceed with long-term policy decisions about the development of its services by establishing (for the first time in its own history) applied clinical research upon whose outcome such decisions might properly be taken. The study undertook to pose and answer practical questions in such a way that forward planning had the benefit both of empirical fact and the experience of its counsellors.

2. MASTERS' AND JOHNSON'S "HUMAN SEXUAL INADEQUACY" : A SUMMARY.

As Human Sexual Inadequacy was itself a new departure point in our understanding of the treatment of sexual difficulties, and is the starting point of the work presented here, Sections 2.1 to 2.5 that follow record the essence of the observations made in Human Sexual Inadequacy. They are followed by Sections 3.1 to 3.5 which set Masters' and Johnson's work in a wider historical context by way of a literature review, and a brief critique of Masters' and Johnson's work follows in Section 3.6. The experimental formulation is then presented in Section 4, followed by the experimental study in Sections 5 to 7. The findings are compared with the other relevant experimental study to have emerged so far, in Section 8. In the light of the findings reported and comparisons made, observations deriving from the results and especially the clinical work undertaken are made in Section 9. Conclusions are drawn in Section 10, together with some observations upon the implications of the study in extending our understanding of Masters' and Johnson's original work. A long range practical outcome of the study is noted following the Appendices and References.

2.1 The Therapy Format

Human Sexual Inadequacy presents an introduction to the therapy concepts, format and techniques developed by Masters and Johnson over "... 15 years of laboratory experimentation and 11 years of clinical trial and error." (p.1). The essence of the treatment situation described is that a male and a female therapist, one preferably a medical practitioner, treat a presenting couple, centering their therapeutic attention not so much on the clinical disorder of either man or woman in the presenting marital unit but on the sexual effectiveness of the partnership. This foursome treatment arrangement is designated by the term 'cotherapy'.

2.2 The Therapy Programme

The therapy programme for sexual dysfunction proceeds over an intensive, 14-day sequence of a structured learning/re-learning process, making step-by-step moves to a "mutually desirable sexual involvement". (p. 14) In the early days of their clinical endeavours, Masters and Johnson record that couples in treatment spent three weeks in the therapy programme. This was found to be unduly long - mostly, it seems, on the pragmatic grounds of the couple's time commitment away from home:

> "Evaluation of experience made clear that three weeks were simply too long for a marital unit's comfortable commitment away from home, and from the standpoint of therapy demand, was an unnecessarily extended period.

> Therefore, the outer limit time demand became two weeks and has remained so for the last nine years." (p. 17)

Masters and Johnson were not unaware of the advantages of isolating couples in treatment from the general pressures of their usual lives.

> "One of the therapeutic advantages inherent in the 2-week phase of rapid education and/or symptom reversal is the isolation of the marital unit partners from the demand of their everyday world. Approximately 90% of all marital units treated by the Foundation are referred from outside the St. Louis area. These people are regarded and treated as though they were guests. Every effort is made to ensure their enjoyment of the "vacation" during their time spent in the city.... Inevitably they rekindle, in part, their own communicative interests when there is no child crying, no secretary reminding them of business commitments....
>
> Yet another advantage of the social isolation factor is its effect upon the sexual interest of the marital partners. With the subject of sex exposed to daily consideration, sexual stimulation usually elevates rapidly and accrues to the total relationship....

As evidence of the advantage to the therapeutic program of the unit's social isolation, those marital units referred to the Foundation from the St. Louis area require three weeks to accomplish symptom reversal rather than the standard two weeks for those living outside the local area. It is difficult to isolate oneself from family demands and business concerns if treatment is being carried out in the environment in which the couple lives. For this reason it has been found more effective to see patients referred from the St. Louis area on a daily basis for the first week, thereafter five times a week and to assign a total of three weeks to accomplish reversal of symptomatology. Partners in sexually distressed marriages who cannot or do not isolate themselves from the social or professional concerns of the moment react more slowly, absorb less, and communicate at a much lower degree of efficiency than those advantaged by social retreat." (pp.17 - 20)

The aspects of their work upon which Masters and Johnson lay special stress are -

1) The involvement of both members of the distressed marital unit.

2) The involvement of two therapists of opposite sex as a dual-sex therapy team.

3) Intensive (daily) treatment work over
a 14-day sequence, and preferably with
a couple beneficially isolated from the
circumstances of their usual every day lives.

4) The shared endeavour of mutually confident
cotherapists who both participate
and observe in a fluid interactive/controlling
therapeutic process.

At its simplest the essence of their work, as of any psychological therapy, involves the commitment of time by patient(s) and therapist(s) in the context of a more-or-less structured use of that time.

It has already been recorded that Masters and Johnson established a treatment sequence lasting 14 days. The essential stages of this 14-day procedure were that couples lived in hotels near the Reproductive Biology Foundation's clinic facilities, were seen by their therapists on a daily basis, and undertook the treatment programme summarised below.

DAY

1 (i) Brief intake interview.

(ii) History-taking (male therapist/male patient;
female therapist/female patient).

2 History-taking (male therapist/female patient; female therapist/male patient).

3 (i) Physical and medical examinations.

(ii) Round table discussion, in which all 4 participants meet for a review and summary of the clinical and historical material elicited, and to establish and agree causes of the origin and persistence of the presenting dysfunction(s).

(iii) Special sense discussion.

(iv) Establishing non-genital sensate focus, in the context of round table goals. These goals (pp 83-84) are to initiate an educational process describing the nature of effective sexual functioning by emphasising and explaining -

a) That sexual functioning is a natural physiological process.

b) The impossibility of employing the goal of end-point release (orgasm) in sexual expression as a means to overcome basic sexual dysfunction.

c) That sexuality (being male or female) is a dimension of personality expressed in every human act.

d) That sex or sexual functioning is specific sexual activity (masturbation, intercourse, partner genital manipulation etc.)

3 (iv) continued.

e) The profound role played by fears of performance (felt by either sex) which grow specifically from lack of knowledge of effective sexual functioning and lead to a spectator's role.

f) The sexual myths, misconceptions, and prejudices that have been defined in the material shared by the marital unit with the cotherapist.

g) The fact that individual sexual preferences may differ because marital partners are two different personalities, having two different sets of attitudes, and often bring two different social, ethnic and religious backgrounds into relationships.

h) That sexual patterns, habits, and values desirable to both partners usually have to be developed or identified by mutual effort.

i) That cotherapists' interest will be focused upon gradual development of pleasurable sexual interaction by means of those elements of sensate focus meaningful to and understood by both sexual partners.

j) That sexual effectiveness will be evolved from this gradual sensory appreciation and not from goal-oriented sexual performance.

3 (iv) continued.

k) That "mistakes" generally are even more contributory to the progress of therapy than successes during the marital unit's attempts to follow the Foundation's authoritative directions.

l) That the marital relationship remains the focus of therapeutic attention during the rapid treatment program rather than either of the marital partners.

4 (i) Evaluate outcome of first experience of non-genital sensate focus.

(ii) Establish knowledge about own and partner's sexual anatomy.

(iii) Continue non-genital sensate focus.

5 (and subsequent days)

(i) Evaluate outcome of previous days' directed sexual experience.

(ii) Move from non-specific and non-demand pleasuring through genital sensate focus to the detailed approach for the remedy of the particular presenting disorder.

2.3 The Cotherapy Situation

Masters' and Johnson's rationale for the involvement of both members of the presenting partnership stems from the assumptions of their statement that -

> "there is no such thing as an uninvolved partner in any marriage in which there is some form of sexual inadequacy....Isolating a husband or wife in therapy from his or her partner not only denies the concept that both partners are involved in the sexual inadequacy with which the marital relationship is contending, but also ignores the fundamental fact that sexual response represents (either symbolically or in reality) interaction between people....Methods of therapy using isolation techniques[1] when approaching clinical problems of sexual dysfunction attempt to treat the sexually dysfunctional man or woman by ignoring half of the problem - the involved partner."
>
> (pp 2 - 3)

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1 i.e., emphasising one-to-one patient-therapist relationships.

In consequence of the above assertions, it is what happens between the couple that is the focus of therapeutic attention, rather than the complaint:

> "... the Foundation's basic premise of therapy insists that, although husband and wife in a sexually dysfunctional marriage are treated, the marital relationship is considered as the patient." (p. 3)

The cotherapy use of the dual-sex therapist team is justified by laboratory experience (not experiment) and an assumption, based upon the biological differences of the adult male and female, that neither male nor female will ever adequately comprehend the nature of the other's sexual response.

> "... No man will ever fully understand a woman's sexual function or dysfunction. What he does learn, he learns by personal observation and exposure, repute or report, but if he is at all objective, he will never be secure in his concepts because he can never experience orgasm as a woman.

> The exact converse applies to any woman...[1]
>
> Since it soon became apparent in the laboratory that each investigator needed an interpreter to appreciate sexual responsivity of the opposite sex, it was arbitrarily decided that the most theoretically effective approach to the treatment of human sexual dysfunction was to include a member of each sex in a therapy team. This same premise, applied in the clinical study, provided husband and wife in a sexually dysfunctional marital unit each with a friend in court as well as an interpreter when participating in the program.[2]" (p. 4)

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1 By which rather paradoxical statement Masters and Johnson clearly mean that the same applies to the woman in that she can never experience male orgasm. They do not mean that the woman can understand the man!

2 Masters and Johnson have, to the English ear, a difficult writing style. Articles are frequently missed out, as well as infinitives (horrendously!) split. No changes in quoted text have been made to remedy this, though in consequence an obvious point is sometimes unnecessarily difficult to grasp.

Given the circumstances of a presenting couple whose sexual interaction is the focus of interest for the dual-sex therapy team, guidelines for the conduct of therapy are outlined. These guidelines are, however, not extensive, and essentially require the therapists to adopt the role of friend-in-court to the patient of the same sex, thereby ensuring a likelihood of accurate clinical information and controlling for the adverse consequences of the phenomena of transference in what is seen as an essentially psychotherapeutic encounter:

> "The major responsibility of each cotherapist ... is to evaluate in depth, translate and represent fairly the member of the distressed marital unit of the same sex. This concept should not be taken to suggest that verbal or directive interaction is limited to wife and female cotherapist or to husband and male cotherapist - far from it. The interpreter role does not constitute the total contribution an individual cotherapist makes in accepting the major responsibility of sex-linked representation. The male cotherapist can provide much information pertaining to male-oriented sexual function to the wife of the distressed marital unit; and equally important, female oriented material is best expressed by the female cotherapist for the benefit of the husband." (p. 5)

The benefits of this are contrasted with the presumed disadvantages of a single therapist setting:

> "Acute awareness of the two-to-one situation frequently develops when the sexually distressed marital unit sees a single counsellor for sexual dysfunction ... A dual-sex team avoids the potential therapeutic disadvantage of interpreting patient complaint on the basis of male or female bias."
>
> (pp. 5 - 6)

The preceived advantages of the therapy foursome are used as fully as possible in the sequence of history taking (as above p. 22).

It is also observed that the therapeutic situation described above has particularly happy consequences:

> " ... an additional fortunate therapeutic return from the presence of both sexes within the therapy team is in the area of clinical concern for transference from patient to therapist as a figure of authority. There is no desire to avoid this influence in the therapeutic program, but ... every effort is made ... to avoid development of a special affinity between either patient and either cotherapist. Instead of generating emotional currents, especially those with sexual connotation, from one side of the desk to the other, the therapeutic team is intensely interested in stimulating

> the flow of emotional and sexual awareness between husband and wife and encourages this response at every opportunity." (p. 7)

In the activity of the dual-sex therapy team, one member of the therapist pair takes the active part, one the silent role of an observer. The silent observer is described as having an especial function:

> "The silent cotherapist is literally in charge of each therapeutic session. He or she, as the observer, is watching for and evaluating levels of patient receptivity to therapeutic concept and to the educative directive material presented by the active cotherapist ... the silent cotherapist really acts as the coach of the team. As soon as it is apparent that the individual subject under discussion can be presented in a different, possibly more acceptable or understandable manner, or that it requires further clarification, the roles reverse and the cotherapist functioning previously as the observer, fortified and advantaged with the salient features of patient reaction to the ongoing situation, becomes the active discussant. The previous discussant then assumes the role of observer... In the finite co-operative interaction between mutually confident cotherapists in any dual-sex therapy team, the currently dominant partner influence at any

particular time is not being exercised by the one that is talking, but by the one that is observing."

(p. 9)

(As will be apparent later in the context of the experimental study, the emphasis which Masters and Johnson place upon the function, roles and value of the dual-sex therapy team appears to make the presence of two therapists a sine qua non of the treatment of sexual dysfunctions. The matter is highlighted here because it is central to the study carried out.)

"The cotherapy endeavour is to stimulate and facilitate communications between the therapy couples. Four-way verbal exchange is maintained at an open, comfortable level during therapy. First, communication is developed across the desk between patients and cotherapists. Within a few days, verbal exchange is deliberately encouraged between patients. ...The cotherapists are fully aware that their most important role in reversal of sexual dysfunction is that of catalyst to communication... The ultimate level in marital unit communication is sexual intercourse ... (but) it should be made abundantly clear, in context, that Foundation philosophy does not reflect the concept that sexual functioning is the totality of any marital relationship.

It does contend, however, that very few marriages can exist as effective, complete and ongoing entities without a comfortable component of sexual exchange."

(p. 15)

The work of the cotherapy foursome also centres itself around the central observation deriving from the physiological work of Masters and Johnson that, in the mature adult, sexual functioning is a natural, physiological process. As such, it is like any other autonomic process. However, sexual responsivity possesses a unique characteristic that no other autonomic process does, which is that it can be selectively or totally delayed or inhibited for a lifetime. If any other autonomic function is so delayed or inhibited, severe physical distress results or death supervenes. Not so in the case of sexual function. Thus sexual responsiveness is uniquely under the control of psychological factors, and Brown (1975) has synthesized Masters' and Johnson's view by observing that the overriding purpose of therapy for the treatment of sexual difficulties is not to teach a couple <u>how</u> to function, but to help the partners stop stopping their natural function.

The causes of the inhibition of natural sexual function are ascribed by Masters and Johnson to fear or ignorance or both. In couples presenting with sexual difficulties of which they are aware, a secondary development is also described which is a particularly

powerful contributor to inhibition of function, and that is fear of sexual performance producing"spectatoring".

> "It should be re-stated that fear of inadequacy is the greatest deterrent to effective sexual functioning, simply because it so completely distracts the fearful individual from his or her natural responsivity by blocking reception of sexual stimuli either created by or reflected from the sexual partner." (pp. 12-13)

In summary, therefore, Masters and Johnson have outlined in Human Sexual Inadequacy a structured approach to the treatment of sexual difficulties based upon clinical experience rather than the systematic investigation of the constituent variables. [1]

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1 This is, of course, a not unfamiliar situation in the development of psychotherapies of many kinds, and it is typically only after an original statement that experimental work to refine and assess the varying effects of the variables involved is possible.

Two aspects of Human Sexual Inadequacy remain for summary, in order to establish the background of the experimental questions. The first is to establish the groups of disorder to which treatment procedures were applied. The second is to record the result s that were obtained.

2.4 The Dysfunctions.

Masters and Johnson identified four main disorders in the male, and four in the female. These were, in the male -

1 Primary impotence

2 Secondary impotence

3 Premature ejaculation

4 Ejaculatory incompetence

and in the female -

1 Primary orgasmic dysfunction

2 Situational orgasmic dysfunction

i) masturbatory

ii) coital

iii) random.

In addition they considered the problem complications of low sexual drive presenting in either male or female; dyspareunia (pain upon intercourse) in both males and females; and vaginismus in the female. They also considered the difficulties of sexual function in the ageing male and female (age 50 and over). It is however on the basis od the four main categories in each sex, listed above, that their detailed treatment results are presented.

The four main categories in each sex above are partly redefinitions of previously established psychiatric classifications, partly new

classifications entirely. In consequence, detailed or accurate comparison with prior studies is impracticable and unproductive, which is reinforced by the entire pattern of treatment, with its emphasis upon the treatment of the partnership by two therapists of the opposite sex.

The newness of the diagnostic formulations can be seen in the following:

Primary impotence is defined " ... arbitrarily as a man never able to achieve and/or maintain an erection quality sufficient to accomplish successful coital connection" (p. 137), whilst a diagnostic statement of Secondary impotence requires that " ... there must be the clinical landmark of at least one instance of successful intromission".

The definition of Premature ejaculation requires that if a man " ... cannot control his ejaculatory process for a sufficient length of time during intravaginal containment to satisfy his partner in at least 50 per cent. of their coital connections" he will be considered a premature ejaculator, whilst Ejaculatory incompetence is considered the reverse of premature ejaculation, and a diagnosis is considered justified when " ... the affected individual cannot ejaculate during intravaginal containment".

The standard psychiatric texts of the period (Mayer-Gross, Slater and

Roth, 1969; Henderson & Gillespie, 1969) do not make any partner-dependant observations upon these disorders at all, and indeed do not regard them in the context of normal sexual function and relationships, but to the extent that any reference to them is made at all, place them in the context of physical and psychological pathology, and in a wide-ranging group of personality deviations and neurotic reactions.

> "Lifelong and complete impotence, that is incapacity for an erection, does exist, but is very rare, and is generally associated with some endocrine abnormality such as pituitary dwarfism. By far the greater number of patients who complain of impotence are impotent only on occasion - even if those occasions are the most critical ones for them. Apart from absolute impotence, there are great individual variations in strength of the libido, which are to some extent correlated with other features of the personality. Men of very weak libido tend to be of pyknic or asthenic rather than athletic build, and to have temperaments of an unaggressive, anergic type. They appear also to be more subject to neurotic illness."
>
> (Mayer-Gross, Slater and Roth, 1969; pp.161-162)

Henderson and Gillespie (1969) do not distinguish the disorder of impotence at all under any category of classification, nor do they for premature or retarded ejaculation. For the latter two categories, Mayer-Gross, Slater and Roth place premature ejaculation (in its Latinate form as 'ejaculatio praecox') as either the consequence of anticipatory anxiety and a variety of impotence; or normal.

> "Anticipatory anxiety is usually the cause of impotence ... during the honeymoon and in the male is likely to take the form of ejaculatio praecox. Many men are in any case subject to a quick orgasm; according to Kinsey three quarters of the average male population reach an orgasm within two minutes."
>
> (p. 162)

Ejaculatory incompetence (or 'ejaculatio retardatus' in its Latinate form) is not considered as a clinical or functional disorder in either text.

So far as the female dysfunctions are concerned, they are restricted to the generalised term 'frigidity' by Mayer-Gross, Slater and Roth and not discussed at all by Henderson and Gillespie. Frigidity is considered (as is impotence, ejaculatio praecox and masturbation, among other aspects of the sexual life) under the specific heading of "The Sexually Perverse", and though " ... not strictly speaking (a) perversion .... may be discussed here." Frigidity is viewed

as the counterpart of male impotence, and in women

" ... frigidity is associated with tendencies to hysterical manifestations." This may be contrasted with the diametrically opposed view upon which Masters and Johnson based their clinical work - i.e., that difficulties of orgasmic expression were the result not of psychopathology but of "negative conditioning" [1]

(Human Sexual Inadequacy, p. 22).

" ... for most primarily non-orgasmic women, repressed expression of sexual identity through ignorance, fear or authoritative direction was the initial inhibiting influence in (the consequential) failure of sexual function."

(Human Sexual Inadequacy, p. 223)

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1 This is not "negative conditioning" in the technical sense of "negative reinforcement", but is the popular sense of social learning and/or influences leading to adverse or negative consequences.

> "A psychophysiological interpretation of female sexual response must be established and accepted, for it is impossible to consider sexual dysfunction with objectivity unless there is a base for comparison afforded by an acceptable concept of woman's sexually functional state. In an effort to establish such a baseline interpretation, female sexual response will be contemplated as an entity separate from male sexual response - not, as might be presumed, because of any vast difference in their natural systems of expression (for beyond the influence of fortunate variations in reproductive anatomy and their individual patterns of physiological function the sexes are basicly similar, not different) but because of sex-linked differences that are largely psychosocially induced."
>
> (Human Sexual Inadequacy, p. 215)

Thus Primary orgasmic dysfunction is characterised by the fact that a woman must report " ... lack of orgasmic attainment during her entire lifespan." In contrast with male categories of impotence, which relate to the effectiveness of coital connection (and hence erectile strength) rather than orgasmic experience, primary orgasmic dysfunction requires a " ... standard of total inorgasmic responsivity," except that "If a woman is orgasmic in dreams or phantasy alone, she

still would be considered primarily nonorgasmic." (Human Sexual Inadequacy, p. 227). Situational orgasmic dysfunction divides itself into three sub-categories - masturbatory, coital and random. In the first a woman can establish orgasmic release by coitus, but not by self or partner stimulation apart from coitus. In the second, a woman can establish orgasm by manipulation or other stimulative techniques, but not by coitus. In the third, and where there is a history of orgasmic release on at least one occasion from both masturbatory and coital experience, the diagnostically descriptive criteria attaching to the relative rarity of orgasmic experience are often accompanied by little or no need for sexual expression.

These diagnostic groupings for women differ from those for men not only in the emphasis that is placed upon orgasmic attachment but also in including the capacity to achieve orgasmic release by means other than coitus. Section 9 below makes more detailed references to this.

It is however pertinent to observe the radical nature of Masters' and Johnson's formulation of female dysfunctions when it is considered that up to 1970, not only does the blanket term 'frigidity' cover all female sexual difficulties (unless a specific category of perversion is accorded) but that masturbation is barely attributed to women as a sexual act at all.

> "As (masturbation) is so easily performed, and an effort is needed to overcome the habit and adapt to a partner, it may persist in a late age in sensitive, reticent, shy and weak-willed persons. Young men may have years of their lives made unhappy by a continuous struggle against something they consider morally sinful or physically harmful ... the main incidence of masturbation is at an age when young males are thrown much in their own company ..."
>
> (Mayer-Gross, Slater and Roth, p. 165)

Henderson and Gillespie do refer to masturbation in both sexes as a normal stage of development, but see it as something to be survived and abandoned in later life.

> "The investigations of Havelock Ellis, Kinsey and many others have shown that practically all persons of both sexes have practised masturbation during some period of their lives, and it can therefore be regarded as a normal stage in one's sexual development. It is something to be lived through, and to be replaced at a later stage by heterosexual interests. This however may not always occur. There are some unfortunate people

who remain stuck at the narcissistic level, and who learn to accentuate their erotic feelings by phantasy thinking. Sooner or later anxiety, shame, guilt rear their ugly heads and the victim may believe that he has done himself irreparable harm, committed the unpardonable sin, and deserves to be punished. An attempt at self mutilation may be the answer to his problems.

... Others of stronger fibre, and they are the majority, pass through this ordeal of development unscathed... It is, therefore, of importance in relation to one's biological development to put away childish ways and habits at as early a date as possible and strive for more healthy and mature outlets."

(Henderson & Gillespie, p. 199)

It is in the context of the above that Masters' and Johnson's classificatory formulations cut across the previously accepted nosology and establish a new starting point for both the classification and treatment of sexual difficulties, basing themselves as they do on concepts of normal sexual function and psychosocial rather than psychopathological determinants when difficulties of function are encountered.

2.5 The Outcome of Treatment

The outcome of the treatment studies reported is as follows:

	Disorders	Male		Female	
		n	%		
Male	Primary Impotence	32	59.4	-	
	Secondary impotence	213	73.7	-	
	Premature ejaculation	186	97.8	-	
	Ejaculatory incompetence	17	82.4	-	
Female	Primary orgasmic dysfunction	-		n 193	% 83.4
	Situational orgasmic dysfunction - masturbatory orgasmic dysfunction	-		21	91.9
	coital orgasmic dysfunction	-		106	80.2
	random orgasmic dysfunction	-		32	62.5
		448 avge 83.1%		342 avge 80.3%	

Table 1. Immediate outcome success rates, Masters' and Johnson's rapid treatment (14-day) program (derived from Human Sexual Inadequacy, p. 358 - 362) *

* Masters and Johnson present their results not in terms of successful outcome but in terms of how many (what proportion of) cases treated were not successful, which they call Initial Failure Rate (IFR). Such a presentation argues either for great caution or great expectation or both ! "Since there is no excuse for failure ...." (p. 370)

In addition the disorder of vaginismus is given a separate category, and in a group of n = 29 women the immediate outcome success rate was 100% .

"Diagnosis and treatment of vaginismus successfully was but a first step in clinical attack upon an orgasmically dysfunctional status. Once diagnosed the dysfunction of vaginismus is clinically reversible."

3. MASTERS' AND JOHNSON'S WORK IN AN HISTORICAL AND DEVELOPMENTAL CONTEXT

3.1. Introduction

The essential newness of Masters' and Johnson's approach to the remedy of a group of disorders which they themselves defined has been implicit in a good deal of the foregoing material and made explicit by specific reference to psychiatric texts of the day in the section on The Dysfunctions (pp. 35 to 43 ~~below~~ above).

It was a quite deliberate intent of Masters and Johnson to establish a new departure point in both knowledge and clinical practice. In the Preface to "Human Sexual Response" they quote Dickinson (1925) as a source of inspiration:

> "In view of the pervicacious gonadal urge in human beings, it is not a little curious that science develops its sole timidity about the pivotal point of the physiology of sex. Perhaps this avoidance ... not of the bizarre and the extreme, the abnormal and the diseased, but of the normal usages and medial standards of mankind ... perhaps this shyness is begotten by the certainty that such study cannot be freed from the warp of personal experience, the bias of individual prejudice, and,

above all, from the implication of prurience. And yet a certain measure of opprobium would not be too great a price to pay in order to rid ourselves of many phallic fallacies. Our rigorous protests against the sensual detail of pornographic pseudoscience lose force unless we ourselves issue succinct statistics and physiologic summaries of what we find average and believe to be normal, and unless we offer in place of the mush of much sex literature the few pages necessary for a standard of instruction covering sex education. Considering the incorrigible marriage habit of the race it is not unreasonable to demand of preventive medicine a place for a little section on conjugal hygiene that might do its part to invest with dignity certain processes of love and begetting."

Noting the 40 years intervening between Dickinson's writing and their own, the observe -

> "As in all things, there must be a beginning. There must be some way to teach the teachers. ... How can biologists, behaviourists, theologicians and educators insist in good conscience upon the continued existence of a massive state of ignorance

of human sexual response to the detriment of the well-being of millions of individuals. There is no man or woman who does not face in his or her lifetime the concerns of sexual tensions. Can that one facet of our lives, affecting more people in more ways than any other physiologic response other than those necessary to our very existence, be allowed to continue without benefit of objective, scientific analysis? ... This text represents the first step, a faltering step at best, but at least a first step towards an open-door policy. The door of investigative objectivity must not be closed again." (Human Sexual Response, pp.5-7)

Whilst the discovery and statement of facts hitherto unknown or avoided is not, in science, an infallible guarantee that such facts will be readily accepted or used, such does occasionally occur in the psychological and medical literature, a recent example being the influence and uptake of Wolpe's seminal work on the application of learning theory to the treatment of maladaptive behaviour.

(Wolpe, 1958)

Like Wolpe, Masters and Johnson brought new definitions and insights to long-established clinical problems, and also produced treatment results of a power hitherto not known. Like Wolpe also, Masters and

Johnson moved from the constraints of psychopathology to the adaptive processes of learning. Unlike Wolpe, Masters and Johnson were not concerned with a set of theoretical assumptions for their treatment procedures. They were however concerned for the basic empirical physiological facts upon which their pragmatic treatment procedures rested. This distinction is of course possible because Masters' and Johnson's prime interest was their physiological response work, and their second strand of interest the extrapolation of their findings to the remedy of specific difficulties. Thus their therapeutic move is outwards from basic research, not, as it were, backwards to find answers to already-defined problems. In consequence, and as has been noted, they defined difficulties which had not previously been classified, especially in the realm of female orgasmic response.

Having observed upon the foregoing, however, it is still a matter of recent history that Masters' and Johnson's work has provoked the tremendous interest that it has, and although clear precursors to their clinical work are absent, the strands which potentiated the applied uptake of their work are worthy of note, not least because a literature has begun to appear since Human Sexual Inadequacy which seeks to integrate Masters' and Johnson's observations into a wider clinical background than they themselves set it in.

It is the purpose of this section, therefore, to indicate the main strands of clinical thought and practice which, it is suggested,

potentiated clinical interest in the treatment procedures described in Human Sexual Inadequacy.

Four main potentiating strands are observed - the psychoanalytic, the sociological, the cultural, and the behavioural. Masters' and Johnson's physiological work is seen as being the development which makes possible the integration and extension of these strands, as it is the first body of work based upon replicable observations within the rigours of experimental method.

3.2 The Psychoanalytic Strand

The psychoanalytic model of sexual difficulties rests upon the observations of Freud (1905) that the maturation of sexuality from infancy to its adult reproductive capacity involves the inseparable and interrelated processes of physiological maturation and psychological development. In normal development these processes lead to an integration which enables the individual to find expressions of sexual drive within the requirements of the culture in which he or she is raised and/or lives. Within the Freudian framework, the sexual drive is a force which is continuously acted upon by external (social) and internal (intrapsychic) controls, and the manner by which the external controls are incorporated into the individual's psychic system during the developmental phases from infancy, through adolescence and into

adulthood. The establishing of control is achieved by the processes of the superego, whose task it is within the Freudian mechanistic framework to manage the forces of the libidinal unconscious. Thus men and women reach their psychosexual maturity through the reconciliation of sexual drives within the requirements of their superegos.

Benedek (1968) observes, however, that psychoanalytic theory, in its early formulations (Freud, op. cit.) took insufficient account of the sexual drive in relation to its goal of procreation, where the difference between the sexes is biologically determined. Deriving its model of female functioning from the genital primacy of male functioning, in which the reproductive function requires only one act that is consummated in sexual coitus and orgasm, she considers that the psychosexual maturity of women was unwittingly characterised by a genital primacy that, parallel to male orgasm, was to culminate in vaginal orgasm. Accordingly, vaginal orgasm implied a transfer of clitoral sensation to the vagina, thus eliminating the "residual male organ" (Freud, 1933, in Benedek, 1968). This concept was made a measure of psychosexual maturity, is often the goal of psychoanalytic treatment, and has given rise to the vaginal-clitoral transfer theory of female psychosexual development.

Freudian theory stresses the interrelatedness and interdependence of male sexuality upon female, and female upon male. Freud (1920)

had been very aware of the fact that his view of female sexual functioning depended heavily upon what he recognized to be the limited biological knowledge of the time, and expressed the hope that there might one day be an explanation of female sexuality from biology which would be "of a kind which would blow away the whole of our artificial structure of hypotheses"about female sexual function. In the absence of such an explanation, however, the hypotheses Freud erected took strong root. They gave rise to the vaginal-clitoral transfer theory of female psychosexual development. This theory accepts the clitoris as the site and source of genital sexual arousal, but limits its relevance to early infantile stages of sexual gratification. Maturity, the theory proposed, arises from the adult woman abandoning the clitoris (with its penis-like implications) as a source of gratification, and hence abandoning personal or partner masturbation and requires that the essential nature of mature female gratification is from the vaginal experience of penile insertion. It is within this context, which confuses the process and test of maturation, that a successful transfer has to be made from clitoral to vaginal sensations.

Masters and Johnson (1966) demonstrated conclusively that the clitoris and vagina are not independent sites of sexual pleasure, but interdependent sites; the clitoris is a highly sensitive receptor, whilst the vagina is the prime site of vasocongestive response. By this means it is prepared both for penetration and the development, in its outer third, of the swelling of tissues which give rise to the

orgasmic platform where the involuntary spasms of the pubococcygeus muscles are perceived as orgasm. Sherfey (1966), a psychoanalyst, asserts that Freud's (1920) hopes (paragraph above) have been more than adequately met by Masters' and Johnson's findings, but this is not a view entirely shared by analytic colleagues. Heiman et al (1968) in an extensive review of Sherfey's introduction of Masters' and Johnson's physiological concepts to the psychoanalytic literature, emphasise in a variety of ways the failure of Masters and Johnson to take account of the psychological processes in adulthood which might be responsible for the sexual difficulties which they discuss in Human Sexual Inadequacy. It is indeed both a strength and weakness of Masters' and Johnson's treatment formulation that they are essentially a-theoretical (Brown and Kolaszynska-Carr 1972). Moore (1968) in trying to integrate Masters' and Johnson's physiological studies of female orgasm into psychoanalytic thinking, proposes that the personal satisfactions deriving from sexual experience, rather than a continued preconception about desirable intensity and location of orgastic experience, should be the criteria of adequacy/ maturity in the woman, and that intrapsychic changes should be the particularly appropriate criteria for assessing improvement in cases of frigidity. As has been noted and as was recognized by him at the time, Freud's theoretical assumptions were limited by lack of adequate biological knowledge, and it is perhaps a measure of the strength of awareness in the psychoanalytic community of this limitation that underlies such extensive discussion of Masters' and Johnson's physiological findings among the psychoanalysts in the latter half of

the 1960's. Pines (1968) notes that Freud accepted the modern embryological theory of his time that the clitoris is an analogue of the penis, and that together with his clinical findings, mostly from the analysis of hysterics, used this anatomical fact as the basis of his theory of the little girl's sexual development. Deutsch (1961), however, arrived at a clinical description of Masters' and Johnson's subsequent physiological findings through her analytical observations, when she expressed her conviction based upon clinical insights that "the female sexual apparatus consists of two parts with a definite division of function. The clitoris is the sexual organ and the vagina primarily an organ of reproduction. The central role of the clitoris is not merely the result of masturbation but serves a biological destiny. Into it flow waves of sexual excitement which may more or less successfully be communicated to the vagina. The transition of sexual feelings from clitoris to vagina is a task performed largely by the active intervention of the man's sexual organ."

Pines (1968) observes that these views seem compatible with Masters' and Johnson's findings, and observes also upon the marked concordance between psychoanalytic and laboratory evidence. Like Deutsch, Benedek (1961) had also asserted the need for a theory of female sexuality that did not derive from the male model of sexual maturity on which psychoanalytic concepts are based, observing that when sexual sensations begin in the clitoris, spread to the vaginal walls, and finally encompass the whole body in orgasm, it is the woman's personality integration (her ego organisation) that allows the clitoral stimulation to spread and be experienced as orgasm.

It is thus apparent in the psychoanalytic literature in the first half of the 1960's, prior to the publication of Masters' and Johnson's physiological work in 1966, that traditional psychoanalytic views of male dominated sexuality were beginning to be questioned from within the mainstream of psychoanalytic thought and writing, and that formulations of the functioning of female sexuality were beginning to appear which were confirmed by the detailed observations that Masters and Johnson provided.

Embryological research has now clearly shown that the early embryo is not sexually undifferentiated, nor bi-sexual, but is female. (Sherfey, 1966; Phoenix, Goy and Resko, 1968). Although genetic sex is established on fertilisation, the influence of the sex genes does not operate until the fifth to sixth week of human life. Until then, all embryos are morphologically female. If the foetal gonads are removed before differentiation occurs, the embryo will develop into a normal female lacking ovaries, regardless of the genetic sex. Sherfey (1966) presents the evidence which establishes that foetal androgen suppresses feminine development in the early foetus.

Gillespie (1969) is an example of an analyst beginning to incorporate the developments of the '60's into practice. In discussing Sherfey's work, and looking at Masters' and Johnson's work from the viewpoint of an analyst, he observes that .. "it seems probable that we must agree that an orgasm is an orgasm, and that one differs from another not in kind but in degree of completeness, or in the emotional satisfaction

that accompanies it. I wish to propose that in future if and when the term 'vaginal orgasm' is used, we should no longer think of this as something excluding an outgrown clitoral erotogenicity; the terms should instead be used exclusively to denote an orgasm that is brought about by thrusting movements in the vaginal barrel, whether or not such movements are indirectly producing excitation of the clitoris. The term ' clitoral orgasm' would then denote orgasm produced by local stimulation in the vicinity of the clitoris, not by thrusting movements in the vagina. Having in this way eliminated the probably misleading idea that female maturity necessitates an outgrowing or 'repression' (to use Freud's early description) of clitoral erotogenicity, we can proceed to consider what obstacles naturally stand in the way of vaginal orgasms as defined above; here we shall find ourselves on familiar psychoanalytic ground and shall be concerned with many psychological problems, such as fear of penetration or invasion, penis envy, masculine identification, and countless others, but one bogey will be out of the way, and I believe this will be a real advance in the psychoanalytic understanding of female sexuality." Glenn and Kaplan (1968) as psychoanalysts also incorporate Masters' and Johnson's physiological work into a redefinition of the types of orgasm in women, while Fink (1970; 1972) relates the concept of orgastic function to the Freudian concept of "actual neurosis". Stoller (1973) reviews Freud's five basic concepts of sexuality against recent advances in our knowledge of sexual physiology, and explores these five concepts (bi-sexuality, the oedipus complex, libido theory, primacy of the penis, and conflict) in the light of this new knowledge. He maintains the analyst's point of view and method of enquiry whilst not

being too dismissive of the new findings, though concludes that the measurable impact of new advances in sex research on psychoanalytic theory "has been mild ... psychoanalysis concerns man, but the new research does not yet have the techniques to answer its own primary, though usually unstated, goal; to show how the findings of any experiment on animals or on an isolated part of the human subject's physiology or psychic function bear on the sexual behaviour of the human in his life as a person, not as a laboratory subject. Still, while the measurable impact on theory has been mild, the impact on analysis may be considerable. Many are listening closely to the researchers; and into the writings and conversations of analysts there is coming an impatience with being confined to theoretical positions that are held together more by tradition than by data ... I think that nothing but good can come from the increased laboratory work but nothing but bad can come from ignoring the single case studied in depth. It will be useful if we can reverse the belief that the clinical method is either too weak (as some laboratory scientists are convinced) or has finished its task (as some psychoanalysts tend to feel). Now, years after the work of such observers as Freud, Krafft-Ebing, and H. Ellis, we still need naturalistic observations on sexual behaviour, normal and abnormal. The work of Masters and Johnson has convinced us of this. But I am not now referring only to the observations of physiological response, which they are doing, but to collecting exact subjective descriptions of the sexual experience, the accompanying fantasies, and the indications of unconscious processes and of childhood influences that the psychoanalytic method can collect."

Robertiello (1970) accepts that there is no physiological difference between a clitoral and vaginal orgasm, but also asserts that clinical investigation distinguishes between two kinds of orgasms in their subjective experience. He also asserts the view that although the more mechanical and educational approaches may help to develop marital sexual adjustment, the only real definitive approach is long range intensive psychoanalytic psychotherapy. Marmor (1971) sees behaviour therapies and dynamic psychotherapies as essentially complementary approaches toward different aspects of the presenting constellation of symptoms, while Harris and Wagner (1973) explore the usefulness of Masters' and Johnson's techniques for the treatment of sexual dysfunctions within a social casework relationship. Bruni (1974) cautions against the development of a breed of sex therapists whose techniques are not broadly based on psychotherapeutic understanding.

There has been one very specific outcome of the Freudian tradition in a UK context, and that has been the work of the Family Planning Association's psychosexual clinics, based upon the brief psychotherapy work of Balint as reported by Friedman (1961). Directed especially at women, this work has sought to resolve the dynamic conflicts presumed, within the dynamic model, to underlie the disorders of vaginismus and frigidity. This tradition is now maintained by the Institute of Psychosexual Medicine and the training programmes of the Balint Society. Its relevance in this context is that, until the uptake of Masters' and Johnson's work in this country as recorded earlier, (p. 14 above), it formed the only systematic body of

assumptions which led to a regularly available (if nevertheless limited) service for help with sexual difficulties. It is also relevant in the context of developments recorded below, last page, stemming from the work reported here.

3.3 The Sociological Strand

The sociological strand derives its importance from presenting factual data which form the basis of normative thinking in the culture. Of prime significance is the work of Kinsey (1948, 1953) in the States and in this country, Chesser (1956) and Schofield (1968, 1973). While Freud might have begun to develop the understanding of sexuality in relation to the integration of adult development, Kinsey showed that while certain explicit cultural sexual conventions are one thing, sexual practices are often another. Kinsey's work undoubtedly led to a freeing of sexual functions from some of the guilt with which it was burdened and Masters and Johnson (1966) recognize the essential nature of the contribution made by Kinsey and his co-workers in re-defining cultural attitudes as the basis for their own work's acceptance.

> "Kinsey and his co-workers published a monumental compilation of statistics reflecting patterns of sexual behaviour in this country from 1938 to 1952. These reports of human sexual practices obtained by techniques of direct interrogation offer an invaluable base line of sociologic information.

> Future evaluation of the work may reveal its greatest contribution to be that of opening the previously closed doors of our culture to definitive investigation of human sexual response."
>
> (Human Sexual Response, p. 3)

Shainess (1968) questions, however, whether the persistence of sexual problems in a more informed society might not be laid at the door of an increasingly mechanical view of sexual function, especially that most recently promulgated by Masters' and Johnson's researches. While Masters and Johnson are explicit about sexuality being a dimension of personality, Shainess wonders whether the fundamental connection for the total personality between relatedness and physiological sex is not destroyed by Masters' and Johnson's work. Lief (1968) is of the view that Shainess has misunderstood Masters' and Johnson's position, and he emphasises Masters' and Johnson's insistence that treatment is aimed at the marital unit, and that while there is a certain emphasis on learning appropriate methods of sexual stimulation and on decreasing inhibitions through deconditioning, the treatment techniques advocated by Masters and Johnson involve, among other things, the opening of channels of communication between the partners that may at least be as significant as the physiological approach.

3.4 The Cultural Strand

The essence of this stream is that, from outside established helping professions, occasional individuals respond to the needs of a society as they see it at the time and focus upon themselves and their actions a good deal of the conflicting attitudes about the active expression of sexuality in sexual behaviour current in the culture of the period. Stopes (1923) and Cole (personal communication) are particular examples of this strand, though into it also might be fitted a good deal of popular sexological writing (e.g., Brown and Faulder, 1978). Stopes centred her interest upon contraception and the resulting possibilities for the enjoyment of sexual expression and freedom from unwanted child-bearing. Cole has centred his interests first upon homosexual law reform, then upon abortion, and more recently, upon the exploration of surrogate partner work in the development of sexual responsiveness. The importance of this stream lies in the development of discussion about sexual matters within the society of the time, and in both the examples quoted above, the providing of a lead to inherently cautious helping professions.

Perhaps in an analogous way, though not by such clear intention, the influence upon sexual attitudes of physiological research in the fields of reproduction should not go unrecorded. Francoeur (1974) has observed that current research into reproductive physiology is increasingly separating the concept of reproduction from the sexual act. He notes that artifical insemination, frozen human sperm banks, embryo

transplantation, artificial wombs, asexual reproduction and cloning, predetermination of foetal sex, transexual operations, uterine transplants and embryo fusions are all now matters not only of scientific activity, but also, quite often, commercial availability. Where once the sexual act itself was the only means of establishing reproduction, current scientific advances may make it increasingly irrelevant for that purpose. Comfort (1974) conceptualizes the view that in a society where there is reliable contraception and a demand for zero growth population, the sexual act may shift from being a procreational to a recreational function, with the attendant changes in sexual mores that might be envisaged.

3.5 The Behavioural Strand

Rachman (1961) provides an early review of behaviour therapy and sexual disorders. At that time the concept "sexual disorders" includes difficulties now distinguished as sexual dysfunctions and sexual variations. (Kaplan, 1974.a)[1]

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1 The term "sexual variations" introduced by Kaplan has an interesting philology attaching to it. The term "sexual perversions" was at one time a blanket description incorporating all sexual acts other than heterosexual intercourse, and also included functional/sexual difficulties as has been noted above in the discussion on the absence of specific terms for sexual difficulties in the standard psychiatric texts. It also carried the legal connotations of some specifically proscribed sexual acts such as transvestism, anal intercourse, and homosexuality below the age of 21 or in public. In the 1950's the term 'sexual deviation' began to be used for the less severe disturbances, or those that began to be recognised as widely practised (such as homosexuality), and Kaplan pursued this trend by introducing the concept of "sexual variations" as part of a general trend in the clinical literature to remove pejorative connotations from clinical classifications. Annon (174, 1975) distinguishes between"behavioural deficits" (dysfunctions) and "behavioural excesses" (fetishisms, transvestism, etc.), the distinction being between acts involving a relationship of a reciprocal kind whilst excesses imply object relationships. Stoller (1976) has recently argued however for a return to the concept of perversion, which he sees in a technical rather than judgemental

Note 1 (continued)

sense as being an accurate description of a development process that has failed to result in an appropriate object choice, and hence has been turned away, or perverted, far from its natural developmental path.

In Rachman's review, impotence is recorded as being successfully treated by desensitization, reciprocal use of sexual responses, and use of assertive responses. Exhibitionism, voyeurism, transvestism, fetishism and homosexuality are also disorders covered by Rachman's review. Lazarus (1963) records the treatment of 16 patients suffering from "chronic frigidity", of whom 9 were discharged "sexually adjusted" after a mean of 28.7 sessions of systematic desensitization. Similarly, Madsden and Ullman (1967) record favourable outcome in cases of frigidity treated by desensitization following the 1963 paper of A. Lazarus, and note the innovation of including the male partner in the treatment programme. They contrast the behavioural method with that of the psychoanalytic (e.g., Fenichel, 1945) and make explicit in the behavioural literature the problems of the male who may sustain a pattern of frigidity in the female by the reduction of sexual drive in response to the lack of reinforcing stimuli. Cooper (1963) employed emetine hydrochloride followed by pilocarpine nitrate and ephedrine hydrochloride to extinguish fetishistic transvestite responses in a 25-year old man who complained of the onset of impotence

during honeymoon, and following successful aversion therapy regained erectile responses over a six week period of rather non-structured desensitization, in a manner that would now be recognised as sensate focus. Haslam (1965) records the use of systematic desensitization in the successful treatment of two cases of dyspareunia.

Feingold (1966) set the behaviour therapy approach to sexual problems in the wider context of the treatment of social problems, and records the case of a 24-year old man whose emerging paedophilia is set in a constellation of social inadequacies including inhibited micturition in the presence of other men, and in which desensitization coupled with the development of assertive responses produced widespread beneficial effects upon social and sexual behaviours. Brady (1966), Friedman (1968) and Kraft and Al-Issa (1968) record the use of intravenous injections of short-acting barbiturates in the treatment of frigidity, impotence, and premature ejaculation respectively. Kraft and Al-Issa (1967) also record the use of hypnotic induction of relaxation and hierarchical desensitization over 84 sessions in the treatment of a 25-year old woman complaining of frigidity in the context of a good deal of maladaptive difficulties, the sexual difficulty being based upon the early traumatic experience as a young girl of being trapped in a railway carriage with an exposeur. Cooper (1969) extends the innovations of Madsden and Ullman (1967) by the introduction of the sensitized male into the behavioural treatment of vaginismus in which by deep muscular relaxation and the hierarchical use of vaginal dilators, the husband

was incorporated actively into the generalised use of the dilators after unsuccessful attempts at intercourse.

In 1968, however, Cooper questioned the use of systematic desensitization as a useful therapeutic method for erectile impotence and Kockott, Dittmar and Nusselt (1972, 1975) established a study in which systematic desensitization for erectile impotence was compared with the results of routine therapy or no therapy at all. The definition of routine therapy was "therapy which is usually done by General Practitioners, Neurologists or Urologists in their private practice, that is, medication and some general advice". In a group of 24 men, divided into three groups of eight matched for age, primary or secondary impotence, I.Q. and neurotism score as measured by the Brengelmann Personality Questionnaire, they concluded that systematic desensitization used alone as a treatment for erectile impotence has very limited therapeutic effect. In the behaviour therapy group, 5 out of 8 patients showed no improvement, and in the waiting list group 7 patients showed no improvement.

Kockott and his colleagues observe that in analysing the behaviour of their patients, a number of factors and their complex interrelationships seemed likely to maintain the behaviour disturbance. Some of these factors they list, being social anxiety, anxiety about level of performance, unrealistic sexual standards, very limited ranges of sexual behaviours, attitudes regarding "sex is dirty", and in general, the absence of the partner. Having finished the experimental part of the study, Kockott and his colleagues changed their therapeutic strategy by taking the patients in the control groups and used a modification of Masters' and Johnson's techniques combined with sex education.

Of 12 out of 16 patients who had completed the treatment at the time of the report, 8 were "very much improved according to our operational definitions ... our overall impression is that we got much better results from this method than with the systematic desensitization alone".

Kockott's paper, together with those of Bancroft (1972, a & b) and Brown and Kolaszynska-Carr (1972) mark the development in the UK of a behavioural literature which incorporates Masters' and Johnson's observations. The behavioural approach unmodified by Masters' and Johnson's observations continues, however, and is exemplified by studies such as that by Sharpe and Meyer (1973) in which a behavioural analysis indicated that tension was the important mediating factor which led to anticipatory anxiety in a 25-year old male who complained of unbearable pain in the tip of his penis while thrusting and ejaculating during intercourse (male dyspareunia). A retraining programme along a dimension of increasing tolerance to penile sensations was successfully carried out by the wife under supervision. Rosen (1973) investigated the effect of contingent feed-back on suppression of elicited tumescence in the male, demonstrating that, under controlled laboratory conditions, an instrumental conditioning procedure could produce substantial suppression of tumescence in normal male volunteers. In a clinical study, Munjack et al. (1976) employed a "multiple-technique behavioural therapy" over 20 sessions to 22 'anorgasmic' women, and by reference to a waiting list control group, demonstrated that treatment was significantly better than no treatment in terms of 1) the percentage of patients experiencing orgasm during at least 50% of sexual relations; 2) the percentage of women reporting satisfactory

sexual relations at least 50% of the time; 3) patients' ratings of positive reactions to various sexual behaviours; and 4) assessors' global clinical ratings. Multiple technique behavioural therapy was applied within "a behavioural and social learning framework", and included a detailed history and behavioural analysis, with intervention tailored to the individual case. Such techniques as systematic desensitization, assertion training, modelling and behavioural reversal were used, to some degree, with all couples. A great deal of direct education was employed, using pictures and plastic models particularly. Couples also received graduated, specifically-allocated assignments to reduce "performance anxiety and to allow for gradual re-exposure and overcoming of fear". Their experiences during these home assignments often determined the content of subsequent therapy sessions. Masturbation training and mechanical devices such as vaginal dilators and vibrators were occasionally employed. No medication was used. In addition, "the therapist facilitated open and intimate communication between the partners, focussing on sexual desires and preferencrs and suppressed or unrecognised resentment. Attempts were made to correct unreasonable expectations, misconceptions, and faulty communication patterns about sexual matters. However, the therapist tried to restrict his interaction with the partners to the treatment of marital discord and sexual dysfunction".

Razani (1972) reports a simple case in a 24-year old male of successful systematic desensitization of ejaculatory incompetence. Dengrove (1971 a) discusses the uses of artifical devices - artifical

penis, a penile constricting device, and a vibrator, as well as a feed-back device for increasing perivaginal muscular control (the Kegel Perineometer) in the treatment of impotence and frigidity. Dengrove (1971 b) begins to introduce concepts of sexual enhancement and sexual enrichment into the literature as extensions of therapeutic intervention under conditions of diagnosable dysfunction.

Nims (1973) emphasises the use of imagery as a device for shaping behaviours towards orgasm. Reisinger (1974) and Kohlenberg (1974) report beneficial effects of directed masturbation in the treatment of primary orgasmic dysfunction, while Snyder, LoPiccolo and LoPiccolo (1975) use solitary masturbation in each partner as the basis for an extinction and successive approximation procedure to transfer orgasmic responsiveness from solitary masturbation to heterosexual coitus.

Sayner and Durrel (1975) supplement the work of Masters and Johnson by describing an approach which utilises biofeedback devices such as penile plethysmogaphy; extinguishing anxiety through flooding exposure to pornographic material in order to teach a freedom of expression technique they call "the exaggerated orgasm"; masturbation; and use of vibrators. Serber (1974) describes the use of videotapes in which couples operate the videotape equipment themselves in order to ensure privacy and then, on the basis of their observations of their own behaviour, discuss the observed problem behaviour with the therapist. He reports the treatment of 6 couples, in which the videotape gives a

better sample of the sexual behaviour than the patients' verbal reports, and facilitates therapist intervention in the clinic setting. Caird and Wincze (1974) used videotaped cassettes of heterosexual behaviour arranged in hierarchical sequence of sexual contact to improve the sexual function of a 24-year old frigid female. Her husband acted as the therapist under instructions, and after 7 sessions significant improvement in the couple's heterosexual behaviour was reported and maintained over 9 months follow-up.

Kaplan (1974 b) describes a group setting for the treatment of four heterosexual couples in which premature ejaculation was the chief sexual complaint. Kaplan's therapy for premature ejaculation is based upon the assumption that the premature ejaculator does not perceive sensations premonitory to orgasm, and therefore does not learn to control the ejaculatory reflex. All four couples were successfully treated, and at four months follow-up, all four couples reported continued and improved sexual functioning. Therapist time averaged 1.5 hours for each couple.

With the rapid integration of Masters' and Johnson's treatment model into broad-band behavioural approaches, there has also begun to be an incorporation of direct sexual function work into marital therapies. Within the behavioural model Weiman et al (1974 have extended Stuart's behaviour exchange model of marital therapy (Stuart, 1969) to include the supplementary use of both communication and sexual skills training. The approach is exemplified by the study of a 31-year old couple who

had sought help in resolving marital conflict. Treatment followed a multiple-base-line design across different behaviours. Results confirm the ethics in the approach in modifying the behaviour patterns of distressed spouses. Similarly, Bancroft (1975) implicates Masters' and Johnson's ideas into the behavioural principles of marital counselling. Strategies adopted by the therapist to effect change include cognitive and behavioural approaches, and Bancroft stresses that the sexual model which focusses on a) communication b) giving pleasure to get pleasure c) sharing pleasure and fostering intimacy, and d) lowering defences and permitting oneself to be vulnerable within the security of the relationship, may also be valuable for solving problems of a non-sexual nature. The results of the study reported here provide support for these latter expectations.

The wide-band application of behavioural therapy to the treatment of sexual and socio-sexual difficulties is most extensively developed by Annon (1971; 1974; 1975), Lobitz and LoPiccolo (1972), LoPiccolo and Miller, (1975a, b) and Caird and Wincze (1977) and LoPiccolo and LoPiccolo (1978). Annon develops a four-stage model of treatment, based upon the clear recognition of the therapist as a potential model and source of suthority, as well as the instrument of the induction of behavioural change. This four-stage model involves in the first place the giving of permission; in the second, the supplying of limited information; in the third, the development of specific suggestions; and in the fourth, engaging in intensive therapy. This sequence, which in any particular instance may appropriately stop at an earlier rather

than a later stage, is designated by the acronym PLISSIT, (Permission, Limited Information, Specific Suggestion, Intensive Therapy). The third stage, specific suggestion, would include Masters' and Johnson's procedures. The fourth stage involves the type of wide-band behavioural approach advocated by Munjak et al (1976). For Annon, sexual difficulties in this sense are difficulties of social assertion, and are more linked to the social expressions of sexuality than the specific difficulties of classifiable sexual response. Lobitz and LoPiccolo (1972) use a behavioural treatment programme emphasising in vivo desensitization supplemented by a variety of clinical methods, either adapted from other psychotherapies, or newly introduced. A systematic masturbation programme, in combination with erotic fantasy and literature, enhances sexual responding. Role-playing orgasmic responses disinhibits female orgasm. Therapist self-disclosure reduces client inhibition and anxiety, as well as acting as a model of open acceptance of sexuality. Refundable penalty fee deposits are used to heighten client motivation.

A particular aspect of the behavioural literature on sexual function therapy at this stage of its development is the tendency of different writers to use different theoretical assumptions for essentially similar therapy procedures. LoPiccolo, (in LoPiccolo and LoPiccolo, 1978) makes the point vividly.

> "The virtually standardised treatment procedures now used for erectile failure may alternatively

be described as a means of reducing performance demands and the spectator role (Masters and Johnson, 1970); or as in vivo systematic desensitization through reciprocal inhibition by sexual arousal (Wolpe, 1958); or as a way of stopping the couple's attempt to voluntarily control an involuntary behaviour (erection) through the use of quasi-hypnotic specific instructions (Haley, 1973); or as a way of disrupting a self-maintaining 'vicious cycle' of fear of erectile failure producing erectile failure by preventing sexual arousal (LoPiccolo and Lobitz, 1973); or as anxiety reduction through specific suggestions based upon paradoxical intention or successive approximation (Annon, 1974) ... At this stage the 'active ingredients' and 'inert fillers' in the direct therapy package cannot be distinguished and the explanations offered for the effectiveness of the approach are simply speculations rather than data-based interpretations."

Nevertheless the behaviour-strand therapies post-Masters and Johnson have a number of distinguishable common elements, and LoPiccolo (in LoPiccolo and LoPiccolo, 1978) summarises these as follows:

1) Shared responsibility : Both partners are responsible for future change and the solution of their problems.

2) Information and education : The therapist ensures that patients

have accurate knowledge of the sexual response cycle through verbal discussion, providing appropriate reading material, and the use of educational films.

3) Attitude change : Unquestioned assumptions regarding sexual function which may be responsible for both producing and maintaining the presenting difficulty are questioned and change induced.

4) Eliminating performance anxiety : Patients are encouraged to enjoy the process rather than strive for orgasm.

5) Increasing communication and effectiveness of sexual technique : Therapy encourages sexual experimentation and open, effective communication about technique and response.

6) Changing destructive life-styles and sex roles : Therapy procedures may involve changes in social aspects of the patient's functioning in order to make opportunity for establishing new behaviours.

7) Prescribing specific changes in behaviour : The detail of the development of sexual behaviours, often within a hierarchical framework, is made available to patients.

It is clear from this summary that the behavioural strand has incorporated all the elements of Masters' and Johnson's procedures (as noted in Section 2 above), with the one addition of 6) above, in which the impact of wider social considerations is taken into account. In their intensive therapy programme Master and Johnson effectively discounted these wider aspects as their focus of therapeutic endeavour

was to establish effective sexual functioning in the context of a specialised and intensive setting, and then trust to its generalisable qualities.

Despite different theoretical assumptions about sexual difficulties, both learning theory and psychoanalytic theory have been combined in treatment approaches. Brady (1968) makes an early illustration of integrating the two approaches where, in the case of a female presenting with frigidity, systematic desensitization brought about increase in sexual responsiveness, and then the problems in the marital and social relationship were the focus of short term dynamic psychotherapy, which was itself followed by further improvement in sexual functioning, as well as improvement in other aspects of her social relationship. Cooper (1969) also explored the behavioural treatment o f a case of non-consummation due to vaginismus and the integration of dynamic concepts of collusive psychopathology between a woman and her submissive, sympathetic and gentle male partner, who was drawn into the treatment with the intention of helping him, in the event, to become sexually appropriately assertive.

Marmor (1971) speculates upon the techniques of reciprocal inhibition, aversive conditioning, and Masters' and Johnson's techniques of treating sexual impotence and frigidity, in terms of the diverse variables which might be presumed to be operating when looked at from a dynamic psychotherapeutic point of view, and concludes that the two broad approaches are complementary. Cooper (1971), on the other hand,

in presenting a representative sample of the literature on the treatment and aetiology of male potency disorders, concludes that, despite the large volume of opinions, firm data on whether psychoanalysis or depth psychotherapies are either effective or ineffective, is lacking, and favours a superficial behavioural approach, especially that of Masters and Johnson. Bieber (1974) proposes that there are three main systems associated with sexual disorders which have as their common denominator unrealistic fears that heterosexual functioning and gratification will be hurtful to the self. These three systems are subsumed under prohibitive, interpersonal, and gender-identity dynamics. He considers that distortions of beliefs and convictions about sexuality are established in childhood as a consequence of adverse influences on sexual development. Destructive attitudes, therefore, underly the common sexual disorders - a view entirely consistent with Masters' and Johnson's assertions that a combination of fear and/or ignorance underlie almost all sexual dysfunctions. Bieber interestingly points out, however, that psychological difficulties linking to behaviours not usually recognised as sexual are far more common - such as falling in love, maintaining long term loving relationships, resistance to marriage, and post-partum reactions. Sollod (1973) considers that in an appropriately sensitive application of behavioural principles, psychodynamic understanding underlies the behavioural intervention and psychodynamic exploration of resistance enhances the effectiveness of behavioural methods. While behavioural techniques facilitate the most rapid implementation of therapeutic insight, it is psychodynamic intervention which will make the application

of behavioural techniques more effective. Kaplan and Kohl (1972) note that there may be adverse reactions to the rapid behavioural treatment of sexual difficulties. The basic treatment strategy elaborated by Kaplan (1974 a) is for the therapist to attempt to identify and diminish the factors that inhibit the patient's sexuality, and at the same time to foster experiences that augment sensuous and sexual feelings. Kaplan and Kohl (1972) presented a case in which the rapid relief of a 48-year old husband's sexual problem precipitated a suicide attempt in the more vulnerable wife. The case is taken to illustrate the potential adverse effects of disrupting a reciprocally defensive system by relieving the sexual symptoms of the healthier partner.

3.6 The Contribution of Masters and Johnson - some observations by way of assessment.

An assessment of any clinical work can stem from two sources. In the first place, clinical experience of other practitioners may lead to questioning or illumination of a valuable kind. In the second place, systematic experimental evidence may support or refute clinical insights and assertions. There are some psychological therapies, especially psychoanalysis and its derivatives, which proceed more on the basis of clinical experience than systematic experimental studies, whilst there are others, and perhaps those especially derived from learning theory, which develop more on the basis of experimental demonstration. In the end, of course, clinical

insight unsupported by clinical enquiry leaves an uncertain foundation, whilst experimental enquiry unschooled by adequate prior clinical insight may be redundant.

At the present stage of development of their own clinical work, Masters' and Johnson's Human Sexual Inadequacy can only be critically assessed on the basis of clinical judgement. In due course it may be possible to assess their work critically by reference to a body of systematic experimental work that it has generated. There has, however, so far (1978) been no attempt to replicate Masters' and Johnson's work nor has there developed a critical experimental literature. What there has been (LoPiccolo, 1978), is an explosive clinical enthusiasm for their work with wide-ranging ad hoc modifications unsupported by experimental rigour. Only Mathews and Bancroft and their colleagues (1976) (then at Oxford) and the present study can lay claim to have established an experimentally-determined approach to evaluating (and hopefully, illuminating) some aspects of their work.[1]

It is no denigration of Masters' and Johnson's clinical work to observe in the first place that they practise from a position of particular power and authority. Many years of extensive laboratory investigations into the physiology of human sexual response give

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1 The work of Bancroft (Mathews, Bancroft et al., 1972) is discussed below with reference to the outcome of this study, (Section 8).

them an unrivalled position of authority in the clinical field. If, as is frequently emphasised in Human Sexual Inadequacy (e.g., p. 61-62, 296-299), authoritative control by therapists is of marked significance in establishing effective therapeutic outcome, it might fairly be reasoned that Masters and Johnson have established a special position of authority from which to establish clinical results.

In the second place, their clinical work appeared in a highly developed form without a series of papers predicating it. Indeed, only two prior papers (Masters, 1967; Masters and Johnson, 1968) had given any slight indication of the body of work which was about to be published. In consequence the impact of their work, incorporating results of a power not usually claimed in the remedy of psychological and psychiatric disorders; involving the then novel assumptions of treating the sexual relationship rather than the disorder per se; and seeing the presenting difficulty more in terms of psychophysiology than indicative of extensive psychopathology; all these factors contributed to the widespread uptake of their work. A parallel has already been drawn with Wolpe's work of 1958 and its impact upon applied learning theory. Masters' and Johnson's writing stands as a watershed in the treatment of a range of newly-defined sexual problems, from which a great deal has started to flow.

In the third place, the work as it stands owes remarkably little in a formal sense to previously established or co-existing theories of psychological function. Whilst there is some discussion of the

psychoanalytically observed phenomena of transference and their application in the cotherapy setting, learning theory and constancy theory, to name but two sets of assumptions which might prima facie be thought to have considerable relevance to their work, are not mentioned at all. The terms 'behavioural' and 'psychotherapy' are intermittently incorporated into their writings without development, except the explicit recognition that the innovations they make in treatment involve assumptions which have not been tested experimentally, and so may transgress accepted practices of psychotherapy. In consequence their writing (despite the mechanical difficulties of expression) has a commonsenseness about it which is perhaps a strength. Indeed it might be thought that had too much attention been paid to the niceties of psychological theorising the assumptive steps in clinical practice which Masters and Johnson established - for instance treating a couple by a couple; observing that adequate sexual function was a normal physiological process;developing the structured approach of non-genital and genital sensate focus; writing in a straightforward way about the benefits of pleasuring; - might not have been taken. It is a continuous implication of their writing that they are not concerned to establish theoretical justifications for their approach, but to let their pragmatic clinical approach stand in its own right, underpinned continuously by their extensive laboratory investigations and descriptions of normal sexual response.

Bancroft (1972) and Brown and Kolaszynska-Carr (1972) have both observed upon the essentially a-theoretical nature of Masters' and Johnson's

approach to treatment and its essentially pragmatic rather than experimental basis. In consequence their approach is open to attempts at theoretical synthesis. Marmor's (1971) is an early and excellent example ...

> "In many ways this technique (of Masters and Johnson) falls midway between a behavioural and a psychodynamic approach and illustrates one of the ways in which a fusion of both can be successfully employed. The Masters and Johnson technique is behavioural in the sense that it is essentially symptom-focused, and that one of its most importnat technical tools is de-sensitisation of the performance anxiety of the patients.
>
> "Conceptually, however, the Masters and Johnson approach to their patients goes considerably beyond simple conditioning or desensitisation processes. For one thing, Masters and Johnson recognised that the problem of impotency or frigidity does not exist merely in the symptomatic individual but in his relationship with his partner. Therefore, they insist on treating the couple as a unit, and the symptoms the problem of the unit. This constitutes a systems approach in contrast to a strictly intrapsychic or behavioural one. Secondly Masters and Johnson are acutely aware of the influence of psychodynamic factors on the sexual behaviour of their couples. In their

preliminary interviews they carefully assess and evaluate the importance of these factors, and if they consider the neurotic components or interpersonal difficulties to be too great they may refuse to proceed with their method and will refer the couple back to their physicians for appropriate psychotherapy.

"This kind of selective procedure has an effect, of course, on their percentage of successful results, as does the high degree of motivation that their patients must have to come to treatment (who, after all, goes to St. Louis for a two-week vacation?) and to commit themselves to the considerable expense and inconvenience that is involved. The fact, also, that Masters and Johnson insist that the therapeutic team consist of a man and a woman reveals their sensitivity to the transference implication of their relationship to their couples. They function as a sexually permissive and empathic mother-surrogate and father-surrogate, who offer not only valuable technical advice and suggestions concerning sexual behaviour, but also a compassion and understanding that constitutes a corrective emotional experience for their patients. Finally, the tremendous charisma and authority of this highly publicised therapeutic team must inevitably have an enormous impact on the expectancy, faith, and hope with which their patients come to them.

> This cannot but greatly accentuate the suggestive impact of the given instructions in facilitating their patients' therapeutic improvement."

Whatever the impact of the technology of reproductive physiology, sociological facts, energetic contributions from social reformers, Freudian thinking, and learning theory, it is with Masters and Johnson that the laboratory investigation of human sexual response is established and carried forward into clinical practice.

In summary, therefore, Masters' and Johnson's work of 1966 and 1970 has established itself as the first body of laboratory-based investigation into human sexual arousal and response which has led directly into treatment procedures. Both the body of knowledge and clinical procedures have provoked considerable discussion in the psychoanalytic and behavioural fields, and the clinical work especially has pervaded the behavioural field to such an extent that, whatever the theoretical assumptions accorded by different practitioners to the treatment processes, Masters' and Johnson's treatment proposals, with the single exception of time-intensity of treatment, are widely incorporated into behavioural approaches and have stimulated considerable discussion in the psychoanalytic field.

4. THE EXPERIMENTAL AND OPERATIONAL QUESTIONS AND THEIR DERIVATION

It has been the argument of this thesis so far that while Masters and Johnson have established themselves as pragmatic clinical innovators of a high order, they have not proceeded in a manner that, for the purposes of evaluation, allows other than a clinical or assumptive response to their work.

This study sets out therefore to question a matter considered central to the treatment proposals that Masters and Johnson have described - viz., as to whether two therapists are necessary for the successful completion of effective sexual function therapy. This is pursued by means of a comparison of treatment outcome under the two different conditions of couples having treatment by either one or two therapists (single therapy vs. co-therapy). This is the main experimental focus of the study, and is framed by the question -

1. "Is the dual-sex therapy team necessary for successful treatment outcome?"

In addition to pursuing the single - vs. co-therapy distinction, the study also set out to elucidate two main matters of operational interest, viz., -

2. "Do counsellors obtain as effective treatment results as a clinician?"

and

3. "How long does treatment take when the time structure of treatment is modified from Masters' and Johnson's daily treatment procedure, lasting fourteen consecutive days, to a weekly out-patient procedure?"

It was hoped, with reference to the experimental question 1. above, that the widespread enthusiasm for Masters' and Johnson's work would in part be set in the context of a more developed understanding of one major treatment variable. It was clearly also a question that carries considerable operational implications for the deployment of therapist resources. With reference to the two specific operational questions, it was also hoped to provide information upon which policy decisions could be taken within the National Marriage Guidance Council and by central Government.

This work, as has already been noted, was conceived in 1972-3. The paucity of an experimental literature in the intervening period is confirmed by Green (1978) and Hogan (1978). Green observes: "The treatment of sexual dysfunction emerged to the front lines of health delivery only during the past decade with the pioneering work of William Masters and Virginia Johnson. In spite of the rush of sex clinics and sex therapists that followed, preciously little solid research has been conducted on the various strategies of therapy, the means of assessing complex interpersonal sexual relationships, and the manner by which clinical change is objectively assessed." Hogan also observes: "While Masters' and Johnson's (1970) arguments all have a certain amount of validity to them, ... the issue is an

empirical one. No controlled studies have been conducted ... Due to the lack of controlled research in the area, there is little definitive knowledge concerning the aetiology, assessment or treatment of sexual dysfunctions. ... the three main factors to be considered are client variables (e.g., type of dysfunction, type of onset, type of marital or psychological problems present), treatment components (e.g., different variations of structured sexual experiences, cognitive/ attentional techniques, and marital therapy), and mode of therapy (e.g., individual, conjoint, group, cotherapy, single therapist, and bibliotherapy.)"

Prior to the publication of "Human Sexual Inadequacy" in 1970, Masters and Johnson published a brief paper entitled "Human Sexual Inadequacy and some Parameters of Therapy" (1968). This made a first brief statement of their principles of treatment. In that paper they proposed five parameters of therapy when treating sexual difficulties:

1 The involvement of both partners to a relationship;

2 Long-term commitment of therapists to follow-up;

3 A male-female cotherapy team;

4 Full physical examination prior to the inception of treatment for the purposes of excluding organic factors before therapy is initiated;

5 Intensive treatment over the short-term.

The therapy format and content described more fully in "Human Sexual

Inadequacy" (1970) includes items 1 and 3 to 5 of the 1968 formulation above. Item 2 is perhaps more a matter of concerned clinical practice than a requirement of therapy per se. Items 1 and 3 appear in the 1970 formulation in the composite concept of "the treatment of a patient couple by a therapist couple", and in 1970 an additional requirement for effective therapy of a sound knowledge of sexual physiology by the therapists is stated, as is also a requirement for education in techniques of verbal and non-verbal communication. Thus by 1970 the five basic concepts of Masters' and Johnson's treatment procedure are:

1) Sound knowledge in the therapists of sexual physiology and endocrinology and metabolic function;
2) The institution or continuation of sexual function therapy only when organic factors have been identified or ruled out by medical examination;
3) Treatment of the couple as a unit by a dual-sex therapy team;
4) A short-term intensive programme;
5) Education of the couple in techniques of verbal and non-verbal communication. [1]

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1 These concepts are reiterated by Masters and Johnson in 1976 as the essentials of their therapy programme.

In developing the experimental and operational questions of this study, these five basic concepts of therapy were seen to have three separate components. In the first place there is the concept that therapists should possess adequate knowledge (1. above), and in the second place is the assumption that treatment should only be instigated when relevant organic factors are known or shown to be absent (2. above). These are precursors of treatment, and state the sensible view that psychological treatment should only be instigated by an appropriately knowledgeable therapist upon completion of appropriate investigations to determine whether, or to what extent, a psychological treatment procedure is appropriate.

Concepts 3, 4 and 5, on the other hand, propose practical aspects of a treatment programme and are more appropriate to experimental and operational enquiry.

The following section describes the manner in which these five basic concepts were taken up in this study.

4.1 The Basic Concepts of Treatment in the context of this study

Concept 1 - adequate knowledge

The marriage guidance counsellors entering into training as sexual function therapists for the purposes of this study could not be presumed to have a professional knowledge of sexual function. Their model of

counselling was (and within the organisation still is) a reflective model based upon psychoanalytic concepts of psychic development and function. It is not part of their counselling training to use a body of knowledge in an instructive or didactic way, or to set treatment goals. The style of therapeutic interaction adopted by counsellors was therefore reactive rather than proactive in the sense that Masters' and Johnson's procedures require organised, knowledge-based intervention and planned management of the therapy strategy. [1] In consequence the training programme developed for this study and detailed below sought to establish an appropriate body of knowledge for the counsellors to use as therapists, and although it was not the main focus of the study to monitor the uptake of training, it was felt that it would strengthen any conclusions that might later be drawn, if some assessment were made of the relevance of the training undertaken to the knowledge and skill of the counsellors.

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1 It should perhaps also be observed, in context, that the body of knowledge used in this study was in any event very new at the time of the start of the study, and most professionals, let alone counsellors, were not conversant with it.

Accordingly three specific measures were used:

i. A sexual knowledge inventory to establish pre- and post-training levels of knowledge of sexual facts, and comparison made with a control group of counsellors not in training as sexual function therapists; (see 5.1.4 below)

ii. A record of the development of accuracy in making diagnostic statements, against a criterion statement; (see p. 142 below and Appendix A)

iii. A comparison of therapists ratings of outcome with those of an external assessor using the same rating scale independently administered. (see p. 145 below)

Concept 2 - establishing presence or absence of relevant organic factors. In considering Concept 2, it was recognised that detailed physical investigations, while desirable, were not only not readily available but were unlikely to be available on a routine basis if the NMGC were to develop its services in the future as a result of this work. Moreover it was also recognised that marriage guidance counsellors were not competent to request or evaluate the results of medical investigations. It therefore became a matter of operational and clinical concern to establish, in the first place, a pattern of referral that safeguarded against the likelihood of sexual difficulties presenting in the guise

of physical complaints; in the second place to ensure that medical resources were available if concern about physiological aspects of sexual function failure was expressed by patients or caused anxiety to counsellors during treatment; and in the third place to study a sequence of referrals by obtaining full medical screening in order to establish, both for the present study and for future operational reasons, what the incidence of physical disorders might be in the presenting patient population that might be linked to the presenting or subsequently observed sexual difficulty.

As is described in more detail later (5.2.1 below), these concerns were met by accepting referrals only from, or with the knowledge and consent of, the general practitioner of at least one member of the referred couple; by establishing medical consultants to the study, in obstetrics and gynaecology and genito-urinary surgery; and by extensive routine standardised medical examination of the couples presenting.

Concept 3 is the matter around which the central experimental question of the study is formed. It questions the detail of the cotherapist situation required by Masters and Johnson.

In asserting the need for a male and female therapist, three justifications are offered. In the first place and of first importance is the presumed capacity for a clinician of one sex to understand not only clinically but also experientially what a patient of the same sex is

trying to convey when relating details of sexual experience, especially when these details are not self-evident physiologically to the patient.[1] The converse of this of course, which is what gives the concept it supports pre-eminence, is the presumed incapacity for a clinician of one sex to understand the sexual experience of a patient of the opposite sex.

In the second place, the therapist of the same sex carries the function of a friend-in-court, interpreting to both the other therapist and the partner of the opposite sex aspects of the presenting information from the patient of the same sex that need elucidating or expanding.

In the third place, the therapist of the same sex acts as a role model in the communicating relationship with the other therapist, thereby offering the presenting couple ~~with~~ an appropriate role model of openness in communication about sexual matters. These three justifications therefore underpin Concept 3. by assertion.

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1 For example, the presence or absence of an erection in the male is self-evident; the presence or absence of vaginal lubrication, or clitoral extension, is not self-evident physiologically to a poorly-informed person.

Concept 4 - short-term, intensive treatment, was modified for the purposes of the study, as is later described (5.2.4. below), so that treatment was both acceptable and available within a familiar cultural context of the delivery of health care. Again, as has already been described, it was the matter of trying to establish what the time flow and structure of a time-modified treatment programme might be that formed the first of the two main operational questions of the study.

The 14-day treatment programme established by Masters and Johnson seems to have been a period of time arrived at pragmatically and based upon the amount of time that couples generally appeared willing to commit away from home for the purposes of treatment. (see p.18 above). It may also be an indirect comment upon Masters' and Johnson's own view of their therapeutic potency. It has been noted already that couples living geographically close to Masters' and Johnson's treatment centre, and who were treated whilst living in their own homes, with all the distractions attaching to that over a period of time, required three weeks of intensive treatment rather than two. ("Intensive" in this context meant full involvement for the first seven days, and then for five days of each of the two weeks following).

In the circumstances of health-care delivery in the UK, weekly out-patient attendance is the most characteristic form of service available for personal (non-medical) distress. In marriage guidance councils, the typical pattern of counselling is for one hour, once a week. It was decided therefore to structure this study on a basis which could,

should the outcome be appropriate, be transferred without undue adjustment to a marriage guidance council setting.

Concept 5 - education of the couple in techniques of verbal and non-verbal communication - was not used as the basis of any declared experimental or operational enquiry. It was however implicit in the treatment programme as it is the basis of the behavioural and interactive aspects of the treatment programmes established.

In summary, therefore, the five treatment concepts which Masters and Johnson described as being central to their therapy procedures were established in this study as described above.

The following section details procedure and method by reference to each of the five basic concepts above, bringing in as appropriate the relevant information about the setting in which the study took place.

5. THE SETTING OF THE STUDY, PROCEDURE AND METHOD

5.1 The Setting:

5.1.1 The National Marriage Guidance Council

The National Marriage Guidance Council is the national body of a federated structure of autonomous Marriage Guidance Councils. It grew as a voluntary organisation in the 1930's out of concern among a group of clergy, magistrates, medical practitioners and social workers for the then-rising divorce rate, which was approaching 7,000 per annum. In 1947 the Denning Committee on Matrimonial Procedures recommended financial support from public funds. The first grant-in-aid was made in 1948. At the same time, similar grants were made to the Family Discussion Bureau (now the Institute of Marital Studies at the Tavistock Institute) and the Catholic Marriage Advisory Council. "The NMGC and CMAC remain essentially the products of their history. They have preserved their status as voluntary organisations with the Home Office grant-in-aid continuing to provide approximately two-thirds of their income." (Tyndall, 1971)

5.1.2 The Population of Counsellors

In the federated structure, local marriage guidance councils are autonomous in counselling services to the public but the national body carries responsibility for the recruitment, selection and training

of local counsellors, and their continuation training and supervised support. Within the structures of the helping professions it is now demonstrable that marriage guidance counsellors stand mid-way between the auxiliary and the professional worker. (" ... they are part-time voluntary workers, ... they are not carrying a case-load on behalf of a professional worker, but are totally autonomous in their counselling. They are indeed volunteers working to a professional standard." (Tyndall, 1971). At the end of 1973, there were 1393 counsellors in England and Wales, who were then established in 154 Councils. The proportion of male to female counsellors throughout the Councils varied considerably, but was generally considered to be of the order 1:4 or 1:5 in favour of women counsellors. (This proportion is reflected in the period 1973/1977 of applications for training, during which time the percentage of men applying varied between 17% and 25%. The actual figures of male/female trained counsellors for the years in question are not known precisely by the organisation).

5.1.3 The Selection of Counsellors for this study

During November and December of 1973 the six Councils involved in the geographical area of study were each visited on an occasion when all counsellors of each Council had been invited to attend a meeting in order to be introduced to the broad outlines of the study. At that visit all women counsellors were invited to consider attending a more detailed Appreciation Conference of a day's duration at Rugby, at which the study would be outlined in greater depth and the commitment of any intending participant volunteer would be requested. From the

original presentation of the principal features of the study to each of the six local MGC's concerned, 27 women counsellors attended an Appreciation Conference in February, 1974, of whom 7 subsequently offered themselves for selection for training. In the event, one of these 7 withdrew immediately following the selection conference through ill-health, and so the training group of six became an essentially self-selected group. The numerical demands of the selection procedures had been most fortuitously met by this outcome, in that the group of counsellors to be trained were not, in the event, selected on any basis other than their own wish to participate.

On 1st February 1975 an Appreciation Conference was held for the male counsellors in the 6 Councils, for the selection of 6 men as participants in the second year of the study. Of the 15 men who attended the Appreciation Conference, all subsequently offered themselves for a Selection Conference on 6th March, 1975. From this group of 15, 6 were invited to participate in the study.

A women counsellor control group was established from the group of 27 women who had attended for the original Appreciation Conference. This control group had two purposes. The first was to assess whether, as a result of training, there were changes in sexual knowledge in the therapist training group as compared with the control group; the second was to establish a separate (independent) study in which the normal remedial counselling of counsellors in training in this study and the members of the control group not in training was monitored in

order to establish whether the sexual function training programme modified counselling skills in any way.

5.1.4 The Personality and Sexual Knowledge Characteristics of the Counsellor Population

During the same period of time, but before the Appreciation Conference, descriptive personality and sexual knowledge measures were taken on the Counsellor population of the six councils involved.

There were, at the end of 1973, a total of 116 counsellors in the six Councils. This represented 8.1% of the national population of counsellors at that time. Of these 116, 105 (90.5%) completed testing in order to establish the personality and sexual knowledge characteristics of the population. This figure of 105 represents a sample of 7.5% of the total national counsellor population at the end of 1973 of 1393 counsellors.

No systematic objective studies have ever been published on the characteristics of the counsellor population, though Hooper and Tyndall (1972) make passing reference to the ad hoc use of psychological tests in selection procedures. It is a matter of policy that at selection conferences selectors are " ... primarily looking for personal qualities rather than academic attainment. Candidates must display the ability to function as counsellors, and this requires some combination of the crucial factors of genuineness, non-possessive

warmth and accurate empathy. Basically conflict-free people are sought who can display creative openness to other people and their problems." (Tyndall, 1972). The training group was established from this selected but not systematically-described population of counsellors.

The two descriptive measures used were Cattell's 16PF, Form A and the Sexual Knowledge Inventory.

The first offers a broadly-based psychometric description of personality structure. The second presents 100 questions on sexual matters. Both met operational requirements of being self-administered paper-and-pencil tests, with completion of both possible in under two hours.

The 16PF (Cattell, Ebor and Tatsuoka, 1970) is one of the main instruments for assessing personality structure to have come from the factor-analytic school of personality theory. Until relatively recent time its limitation in clinical and descriptive use has been the lack of normative data for an English population. However, recent publication (Saville, 1972) of a British standardisation of the 16PF, forms A and B, makes the instrument of more immediate value in the type of descriptive study for which the population descriptive phase of this work called.

It is not the purpose of this section to argue the merits of the variety

of methods of assessing personality functioning and structure. In the broad distinction between the nomothetic and idiographic, however, the nomothetic has a high degree of replicability, and permits numerical comparison of groups and sub-groups. (Meehl, 1954)

It was judged that these characteristics indicated a nomothetic approach in this study. Within the nomothetic approach the 16PF is a device both widely used and accepted, with measurement characteristics that are well known, permitting the assessment of a wider range of factorially established parameters of personality than its nearest English counterpart, the Eysenck Personality Inventory, Cattell and Eysenck being two representatives of the multivariate experimental approach to the study of personality structure. The essence of Cattell's emphasis on the multivariate approach derives from his concept of the personality as an undifferentiated sphere of n dimensions, whose space might be systematically exhausted by the continual validation and intercorrelation of data deriving from questionnaire, life, and observational behaviours. The 16PF relies upon questionnaire-based information and establishes its 16 factors through 187 items. From the 16 first order factors, 8 second order factors can be derived, although only the first 4 of these are generally used. The first order factors have been related to the systems proposed in the other major factorially-derived systems (Guildford-Zimmerman, Eysenck, and MMPI). Cattell has in recent years begun to distinguish between those factors which are relevant to the broad range of the (statistically) normal population and those which can be shown to have psychopathological implications and which relate to the structural disturbances of the psychopathology of the criminal population. These are incorporated

into the clinical extension of the 16PF - the Clinical Analysis Questionnaire (Delhees and Cattell, 1972). The relative absence of questions obviously probing areas of psychopathology also makes the 16PF useful in a population which might be expected to be relatively free from the manifestations of established psychopathology. It can only be asserted that the counsellor population sampled might be expected to be such a population.

The Sexual Knowledge Inventory (SKI) (McHugh, 1955) is the only [1] questionnaire established for assessing sexual knowledge which also incorporates recent physiological information on sexual matters. In the choice of sexual knowledge questionnaires, it was first established that no current catalogue of a British psychological test supplier listed an instrument available in the U.K., with U.K. norms. A second search via the Mental Measurements Year Book (Buros, 1970) offered no U.K. devices with U.K. norms. On descriptive grounds only, the SKI and an instrument called the Sexual Knowledge and Attitude Inventory (SKAT: Lief and Reed, 1972) appeared to meet the requirements of a readily-administered paper-and-pencil questionnaire about sexual matters. On assessing the two, however, it became readily apparent

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1 As at 1972

that while the SKI concentrated essentially on matters of fact, the SKAT concentrated more on matters of opinion derived from knowledge (or lack of knowledge)of the facts, and cultural influences appertaining to the facts. In these circumstances, the fact that neither instrument had a well-validated research background left face validities the essential basis of a pragmatic choice between the two, and it was in these circumstances considered appropriate to adopt the device which assessed facts rather than judgements. Such a device also presents fewer theoretical barriers in the subsequent summing of scores, test-re-test comparisons, and interpretation of the data.

Consideration was given to developing a device specifically for the purposes of the study. While this had its attractions from the experimentalist's point of view, practical considerations in the main interest of the study mitigated against it. The primary interest of the study was not in developing sexual knowledge questionnaires but in looking at Masters' and Johnson's treatment procedures. Moreover, in the context of the National Marriage Guidance Council, particular interest was focused on the possibility of developing the skills of counsellors in relation to the needs of the client population that the agency seeks to meet. It was felt that the extensive testing procedures necessary to the proper development of a question-naire might militate against the acceptance of the study by the counsellor population it was designed to interest. In a setting where measurement is not part of the culture, and where, indeed, there is a very strong ethos against the outside observation of any one individual's work at all, the introduction of outside observers and

measurers must perforce be handled with tact. The adopting of a test, therefore, which, while not perhaps ideal, appeared to be the best for the circumstances, and which at the same time did possess acceptable face validity, was felt to be justified. Subsequent events demonstrated that the approach adopted did engage the interest and responsiveness of the population. Whether or not another more fundamental approach would have done so can only remain a matter of speculation or subsequent experimental enquiry. As it is, the results presented below give the basis for establishing normative data on the instrument used in an English population.

It was with the above considerations in mind that SKI was adopted as the sexual knowledge measure of choice.

The SKI (Appendix J) is a 100-item questionnaire divided into three parts. The first part offers pictorial representations of male and female sexual anatomy, presenting the pelvic area in vertical section in the sagittal plane. Each diagram is numbered at 14 points, and 20 questions (11 male, 9 female) require the respondent to match the numbers with the correct anatomical term. The first part is thus a brief test of nomenclature, and responses are scored right or wrong. The second part is of 32 questions, in which 6 have sub-sections, providing a total of 40 possible correct/incorrect answers. Questions refer to function. The respondent is required to indicate by reference to the numbered anatomical charts which part of the structure does what. Answers are numbers, not words. This section therefore attempts to assess knowledge of function without the requirement for correct anatomical nomenclature. The third part presents 40 statements in 4

blocks of 10. Each block of 10 statements is preceded by 12 possible single-word answers, so that the task is essentially a response-choice task. The first 10 statements relate to maturational and reproductive processes; the second 10 to reproductive and sexual act matters; the third 10 to sexual act and socio-sexual matters; and the final 10 to socio-sexual and sexually transmitted disease matters.

In the scoring procedure 1 point is allocated for each correct answer. No judgement about partially-correct alternatives is required on the part of the scorer. The maximum possible score therefore is 100. In the face validity assessment of the questionnaire, however, one statement (the penultimate of part 3) appeared to have cultural implications, and so it was excluded from the scoring. The statement reads: "A device or chemical used to keep one from catching a venereal disease through sex contacts."' The required answer from the answers offered is "prophylactic". This term, used in the U.S.A. as the generic for the qualities referred to above, and specifically for the male contraceptive sheath, is not a term generally used in such a context in Europe where the sheath is presented more as a contraceptive device than as a prophylactic against sexually transmitted diseases.

In consequence the scoring procedure provides for a maximum score of 99.

At the time of completing the 16PF and SKI questionnaires, respondents also provided simple biographical information about themselves, on a sheet as below, which was attached to the front of the SKI questionnaire

presented. This formed the basis of the information in table 2, p. 107 below.

MARITAL SEXUAL DYSFUNCTION PROJECT

1. Please ignore the front sheet of the attached pamphlet, and complete only the personal materials below, before going on to Parts 1, 11, and 111 of the pamphlet.

2. PLEASE DO NOT DISCUSS THE QUESTIONNAIRES WITH ANY OTHER COUNSELLOR WHO HAS NOT YET COMPLETED THEM.

3. The information that you let us have will be completely confidential. If anyone, however, is interested in their particular results, I will be pleased to discuss them with them on some convenient occasion at Rugby. Under no other circumstances will individual results be made known.

P. T. Brown.

NAME ..... SEX (M or F).....

AGE .....M.G. COUNCIL .....

YEARS AS COUNSELLOR AFTER BASIC TRAINING .....

IF STILL IN BASIC TRAINING, PLEASE CIRCLE LAST STAGE COMPLETED

A ..... B ..... C ..... D ..... E .....F .....

PRESENT OCCUPATION .....

PROFESSIONAL QUALIFICATIONS .....

(e.g., S.R.N., as appropriate) .....

N.M.G.C. 8.2.74

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Figure 1 : Information form, personal data, counsellor population.

As recorded above, 105 individuals completed both the 16PF and SKI questionnaires. This 105 included 6 women who offered themselves for training, six women who were those selected from those presenting at the Appreciation Conference as the control group, six men who eventually became the second year male training group, and 87 other male and female counsellors in the Councils of the study. Of these 87, 52 were established counsellors who had completed their full counselling training, while 35 were in the two-year process of becoming established counsellors by supervised practice and formal training. All the male

female, and control group members of this study were established counsellors who had completed the organisation's counsellor training requirements, and table 2 below shows the basis of matching the control group.

Table 2 below records the mean scores for age, years married, and years as a counsellor for the experimental and control groups.

		Variables used in matching groups		
		Age	Years married	Years as counsellor
Therapist training group n = 6	$\bar{X}$	46.2 yrs.	23.5 yrs.	7.6 yrs.
	Range	37 - 58	16 - 33	2 - 15
Control group n = 5*	$\bar{X}$	45.4 yrs.	22.8 yrs.	6.6 yrs.
	Range	40 - 52	16 - 29	2 - 12

Table 2 : Personal data of therapist training and control groups.

* At the conclusion of psychometric data collecting, one member of the control group discontinued participation.

The group comparisons on both 16 PF and SKI data were conducted for the following 8 groups, which are present in the whole population of N = 105 studied.

Women		n
1.	Therapist training group, trained counsellors (1st year training group)	6
2.	Control group, trained counsellors	6
3.	Trained counsellors	39
4.	Trainee counsellors	27
	n =	78

Men		n
5.	Therapist training group, trained counsellors (2nd year training group)	6
6.	Trained counsellors who offered for therapy training, but were not selected	9
7.	Trained counsellors	4
8.	Trainee counsellors	8
	n =	27
	N =	105

Comparison of sub-groups 16 PF Data

As noted above, the trained women counsellors who comprised the therapist training group were, in the event, a self-selected group. It was considered that a comparison of groups 1 and 2 (fig.2) therefore would establish whether or not they were like or unlike other trained counsellors who expressed some interest in sexual dysfunction training, while comparison of 1 and 3 (fig. 4) would establish whether or not the therapist training group was like or unlike the generality of trained counsellors who did not present for this training. It was considered that the demonstration that there were high similarities between 1 and 2 and 1 and 3 would permit the inference that the self-selected therapy training group was not an uncharacteristic sample of the women counsellor population.

A comparison of groups 3 and 4 (fig. 8) was undertaken to establish whether or not women currently in training as counsellors were like or unlike those already trained. It was expected that the demonstration of similarity would permit the inference that results from this study could be generalised with more confidence to the total women counsellor population than if there was dissimilarity between the two.

Groups 1 and 5 (fig. 6) were compared in order to ascertain whether men and women counsellors coming into sexual dysfunction training were similar or not, and likewise groups 5 and 7 (fig. 5) were

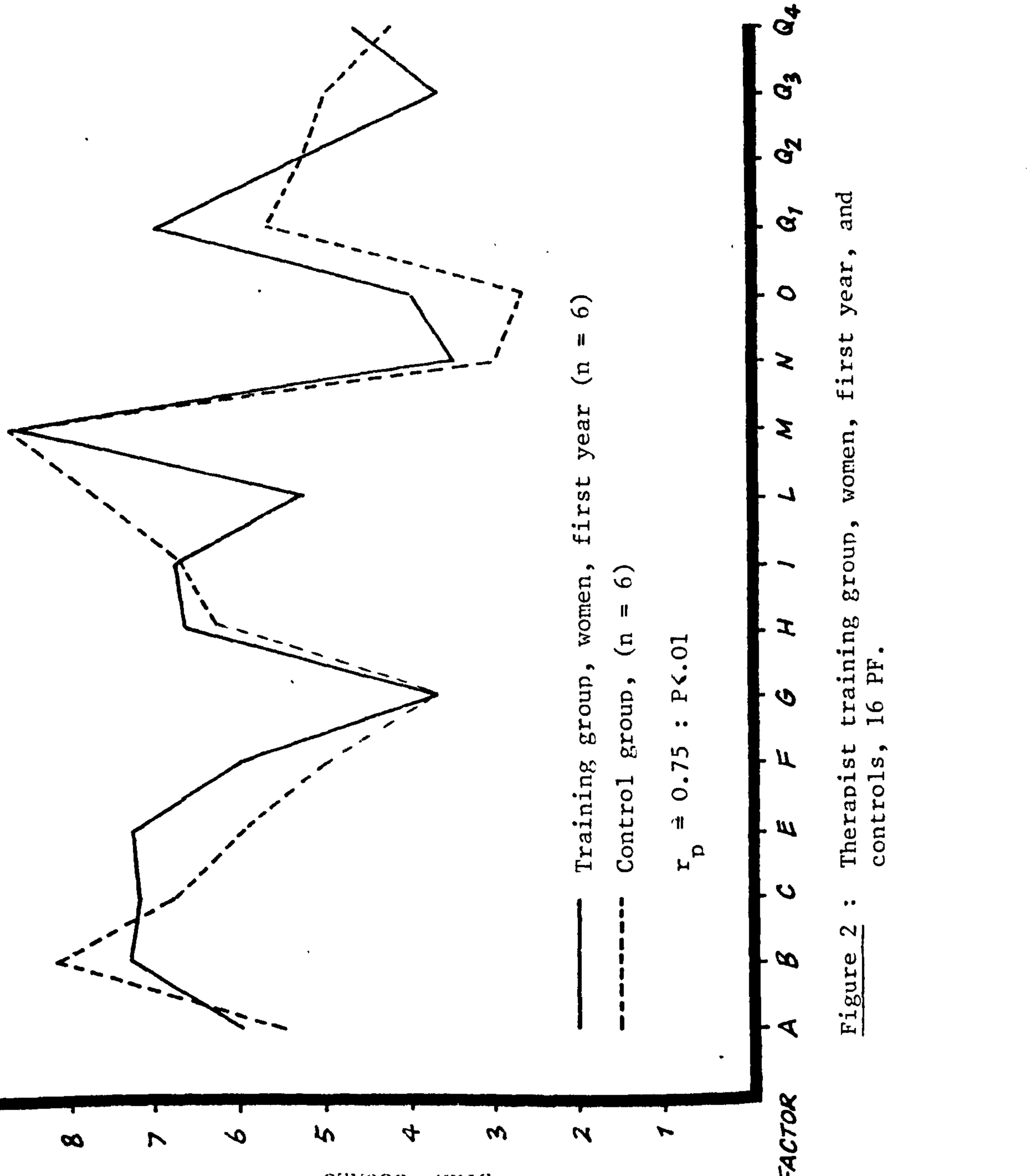


Figure 2 : Therapist training group, women, first year, and controls, 16 PF.

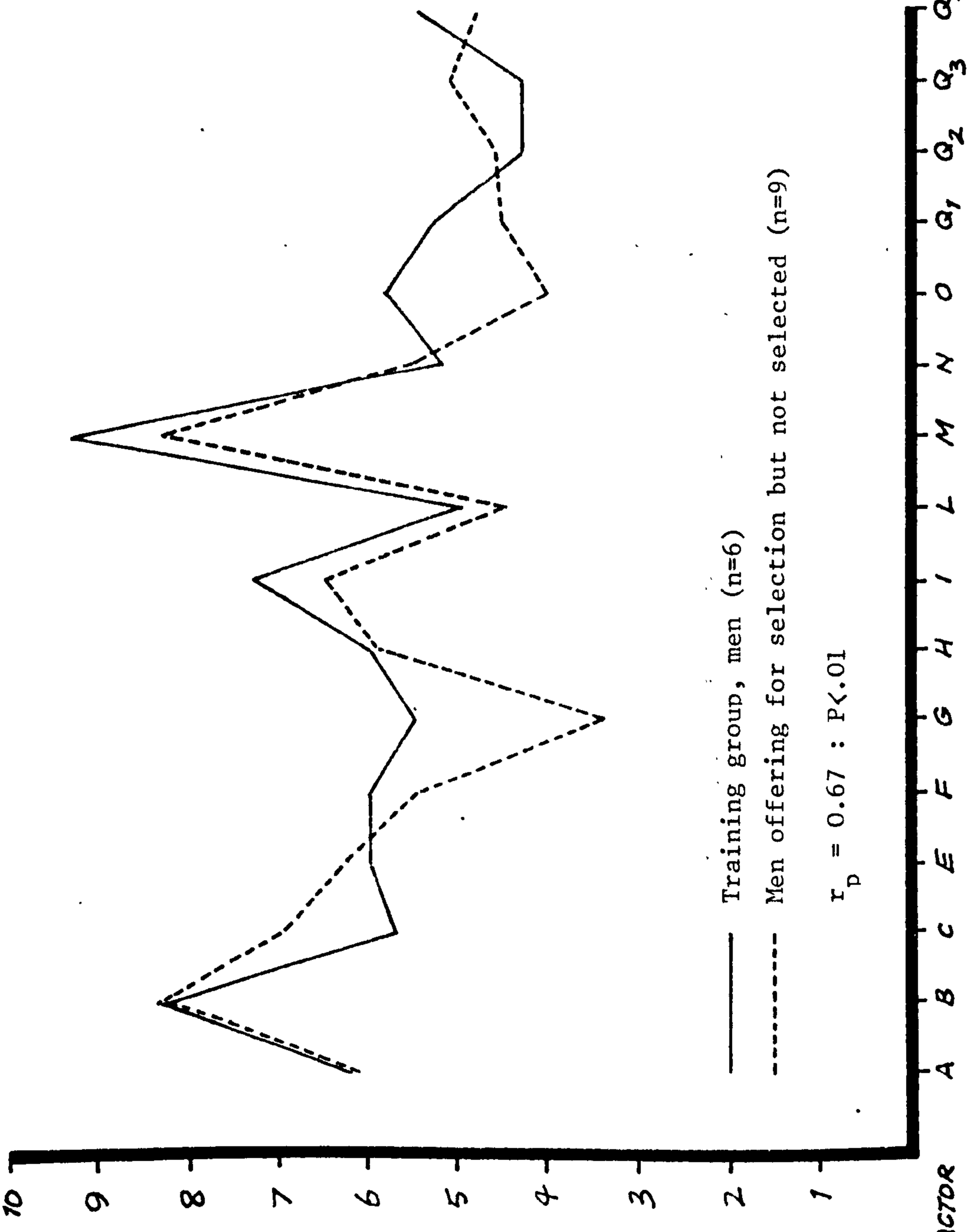


Figure 3 : Training group men, second year, and men offering for selection but not selected 16 PF

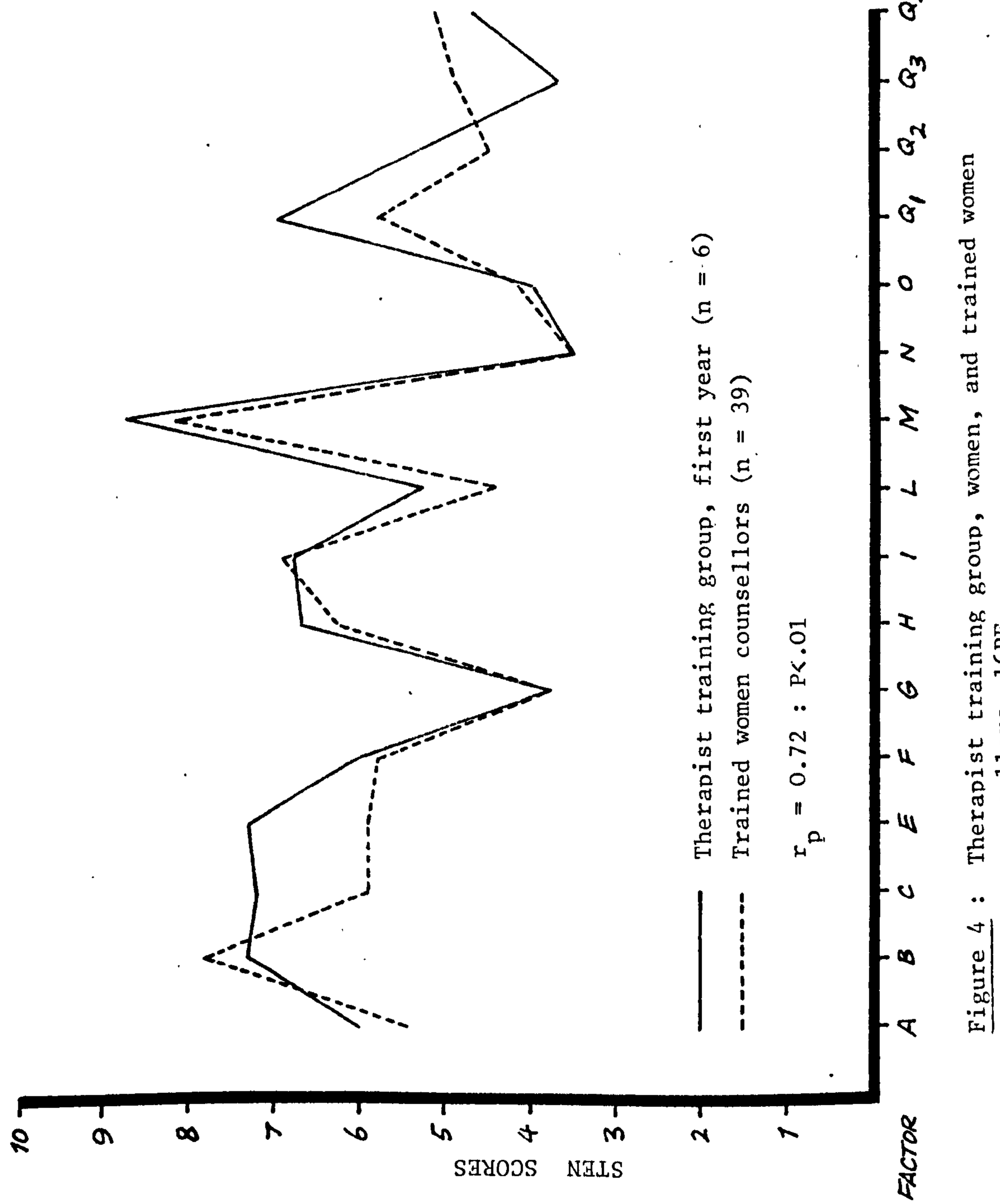


Figure 4 : Therapist training group, women, and trained women counsellors, 16PF

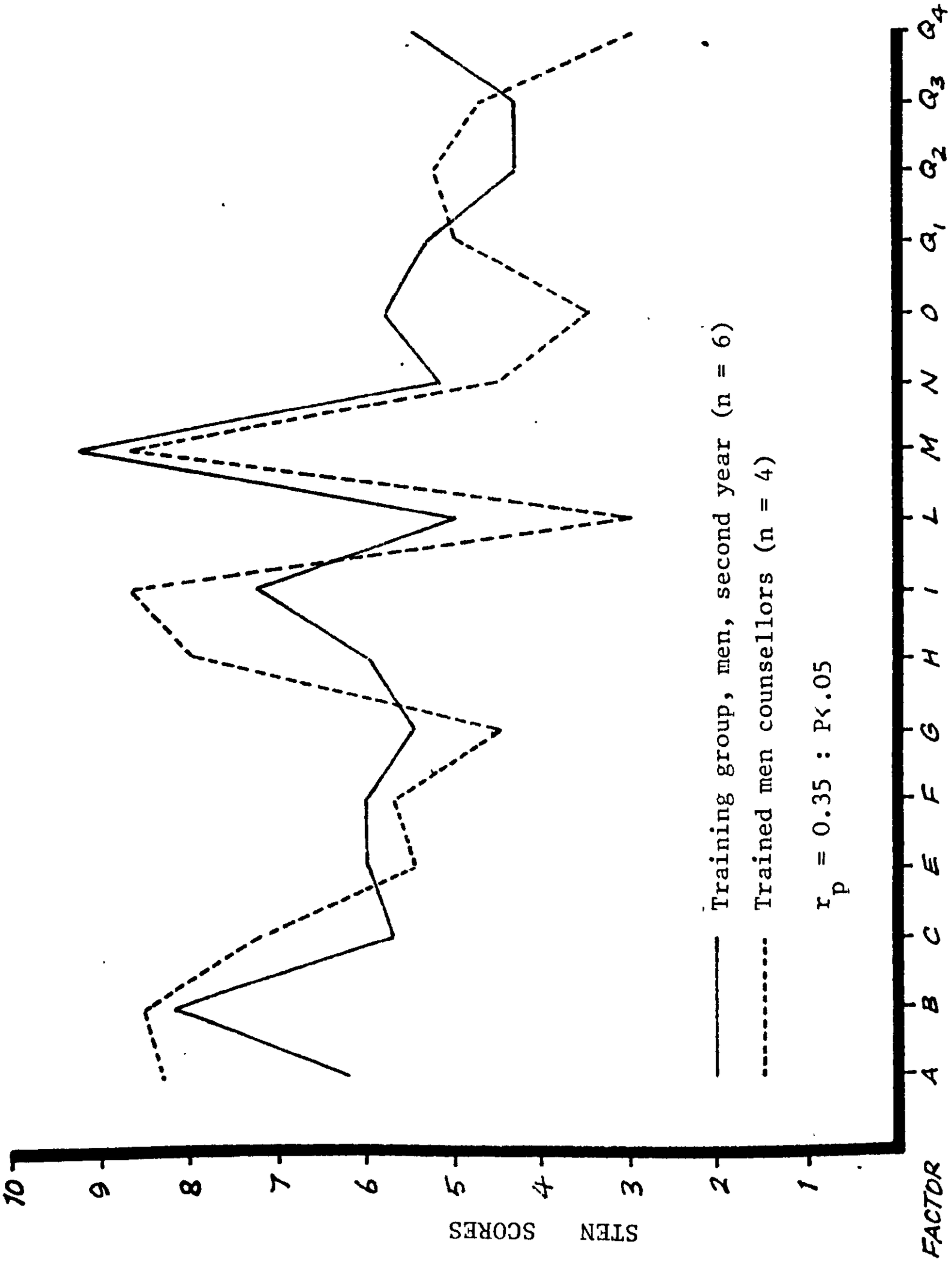


Figure 5 : Men trainess and trained men counsellors, 16PF

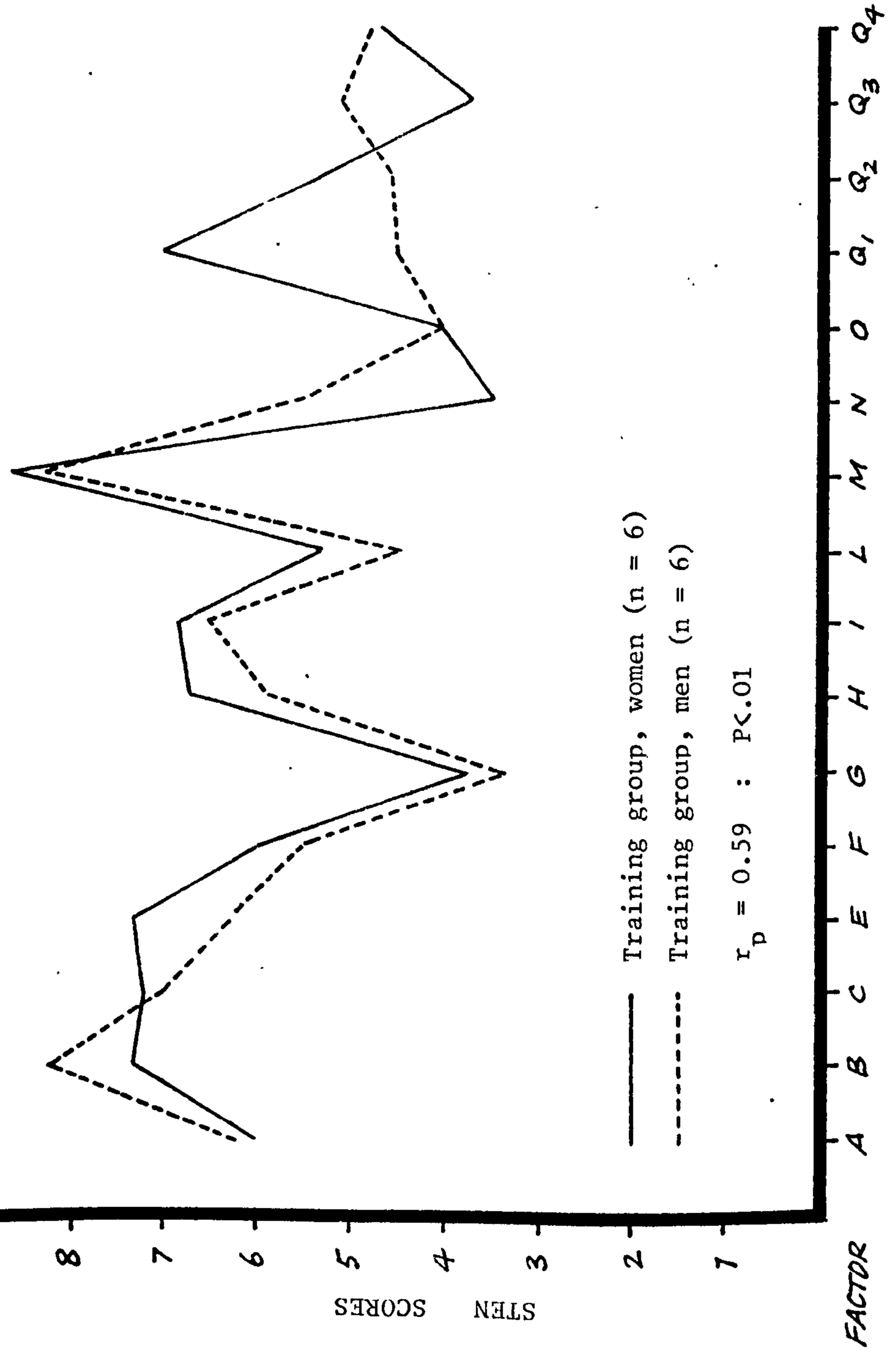


Figure 6 : Therapist training groups, men and women, 16PF

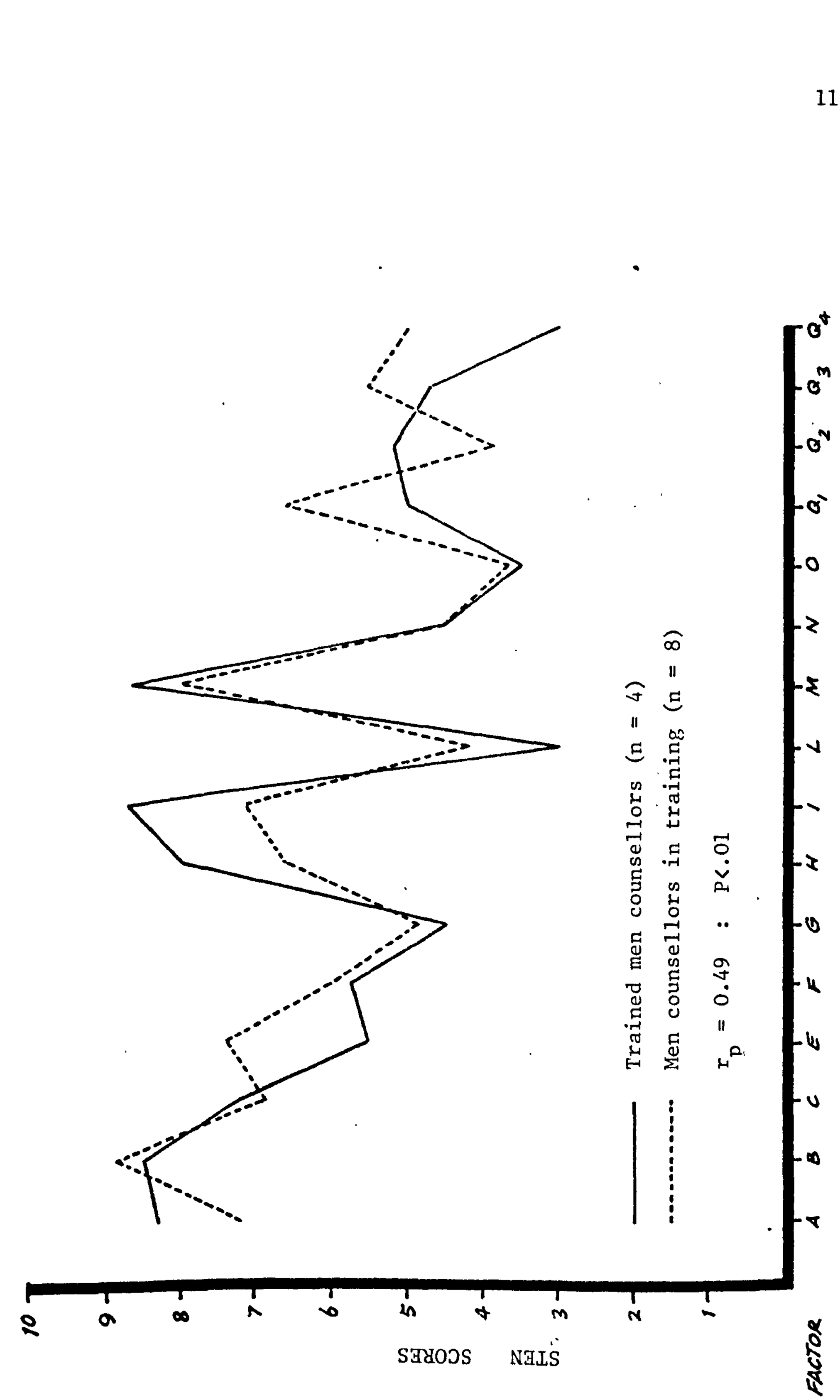


Figure 7 : Trained men counsellors and men counsellors in training, 16PF

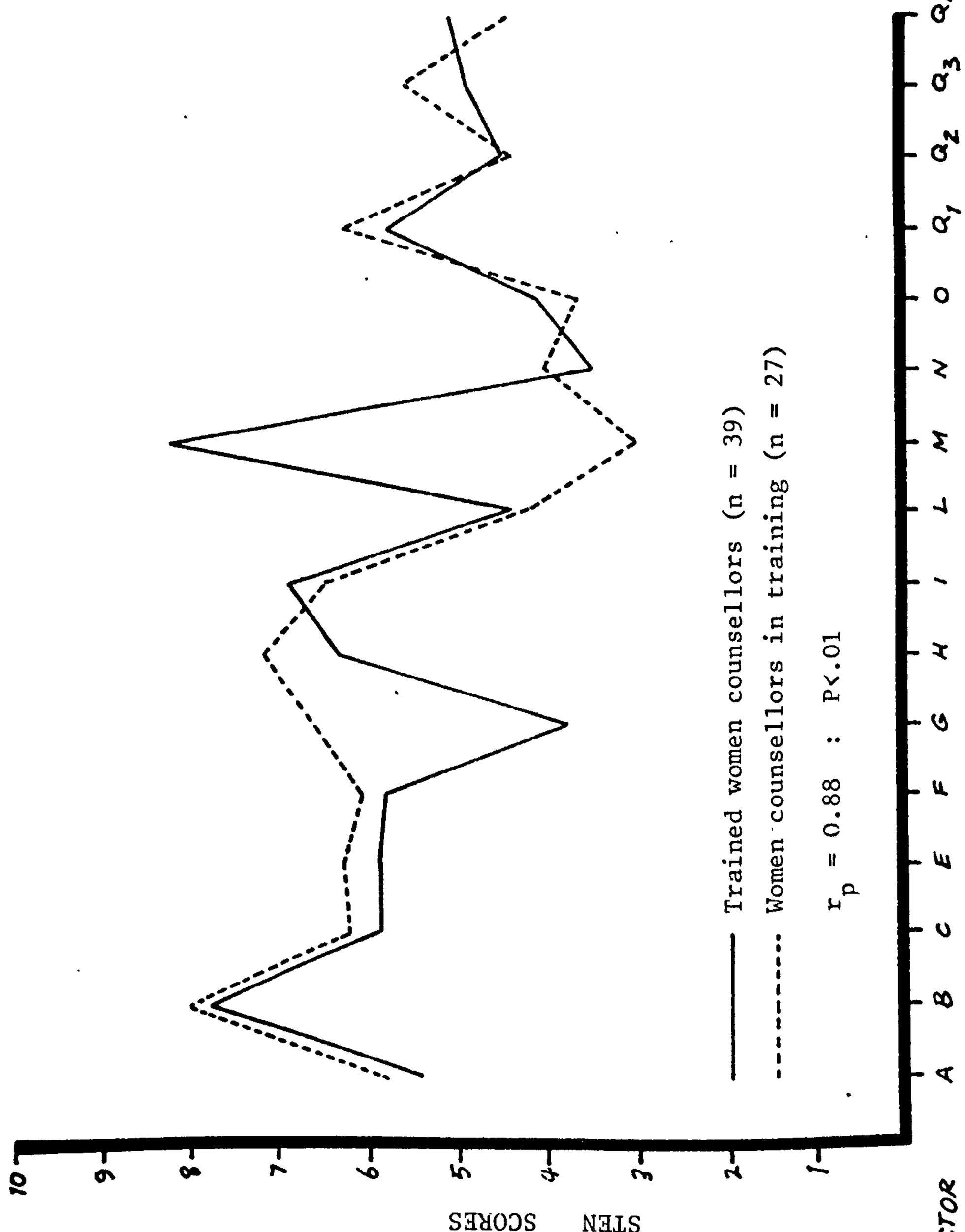
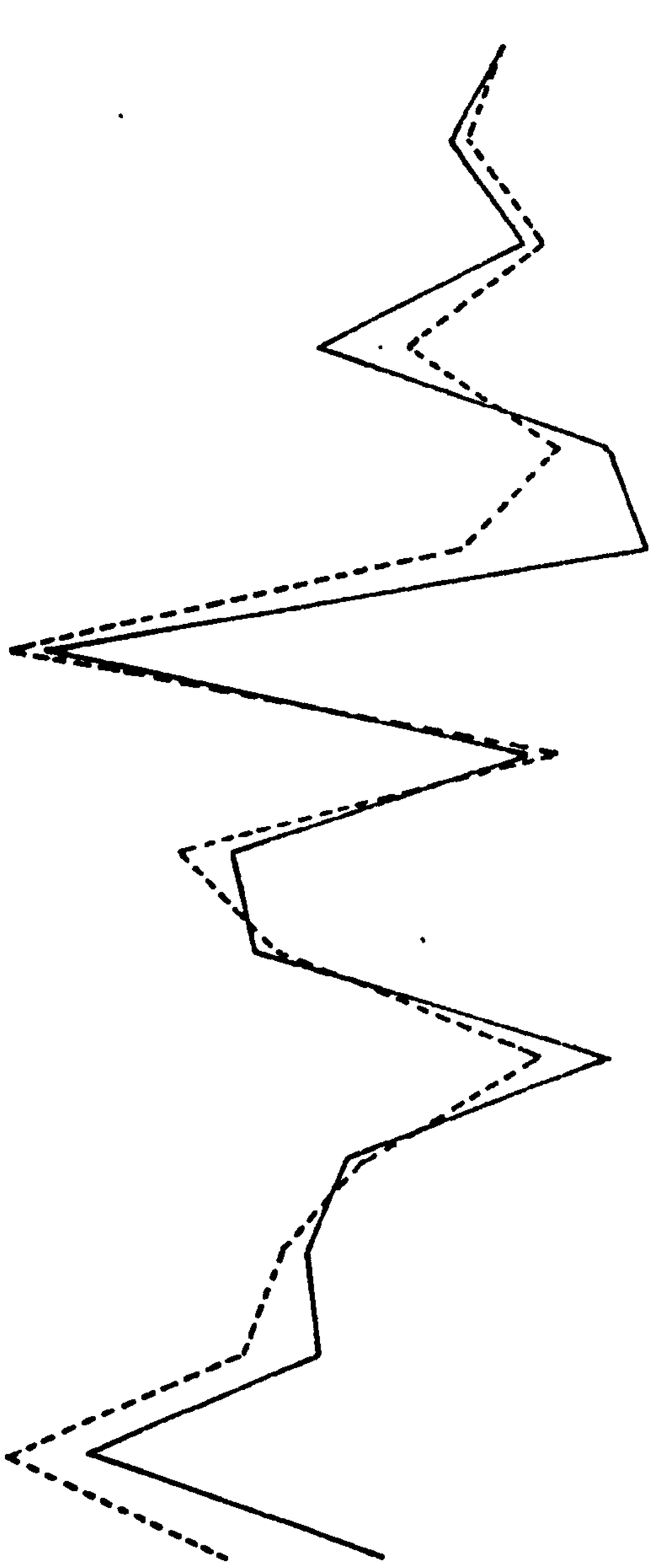


Figure 8 : Trained women counsellors and women counsellors in training, 16PF



—— All women counsellors (n = 78)

---------- All men counsellors (n = 27)

r_p = 0.89 : P<.01

Figure 9 : All women and all men counsellors, 16PF

compared to ascertain whether or not trained men counsellors coming into such training were like the general population of trained men counsellors. The comparison of groups 5 and 6 (fig. 3) was to establish whether or not, in the group of 15 men who offered for sexual dysfunction training, those selected (though selected without knowledge of the psychometric results) were different or not on the measures used from those not selected. Groups 7 and 8 (fig. 7) were compared for the same reasons as groups 3 and 4 for the women.

The procedure deriving from Cattell (1969) based on Horne (1961) was used in assessing the 16PF results. The statistic used is the profile matching statistic (r_p) based on a correlation; the more significant the correlation the more similar (i.e., the less unlike each other) are the groups compared.

It can be seen from the preceding figures, 2 - 9, that there is high similarity in all the profile results compared, with $P < .01$ in all comparisons except for that between the male groups 5 and 7 where it is lower than .05 but not quite .02. The numbers here are at their smallest (group 7 n = 4), and it is perhaps more a measure of the homogeneity of the population than otherwise that an r_p of an order greater than .05 is established on such a small group. This group of 4 is distinguished from groups 5 and 6 only in being part of the male counsellor population that did not offer for sexual dysfunction training and the comparison between groups 5 and 6 shows a high r_p (0.67:$P < .01$).

Figure 9 shows the 16PF characteristics of the whole male and female counsellor groups. It is characterised by being of well above average intelligence (B), imaginative (M), self assured (O-), capacity for warm involvement (N-), and lack of rigid moralistic stand (G-). The training group (figure 3) shows these characteristics and, in addition, is particularly unruffled (C), assertive (E), radical (Q10), and individualistic (Q3-). These last three characteristics are more apparent in the training group than in the control group of counsellors as a whole, but from the statistical point of view there are no significant differences between the groups on personality data.

Comparison of groups - SKI Data

The Sexual Knowledge Inventory scores similarly show no significant difference between the groups. Table 3 below shows the pre-training mean scores and there are no significant differences between them on tests for the significance of differences between means.

	Pre-training mean scores at Nov. 1973 (Max. score = 99)	
First year training group (female) n = 6	86.00 range 78 - 94	n.s.
Female control group n = 5	80.20 range 76 - 84	n.s.
Second year training group (male) n = 6	84.33 range 73 - 94	n.s.

Table 3 : Pre-training scores, training and control groups, Sexual Knowledge Inventory

5.1.5 The Development and Organisation of Clinics

The study had two main phases. In the first phase, lasting a year, a clinic was established at the headquarters of the National Marriage Guidance Council, Herbert Gray College, Rugby, in which six women marriage guidance counsellors were further trained in sexual function knowledge and as co-therapists. Each member of that group had the same male cotherapist (PTB). This group is referred to throughout as the training group. In the second phase, lasting a further year, three members of this training group, now trained for a year, themselves each trained two male cotherapists, and established a clinic for this purpose in their local Marriage Guidance Council, (Northampton, Lichfield and Coventry). The remaining three members of the training group each established a clinic in their local Council (South Warwickshire, Kettering, and Rugby), where each worked as a single therapist. PTB also continued the second year as a single therapist. The following diagram represents this.

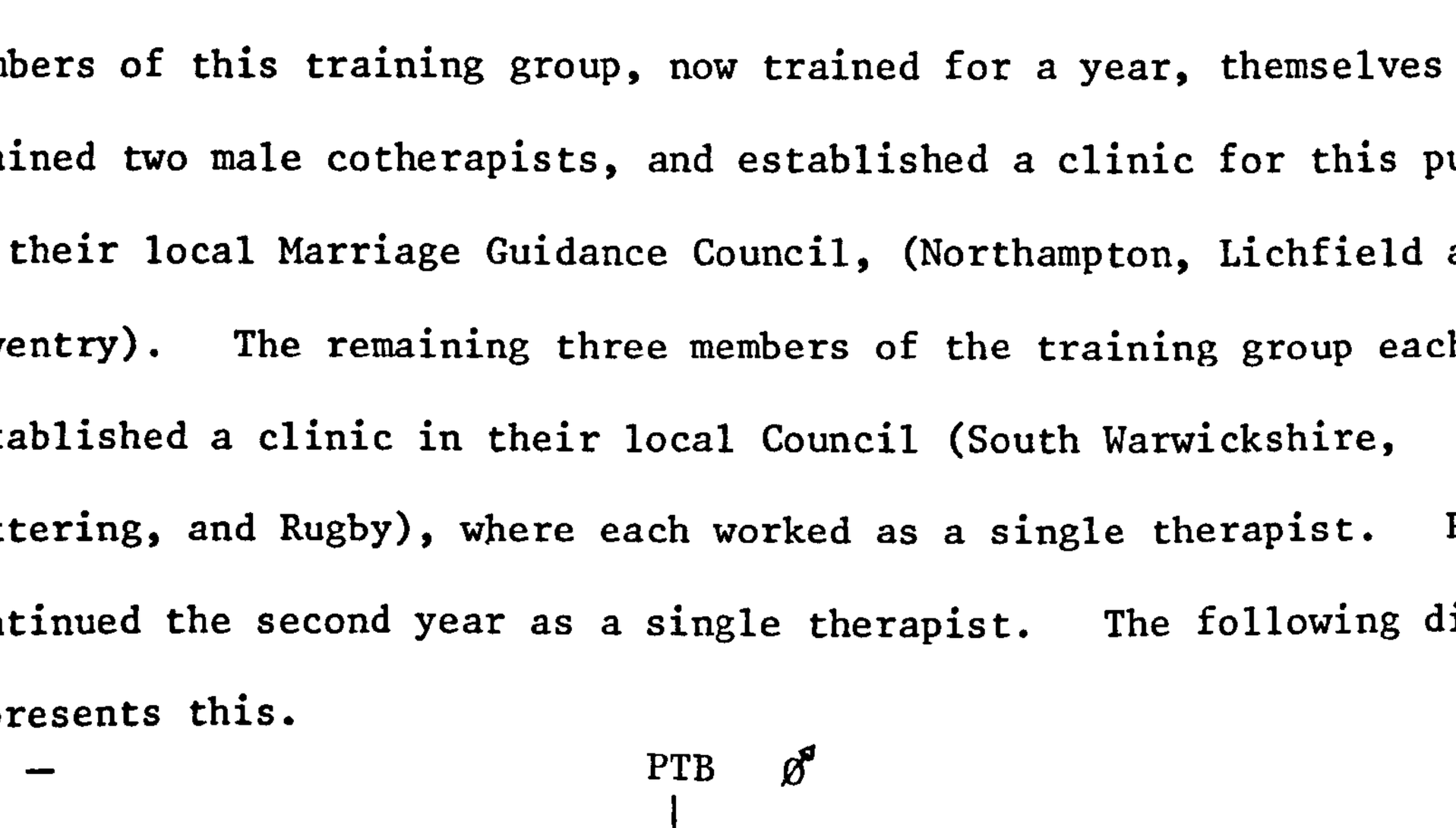


Diagram 1. First and second year clinic/training personnel.

All training and treatment took place in the context of treatment clinics specially established for the purposes of the study. In the first year there was one once-weekly clinic, at which couples presenting with sexual difficulties were seen by a cotherapist pair (PTB and one member of the training group). On any clinic day successive couples were seen by PTB and a different female therapist, so that on any one clinic day, when typically six couples were seen, each member of the training group acted as female cotherapist for one of those couples, while PTB acted as male cotherapist for all couples. Once the cotherapist pair had started work with a presenting couple the same pair remained as cotherapist to that couple until the termination of the treatment of that couple. While the cotherapists were in a treatment encounter, the five members of the training group not actively involved in the particular couple presenting at that time monitored the treatment session by audiothroughput from the treatment room. Thus on a clinic day when six couples were seen successively, any one member of therapist training group would typically act as a cotherapist for one couple and monitor the treatment of five other couples.

In the second phase through the second year, six additional once-weekly clinics were established. In three of these a member of the first-year training group established a single therapist session. In the remaining three clinics each of the remaining three members of the first year training group established a cotherapy session by training two male marriage guidance counsellors, who were selected prior to the start of the second year, thus establishing a cotherapist situation. Meanwhile the original first year clinic was continued in the second year by PTB as a single therapist clinic.

5.2 Procedure and Method:

5.2.1 The Source and Supply of Couples

Couples were referred directly by General Practitioners or with the agreement of their General Practitioners (p .127 below). All couples undertook medical screening at the inception of treatment (p .126 below). Prior to the inception of treatment couples were assessed by interview and also on 7-point scales constructed to describe aspects of the general relationship and sexual function of the partnership presenting. Section 5.2.3 below describes the procedures used. In brief, they fall into three categories - those used by therapists for assessing couples before the commencement of treatment and immediately upon the conclusion of treatment; those used by couples for recording their observations upon the outcome of treatment; and those used by an external assessor,who recorded his views of the outcome of treatment in one-third of the couples.

The catchment area for the study was defined as the Area Health Authorities listed above covered by the Marriage Guidance Councils of Northampton, Rugby, South Warwickshire, Coventry. Leicester and Birmingham. For practical reasons, a subsidiary Council of Birmingham at Lichfield was also included, though geographically just outside the AHA boundaries listed.

Discussion with the DHSS and correspondence with the General Medical Services Committee resulted in the following letter being sent to

medical practitioners in March 1974, inviting referrals.

The National Marriage Guidance Council
Herbert Gray College, Little Church St.,
Rugby CV21 3 AP

March, 1974

Dear Doctor,

Marital Sexual Dysfunction Project

In recent years there has been growing interest in the treatment of sexual difficulties. In discussion with the Department of Health and Social Security and with the approval of the General Medical Services Committee of the B.M.A., the National Marriage Guidance Council is setting up a two-year research programme to investigate the development of its counselling work in the specific area of sexual difficulties.

As part of the research programme, a treatment clinic is being established in Rugby at the end of April 1974. I am writing to all general medical practitioners and consultants in the area served by the project (Northampton, County Borough and County, Warwickshire, Leicester County Borough and County, Coventry, Solihull and Birmingham), to make this information about the clinic's existence available and to invite doctors to inform their patients about it in appropriate cases.

The background work to the Project is that described by Masters and Johnson (1966, 1970). The application of Masters' and Johnson's work in this country has been the subject of some preliminary reports to date (Bancroft, 1972; Brown and Kolaszynska-Carr, 1972), and the combined results of this work suggest that a marked alleviation of some disorders previously responsive only occasionally to psychotherapy may be possible.

The disorders in question are, in the male, premature ejaculation, primary impotence, secondary impotence, ejaculatory incompetence (coitus retardus), and dyspareunia; in the female, lack of orgasmic satisfaction (which may have existed throughout the sexually mature life-span, or be variably in evidence, and in which vaginismus and/or dyspareunia may or may not play a part). Women with these kinds of difficulties may complain of "frigidity".

All those attending for treatment will be seen and treated with their sexual partner by two cotherapists, one male and one female. Full physical investigations by hospital consultants will be carried out on both partners as a precursor to detailed investigations of sexual functioning, and it is expected that the treatment will be carried out over a 12 - 16 week period of weekly attendances. No fee will be charged.

The criteria for the acceptance of couples into the Project are: that the couple are married or that the sexual relationship has lasted

for at least a year; that neither partner is older than 60; and that if there are relationship difficulties, they appear to be the effect rather than the cause of the sexual dysfunction.

If clients present themselves directly to local Marriage Guidance Councils (or to the clinic itself), they will only be accepted for treatment in the clinic with the consent of their own doctor.

If you have any patients who you consider might usefully be introduced to the clinic, or any enquiries about it, please write to me: -

Mr. P. T. Brown,
Director,
Marital Sexual Dysfunction Project,
Herbert Gray College,
Little Church St.,
Rugby, CV21 3 AP.

Yours faithfully,

PAUL T. BROWN

B.A., Dip.Psych., ABPsS.

List of references:-

Masters, W.H. & Johnson, V.E. - Human Sexual Response
(Boston; Little Brown, 1966)

Masters, W.H. & Johnson, V.E. - Human Sexual Inadequacy
(Boston; Little Brown, 1970)

Bancroft, J.H.J. - Problems of sexual inadequacy in medical practice;
in Mandelbroke, B.M. and Gelder, M.G. (eds.)
Psychiatric Aspects of Medical Practice (London;
Staples, 1972)

Papers delivered at the Second European Conference on Behaviour Modification, Wexford, 1972;

Bancroft, J.H.J. - The Masters and Johnson approach to marital sexual problems in a N.H.S.

Brown, P.T. and Kolaszynska-Carr, A. - The relevance of Masters' and Johnson's methodology to the treatment of sexual disorders in an out-patient clinic.

18 months later the following letter designed to diminish the flow of referrals was despatched.

The National Marriage Guidance Council,

Herbert Gray College,

Little Church Street,

Rugby, CV21 3AP

October 1975

Dear Doctor,

MARITAL SEXUAL DYSFUNCTION PROJECT

You may recall that in March 1974 I wrote to all General Practitioners, and to Consultants in certain specialities, in Leicestershire, Northamptonshire, Warwickshire, and parts of West Midlands, to inform them about a treatment clinic in Rugby for couples experiencing sexual difficulties. The clinic was then about to be set up as part of a two-year research programme by the National Marriage Guidance Council, with the support of the DHSS and with the approval of the General Medical Services Committee of the BMA.

In accordance with the original scheme and following satisfactory completion of the first year's work, treatment is now being carried out at the premises of Marriage Guidance Councils at Northampton, Kettering, Leamington Spa, Coventry, and Lichfield, as well as at Rugby. However, so many couples were introduced to the clinic by their doctors during the first year of the programme that a waiting list had to be made, and it will not be possible to offer treatment during the second year of the programme to any couple not already on the waiting list.

It is expected that treatment will continue to be regularly available at these centres after the end of the research programme, in April/May 1976, and I am asking Marriage Guidance Councils to write to you, when it becomes possible to accept further clients, to invite you to inform any of your patients about the service if you think it might be suitable for them.

You will recall that the disorders in question are, in the male, premature ejaculation, impotence, ejaculatory incompetence, and dyspareunia, and in the female, lack of orgasmic satisfaction, in which vaginismus or dyspareunia may or may not play a part. The responsiveness of these disorders to treatment is heavily dependent on the emotional relationship between husband and wife, and this is carefully considered in assessing what treatment is appropriate.

Yours faithfully,

PAUL T. BROWN, B.A., Dip. Psch., ABPsS

Clinical Psychologist.

Director,

Marital Sexual Dysfunction Project.

Couples were allocated to treatment on a strictly sequential basis, the sequence being by date of referral and the type of treatment (single- or co-therapy) being determined by the facility available in the clinic

to which the couple were being referred. Hence the geography of a source in relation to the type of treatment available in the local clinic combined to determine the particular treatment any particular couple received. No clinic offered a choice of treatments. At no stage were couples selected for one type of treatment in preference to another by the therapists involved or through any of the administrative processes that were under experimental control.

Throughout the period of the study 305 referrals of couples were made. The table below shows the total number of referrals, together with the sources of referrals and the percentage of referrals deriving from each source.

Source of referral	No. from each source	% of total
General practitioners	188	62
Medical specialists - psychiatry and gynaecology	45	15
Other sources (F.P.A., G.P. consent)	45	15
Marriage guidance counsellors	27	8
TOTALS	305	100

Table 4 : Sources of referral in 305 referrals.

As each referral represents the referral of a couple, then 610 individuals were referred in the period of time, the majority (62%) from General Practitioners.

The outcome consequences for the 305 couples referred is as follows:

OUTCOME OF 305 REFERRED COUPLES	NO. OF COUPLES	% OF TOTAL
1. Entered treatment in this study	72	24
2. Referred elsewhere	53	17
3. Assessed and on waiting list (at 1.6.76)	53	17
4. Waiting for assessment	8	3
5. In treatment at termination of study	8	3
6. Withdrawn	30	9
7. Did not attend appointment offered	59	19
8. Unable to complete referral request	11	4
9. Reported improved after initial assessment upon offer of treatment	10	4
10. Unknown	1	0
TOTAL	305	100

Table 5 : Outcome of 305 referrals

It can be seen from the table above that 65% of referred couples were serviced one way or another by the existence of the research service established - 24% entered treatment, 17% were referred elsewhere, 17% were assessed and awaiting treatment in a continuing service, 3% were

continuing treatment at the termination of the study, and 4% reported themselves improved after an initial assessment. Of the remaining 35% more than half, 19% of the total group, did not attend appointments offered, while 9% withdrew at their own instigation during the course of the treatment. There are thus 28% of clients who, for one reason or another, do not avail themselves of the service offered. Mechanical difficulties (change of address, unwillingness to attend) prevented the adequate completion of 4% of referrals and the remaining 3% of referrals were on a waiting list at 1.6.76 for an initial assessment in a continuing service.

5.2.2 The Treatment Programme

The structure of the treatment programme offered was as follows, and is based upon the work undertaken by Brown in an N.H.S. out-patient setting (Brown and Kolaszynska-Carr, 1972) in modifying Masters' and Johnson's procedures for U.K. health-care delivery.

Weeks of active Involvement:	Couple referred. First assessment appointment offered as soon as possible.
Week 1	"Hello" interview. Couple state problem. Cotherapists form view as to whether the presenting difficulty is one of sexual dysfunction, (if yes, make preliminary diagnostic statement) and whether the

relationship appears to be of sufficient strength to accept therapeutic intervention in its sexual functioning. (If yes, offer next available full assessment appointment with the expectation of going on to treatment). Initiate medical screening appointment. If the problem is not sexual dysfunction, or the relationship appears vulnerable, offer suggestions for further referral and initiate if agreed, with the option of returning to sexual function treatment at a later stage if the relationship vulnerability has been the cause of non-acceptance and it is successfully modified. (Duration of session about 1 hour). Therapists complete Behavioural Rating Scale and Assessor's Rating Scale (see Appendix C and Appendix D).

Week 2

Full history taking assessment, (see Appendix I) round table, and introduction to nongenital sensate focus: Completion of diagnostic formulation, pre-treatment filling-in of rating scales by therapists. History taking conducted in Masters and Johnson-specified fashion of male therapist/client and female therapist/client establishing independent histories; therapists confer briefly, then interview client of opposite sex; then confer, and then meet couple for round-table. Subsequently always meet as foursome.

Establish round table conclusions and set up first week's nongenital sensate focus exercises. (Duration of session about 3½ hours).

On the modified time basis, each week requires the presenting couples to establish three separate one-hour sessions at home that they devote to the current stage of behavioural sexual experience.

Week 3 — Verbal report of outcome of nongenital sensate focus; repeat or move to genital sensate focus for ensuing week, as appropriate.

Week 4 — Verbal report of outcome of previous week's exercises; detailed information session, supported by photographic and diagrammatic material of sexual anatomy and physiology (see Appendix G) : repeat or move as appropriate.

Week 5 — Verbal report of outcome of previous week's exercises: develop specific techniques for specific presenting disorder, as described in Masters and Johnson (1970).[1]

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1 Exercises for the development of non-genital and genital sensate focus have been elaborated and described in detail by Brown and Faulder (1978).

Week 6 and subsequently	Continue as necessary, establishing appropriate behavioural goals, learning from mistakes, facilitating communication, and assessing progress weekly.
	Upon conclusion therapists repeat rating scales. Couples also complete rating scales independently of each other and of therapists. External assessor completes rating scale on specific return visit of couple for this purpose.

5.2.3 The Data Collected

For all couples the following facts were recorded -

1. Name
2. Age
3. Source of referral
4. Interval between referral and starting treatment (weeks)
5. Interval between initial assessment and starting treatment (weeks)
6. Number of weeks in treatment
7. Number of treatment sessions

and the following assessments were made -

8. Diagnostic incidence and severity scale, rated by therapist pre- and immediately post-treatment, (Behavioural Rating Scale Appendix C)
9. Assessment of the relationship and assessment of the sexual relationship by therapist pre- and immediately post-treatment (Assessor's Rating Scale Appendix D)
10. Assessment of the relationship and assessment of the sexual relationship by external assessor, post-treatment (Assessor's Rating Scale).
11. Male client assessment of outcome, immediately upon conclusion of treatment, assessment made independently of female partner but using same scale (Appendix B)
12. Female client assessment of outcome immediately upon conclusion of treatment, assessment made independently of male partner but using same scale (Appendix B).

5.2.4 The Form and Analysis of the Data

In considering the question of the measurement of change in the client population, it was borne in mind that it is characteristic of the population which presents for sexual dysfunction treatment that a major source of difficulty stems from ignorance of sexual function (Masters and Johnson, 1970). In consequence the early formulations by clients about the difficulties which prompt attendance are usually vague, are clarified only by detailed enquiry, and are themselves very often used by therapists during treatment as the starting point for giving information and knowledge about sexual matters.

Against this background it was decided to record pre-treatment assessments of the presenting difficulty from therapists only, and not from couples, and to repeat these assessments immediately upon the conclusion of treatment. At the conclusion of treatment however the couples were also asked to assess change, and at that point also to make comparison with their pre-treatment state. These assessment procedures were designated 'Therapists Rating Scale' (Appendix C) and 'Couple's Rating Scale' (Appendix B).

As sexual difficulties present in the context of an ongoing relationship it might be expected that changes in the difficulty would have effects, for better or worse, on the couple's perception of, and experience of, that relationship. The pre- and post-treatment assessments by therapists and couples sought to distinguish between the general and the sexual relationship aspects of the presenting difficulty and to monitor the effects of treatment upon these two differing aspects of the presentation. Thus pre- and post-treatment assessments distinguished between the observed general relationship and sexual relationship, and the analysis of data looked at the effects of treatment on each of these aspects of the presenting difficulties.

In addition to therapists' and couples' assessments of outcome, an external assessor was incorporated into the study. The function of the external assessor was to use one of the rating sheets (Assessor's Rating Sheet), which was also used pre- and post-treatment by the therapists, in order that as external a view as possible might be taken

of the outcome of treatment as it appeared to a skilled observer. Professor Derek Jehu, then of the University of Leicester, acted in this capacity. The ratings by the therapists and the external assessor on the rating sheet in question were completed independently. Appendix D details the Assessor's Rating Sheet.

The procedure adopted for analysing the data, which is presented in its raw form in Appendix H, columns 8 - 15 inclusive, was that proposed by Scheffé (1953) for the post hoc comparison of differences between means - a method that is essentially one for judging all contrasts in an analysis of variance. Kirk (1969) has described these kinds of a posteriori comparisons as "data snooping", and recommends the Scheffé procedure for multiple comparisons with unequal group sizes. The procedure is a conservative one in which findings are best depicted by ranging the group means in order of magnitude and calculating the value which must be exceeded if differences between means are to be significant. Since multiple orthogonal comparisons are made groups can be put into subsets within which differences are not significant. If, for example, four groups are being compared, and only the extreme groups differ significantly, then there will be two subsets, one with the lowest group plus the middle two groups and the other with the highest group plus the same middle two groups.

6. THE LINKAGE OF PROCEDURE AND METHOD TO THE BASIC CONCEPTS OF TREATMENT.

6.1 Concept 1 - adequate knowledge

6.1.1 Acquisition of sexual knowledge

Table 3 above has already shown that there were no significant differences between counsellors in training and a control group on an appropriate measure of sexual knowledge. Table 6 below shows the effect upon these scores of the training experience in comparison with a control group. Both the first year (female) and second year (male) training groups show a significant change in their scores, whilst the control group does not. It will be recollected that the training of the first and second year groups took place under manifestly different conditions - the first year training was in a group setting; there was continuous monitoring of other counsellors' treatments; and training was by a health professional, to name the most obvious differences from the second year, where training had its emphasis almost entirely on apprenticeship experience. Nevertheless the experience of training, whatever its particular form, appears to be linked to positive changes in knowledge. It can be observed that for both training years the common factor was regular contact with couples in treatment, which might reasonably be thought to be a significant stimulus to the acquisition of relevant knowledge.

The table below shows the results of a replication of the SKI test for the 1st year training group in comparison with a control group not engaged in training but maintaining normal remedial counselling work. Also shown are the results of pre- and post-training SKI scores for the male cotherapist trainees of the second year.

	Pre-training mean scores at Nov. 1973 (Max.score = 99)	Post-training mean scores at June 1976 (Max.score = 99)	t.
Female training group (1st year)	86.00	95.50	3.94
	range	range	P < .05
n = 6	78 - 94	94 - 99	
Female control group	80.20	82.80	0.95
	range	range	n.s.
n = 5	76 - 84	71 - 91	
Male training group (2nd year)	84.33	90.50	6.52
	range	range	P < .01
n = 6	73 - 94	79 - 98	

Table 6 : Pre- and post-training scores, training and control groups, Sexual Knowledge Inventory.

It should be noted in the above that while the intervals of assessment are the same for all three groups, the female training group of the first year is in training and clinical practice for the two-year plus period April 1974 - June 1976, whilst the male training group of the second year is in training and practice for only the second half of that period.

It is concluded on the basis of this table that the experience of training and clinical practice does result in an increase in sexual knowledge as assessed by the Sexual Knowledge Inventory.

6.1.2 The development of accuracy in making diagnostic statements in the training group

At the conclusion of each history-taking sequence, and before the round table discussion (in Week 2, p.134 above), all six members of the training group made independent diagnostic judgements using the diagnostic checklist of Appendix A. The results were then compared with a criterion judgement by PTB.

Couples were time-tabled into the first year of the study in groups of six, and 18 couples completed treatment in the first year. The procedure described above was applied to 17 of these couples, giving three intakes of 6, 6 and 5, which occurred in May/June, 1974, September/October, 1974 and January/February, 1975 respectively. For each couple two observations on a diagnostic check-list from each

counsellor were required, one for each partner. (The statement that there was no sexual dysfunction in one or other partner was for this exercise counted as a diagnostic statement, as it is as important not to treat a dysfunction which is not present as to treat one that is!). Thus, for each group of 6 couples in the first two intakes (2 x 6) x (6 counsellors) = 72 observations were possible in principle, while in the final group of 5, when no counsellor diagnostic observations were made on the final couple of the intake (2 x 3) x (6) = 60 observations were possible in principle. Occasional counsellor absences reduced the actual number of observations that were made from the totals possible. The following table presents the total information, together with percentages of correct observations occurring for each of the 3 intake groups. In this data the strictest criterion has been used - i.e., that the diagnosis given by the counsellor was unequivocally the same as that of the criterion. A mixed diagnosis which included the correct one has not been accepted as correct for the purposes of this analysis. As can be seen from the final column, diagnostic accuracy improves markedly over the period of training.

Intake group	No: of possible diagnostic observations	No. of actual diagnostic observations	No. of observations correct	% correct
1 : n = 6 couples	72	66	29	43%
2 : n = 6 couples	72	66	34	51%
3 : n = 5 couples	60	60	47	78%

Table 7 : Therapy training group: development of diagnostic accuracy over first year of training

It is concluded from the above that diagnostic accuracy does improve over the period of training and practice, and appears to improve in an orderly and incremental fashion as might be hoped. It is also apparent that at the conclusion of the study 1 in 5 (22%) diagnostic statements is not accurate.

6.1.3 A comparison of therapists ratings of the outcome of treatment with the independent ratings of an external assessor

Table 8 compares the therapists' ratings immediately upon outcome with

the external assessor's ratings on the same scale, using the correlations between the variables:

		ASSESSOR	
		General	Sexual
THERAPIST	General	.271*	.478**
	Sexual	.134 n.s.	.659**
		.110 n.s.	.667**

** signif. beyond .01 level

* signif. beyond .05 level

Table 8 : Comparison by correlations of post-treatment ratings by therapists and external assessor on same scale : twenty five couples

It appears from these intercorrelations that whilst the Assessor is distinguishing between a sexual and a general relationship, as evidenced by the low intercorrelation (.110), therapists are not doing so (.667). However, the correlations do also suggest a degree of concordance between independent views (assessor's and therapists') of the same clients, particularly in the observation of the sexual relationship where a correlation of .659 on a small group (n =25) is obtained.

With the assessor's ratings taken as criterion judgements, this correlation argues for some degree of therapist accuracy in making post-treatment judgements about outcome.

The above three attempts to record matters of relevance to the process of training and the application of training all show evidence in the same direction - viz., that the experience of the training established and described here does afford some confidence in the supposition that counsellors who started with some knowledge of sexual function improved that knowledge over the period of training and used it appropriately in making diagnostic statements and post-treatment assessments.

6.2 Concept 2 - ensuring presence or absence of relevant organic factors

In all, 65 men and 48 women (113) of the 72 couples entering the study completed the medical screening. Appendices E and F record the details of the medical enquiries pursued.

In no case in the 113 individuals was there evidence of physical pathology which contra-indicated the treatment of the presenting sexual difficulty by the procedures described above. In three cases of the male, however, and following the inception of treatment, restriction of the foreskin upon sexual excitement was found to be an inhibiting component of sexual functioning, and referral of these clients

resulted in adult circumcision in two cases and foreskin manipulation in the third. The two cases of circumcision returned to treatment post-operatively and completed successful work on the development of their sexual function.

In addition to the above difficulties presenting during the course of treatment, one further male, presenting with retarded ejaculation which was not resolved by treatment, maintained contact with the consultant surgeon with a view to engaging in AIH procedures.

It was concluded on the basis of these observations that, in a population presenting for the treatment of sexual difficulties through or with the agreement of general practitioners, no instances were demonstrated by extensive medical examination of pre-existing physical pathology contra-indicating the inception of sexual function therapy.

To extend this picture, however, the following additional observations are germane.

In the female clients who entered treatment, one found herself unwillingly pregnant as a consequence of intercourse just before treatment began. The question of sterilisation had previously been important in the dynamics of this relationship, and the referral had originally come from a consultant gynaecologist after the husband's refusal to allow his wife to be admitted to hospital for sterilisation. As a consequence of the pregnancy, abortion and sterilisation was undertaken in the third month of treatment, which was carried through to a successful

conclusion, and undoubtedly the woman's sexual function was facilitated by the removal of her anxieties about further pregnancies. Two further women with extensive psychiatric histories, both with obsessive compulsive elements, were referred for further psychological work at the end of treatment, which had, in one case, helped the general marital relationship, but had in neither case improved the sexual functioning of the partnerships in any permanent way. One further woman was referred for gynaecological investigations on account of pain in the introitus during intercourse, and proved to have minor vaginal warts not diagnosed at medical screening. They responded to treatment and their removal helped the development of a previously painful and limited experience of intercourse.

Among the males already referred to, one partnership was referred for more extensive sexual functional work elsewhere, and one further partnership was referred for bio-energetic work in an attempt to help the male understand aspects of the repressed anger which were preventing the development of the marital relationship.

Thus out of 72 couples who started treatment, 9 were subsequently referred during the course of treatment for other specialist help, but in no case in a total of 113 individuals who underwent medical screening was there physical pathology in the presentation which contra-indicated sexual function treatment in a counselling setting. It is perhaps of a special note here that the one disorder that is perhaps most readily thought of as requiring medical intervention - vaginismus, of which two cases presented - showed an excellent response to treatment.

These figures show therefore that 12.5% of the couples in the sexual function treatment programme required additional specialist medical help after the inception of treatment (1 in 8 couples, or 1 in 16 individuals), but that there is an absence of evidence of physical pathology prior to the inception of sexual function therapy. It also appears that the process of sexual function therapy can make the significance of pre-existing but undiagnosed relevant symptoms manifest. [1]

6.3 Concept 3 - the requirement for cotherapists

This concept is the basis of the main experimental question, and together with the results regarding the operational questions is the subject of Section 7 below.

6.4 Concept 4 - the requirement of short-term, intensive treatment - was, as already described above (Section 5.2.2) modified and held constant for the purposes of the study. It is also the basis of the first

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1 Severe for the logistics of treatment though they are if the discovery is made after the inception of treatment in a tightly-timetabled programme! The fact that some physical disorders affecting sexual function became apparent only on sexual stimulation also raises questions regarding the appropriate content of physical examinations for sexual problems.

operational question (see Section 4 above) and is also considered in detail in Section 7 below.

6.5 Concept 5 - education of the couple in techniques of verbal and non-verbal communication - was not a matter of systematic experimental or operational modification. So far as a useful distinction can be made, this study was concerned not so much with the content of treatment but with the structure of treatment. As already described under 5.2.2 above, the Treatment Programme used in the study specified a structure and organisation of the week-by-week treatment sequence, whilst content was controlled in an experimental sense by training a group of counsellors whose previous training had all been similar; who did not have independent helping profession skills; and who for the purposes of this study had a common model of therapeutic intervention provided by the experimenter.

At the time of the inception of the study there had been no reports of variations in the content or structure of Masters' and Johnson's therapy procedures. At much the same time as this study began, Bancroft (Mathews and Bancroft, 1976) initiated an experimental study which examined aspects of both structure and content, and the outcome of this study is discussed in more detail below. The last five years of interest in Masters' and Johnson's work has, for the greater part, consisted of ad hoc variations of their treatment proposals. The paucity of a systematic clinical/experimental literature has already been discussed. Appendix G however displays the visual material

that was used in week 4 of the treatment programme as the means of establishing for couples accurate information regarding the sexual functioning of the body.[1]

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1. The photographic material is reproduced in monochrome in this presentation. In use, the material was displayed by back-projecting colour transparencies onto a small table screen around which therapists and couples sat for discussion of the material. It is also the case that the present author does not hold the copyrights to the slides that were used, and for this reason also they are reproduced in monochrome and at actual slide size.

7. THE RESULTS IN RELATION TO THE EXPERIMENTAL AND OPERATIONAL QUESTIONS

As described above (Sections 5.2.3 and 5.2.4), the data by which the experimental question was tackled derived from self-report (couples) and therapist rating sheets. The self report scales at the end of treatment attempted to evaluate change as a consequence of treatment on sexual and general relationships; the therapist ratings, applied before and after treatment, attempted to estimate change on sexual and general relationships as a consequence of treatment and also change in the incidence and severity of specific dysfunctions.

7.1 Single vs Cotherapy

The following section presents the outcome of the analysis of the data in relation to the experimental question -

"Is the dual-sex therapy team necessary
for successful outcome?"

by examining the difference on the scales described above when different couples are treated on an unselected basis by one or two therapists - the single vs. cotherapy distinction.

72 couples entered treatment during the course of the study, 18 in the one first year clinic and 54 in the 7 second year clinics. All data therefore is derived from a maximum of n = 144.

There was no basis of selection as to which couples attended single or cotherapy clinic sessions. As has already been noted, specific clinics were established in specific geographical centres of the Midlands, as either cotherapy or single therapy clinics for the purposes of this study. Thus whether any couple presenting for treatment received single or cotherapy depended upon the resources available in their particular location.

The similarity of the two groups who entered different treatment procedures can be seen in the following table, which presents the factual data characteristics on the single - vs. - cotherapy comparison:

	N	$\bar{x}$ Single (s.d.)	$\bar{X}$ Co-therapy (s.d.)	F ratio	Significance level
Age of clients	144	34.61 (10.49) (n = 54)	33.58 (9.23) (n = 90)	.382	ns
Interval (weeks) from referral to starting treatment	144	29.26 (16.32) (n = 54)	33.62 (13.96) (n = 90)	2.87	ns
Interval (weeks) from assessment to starting treatment	144	23.55 (15.25)	25.40 (13.60)	.566	ns
No. of sessions of treatment	132	12.62 (5.34) (n = 52)	11.50 (4.78) (n = 80)	1.56	ns
No. of weeks of treatment	132	18.54 (9.13) (n = 52)	15.93 (9.41) (n = 80)	2.49	ns

Table 9 : Single versus co-therapy : factual data

In the absence of significant differences between the two groups, the mean results for the total group show an average age of 34 years (33.97: range 21-59); an average interval between referral and starting treatment of almost 8 months (31.99 weeks: range 8 -83); an average interval between assessment and starting treatment of just over 6 months (24.71 weeks: range 2 - 69); that treatment typically takes 12 sessions (11.94: range 3 - 24); and that the average number of weeks in treatment is 17 (16.95: range 3 - 45).

Therapists' assessment of outcome

Before the inception of treatment, but after full history-taking, pre-treatment assessment ratings showed the following results: [1]

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1 In all scales, which are on either a 1 to 5 or 1 to 7 basis, lower numbers signify lower or poorer or less satisfactory enjoyment, satisfaction, or function; whilst conversely higher numbers signify higher, better, or more satisfactory enjoyment, satisfaction, or function. The problems of intervals in the scales used and the distributions resulting have not been considered in an experimental fashion in the study.

		N	$\bar{X}$ Single(s.d.)	$\bar{X}$ Cotherapy(s.d.)	F ratio	Significance level
Therapists ratings	Enjoyment of sexual contact (scale 1-5)	139	3.04 (1.60) (n = 54)	2.18 (1.34) (n = 85)	11.70	.001
	Assessment of general relationship (scale 1-5)	138	3.48 (1.28) (n = 54)	2.96 (1.14) (n = 84)	6.09	.015
	Assessment of sexual relationship (scale 1-5)	137	2.30 (1.36) (n = 54)	2.07 (1.02) (n = 83)	1.21	ns

Table 10 : Single versus co-therapy : pre-treatment, therapist assessments

It appears therefore that couples attending for cotherapy are assessed as having less enjoyment of sexual contact and being more impaired in their general relationship, whilst there are no significant differences between the groups in the sexual relationship.

The same assessments conducted by therapists at the conclusion of treatment show the following:

	N	$\bar{X}$ Single (s.d.)	$\bar{X}$ Cotherapy (s.d.)	F ratio	Significance level
Enjoyment of sexual contact (scale 1-5)	108	4.14 (1.34) (n = 44)	4.03 (1.35) (n = 64)	.160	ns
Assessment of general relationship (scale 1-5)	108	4.41 (.90) (n = 44)	4.11 (1.17) (n = 64)	2.05	ns
Assessment of sexual (scale 1-5)	108	3.84 (1.52)	3.84 (1.36)	.000	ns

Table 11 : Single versus co-therapy : post-treatment, therapists assessments

There is now no significant difference between the groups. All groups show positive change, but the cotherapy group shows greater change than the single therapy group on enjoyment of sexual contact and in the general relationship. Both groups show similar change on sexual relationship scores, which are themselves slightly lower on

post-treatment assessment (as in pre-treatment assessment) than enjoyment of sexual contact and general relationship.

Change attributable to single- as against co-therapy procedures was examined, in view of the above table, by calculating change scores as the difference between pre- and post- treatment assessment scores.

	N	Single (s.d.)	Co-therapy (s.d.)	F ratio	Significance level
Enjoyment of sexual contact	144	1.28 (.18) (n = 54)	2.18 (.14) (n = 90)	1.12	.001
Assessment of general relationship	144	1.080(.12) (n = 54)	1.13 (.13) (n = 90)	0.45	.036
Assessment of sexual relationship	144	1.17 (.18) (n = 54)	1.19 (.11) (n = 90)	0.39	ns

Table 12 : Single versus co-therapy : change (improvement) scores

It is clear on the basis of this change score that cotherapy procedures have a stronger effect (produce more change) in the enjoyment of sexual contact and upon the general relationship than do single therapy procedures. However it is apparent from Table 10 above that the starting point of couples treated by cotherapy is worse on both these scales than for single therapy, whilst the actual state as assessed by therapists at the conclusion of treatment (Table 11) leaves couples in much the same position despite the actual procedure.

It is concluded therefore that cotherapy procedures affect the enjoyment of sexual contact and the general relationship more strongly than they affect the functioning of the sexual relationship, where they are neither more nor less effective than single therapy.

Couples' assessments of outcome

As described earlier, couples completed a 7-point self-report questionnaire immediately upon the conclusion of treatment (Appendix B) and each member of each couple completed the questionnaire separately. Table 13 below displays the results of immediate outcome for the first scale, A:[1].

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[1]. In the tables that follow, the sign + denotes significance at or beyond the .05 level, while the sign ++ denotes significance at or beyond the .01 level. These signs usually accompany a precise figure giving the actual level of significance, but are included as an aid to scanning the tabulated material.

A. Treatment has made our sexual relationship:

Considerably worse -:-:-:-:-:-:- Considerably better
so far as I am concerned so far as I am concerned

Single therapy n = 44		Cotherapy n = 62		F ratio	Significance level
$\bar{X}$	s.d.	$\bar{X}$	s.d.		
5.84	1.14	6.16	1.20	1.90	.171 ns

Table 13 : Single vs. Co-therapy : immediate outcome, couples assessment, effect of treatment in sexual relationship.

Under both conditions of treatment, couples report a change for the better in their sexual relationship, with a non-significant trend towards a slightly greater change under the cotherapy condition.

The second scale, B, asked each member of each couple to compare their sexual relationship before treatment with its state immediately upon the conclusion of treatment, and to record the extent of change in terms of howwell the expectations invested in presentation for

treatment had been met. Table 14 below records the outcome.

B. Thinking back to the time before we came for treatment and comparing our sexual relationship now with then, our sexual relationship now is:

not at all as I -:-:-:-:-:-:- very much as I hoped it would be hoped it would be

Single therapy		Co-therapy		F ratio	Significance level
n = 44		n = 62			
$\bar{X}$	s.d.	$\bar{X}$	s.d.		
4.66	1.89	5.42	1.75	4.54	.036 +

Table 14 : Single vs. Co-therapy: immediate outcome, couples' assessment, effect of treatment on sexual relationship in comparison with pre-treatment state

It is apparent that the cotherapy procedure is, from the client's point of view, more powerful in producing change in the sexual relationship in the desired direction than is the single therapy procedure. The same is seen in the fourth scale (Table 16 below) for the general relationship.

As the simplest possible statement of the clients' assessments of the efficacy of treatment, however, which was avowedly offered for direct help with sexual rather than general relationship difficulties, the third scale, C, asked for a simple judgement of the present state of the sexual relationship:

C. Our sexual relationship now is

not at all as I would want it to be -:-:-:-:-:-:- very much as I would want it to be

Single therapy n = 44		Co-therapy n = 62		F ratio	Significance level
$\bar{X}$	s.d.	$\bar{X}$	s.d.		
4.41	2.08	5.06	1.96	2.74	.10 ns

Table 15 : Single vs. Co-therapy, immediate outcome, couples' assessment, assessment of sexual relationship

Without there being a significant difference in outcome between the two procedures, the trend in favour of cotherapy is in the same direction as already noted. It is also clear that couples report only a limited level of satisfaction in the immediate outcome of treatment

based upon this (single vs. cotherapy) distinction.

The fourth scale, D, is similar to B except that it enquires after the general rather than the sexual relationship, and phrases the question more directly in terms of change rather than prior expectations.

D. Thinking back to the time before we came for treatment, and comparing our general relationship now with then, our general relationship is :

changed very much -:-:-:-:-:-:- changed very much
for the worse for the better

Single therapy		Co-therapy		F ratio	Significance level
n = 44		n = 42			
$\bar{X}$	s.d.	$\bar{X}$	s.d.		
5.75	1.20	6.34	1.o4	7.24	.008 ++

Table 16 : Single vs. co-therapy, immediate outcome, couples' assessment, effect of treatment on change in general relationship

Couples receiving cotherapy perceive greater change in their general relationship than do couples receiving single therapy; both however record higher mean scores for the treatment effects on the general relationship than on the sexual relationship (ref. Table 14 above).

An assessment of the partners' perceived feelings of satisfaction with the outcome of treatment was obtained by Scale E :

E. I think my partner would feel:

very dissatisfied with the outcome of treatment -:-:-:-:-:-:- very satisfied with the outcome of treatment

Single therapy n = 44		Co-therapy n = 62		F ratio	Significance level
$\bar{X}$	s.d.	$\bar{X}$	s.d.		
5.27	1.70	6.02	1.32	6.38	.013 ++

Table 17 : Single vs. co-therapy: immediate outcome, couples' assessment: assessment of partner's perceived feelings of satisfaction at outcome

Again the effects of cotherapy procedures can be seen in that higher partner satisfaction is ascribed by those couples undergoing cotherapy, and similarly, in Table 18, higher levels of partner's expectation about

personal (rater's) satisfaction with the outcome of treatment are accorded to the cotherapy procedures.

F. I think that my partner would think that I am :

very dissatisfied with -:-:-:-:-:-:- very satisfied with
the outcome of treatment the outcome of treatment

Single therapy n = 44		Co-therapy n = 62		F ratio	Significance level
$\bar{X}$	s.d.	$\bar{X}$	s.d.		
5.11	1.74	5.95	1.31	7.99	.006^{++}

Table 18 : Single vs. co-therapy, immediate outcome, couples' assessment: views ascribed to partners concerning rater's satisfaction with outcome of treatment

Table 19 shows the inter-correlations between the scales of immediate outcome:

Scale	A	B	C	D	E	F
A	1.0					
B	.61	1.0				
C	.51	.87	1.0			
D	.72	.50	.43	1.0		
E	.63	.70	.61	.59	1.0	
F	.66	.83	.77	.58	.81	1.0

Table 19 : Inter-correlations between scales of immediate outcome, couples' assessments

All scales are intercorrelated positively, and to a degree of significance beyond the .01 level.

External Assessor's view

For those couples returning for an external assessor's view of the functioning of the general and sexual aspects of the relationship, Table 20 displays the outcome:

External Assessor	N	$\bar{X}$ Single (s.d.)	$\bar{X}$ Co-therapy (s.d.)	F ratio	Significance level
General relationship	49	5.00 (0) (n = 16)	4.45 (.19) (n = 33)	3.94	ns (.053)
Sexual relationship	49	3.94 (1.24) (n = 16)	3.88 (1.58) (n = 33)	0.17	ns

Table 20 : Single vs. co-therapy: post-treatment, external assessor

The External Assessor shows no significant difference between the treatment procedures, but observes the same pattern of difference between the sexual and general relationship within the couples as therapists also recorded (Tables 11 and 12) - that the general relationship in the couples is seen as better than the functioning of the sexual relationship after treatment.

The first of the two operational questions raised the issue of whether marriage guidance counsellors would establish treatment results that were like or unlike those of an experienced clinician (see p. 5 above).

7.2 Clinician vs. counsellor

The first approach to the data was to look at treatment results for couples seen by PTB as against couples seen by counsellors.

It might be expected a priori that a qualified clinician with over ten years experience is likely to produce treatment effects that are different from, and probably greater than, counsellors trained and practising in a part-time voluntary capacity. Differences might be expected either in speed of treatment (sessions, weeks) or power (amount of improvement), or both.

The factual clinic data analysed in terms of the clinician/counsellor variable is as follows:

	N	$\bar{X}$ Clinician (s.d.)	$\bar{X}$ Counsellor (s.d.)	F ratio	Significance level
Age of clients	144	34.79 (11.11) (n = 54)	33.47 (8.76) (n = 90)	.633	.428 ns
Interval (weeks) from referral to seeking treatment	144	29.89 (15.58) (n = 54)	33.24 (15.56) (n = 90)	1.70	.194 ns
Interval (weeks) from assessment to starting treatment	144	20.74 (12.59) (n = 54)	27.09 (14.67) (n = 90)	7.01	.009 (.01)
No. of sessions of treatment	132	12.58 (4.81)	11.52 (5.09)	1.39	.241 ns
No. of weeks of treatment	132	18.31 (10.64)	16.07 (8.36)	1.81	.181 ns

Table 21 : Clinician vs. counsellor: factual data

The information presented is almost identical to that of Table 9 above, except that there is a significant difference between the number of weeks taken from assessment to starting treatment. The couples coming to the clinician wait significantly fewer weeks than do those attending counsellors. However, this appears to be an isolated effect, and is not reflected in the number of weeks in treatment or number of sessions in treatment. There thus appears to be no real difference in terms of speed of treatment between clinician and counsellors.

Table 22 presents the pre-treatment results of therapist ratings:

		$\bar{X}$	$\bar{X}$		
	N	(s.d.)	(s.d.)	F ratio	Significance level
Therapists ratings	Enjoyment of Sexual contact (scale 1-5)	139	2.20 (1.24) (n = 50)	2.68 (1.61) (n = 89)	3.41	.067 ns
	Assessment of General relationship (scale 1-5)	138	2.74 (1.24) (n = 50)	3.41 (1.15) (n = 88)	10.17	.002 ++
	Assessment of sexual relationship (scale 1-5)	137	1.94 (0.97) (n = 49)	2.28 (1.25) (n = 88)	2.80	.096 ns

Table 22 : Clinician vs. counsellor: pre-treatment, therapists' assessments

and shows that the clinician group is assessed as having significantly poorer general relationships before treatment than the counsellor group, and a tendency, not quite significant, to have lower enjoyment of sexual contact. After treatment, as Table 23 displays, the differences between the two groups are much the same; while all groups show change, their relative positions are unaltered.

		$\bar{X}$		$\bar{X}$			
	N		(s.d.)		(s.d.)	F ratio	Significance level
Therapists ratings	Enjoyment of sexual contact (scale 1-5)	108	3.84 (1.45) (n = 50)	4.28	(1.21) (n = 58)	2.90	.091 ns
	Assessment of general relationship (scale 1-5)	108	3.96 (1.07) (n = 50)	4.46	(1.03) (n = 58)	6.25	.014+
	Assessment of sexual relationship (scale 1-5)	108	3.58 (1.39) (n = 50)	4.07	(1.43) (n = 58)	3.24	.075 ns

Table 23 : Clinician vs. counsellor: post-treatment, therapists' assessments

Thus no difference can be seen between clinician and counsellor intervention. This is confirmed by Table 24, which shows the change scores under the clinician/counsellor conditions: (cf. Table 12 above).

	N	$\bar{X}$ (s.d.)	$\bar{X}$ (s.d.)	F ratio	Significance level
Enjoyment of sexual contact (scale 1 - 5)	144	11.78 (1.59) (n = 54)	11.88 (1.64) (n = 90)	.128	.721 ns
Assessment of general relationship (scale 1 - 5)	144	11.35 (1.35) (n = 54)	10.91 (1.16) (n = 90)	4.318	.040 +
Assessment of sexual relationship (scale 1 - 5)	144	11.74 (1.38) (n = 54)	11.83 (1.43) (n = 90)	.145	.704 ns

Table 24 : Clinician vs. counsellor: post-treatment change scores, therapists' assessments

The significant difference between the two groups is maintained on the general relationship scale, and neither of the other two scales shows a significant difference between the two groups.

Thus the couples who happen, without prior selection, to be allocated to the clinician treatment do not improve any more significantly than do those allocated to the counsellor categroy. It can be concluded therefore that on the basis of therapist assessment there is no difference between the clinician and counsellor variables so far as speed and power of treatment are concerned.

Couples' observations on outcome

There is no significant difference between the two conditions of treatment so far as the assessment of outcome by couples is concerned.

Table 25 displays this observation.

A. Treatment has made our sexual relationship

considerably worse so far -:-:-:-:-:-:- considerably better so far as I am concerned

Clinician		Counsellor		F ratio	Significance level
n = 48		n = 58			
$\bar{X}$	s.d.	$\bar{X}$	s.d.		
6.00	1.30	6.05	1.08	.05	.824 ns

B. Thinking back to the time before we came for treatment and comparing our sexual relationship now with then, our sexual relationship now is

not at all as I had hoped it would -:-:-:-:-:-:- very much as I hoped it would be

$\bar{X}$	s.d.	$\bar{X}$	s.d.		
4.98	1.98	5.21	1.72	.40	.529 ns

C. Our sexual relationship now is

not at all as I would want it to be -:-:-:-:-:-:- very much as I would want it to be

$\bar{X}$	s.d.	$\bar{X}$	s.d.		
4.58	2.13	4.96	1.94	.933	.336 ns

D. Thinking back to the time before we came for treatment, and comparing our general relationship now with then, our general relationship now is

changed very much -:-:-:-:-:-:- changed very much for the worse for the better

$\bar{X}$	s.d.	$\bar{X}$	s.d.		
6.12	1.10	6.07	1.18	.063	.803 ns

E. I think my partner would feel

very dissatisfied with -:-:-:-:-:-:- very satisfied with the outcome of treatment outcome of treatment

$\bar{X}$	s.d.	$\bar{X}$	s.d.		
5.65	1.36	5.76	1.67	.141	.708 ns

F. I think that my partner would think that I am

very dissatisfied with the -:-:-:-:-:-:- very satisfied with the outcome of treatment outcome of treatment

$\bar{X}$	s.d.	$\bar{X}$	s.d.		
5.52	1.49	5.67	1.61	.248	.619 ns

Table 25 : Clinician vs. counsellor: immediate outcome: couples' assessment, on six scales

The external assessor's ratings shows no difference between the two groups, as seen in Table 26 below:

	N	$\bar{X}$ Clinician (s.d.)	$\bar{X}$ Counsellor (s.d.)	F ratio	Significance level
General relationship	49	4.63 (.69) (n = 27)	4.63 (1.17) (n = 22)	.001	.98 ns
Sexual relationship	49	3.70 (1.68) (n = 27)	4.14 (1.12) (n = 22)	1.064	.308 ns

Table 26 : Clinician vs. counsellor : post-treatment, external assessor

However, it can be observed from Table 26 that the same tendency as previously observed in all the ratings appears again - that is, that scores for general relationship are higher than for sexual relationship, confirming the observation that, whatever the condition of treatment, the general relationship appears to be affected to a more marked extent than the sexual relationship.

The overall outcome of the analysis of the data by reference to the clinician vs. counsellor dichotomy is that there is no effect attributable to the variable.

The operational outcome from these observations is to provide positive evidence for a view that counsellors produce the same or similar treatment effects as a clinician.

A further means of looking at the counsellor/clinician variable was to consider the results of the first year's work as against the results of the second year.

7.3 1st vs. 2nd year

As will be recalled from the description of the setting of the clinics and the procedure and method (Section 5 above), in the first year the clinician (PTB) was the constant factor in therapeutic outcome, being the male therapist for all 18 couples treated;whilst in the second year a preponderance of couples were seen by counsellors in single- or co-therapy without PTB's involvement. It might therefore be expected that, if any specific effects were to be observed of counsellors as against clinicians, a comparison of the results as between first and second years might indicate areas of possible difference.

As already described, the first year of the study took place in the headquarters of the National Marriage Guidance Council at Rugby, whilst in the second year clinics were established in the local Marriage Guidance Council settings of the six centres used. These latter settings were typical of Marriage Guidance Council settings around the country - local facilities offering a simple consulting room, armchairs, and no ancillary equipment; held variably in the evening or the daytime; familiar and, to some extent, deliberately, low-key and anonymous. In contrast, the setting of the first year was one in which clients are not usually seen; many were conscious of reception facilities and high identification as 'special couples'; they were informed of, and introduced to, the counsellors listening in an adjacent room; had often made a considerable journey to attend; and were always seen during the daytime rather than the evening. From the point of view of forward planning, it seemed important to establish whether there were differences in the groups upon outcome that could be attributed to the circumstances of the clinic setting, and if so, in what direction these effects lay.

(It should be observed in this context that the clinic which continued in the original setting during the second year changed its character in almost all aspects to that of a typical second year clinic. The room in use was like other Marriage Guidance Council rooms; no equipment was apparent, or counsellors listening in an adjoining room, or particular emphasis placed upon the training/experimental nature of the clinic).

Factual data are as follows:

	N	$\bar{X}$ 1st year (s.d.)	$\bar{X}$ 2nd year (s.d.)	F ratio	Significance level
Age of clients	144	33.70 (10.51) (n = 40)	34.06 (9.42) (n= 104)	.041	.839 ns
Interval (weeks) from referral to starting treatment	144	28.40 (12.55) (n = 40)	33.36 (15.66) (n = 104)	3.221	.075 ns
Interval (weeks) from assessment to starting treatment	144	18.05 (7.26) (n = 40)	27.27 (15.39) (n = 104)	13.184	.0001 ++
No. of sessions of treatment	132	12.16 (3.85) (n = 38)	11.85 (5.44) (n = 94)	.100	.752 ns
No. of weeks of treatment	132	16.89 (10.03) (n = 38)	16.98 (9.12) (n = 94)	.002	.963 ns

Table 27 : 1st vs. 2nd year: factual data.

It appears from this data that there was in the second year a much longer waiting period between assessment and starting treatment than in the first year, but there are no effects upon the duration of treatment by sessions or weeks in the comparison between the two years.

Table 28 shows the results of pre-treatment assessment by the therapists.

	N	$\bar{X}$ 1st year (s.d.)	$\bar{X}$ 2nd year (s.d.)	F ratio	Significance level
Therapists' ratings: Enjoyment of sexual contact (scale 1 - 5)	139	2.08 (1.16) (n = 36)	2.66 (1.58) (n = 103)	4.029	.047+
Therapists' ratings: Assessment of general relationship (scale 1 - 5)	138	2.50 (1.13) (n = 36)	3.40 (1.17) (n = 102)	16.042	.001++
Therapists' ratings: Assessment of sexual relationship (scale 1 - 5)	137	1.94 (.97) (n = 35)	2.23 (1.22) (n = 102)	1.65	.201 ns

Table 28 : 1st vs. 2nd year: pre-treatment, therapists assessments

It is apparent that couples assessed in the first year are considered to have lower enjoyment of sexual contact, and poorer general relationships, than couples assessed in the second year. There is also a non-significant tendency for the couples of the first year to have poorer sexual relationship.

The overall statement about the couples of the first year is that they are assessed as presenting with problems of greater severity than in the second year.

Immediately upon conclusion of treatment, the following pattern of therapists' scores is apparent:

	N	$\bar{X}$ 1st year (s.d.)	$\bar{X}$ 2nd year (s.d.)	F ratio	Significance level
Therapists' ratings: Enjoyment of sexual contact (scale 1 - 5)	108	3.72 (1.52) (n = 36)	4.25 (1.21) (n = 72)	3.836	.053 ns
Therapists' ratings: Assessment of general relationship (scale 1 - 5)	108	3.92 (1.16) (n = 36)	4.39 (1.00) (n = 72)	4.813	.030+
Therapists' ratings: Assessment of sexual relationship (scale 1 - 5)	108	3.55 (1.38) (n = 36)	3.99 (1.43) (n = 72)	2.226	.139 ns

Table 29 : 1st vs. 2nd year: post-treatment therapists' assessment

Whilst it is not dissimilar to the pre-treatment scores, the strength of the significant differences on the first two scales is reduced, and inspection suggests that there is a stronger effect (larger change) operating in the first year than the second year, especially in the effect upon the general relationship.

An analysis of the change scores, Table 30, shows that on enjoyment of sexual contact, the two groups have changed in much the same manner, and there is no significant difference between them. On the general relationship scores, however, it is apparent that the groups have changed differently, confirming the observation by inspection that there are larger changes in the first year than in the second upon the general relationship.

		N	$\bar{X}$ 1st year (s.d.)	$\bar{X}$ 2nd year (s.d.)	F ratio	Significance level
Therapists' ratings	Enjoyment of sexual contact (scale 1 - 5)	144	11.82 (1.43) (n = 40)	11.84 (1.69) (n = 104)	.005	.944 ns
	Assessment of general relationship (scale 1 - 5)	144	11.57 (1.28) (n = 40)	10.88 (1.18) (n = 104)	9.38	.003+
	Assessment of sexual relationship (scales 1 - 5)	144	11.75 (1.21) (n = 40)	11.81 (1.48) (n = 104)	.066	.798 ns

Table 30 : 1st vs. 2nd year: post-treatment, therapists' assessment, change (improvement) scores

Immediately upon outcome, couples record no significant differences between the first and second year. Table 31 records this fact:

A. Treatment has made our sexual relationship

considerably worse so far -:-:-:-:-:-:- considerably better so far as I am concerned as I am concerned

1st year (n = 34)		2nd year (n = 72)		F Ratio	Significance level
$\overline{X}$	s.d.	$\overline{X}$	s.d.		
5.94	(1.39)	6.06	(1.08)	.270	.605 ns

B. Thinking back to the time before we came for treatment and comparing our sexual relationship now with then, our sexual relationship now is

not at all as I hoped it would be -:-:-:-:-:-:- very much as I hoped it would be

$\overline{X}$	s.d.	$\overline{X}$	s.d.		
5.06	(1.97)	5.12	(1.79)	.030	.864 ns

C. our sexual relationship now is

not at all as I would -:-:-:-:-:-:- very much as I would want it to be — want it to be

$\bar{X}$	s.d.	$\bar{X}$	s.d.		
4.73	(2.15)	4.82	(1.98)	.039	.843 ns

D. Thinking back to the time before we came for treatment and comparing our general relationship now with then, our general relationship now is

changed very much for the worse -:-:-:-:-:-:- changed very much for the better

$\bar{X}$	s.d.	$\bar{X}$	s.d.		
6.18	(1.17)	6.06	(1.14)	.257	.613 ns

E. I think my partner would feel

very dissatisfied with the outcome of treatment -:-:-:-:-:-:- very satisfied with the outcome of treatment

$\bar{X}$	s.d.	$\bar{X}$	s.d.		
5.59	(1.44)	5.76	(1.58)	.302	.584 ns

F. I think that my partner would think that I am very dissatisfied with the outcome of treatment				-:-:-:-:-:-:-	very satisfied with the outcome of treatment
$\bar{X}$	s.d.	$\bar{X}$	s.d.		
5.53	(1.48)	5.64	(1.59)	.114	.737 ns

Table 31 : 1st vs. 2nd year : immediate outcome; clients' assessment on six scales

The external assessor's scorings show no significant differences between the groups, as the following table shows:

		N	1st year (s.d.)	2nd year (s.d.)	F ratio	Significance level
Assessor's rating	General relationship	49	4.56 (.73) (n = 23)	4.69 (1.09) (n = 26)	.225	.638 ns
	Sexual relationship	49	3.56 (1.78) (n = 23)	4.19 (1.06) (n = 26)	2.309	.135 ns

Table 32 : 1st vs. 2nd year : post-treatment, external assessor

It is concluded, therefore, on the analysis by years, that therapists ascribe somewhat more significance to the first year circumstances than do either clients or the external assessor. This is seen in judgements about the effect of treatment upon changes in the general relationship of clients, which are held by therapists to have changed more extensively for clients attending during the first year than during the second.

It is possible that therapists were themselves variable, changing in their own expectations of themselves, their clients, and their consequential assessments of situations as the two years progressed.

The data provides no support for any expectation that a clinician is a more effective agent of change than counsellors.

The second operational question (see p. 4 above) concerned the length of treatment time involved when a modified Masters and Johnson procedure was instituted, without limitation of time.

7.4 Male and female dysfunctions

Within the data already presented, number of treatment sessions does not differ significantly between single- and cotherapy (Table 9 above), between clinician and counsellor (Table 21 above); or between first and second year circumstances of treatment (Table 27 above). In all settings treatment typically lasts 12 sessions ($\bar{X}$ = 11.94; range 3 - 24). Similarly the number of weeks in treatment does not vary under different conditions, being typically 17 ($\bar{X}$ = 16.95: range 3 - 45). There is a non-significant trend to suggest that single therapy takes a little longer than co-therapy, and that the clinician is partly responsible for this, having couples for a non-significant greater mean number of weeks in treatment than do counsellors.

However, once the therapist and circumstances variables are accounted for, there remains the fact that couples present with differing disorders. It has already been observed that Masters and Johnson recorded different treatment outcome rates for different disorders, but that these rates were obtained within a fixed time scale of treatment. It was considered appropriate therefore, to examine the question of duration of treatment by disorder and to observe also upon

variation in outcome between disorders, as observed by couples, therapists, and the external assessor.

Male Disorders

Table 33 below presents the factual data on the categories of male disorders presenting. As can be seen, 15 present with premature ejaculation, 11 with primary impotence, 17 with secondary impotence, 3 with retarded ejaculation, 0 with low sexual drive, and 23 males appear with their partner for treatment in the absence of any classifiable sexual difficulty. In the data collection 3 male records made classification doubtful, hence the total of 69 rather than 72.

		1. PREMATURE EJACULATION		2. PRIMARY IMPOTENCE		3. SECONDARY IMPOTENCE		4. RETARDED EJACULATION		5. LOW SEX'L DRIVE		6. NO CLASSIF'D DISORDER		F ratio	Significance level
	N	$\bar{X}$	(s.d.)	$\bar{X}$	(s.d.)	$\bar{X}$	(s.d.)	$\bar{X}$	(s.d.)	$\bar{X}$	(s.d.)	$\bar{X}$	(s.d.)		
Age of clients	69	31.27	(7.11) (n = 15)	39.64	(10.98) (n = 11)	39.35	(11.19) (n = 17)	37.67	(7.09) (n = 3)	-	-	31.65	(7.19) (n = 23)	3.246	.017+
Interval from referral to starting treatment	69	26.87	(10.55) (n = 15)	23.64	(12.20) (n = 11)	35.00	(13.93) (n = 17)	51.33	(28.18) (n = 3)	-	-	33.52	(15.94) (n = 23)	2.981	.025+
Interval from assessment to starting treatment	69	19.93	(11.23) (n = 15)	16.73	(11.41) (n = 11)	29.35	(13.98) (n = 17)	44.00	(22.60) (n = 3)	-	-	25.30	(14.44) (n = 23)	3.432	.013+
No. of sessions of treatment	64	11.29	(3.49) (n = 14)	13.00	(4.69) (n = 11)	11.61	(5.88) (n = 13)	18.33	(7.23) (n = 3)	-	-	11.87	(4.68) (n = 23)	1.479	.220 ns

No. of weeks of treatment	64	14.79(6.62) (n = 14)	19.45(11.80) (n = 11)	16.46(10.99) (n = 13)	28.00(12.77 (n = 3)	-	-	17.09(7.15) (n = 23)	1.494	.216	ns

Table 33 : Male Disorders: factual data

There are no significant differences between disorders in the number of treatment sessions or in the number of weeks in treatment. There is nevertheless considerable variation between the disorders on these parameters as the following expanded table illustrates:

	No. of sessions of treatment				No. of weeks in treatment		
Disorder	$\bar{X}$	s.d.	range	N	$\bar{X}$	s.d.	range
Premature Ejaculation	11.29	3.49	6-19	14	14.79	6.62	7-30
Primary Impotence	13.00	4.69	4-20	11	19.45	11.80	6-45
Secondary Impotence	11.61	5.88	3-23	13	16.46	10.99	3-39
Retarded Ejaculation	18.33	7.23	10-23	3	28.00	12.77	14-39
Low Sexual Drive	-	-	-	0	-	-	-

Table 34 : Male Disorders : duration of treatment data

Although small, the retarded ejaculation group characteristically stays in treatment for a longer number of sessions and weeks than do other groups though for all groups treatment may last as long as between 30 and 45 weeks at its upper range. The premature ejaculation group is characteristically the most rapidly treated group, both by numbers of sessions and weeks, and so is at the other end of the continuum from the retarded ejaculate group.

This factual clinic data does show a significant difference in age between the groups by disorder. The premature ejaculation group is significantly younger (31.27 years) than the primary impotence (39.64 years) and secondary impotence (39.35 years) groups. The retarded ejaculate group also appears to have waited longer for treatment than the other groups. Apart from the observation that the slowness in coming might be a generalised behaviour, there is no obvious reason for this long period and the consequential long interval from assessment to starting treatment. The range over the three cases for the interval from referral to starting treatment is markedly higher at both ends (29 - 83 weeks) than for other diagnostic groups.

Table 35 below shows the pre-treatment assessment by therapists.

		1. PREMATURE EJACULATION		2. PRIMARY IMPOTENCE		3. SECONDARY IMPOTENCE		4. RETARDED EJACULATION		6. NO DISORDER CLASSIFIABLE		F ratio	Significance level
	N	$\bar{X}$	(s.d.)	$\bar{X}$	(s.d.)	$\bar{X}$	(s.d.)	$\bar{X}$	(s.d.)	$\bar{X}$	(s.d.)		
Therapists' ratings: Enjoyment of sexual contact (scale 1-5)	69	2.87	(1.59)	1.54	(1.29)	4.00	(1.41)	3.00	(2.00)	2.91	(1.62)	4.321	.004 ++
		(n = 15)		(n = 11)		(n = 17)		(n = 3)		(n = 23)			
Assessment of general relationship (scale 1-5)	69	2.67	(1.11)	3.91	(1.22)	3.23	(1.14)	4.67	(0.58)	3.43	(0.94)	3.484	.012 ++
Assessment of sexual relationship (scale 1-5)	68	2.21	(0.97)	1.27	(.467)	3.=2	(1.45)	4.00	(1.00)	2.17	(1.34)	5.61	.001 ++
		(n = 14)		(n = 11)		(n = 17)		(n = 3)		(n = 23)			

Table 35 : Male Disorders : Therapists' assessment, pre-treatment

So far as enjoyment of sexual contact is concerned, the primary impotent group is assessed as significantly different from the secondary impotent group, and very low in the enjoyment of sexual contact. It is the general relationship of the premature ejaculation group which is assessed as the least good of the groups, and significantly distinguished from the retarded ejaculate group at the opposite end of the continuum, where almost no disturbance of general relationship is assessed, only points 4 and 5 of the scale being used by therapists. So far as sexual relationship is concerned, however, the primary impotent group is again assessed as having the worst, and it is significantly distinguished from the retarded ejaculate and secondary impotent groups at the other end of the scale.

Thus in the pre-treatment assessment the primary impotent group is seen as significantly poorer in enjoyment of sexual contact and sexual relationship than the secondary impotent group, whilst the retarded ejaculate group is assessed as having the best general and sexual relationship among the diagnostic groups.

Immediately upon the conclusion of treatment, therapists see couples as follows:

		1. PREMATURE EJACULATION	2. PRIMARY IMPOTENCE	3. SECONDARY IMPOTENCE	4. RETARDED EJACULATION	6. NO DISORDER CLASSIFIABLE		
	N	$\bar{X}$ (s.d.) (n=13)	$\bar{X}$ (s.d.) (n = 9)	$\bar{X}$ (s.d.) (n = 10)	$\bar{X}$ (s.d.) (n = 3)	$\bar{X}$ (s.d.) (n= 19)	F ratio	Significance level
Therapists' ratings								
Enjoyment of sexual contact	54	4.15 (1.21)	2.11 (1.45)	4.30 (1.34)	4.33 (1.15)	4.84 (0.50)	9.877	$>.001$ ++
Assessment of general relationship	54	4.15 (0.89)	4.11 (0.93)	4.20 (1.03)	4.67 (0.58)	4.58 (1.02)	.679	.610 ns
Assessment of sexual relationship	54	4.00 (1.47)	2.11 (1.27)	4.00 (1.25)	4.33 (1.15)	4.42 (0.96)	5.876	.001 ++

Table 36 : Male Disorders : Therapists' assessment, post-treatment

The primary impotent group is seen as having least enjoyment of sexual contact still, and the sexual relationship is assessed as still being the poorest. This group is distinguished in the score range by having a mean score post-treatment (2.11 on both scales) that is below the average of the scale (2.5). On both these scales the primary impotent group is again at the opposite (low) end of the continuum to the retarded ejaculate group, and it is possible to speculate upon the fact that the disorders are clearly distinguished by the male being able on the one hand to make an erection available (retarded ejaculate) and on the other not to be able to make it available at all (primary impotence).

After treatment the general relationship is assessed as being well towards the top end of the scale across all disorders, and after treatment there is no significant difference between the groups. There thus appears to be a beneficial effect of treatment upon the general relationship even in the absence of specific effects upon the sexual relationship.

Improvement (change) scores appear as follows (Table 37 below) :

			1. PREMATURE EJACULATION	2. PRIMARY IMPOTENCE	3. SECONDARY IMPOTENCE	4. RETARDED EJACULATION	6. NO DISORDER CLASSIFIABLE	F ratio	Significance level
		N	$\bar{X}$ (s.d.) (n = 15)	$\bar{X}$ (s.d.) (n = 11)	$\bar{X}$ (s.d.) (n = 17)	$\bar{X}$ (s.d.) (n = 3)	$\bar{X}$ (s.d.)		
Therapists' ratings	Enjoyment of sexual contact	69	1.16 (0.17)	1.11 (0.14)	1.12 (0.19)	1.13 (0.23)	1.18 (0.15)	.472	.756 ns
	Assessment of general relationship		1.15 (0.11)	1.01 (0.14)	1.10 (0.07)	1.00 (0.10)	1.11 (0.11)	3.524	.012 +
	Assessment of sexual relationship		1.20 (0.11)	1.08 (0.09)	1.13 (0.18)	1.03 (0.06)	1.20 (0.15)	2.553	.047 +

Table 37 : Male disorders :. Therapists' assessments, post-treatment, change (improvement) scores

Within the diagnostic groups there are no significant differences on enjoyment of sexual contact, all groups showing a change in the order of just over one scale point. On the improvement in general relationship scores, however, the retarded ejaculate group change to a significantly smaller extent than the premature ejaculation group. The fact of the small change in retarded ejaculate scores is not surprising in view of the observation that, in pre-treatment assessments, the upper reaches of the scale were already being used. The premature ejaculation group on the other hand show a marked improvement in general relationship, with a shift from a pre-treatment mean score of 2,67 to a post-treatment mean score of 4.15 (scale range 1 - 5), and make a larger shift than any other diagnostic group.

On the sexual relationship scores it is the premature ejaculation group that shows the largest change among the diagnostic categories and is significantly distinguished in the amount of change from the other diagnostic categories. Discounting again the retarded ejaculate scores, where the amount of potential change is restricted by the extent of the scale, the sexual relationship change scores show the smallest change for the primary impotent group. Considering the low pre-treatment assessment ratings for this category, it is apparent that the sexual relationship for the primary impotent group is affected to the least extent by treatment.

Immediately upon the outcome of treatment, the diagnostic categories do show differences on some of the scales, as is shown by the couples' ratings in Table 38.

	1. PREMATURE EJACULATION $\bar{X}$ (s.d.) (n = 12)	2. PRIMARY IMPOTENCE $\bar{X}$ (s.d.) (n = 9)	3. SECONDARY IMPOTENCE $\bar{X}$ (s.d.) (n = 10)	4. RETARDED EJACULATION $\bar{X}$ (s.d.) (n = 3)	6. NO CLASSIFIABLE DISORDER $\underline{X}$ (s.d.) (n = 19)	F Ratio	Significance level
N 53							
Scale (1-7)							
A	6.50 (0.67)	5.11 (1.76)	6.20 (0.79)	4.67 (1.15)	6.37 (1.01)	3.872	.008^{+}
B	5.92 (0.90)	4.22 (2.11)	5.00 (1.33)	4.00 (2.00)	5.42 (1.73)	1.954	.117 ns
C	5.42 (0.90)	3.55 (2.45)	4.60 (1.50)	4.67 (3.21)	4.89 (1.94)	1.356	.263 ns
D	6.33 (0.78)	5.11 (1.69)	5.90 (0.87)	5.33 (1.15)	6.37 (1.06)	2.510	.054 $^{+}$
E	6.33 (0.78)	4.33 (1.66)	5.60 (1.43)	5.00 (1.00)	6.00 (1.69)	2.947	.029 $^{+}$
F	6.08 (0.99)	4.55 (1.33)	5.40 (1.65)	4.00 (2.00)	5.95 (1.51)	2.768	.038 $^{+}$

Table 38 : Male disorders, post-treatment, couples' assessments

Taking the diagnostic groups one by one, it is apparent that after treatment the premature ejaculation group has a sexual relationship more rather than less as it would wish (scale C); feels that treatment has made the sexual relationship considerably better (scale A); has moved a good way towards establishing the kind of sexual relationship hoped for before the onset of treatment (scale B); feels the general relationship has changed considerably for the better (scale D) and slightly more than the sexual relationship; feels the partner would be more than satisfied with the outcome of treatment (scale E); and concludes that the partner would feel only slightly less satisfied than the rater's satisfaction at the outcome of treatment.

The primary impotence group finds after treatment that the sexual relationship now is equidistant from both the most negative and the most positive hopes for it (scale C); that treatment has made the sexual relationship somewhat better, and decidedly not worse (scale A), though not to the extent that might have been hoped in comparison with its pre-treatment state (scale B); the general relationship, in comparison with its state before treatment, has changed for the better (scale D) and to a greater extent than the sexual relationship; whilst it is felt that the partner would feel only marginally satisfied with the outcome of treatment (scale E) though with a somewhat higher expectation of the rater's satisfaction.

The secondary impotence group feel after treatment that there is still room for improvement in the sexual relationship, though it is more rather than less as respondents would wish it to be (scale C); it is felt that treatment has made the sexual relationship markedly better (scale A); that it has moved in the direction that might have been hoped before treatment (scale B); and that it has had a slightly more beneficial effect on the general relationship than the sexual, the former being changed for the better in comparison with the period before treatment (scale D); it is expected that partner satisfaction is slightly higher (scale E) than partner's expectations of respondent's satisfaction.

The retarded ejaculate group views the sexual relationship now as more rather than less as it would be wished, but with room for further improvement still (scale C); that treatment has made the sexual relationship somewhat,though not greatly, better (scale A), and that there is only a slight shift in the direction of how it was hoped it might be when a pre-treatment comparison is made (scale B); there is markedly more treatment effect observed upon the general than sexual relationship (scale D), and while it is felt that the partner would be more than satisfied with the outcome of treatment (scale E) it is thought that slightly less satisfaction would be attributed to the rater (scale F).

Comparing these four diagnostic groups, on their own assessment of the outcome of treatment, it is apparent that the premature

ejaculation and secondary impotence groups generally express a stronger response to treatment, and perceive more change as a consequence of treatment on both sexual and general relationships, than do primary impotent and retarded ejaculate groups.

When the therapists' and external assessor's post-treatment observations are taken into account too, it does appear to be the case that the retarded ejaculate group are markedly differentiated from the primary impotent group, the latter changing little from the most impoverished starting point, while the former changes little from a much stronger starting point. On those scales which show significant (A, E, F) or near significant (D) differences among the diagnostic groups, the premature ejaculation group is invariably the highest responding group, whilst the lowest responding alternates between the retarded ejaculate and primary impotence.

The external assessor shows no significant difference among the diagnostic groups on his assessment of the general relationship, though the trends are the same as for therapists' post-treatment assessment. The retarded ejaculate and secondary impotence group have the best general relationship, the primary impotence and premature ejaculation groups slightly worse, though all means are well above the mid-point of the scale in both therapists' and external assessor's ratings. In the sexual relationship however the external assessor does distinguish between the diagnostic categories, and concurs

with therapists' ratings in observing that the sexual relationships of the primary impotence group are significantly poorer than are those of the other diagnostic groups. Table 39 below displays the external assessor's general and sexual relationship scores for the diagnostic groups.

		1. PREMATURE EJACULATION	2. PRIMARY IMPOTENCE	3. SECONDARY IMPOTENCE	4. RETARDED EJACULATION	6. NO DISORDER CLASSIFIED		
	N	$\bar{X}$ (s.d.) (n = 5)	$\bar{X}$ (s.d.) (n = 4)	$\bar{X}$ (s.d.) (n = 3)	$\bar{X}$ (s.d. (n = 2)	$\bar{X}$ (s.d.) (n = 11)	F ratio	Significance level
Assessor's rating: Assessment of general relationship	25	3.60 (1.67)	4.50 (1.0)	5.00 (0.00)	5.00 (0.00)	4.91 (0.30)	2.28	.096 ns
Assessment of sexual relationship	25	3.60 (1.51)	1.75 (1.50)	3.00 (1.73)	4.50 (0.71)	4.73 (0.47)	5.961	.003 ++

Table 39 : Male Disorders : post-treatment, external assessor's ratings, general and sexual relationship

Female Disorders

This section presents similar detail to the section above but for female disorders.

Table 40 presents the factual clinic data:

	1. PRIM. ORG.	2. COITAL	3. M b.	4. RANDOM	5. VAG.	6. L.S.D.	7. N.C.D.	F ratio	Signi-ficance level
N	$\overline{X}$ (s.d.)	$\overline{X}$ (s.d.)	$\overline{X}$ (s.d.)	$\overline{X}$ (s.d.)	$\overline{X}$ (s.d.)	$\overline{X}$ (s.d.)	$\overline{X}$ (s.d.)		
Age of clients									
69	31.75(9.01) (n = 20)	33.89(10.90) (n = 9)	29.00(0.00) (n = 1)	34.95(8.92) (n = 21)	29.00(11.31) (n = 2)	26.50(3.87) (n = 4)	30.67(8.07) (n = 12)	.799	.589 ns
Interval from referral to starting treatment									
	31.10(14.35)	29.44(14.59)	27.00(0.00)	33.05(14.09)	32.50(4.95)	36.25(25.55)	30.42(19.12)	.144	.990 ns
Interval from assessment to starting treatment									
	24.25(14.58)	25.67(14.87)	26.00(0.00)	24.38(12.54)	25.50(4.95)	28.50(24.91)	23.08(17.59)	.077	.998 ns
No. of sessions of treatment									
64	11.16(5.64) (n = 19)	10.37(2.87) (n = 8)	8.00(0.00) (n = 1)	12.30(5.02) (n = 20)	14.50(2.12) (n = 2)	12.33(4.16) (n = 3)	15.00(4.58) (n = 11)	1.133	.355 ns
No. of weeks of treatment									
64	14.95(7.89)	13.12(4.88)	12.00(0.00)	18.40(9.77)	21.50(6.36)	13.33(4.51)	23.64(11.63)	1.178	.133 ns

Table 40 : Female Disorders : factual data

There are no significant differences between the disorders on any of the variables, and no systematic trends approaching significance. However, the range of number of weeks in treatment and number of treatment sessions is wide, as Table 41 below, illustrates, and is not dissimilar to the male disorders (see Table 34 above).

Disorder	No. of sessions of treatment $\bar{X}$	(s.d.)	range	N	No. of weeks of treatment $\bar{X}$	(s.d.)	range
1. 1^{o} orgasmic	11.16	5.64	3-24	19	14.95	7.89	3-30
2. Coital	10.37	2.87	7-15	8	13.12	4.88	9-20
3. Masturbatory	8.00	0.00	8	1	12.00	0.00	12
4. Random	12.30	5.02	4-23	20	18.40	9.77	6-39
5. Vaginismus	14.50	2.12	13-16	2	21.50	6.36	17-26
6. Low Sexual Drive	12.33	4.16	9-17	3	13.33	4.51	9-18
7. No disorder	15.00	4.58	10-23	11	23.64	11.63	10-45

Table 41 : Female Disorders : duration of treatment data

The pre-treatment assessment of female disorders by therapists is shown in Table 42 below :

		1.		2.		3.		4.		5.		6.		7.		
	N	$\bar{X}$	(s.d.)	$\bar{X}$	(s.d.)	$\bar{X}$	(s.d.)	$\bar{X}$	(s.d.)	$\bar{X}$	(s.d.)	$\bar{X}$	(s.d.)	$\bar{X}$	(s.d.)	F ratio	Significance level
Therapists' ratings: Enjoyment of sexual contact (scale 1-5)	69	1.75 (n = 20)	(0.97)	2.56 (n = 9)	(0.73)	1.00 (n = 1)	(0.0)	2.28 (n = 21)	(1.31)	1.00 (n = 2)	(0.0)	2.25 (n = 4)	(0.50)	2.17 (n = 12)	(1.55)	1.100	.372 ns
Assessment of general relationship (scale 1-5)	69	3.00	(1.12)	3.56	(1.13)	1.00	(.))	2.71	(1.38)	3.50	(0.71)	2.50	(1.29)	3.25	(1.42)	1.106	.369 ns
Assessment of sexual relationship (scale 1-5)	69	1.60	(0.68)	2.56	(0.88)	1.00	(0.0)	2.05	(0.86)	2.00	(1.41)	2.00	(0.0)	2.08	(1.31)	1.432	.217 ns

Table 42 : Female disorders : pre-treatment assessment, therapists' ratings

There are no significant differences between the groups. The scale position of scores is generally lower than for male disorders as Table 43 below shows, and as with male disorders the general relationship is given scale scores that are typically higher than the sexual relationship.

	Female Disorder				Male Disorder			
	Group $\bar{X}$	s.d.	range	N	Group $\bar{X}$	s.d.	range	N
Enjoyment of sexual contact	2.09	1.16	1 - 5	69	2.96	1.67	1 - 5	69
Assessment of general relationship	2.98	1.28	1 - 5	69	3.35	1.15	1 - 5	69
Assessment of sexual relationship	1.97	0.92	1 - 5	69	2.35	1.35	1 - 5	69

Table 43 : Female Disorders in comparison with male disorders, group data, scale range usage

Therapists' assessment immediately upon the conclusion of treatment shows no significant differences between the groups (Table 44 below), and this absence of difference is confirmed by the external assessor (Table 46 below)

Improvement (change) scores also fail to show any distinction between the groups (Table 45 below).

		1.	2.	3.	4.	5.	6.	7.	F	Significance
	N	$\bar{X}$ (s.d.)	$\bar{X}$ (s.d.)	$\bar{X}$ (s.d.)	$\bar{X}$ (s.d.)	$\bar{X}$ (s.d.)	$\bar{X}$ (s.d.)	$\bar{X}$ (s.d.)	ratio	level
	54	(n = 14)	(n = 8)	(n = 1)	(n = 15)	(n = 2)	(n = 3)	(n = 11)		
Therapists' assessment	Enjoyment of sexual contact	3.50(1.56)	4.25(1.16)	5.00(0.0)	4.53(0.74)	5.00(0.0)	3.00(2.00)	4.00(1.26)	1.519	.193 ns
	Assessment of general relationship	3.93(1.49)	4.50(1.07)	5.00(0.0)	4.40(0.83)	5.00(0.0)	3.00(1.73)	3.82(1.08)	1.212	.317 ns
	Assessment of sexual relationship	3.43(1.60)	4.37(1.06)	5.00(0.0)	4.07(1.28)	5.00(0.0)	3.33(2.08)	3.45(1.57)	.952	.467 ns

Table 44 : Female disorders, post-treatment, therapists' assessment

Comparison of Tables 44 and 46 by inspection suggests that while all groups show post-treatment change, the low sexual drive group (6) shows less change than the others, and, without there being significant effects attached to it, the change scores of Table 45 confirm this observation, where the amount of change in group 6 is slightly less on all three assessments than for other groups. This does not appear to be accounted for by a poorer starting position (Table 42 above).

		1.		2.		3.		4.		5.		6.		7.	F	Significance
	N	$\bar{X}$	(s.d.)	$\bar{X}$	(s.d.)	$\bar{X}$	(s.d.)	$\bar{X}$	(s.d.)	$\bar{X}$	(s.d.)	$\bar{X}$	(s.d.)	$\bar{X}$	(s.d.)	ratio	level
	69	(n = 20)		(n = 9)		(n = 1)		(n = 21)		(n = 2)		(n = 4)		(n = 12)			
Therapists' assessment	Enjoyment of sexual contact	1.20	(0.18)	1.18	(0.13)	1.40	(0.0)	1.21	(0.13)	1.40	(0.0)	1.12	(0.17)	1.18	(0.14)	1.117	.363 ns
	Assessment of general relationship	1.10	(0.11)	1.11	(0.08)	1.40	(0.0)	1.13	(0.16)	1.15	(0.07)	1.05	(0.06)	1.06	(0.12)	1.490	.196 ns
	Assessment of sexual relationship	1.19	(0.15)	1.20	(0.10)	1.40	(0.0)	1.20	(0.11)	1.30	(0.14)	1.15	(0.17)	1.13	(0.14)	1.166	.336 ns

Table 45 : Female Disorders, post-treatment change (improvement) scores, Therapists' assessments

		1.		2.		3.		4.		5.		6.		7.			
	N	$\bar{X}$	(s.d.)	$\bar{X}$	(s.d.)	$\bar{X}$	(s.d.)	$\bar{X}$	(s.d.)	$\bar{X}$	(s.d.)	$\bar{X}$	(s.d.)	$\bar{X}$	(s.d.)	F ratio	Significance level
		(n = 3)		(n = 4)		(n = 1)		(n = 9)		(n = 1)				(n = 6)			
Assessor's ratings	24																
	Assessment of general relationship	5.00	(0.0)	4.75	(0.£0)	5.00	(0.0)	4.22	(1.39)	5.00	(0.0)	-	-	5.00	(0.0)	.668	.652 ns
	Assessment of sexual relationship	4.33	(0.58)	4.50	(0.58)	5.00	(0.0)	3.44	(1.88)	5.00	(0.0)	-	-	4.00	(1.55)	.525	.754 ns

Table 46 : Female disorders, post-treatment, external assessors ratings

Immediately upon the outcome of treatment, no significant differences are recorded by the couples for the effects of treatment, as Table 47 below displays.

	1° ORG.	COITAL	M b	RANDOM	VAG.	L.S.D.			
	1.	2.	3.	4.	5.	6.	7.	F	Significance
	$\bar{X}$ (s.d.)	$\bar{X}$ (s.d.)	$\bar{X}$ (s.d.)	$\bar{X}$ (s.d.)	$\bar{X}$ (s.d.)	$\bar{X}$ (s.d.)	$\bar{X}$ (s.d.)	ratio	level
N	53 (n = 13)	(n = 8)	(n = 1)	(n = 15)	(n = 2)	(n = 3)	(n = 11)		
Scale (1-7)									
A	5.77(1.30)	6.50(1.07)	7.00(-)	6.27(1.16)	6.00(0.0)	5.67(1.53)	5.54(1.13)	.874	.522 ns
B	4.46(2.07)	6.12(0.99)	7.00(-)	5.40(1.68)	7.00(0.0)	4.67(3.21)	4.00(2.28)	1.780	.124 ns
C	4.08(2.39)	6.25(1.03)	7.00(-)	5.13(1.81)	7.00(0.0)	4.67(3.21)	3.91(2.34)	1.874	.106 ns
D	5.92(1.32)	6.50(0.93)	7.00(-)	6.33(1.05)	7.00(0.0)	6.00(1.00)	5.91(1.22)	.641	.697 ns
E	5.69(1.75)	6.62(0.74)	4.00(-)	6.07(1.03)	6.50(0.71)	5.00(2.65)	5.00(1.73)	1.512	.196 ns
F	5.23(1.54)	6.62(0.74)	7.00(-)	6.07(1.33)	7.00(0.0)	4.67(3.21)	4.91(1.64)	1.967	.090 ns

Table 47 : Female disorders : post-treatment, couples' assessments

By inspection it appears that the primary orgasmic and low sexual drive groups are least satisfied with outcome, although all mean scores are above the mid-points of all scales.

It is apparent again however that the general relationship (scale D) is affected more extensively for the better by treatment than the sexual relationship (scale B), though all groups record a strong positive effect of treatment upon the sexual relationship (scale A).

8. THE RESULTS WITH REFERENCE TO THE LITERATURE

As has been observed above, an empirical approach to Masters' and Johnson's work is rare at this stage in its development. Moreover, there are no studies which are directly comparable to the present study, in using an essentially volunteer counsellor group as therapists or in establishing open-ended time commitment to treatment.

However, one study (Mathews, Bancroft et al., 1976) bears consideration as it also considered the single vs. co-therapy question in an experimental clinical trial designed to investigate Masters' and Johnson's procedures in comparison with two other clinical procedures.

In the study in question, thirty-six couples were treated by one of three procedures:

1. Systematic desensitization plus counselling;
2. Directed practice - based on Masters and Johnson - plus counselling;
3. Directed practice with minimal contact - essentially a postal treatment procedure.

In groups 1 and 2 both members of each couple were seen together, but half in each treatment group were treated by a single therapist and half by a therapist pair. Treatment was limited to ten weeks after the initial assessment.

On the analysis of single vs. co-therapy effects, the cotherapy situation,using Masters' and Johnson's procedures, produced an interactive effect in which cotherapy with this procedure gave consistently (though not significantly) better outcome, as rated by therapists, than any other combination of therapist/treatment procedure. The authors conclude however that the results are inconclusive and it remains debatable whether the superiority, if real, of a cotherapy team is sufficient to justify the general adoption of a dual therapist team for the treatment of sexual dysfunction.

In support of the single therapist position, Prochaska and Marzilli(1973) point out that Masters and Johnson used no control groups in their work, which leaves unsupported their assertion that the dual sex therapy team is necessary. Frank and Wilson (1974) state that no research supports Masters' and Johnson's claim that the teams are essential, [1] and go on to cite clinical evidence that single male therapists can treat female dysfunctions successfully. Prochaska and Marzilli(op.cit.) assert that skill in marital counselling is the main component of effective treatment outcome for a single therapist treating a couple with a sexual dysfunction, which is supported by McCarthy (1973). Kaplan (1974)a views cotherapy as a useful training procedure, but not a necessary requirement of effective therapy.

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1 though this is circumlocutory, when there has been no research!

9. OBSERVATIONS DERIVING FROM THE CLINICAL WORK OF THE STUDY

It is in the nature of a clinical research programme that aspects of one's study become clearer in the course of practice, and would ideally have been part of one's questioning at the outset of the study and incorporated into the formulation of the experimental approach. It is equally in the nature of the growth of clinical skills and insight that, by such an approach to experiment, one would never start. It is the purpose of this section to record some observations which the research programme brought into sharper focus.

9.1 Diagnostic Concepts

Masters and Johnson (1970) offered a new structuring of the previously accepted diagnostic formulation of sexual difficulties, and established the following classifications :

Male Dysfunctions	Female Dysfunctions
Primary impotence	Primary orgasmic dysfunction
Secondary impotence	Situational orgasmic dysfunction
Premature ejaculation	i) Coital
Ejaculatory impotence	ii) Masturbatory
Low sexual drive	iii) Random
	Low sexual drive

The difficulty of dyspareunia was also noted as appearing in both the male and female, and vaginismus was also observed in the female, though not classed as a sexual dysfunction in its own right but as a precursor to orgasmic dysfunction of one form or another.

In their physiological work, Masters and Johnson had delineated a four-stage process of sexual arousal - the excitement, plateau, orgasmic, and resolution phases completing the cycle in both male and female. Kaplan (1974) offered the view that Masters' and Johnson's diagnostic formulations were unnecessarily complicated, in that they sub-divided orgasmic difficulties in the female to a degree not apparent in the physiological data; did not take sufficient account of difficulties of arousal; and did not maintain a close enough relationship to the physiological findings. While recognising that Masters and Johnson had contributed considerably in helping to abolish the concept of "frigidity" in the female, Kaplan questioned whether the alternatives proposed above were an adequate revision.

Kaplan herself also proposed that the term "impotence" contained the same kind of pejorative connotations for the male that"frigidity" contained for the female, and made the plea for abandoning the use of the term in favour of a concept more related to erectile difficulty. In practice, however, she continued to use the term "impotence" because of the cumbersome nature of an alternative such as 'erectile insufficiency.'

In considering that Masters' and Johnson's four-stage model of the sexual arousal/resolution process is unnecessarily extended, Kaplan

also observed that their physiological findings demonstrate no more than a two-stage process - arousal, mediated by the processes of vasocongestion; and orgasm, mediated by involuntary muscular responses under appropriate conditions of intensity of physical and/or psychological stimulation. She proposes, therefore, that a diagnostic schemata should take account of disorders of arousal and disorders of response, and suggests the following pattern :

Male Disorders	Female Disorders
Disorders of arousal:	Disorders of arousal:
Impotence (erectile insufficiency)	General sexual dysfunction
Disorders of response:	Disorders of response:
Premature ejaculation	General orgasmic dysfunction
Retarded ejaculation.	

The limited specificity of the female diagnostic terms is justified on the basis of Masters' and Johnson's and Kaplan's observations that sexual arousal and response is much more diffuse in the female than in the male, and so merits a rather more diffuse diagnostic terminology, in which a more detailed clinical description of aetiology in any one particular case is more important than a more detailed, but not necessarily more meaningful, diagnostic classification. Brown and Faulder, (1978) have presented a diagnostic classification which develops Kaplan's 2-stage process to include disorders of drive, and which also seeks to bring the dysfunction of vaginismus into the

scheme. The following diagnostic pattern suggests itself, and it is clear that the parallels between the male and female disorders may lead to useful analogies in treatment :

Disorders of -	Male	Female
Arousal	Erectile Insufficiency	General sexual dysfunction
Orgasmic response	Premature ejaculation	General orgasmic dysfunction
	Retarded ejaculation	
Intromission	Dyspareunia	Dyspareunia
	Anapriapism	Vaginismus
Drive	Hypersexuality	Hypersexuality
	Hyposexuality	Hyposexuality

It is suggested that this classification usefully exhausts the classification for dysfunctions, which in clinical practice are now

required to be clearly differentiated from the problems previously called sexual perversions and now more frequently referred to as sexual variations.

In the above scheme, the term "anapriapism" was coined in order to describe the male analogue of vaginismus in the female. The specific characteristic of vaginismus is spasm constriction of the lower third of the vaginal barrel upon any attempt at intromission, which has the effect of preventing intromission. Similarly, in the male there is a category of erectile difficulty in which the male experiences catastrophic loss of erectile function upon the point of intromission, thus effectively inhibiting insertion.

It is suggested that by bringing attention to the analogue with vaginismus and giving this particular difficulty a diagnostic category of its own, treatment approaches to the difficulty may separate it from the more general class of erectile difficulties and possibly, by drawing upon treatment parallels with vaginismus, establish similarly effective treatment outcomes.

Giving Sexual Knowledge and Information

In describing the pattern of treatment used in this study (Section 5.2.2 above), reference was made to sessions of formal history taking and sexual information giving.

In their treatment paradigm Masters and Johnson excluded direct physical contact with their patients, except in the context of routine medical examination, and/in the study reported here this exclusion was accepted. Since the inception of the study, however, there has developed a literature, of which Hartman and Fithian (1972) are the first proponents, arguing the case for a sexological examination. This is both a physical examination and an educational process, which seeks to teach couples by direct observation of their own sexual responses in the presence of therapists about the sexual response cycle.

Such a departure from the traditional clinical practice raises ethical questions regarding body involvement between client and therapist. In the context of this particular study it was considered that the shift that counsellors would have to make in developing their practices from an essentially reflective counselling model to one involving such direct physical contact was one that required an inappropriately large shift. Moreover, at a practical level, the typical Marriage Guidance Council setting does not provide

facilities for comfortable physical investigation and body observation. Nevertheless, the logic of this approach is demonstrated in part by the observations made in this study that routine medical examination did not demonstrate the four instances of physical difficulty in clients which did hinder the development of sexual responsiveness. (These difficulties were : in three men sexual excitement caused pain because of foreskin constriction; and in one woman, sexual excitement produced an irritant response in minor vaginal warts). It is possible that the treatment of sexual difficulties will move into a context which stresses sexual enrichment as its main focus, rather than recovery from sexual difficulties, and if this were to be the case, then treatment programmes involving a more direct involvement with the physical manifestations of sexual function will conceivably develop.

What is Co-therapy?

During the life of the research programme it proved possible to extend the author's knowledge of Masters' and Johnson's work by discussion with Dr. and Mrs. Sorrel, who had themselves been trained as cotherapists by Masters and Johnson. It became apparent in consequence, right at the end of the treatment programme, that cotherapy in the sexual function field as conceived by Masters and Johnson is not just a particular variant of conjoint therapy, in which

there happens to be a fourth partner making up the balance of the sexes, but is a therapeutic technique tightly bound by the ideas that

a) there is a format - the therapeutic foursome;

b) that there is a particular style of interaction - verbal interaction is only between members of the same sex and not across the sexes; [1].

c) that there is a clear explication of goals.

It is thus a more precise model of therapeutic interaction in its form as practised by Masters and Johnson than they have either described, or than has so far been practised spontaneously in this country, where only the involvement of two therapists and explication of goals have been seen as the main aspects of therapy format.

It is clear that there are a number of routes, professionally speaking, of arriving at an interest in sexual function work. Practitioners come from a counselling route, or a behavioural route, or via traditional psycho- or analytic therapy, and in the present state of development of the field it is clear that important contributions can be made from all directions. It is, however, possible that a stricter regard should be given to the particular nature of cotherapy intervention, as briefly described above, than has been characteristic of this study or of the other studies reported in this country using a modification of Masters' and Johnson's techniques.

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[1]. This is in fact in direct contradiction to Masters' and Johnson's published statement about therapist/client interaction in cotherapy (see p. 28 above). It remains an enigma, though the therapists trained by Masters and Johnson were adamant in discussion that verbal interaction in the treatment session was same-sex linked.

It may also be that a distinction needs to be made between the practice of cotherapy and the use of the cotherapy model as a training format. In the study reported here, an apprenticeship model was used - trainee therapists were involved as the functioning part of the therapy pair in the therapist/couple pair setting, and used the male (1st year) or female (2nd year) therapist as both colleague and model.

Some limited personal experience suggests, however, that working in a cotherapy setting with a colleague who is of equal clinical experience changes the nature of the professional experience for the cotherapist quite markedly. The professional relationship is much more that of equals than of learner/expert, and so the treatment encounter for couples seems to flow and extend itself much more considerably than in the situation where one of the therapist pair is manifestly learning.

Whilst these observations are perhaps not surprising retrospectively, they have not been explicated in the literature, and it may be in the future that a distinction ought to be drawn between cotherapy as practised between trained cotherapists of more-or-less equal clinical standing, and cotherapy which is established as a training experience for one of the therapists.

A final aspect of cotherapy that requires more detailed exposition

relates to the nature of cotherapy itself. The question of whether to pursue training or therapy programmes in co- or single therapy, or both, may rest not only upon a question of the demonstrable therapeutic efficacy of either, but upon other considerations which concern the nature of the therapeutic exercise and its underlying purposes for the therapists themselves. It is a not unfamiliar statement that individuals entering the psychotherapeutically related professions do so in response to a variety of their own needs, of which one is an overt wish to be of benefit to others. In the treatment of sexual difficulties in the cotherapy format, however, such a statement would need to expand upon the covert and overt sexual implications of the choices being made by the cotherapists. While it may at this stage not be possible to elucidate the potential difficulties and advantages implicit in cotherapy, and the means of containing and utilising them, it is an issue of which potential cotherapists may need to be aware. It is a matter of observation that a large number of cotherapists tend to be spouses of, or in an established sexual relationship with, their cotherapist. While of course an established sexual relationship with a cotherapist is by no means a sine qua non for cotherapy, the frequency of the nature of an intimate relationship between cotherapists appears to be more than a matter of chance.

Woody and Woody (1973) have attempted to examine this matter to some extent, as has Kaplan (1974a). The Woodys' formulation proposes that cotherapy involves a particular aspect of caring on the part of each

cotherapist for the other which extends beyond the normal professional concerns of one colleague for another, though they do not undertake discussion whether or not it necessarily involves sexual intimacy.

It is not the intention of this section to resolve these issues, simply to observe upon them as issues which require detailed consideration in the development of cotherapy training and treatment programmes.

Consideration of this issue among intending or practising therapists does, however, raise especially the question of the 'uninvolved spouse'.

If it is, as Woody and Woody suggest, a characteristic of cotherapy that a caring relationship of a particular kind develops between cotherapists, then in the same way that there is no uninvolved partner in a sexually dysfunctioning relationship, there may be no uninvolved partner in a cotherapy relationship where the cotherapists are not themselves active marital or sexual partners. The late Dr. Tonge (in personal discussion) considered this matter to be one requiring clear explication between the involved 'uninvolved spouses'. The incorporation of non-therapist spouses into the more sexually explicit parts of therapists training programmes would be one approach to an active and appropriate consideration of this issue.

10. IN CONCLUSION

The text of this thesis has contained very little discussion of the assumtpions underlying the investigative procedures adopted, and has not generally sought to discuss alternative inferences that might be drawn from the data.

Some justification of these observations seems appropriate, lest a deliberate strategy fails under attack for want of an appropriate defence.

The opportunity to be discursive on an inferential basis about alternative explanations for results rests, I suggest, upon the tightness of experimental design and procedure, and where both design and procedure can be shown to have a clear link to results and where the results are understood within the limitations and freedoms (statistical and inferential) of the design and procedure. Paradoxically the tighter the design and procedure and the more controlled the experimental variables the greater freedom there is to discuss alternative explanations for results because the sense, or nonsense, of alternative explanations can be tested by reference to design and procedure. This mix of tightness and freedom occurs most readily under those laboratory conditions where elegant multivariate designs attack a null hypothesis in a replicable fashion.

In naturalistic settings, however, the experimenter is more an observer of events than a systematic manipulator of variables, and can therefore hope only to illuminate rather than demonstrate. The illumination may be improved by the systematic collecting of data and subjecting that data to appropriate analysis. This procedure is not experimental though in the sense that the natural sciences have developed that concept; yet it is more than experiential. It relies on externalised facts (data) whose substance is inevitably open to question. The more inferences are made, the more insubstantial becomes the facts because they are drawn from observation, not experiment. If one is to proceed at all in naturalistic settings the substance of the facts may be no greater than the face validity accorded to them by competent observers agreeing upon them. Campbell and Stanley (1966) have discussed this process of what they call 'quasi-experimental' procedures from a statistical point of view. In the context of the presentation of a thesis, competent persons establishing face validity are those colleagues to whom the work is addressed and by whom it is assessed, as well as its reception in the public domain. It is in the latter context that the statement of the then Secretary of State for Social Services in the House of Commons upon the outcome of the work is included as the final aspect of the presentation:

The naturalistic setting of the National Marriage Guidance Council and the clinics that were established for the purposes of the study

precluded the establishing of control group designs so far as the treatment procedures were concerned, so that there was no direct attempt to assess the efficacy of the modified treatment procedure adopted. That it was effective in producing beneficial change there was no doubt from clinical observation and the systematic scale reports of couples. Whether or not this was better than chance, or no treatment, or any other treatment, it was not the purpose of the study to determine. Had there been no change of course, the question of central concern regarding the relative effectiveness of cotherapy and single therapy would have been unanswerable in the context. It was considered however that this question did have meaning, and could be systematically investigated, in the naturalistic setting that was available and, moreover, that this could be done in such a way that the answers deriving therefrom could be generalised into the continuing work of the National Marriage Guidance Council. In the event, the quasi-experimental approach might as readily be called 'the experiential method made more public' .

The quasi-experimental method does not give excuse, however, for not continuing to observe and ask questions, and in the light of the experience of conducting this study some observations are made below about future directions in the context of conclusions as to what this study has added to knowledge of the efficacy of

cotherapy procedures. They follow a brief reiteration of the main substance of the outcome of the study, by way of synthesis and conclusion.

The central question (Section 7.1) considered whether the situation of having two therapists was a sine qua non of successful treatment outcome. To this end different client couples were treated by one or two therapists, there being no prior selection of which couples entered which treatment procedure. A pre- and post-treatment assessment was made by therapists on a number of scales that have been described, and couples themselves made individual and independent assessments of their responses to treatment. A distinction was made between effect upon general relationship, sexual relationship, and sexual functioning. An independent external assessor also made judgements after treatment upon outcome.

Therapists assessed couples who had engaged in cotherapy as showing greater change in their general relationship and in their enjoyment of sexual contact than did couples who had engaged in single therapy, and following the expansion of this observation in the text it was concluded that cotherapy procedures affect the enjoyment of sexual contact and the general relationship more strongly than they affect the functioning of the sexual relationship, where they are neither more nor less effective than single therapy procedures. Couples reported in

favour of cotherapy affecting change in sexual relationship more strongly than single therapy, but that neither procedure was significantly stronger than the other in establishing a sexual relationship of the kind that was wanted, though there was a trend in favour of cotherapy. The general relationship was affected more by cotherapy than single therapy procedures, and the outcome of therapy was assessed as more satisfactory under cotherapy conditions. The external assessor showed no significant difference between the two, though with a smaller n than in the main body of the data he did also demonstrate a marked trend in favour of the cotherapy procedures.

It appears possible to conclude therefore that while both cotherapy and single therapy procedures produce change, cotherapy procedures produce greater change in the general and sexual relationship than do single therapy procedures. The procedures are not however distinguished in their capacity to produce change in the sexual functioning of the couples, though both do produce change.

These are the central results of the study. The question of the differentiation between general relationship, sexual relationship and sexual functioning is taken up further below.

A number of observations were also made around two operational

questions - whether counsellors produced results that were like or unlike those of a clinician; and what the duration of treatment proved to be when Masters' and Johnson's intensive procedures had been modified for use in a weekly attendance, non-residential setting.

So far as duration of treatment was concerned, it was established that across all disorders treatment typically took twelve sessions over seventeen weeks, and that while there was no significant difference on these parameters between disorders there was considerable variation between and within disorders for both men and women.

So far as the difference between clinician and counsellors was concerned, none of any operating significance were observed by therapists, clients or the external assessor.

While the significant trends of this study are quite clear, the central results of the study leave an equivocal position regarding an answer to the central question, and this arises from the distinction between general relationship, sexual relationship, and sexual functioning.

It is possible to observe, in retrospect, that the scales used in the study by therapists and clients (Appendices B, C & D) distinguished between the non-sexual aspects of the relationship,

the sexual enjoyment/pleasure aspects of the relationship, and the sexual functioning or performance of the couple together. The significant cotherapist effect is established in regard to the general relationship and enjoyment of the sexual relationship rather than in regard to the sexual functioning of the couple, even though both conditions of treatment affect all three aspects. But this leaves an area of uncertainty as to what it might have been that couples were recording in responding to questions about their sexual relationship, as it is not possible to distinguish on the couples' rating scale (Appendix B) between sexual relationship and sexual functioning, whilst it is possible to make this distinction on the therapists' rating scales (Appendix C & D). It is apparent, again in retrospect, that the wish to avoid a sexual performance/achievement orientation in the scales presented to couples has led to the differentiation between enjoyment and function being obfuscated, though this distinction has itself arisen out of the study, in the analysis of therapists' ratings, and so the obfuscation is one of experimental discovery rather than prior neglect.

Future work might explore this area more unequivocally. Masters and Johnson have demonstrated a treatment procedure that, in a specific context and using two therapists, has produced considerable therapeutic results. This study, in a different context, lends support to their view that the presence of two therapists is therapeutically advantageous. It has however

also raised the question as to whether the effects of two therapists are to be seen more upon the relationship and the enjoyment of the sexual relationship than upon the sexual function of the couple, and it is in pursuing this question that further elucidation of Masters' and Johnson's work will arise.

The main conclusions of this study have been drawn in the recognition that the problems of ceiling effects on scale score data leave some room for uncertainty as to the full weight that can be accorded the conclusions; and that this uncertainty is reinforced by the observation that, in the analysis of single- vs. co-therapy data (pp 152-167 above), the cotherapy group are assessed by therapists prior to the inception of treatment as being more impaired in enjoyment of sexual contact and in the general relationship than the single therapy group. In consequence it could be argued that no treatment effects can be assigned to cotherapy that distinguish it from single therapy.

However, the conclusions that have been drawn from the data as presented are, it is suggested, the most likely conclusions when the overall picture of scale usage is examined. In the analysis of diagnostic groups, for instance, (pp 194-223 above), it is apparent that the variability of change across the groups shows that the scales are used consistently and sensitively. Moreover throughout the study there is a high degree of concordance between therapists, couples and external assessor in the direction of change in scale scores.

APPENDICES

APPENDIX A

Diagnostic Checklist

COUNSELLOR TRAINING

Diagnostic Check List.

Co-therapists

Clients

Date

Diagnosis

Male

1. Primary impotence
2. Secondary impotence
2a. Secondary impotence with 3
2b. Secondary impotence with 4
3. Premature ejaculation
4. Ejaculatory incompetence

Female

1. Vaginismus
2. Dyspareunia
3. Primary orgasmic dysfunction
4. Random orgasmic inadequacy
5. Coital orgasmic inadequacy
6. Masturbatory orgasmic inadequacy

Check list completed after:-

1. Hello
2. Interview 1
3. Co-therapists' discussion
4. Interview 2
5. Co-therapists' second discussion
6. Roundtable.

Interview observed:- Therapist/Client

MM
MF
FM
FF

Counsellor:- .....

APPENDIX B

Couples' Rating Scale

NAME:

DATE:

On the attached sheet are six statements about aspects of the treatment programme you have undergone with us here. Beneath each statement is a scale for recording how you yourself assess the relevance of each statement to yourself.

Please place one cross on each scale to record your assessment.

For example, on the following statement

I am miserable - : - : - : - : - : - : - I am happy

a cross placed on the very left-hand line, thus

X
- : - : - : - : - : - : -

would mean "I am miserable".

A cross placed at the other end

- : - : - : - : - : - : X

would mean "I am happy". And a cross placed right in the middle

- : - : - : X : - : - : -

would mean "I am in between, neither happy nor miserable".

So the further away from the middle, in either direction, that you place the cross on one of the seven lines the more you feel like the statement at that end of the line.

We are asking you and your partner to fill in a sheet separately. Please do it as honestly as you can from your point of view. It is important to us in evaluating the treatment programme here to know what the people experiencing it really got out of it.

Treatment has made our sexual relationship

A. Considerably worse so far as I am concerned — - : - :- : -: - : - : - — Considerably better so far as I am concerned

Thinking back to the time before we came for treatment, and comparing our sexual relationship now with then, our sexual relationship now is

B. Not at all as I hoped it would be — - : - : - : - :- : -: - — Very much as I hoped it would be

Our sexual relationship now is

C. Not at all as I would want it to be — - : - : - : - : - : - : - — Very much as I would want it to be.

Thinking back to the time before we came for treatment, and comparing our general relationship now with then, our general relationship is

D. Changed very much for the worse — - : - : - : - : - : - : - — Changed very much for the better.

I think my partner would feel

E. Very dissatisfied with the outcome treatment — - : - : - : - : - : - : - — Very satisfied with the outcome of treatment.

I think that my partner would think that I am

F. Very dissatisfied with the outcome of treatment — - : - : - : - : - : - : - — Very satisfied with the outcome of treatment.

APPENDIX C

Therapists' Rating Scale.

THERAPISTS' RATING SCALE

Male Partner ..... Pre-treatment (after interview)

Female partner .....

Therapist ..... Post-treatment

Date .....

1. Enjoyment of Sexual contact

M	F	
0-	0-	Finds sexual contact unpleasant or anxiety-provoking on majority of occasions.
1-	1-	Gets no pleasure from sexual contact at any time.
2-	2-	Enjoys sexual contact occasionally, but on the majority of occasions does not.
3-	3-	Enjoys sexual contact on approximately half of the occasions.
4-	4-	Enjoys sexual contact on the majority of occasions.

2. Erectile Function

0- Never gets an erection.
1- Gets an erection but never in loveplay with partner.
2- Gets erections in love-play with partner, but never sufficient for S.I.
3- Gets erections in love-play with partner, but sufficient for S.I. on less than 50% of occasions.
4- Gets erections in love-play with partner, sufficient for S.I. on more than 50% of occasions.
8- Cannot be rated (e.g., because S.I. is not attempted for some reason other than impotence)
9- Not applicable (impotence has not been a clinical problem during the pre-treatment, treatment and follow-up period)

3. Ejaculatory Function

i) Premature
0- Never occurs in waking state
1- Occurs in waking state but never in partner's presence.
2- Occurs during love-play with partner, but not during S.I.
3- Occurs during S.I. on less than 50% of occasions.
4- Occurs during S.I. on more than 50% of occasions.
8- Cannot be rated.
9- Not applicable.

ii) Retarded
0- Can never ejaculate in waking state
1- Can ejaculate alone, but never in front of partner
2- Can ejaculate during love-play, but not during vaginal intercourse
3- Can sometimes ejaculate during vaginal intercourse, but less than 50% of occasions
4- Can usually ejaculate during vaginal intercourse (more than 50% of occasions)
8- Cannot be rated
9- Not applicable.

4. Female sexual interest and arousal.

0- Repulsed by thought of sexual activity
1- No interest or desire at any time
2- No spontaneous interest or desire but slight or occasional arousal during love-play (feeling of involvement)
3- Occasional spontaneous interest or desire,andor moderate arousal during love-play. (Presence of vaginal lubrication).
4- Frequent spontaneous interest or desire and/or marked arousal during loveplay.

5. Orgasm.

0- Never occurs in waking state
1- Occurs in waking state, but never in partner's presence
2- Occurs in love-play with partner but not during S.I.
3- Occurs during S.I. on less than 50% of occasions
4- Occurs during S.I. on more than 50% of occasions.
8- Cannot be rated
9- Not applicable.

6. Vaginal Entry.

0- Will not allow partner to touch her genitalia
1- Will allow stimulation of external genitalia, but not vaginal entry.
2- Will allow vaginal entry of finger but not penis
3- Will allow vaginal entry of penis, but with difficulty on more than 50% of occasions
4- Will allow vaginal entry of penis, with difficulty on less than 50% of occasions
8- Cannot be rated
9- Not applicable.

APPENDIX D

Assessor's Rating Scale

ASSESSOR'S RATING SCALE

General Relationship with Partner (other than sexual)

0) Severe impairment. Feelings almost wholly negative, patient feels that he/she cannot continue living with partner unless improvement occurs.
1) Marked impairment. Feelings tend to be negative, very frequent nagging, quarrels or friction. Predominating feeling of dissatisfaction.
2) Moderate impairment. Feelings positive on the whole, frequent nagging, quarrels or friction. Definite expressed dissatisfaction.
3) Mild impairment. Positive feelings, but occasional nagging, quarrels or friction causes some expressed dissatisfaction.
4) Satisfactory. Positive affection, no expressed dissatisfaction.

Sexual Relationship

0) Severe impairment. Sexual intercourse impossible or abandoned.
1) Marked impairment. Performance very rarely adequate, not at all enjoyable, inclination definitely negative.
2) Moderate impairment. Performance frequently inadequate, not usually satisfying or enjoyable, inclination usually indifference or negative.
3) Mild impairment. Performance variable, not always satisfying and enjoyable, inclination often lacking.
4) Satisfactory. Sexual performance adequate and usually or always satisfying and enjoyable.

Client .....

Therapist .....

Date .....

Pre-treatment (initial assessment)
Pre-treatment (after history-taking and before round table)
Post-treatment (at conclusion of final interview)
Post-treatment (external assessor).

APPENDIX E

Medical Assessment, Male.

MALE

Date ..... Due to start at N.M.G.C. .....
Name .....
Age ..... Occupation .....
Address .....
G.P. .....
Marital status including length .....
previous marriage .....

HISTORY

Pregnancy history .....
difficulties .....
Contraception.....
Frequency coitus .....
% orgasmic response .....
difficulties .....
Previous treatment etc. .....
.....

Systems

Skin .....
ENT .....
Eyes .....
Cardiac .....
Resp. .....
G.I. .....
G.U. .....
C.N.S. .....
Endocrine .....

P.H. Childhood illnesses .....
Major illnesses .....
Operations .....
Injuries .....
Alcohol .....
Tobacco .....

F.H. Mother .....
Father .....
Siblings .....

EXAMINATION

Weight ..... Height .....
B.P. .....
General appearance .....
Skin and hair .....
Eyes .....
Mouth ..... Ears .....
Neck ..... CUS .....
Lungs ..... Abdomen .....
Skeletal .....
Lymphatic ..... CNS .....
Ext. genitalia .....
P.R. .....
Hb. etc. .....
Electrolytes .....
Urine .....
L.F.T's .....
P.B.I. .....
W.R. .....
etc.
G.C.F.T. .....

APPENDIX F

Medical Assessment, Female.

FEMALE

Date ..... Due to start at N.M.G.C. .....
Name .....
Age ..... Occupation .....
Address .....
.....
G.P. .....
Marital Status including length .....
Previous marriage .....

HISTORY

Pregnancy history .....
difficulties .....
Contraception .....
Frequency Coitus .....
% Orgasmic Response .....
difficulties .....
Previous treatment etc. .....
.....

Menarche and Menstrual History .....
.....
.....

Post Gynaecological History .....
.....
.....
History of Vaginal Discharge .....
.....
.....

Systems

Skin .....
ENT .....
Eyes .....
Cardiac .....
Resp. .....
G.I. .....
G.U. .....
C.N.S. .....
Endocrine .....

P.H. Childhood illnesses .....
Major illnesses .....
Operations .....
Injuries .....
Alcohol .....
Tobacco .....

F.H. Mother .....
Father .....
Siblings .....

EXAMINATION

Weight ..... Height .....
B.P. .....
General appearance .....
Skin and Hair .....
Eyes .....
Mouth ..... Ears .....
Neck ..... CUS .....
Lungs ..... Abdomen .....
Skeletal .....
Lymphatic ..... CNS .....
Ext. genitalia .....
P.V. .....

Hb. etc. .....
Electrolytes .....
Urine .....
L.G.T's .....
P.B.I. .....
W.R. etc. .....
Smear .....
Vaginal swab .....

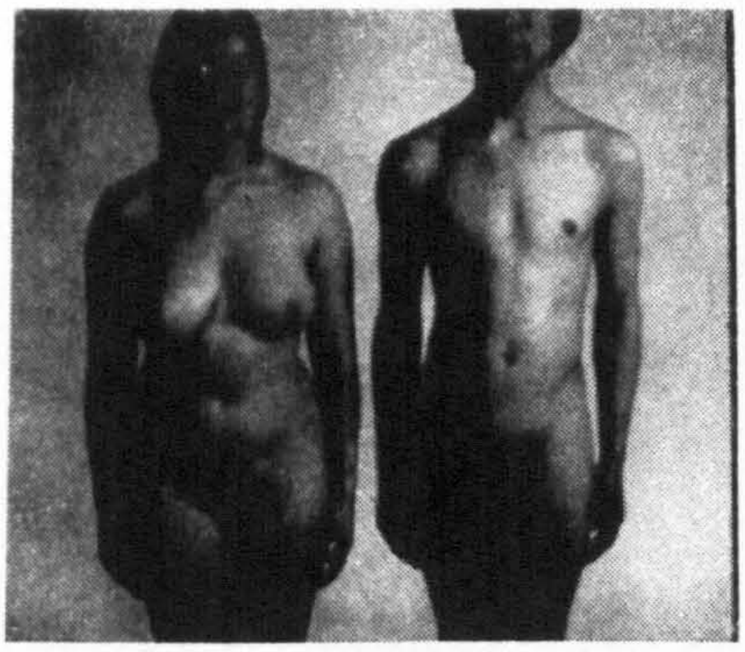
APPENDIX G

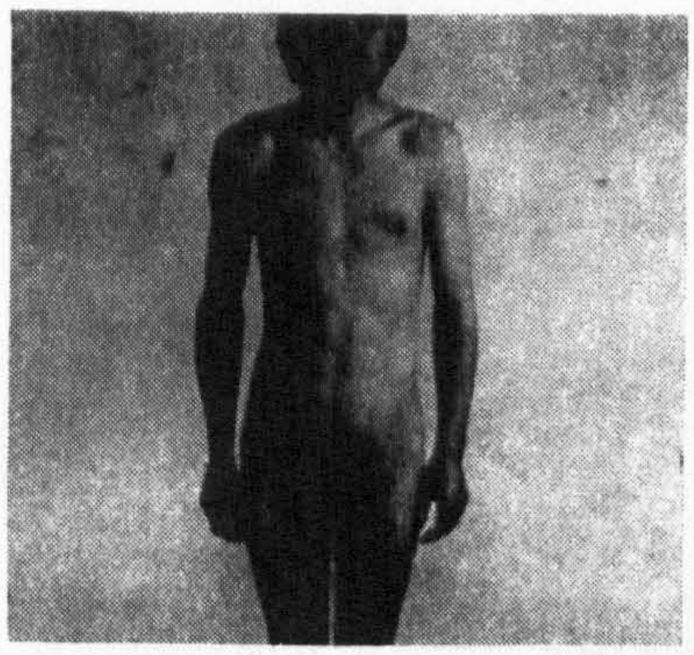
Photographic material for

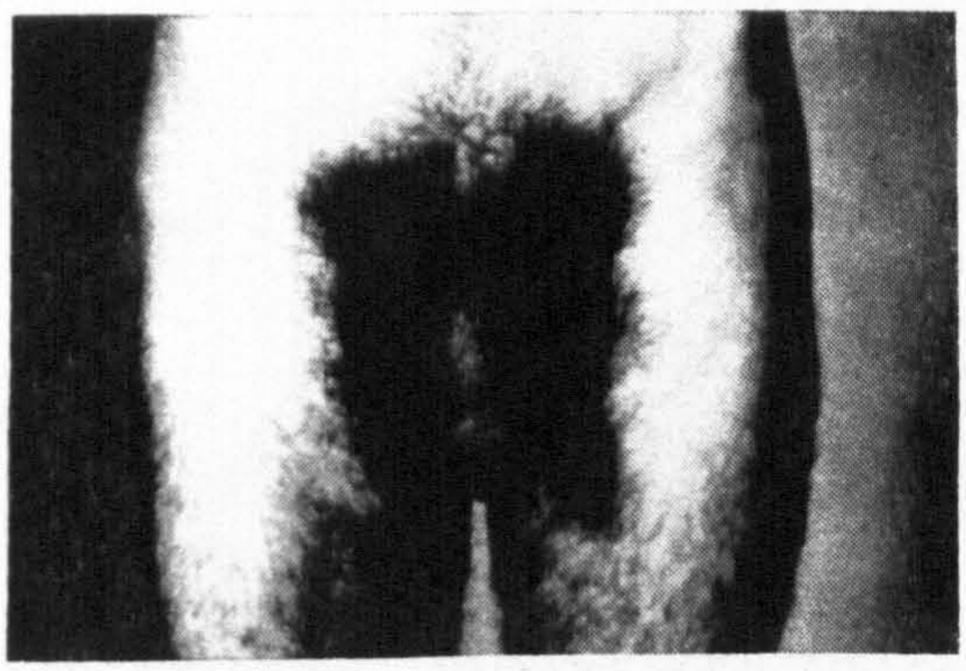
information session

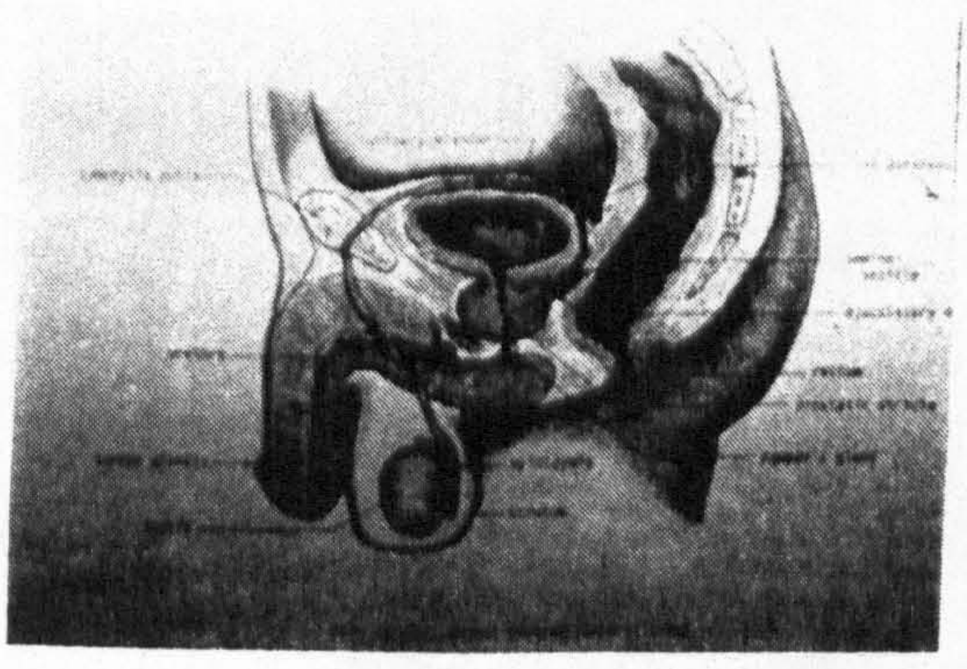
with couples.

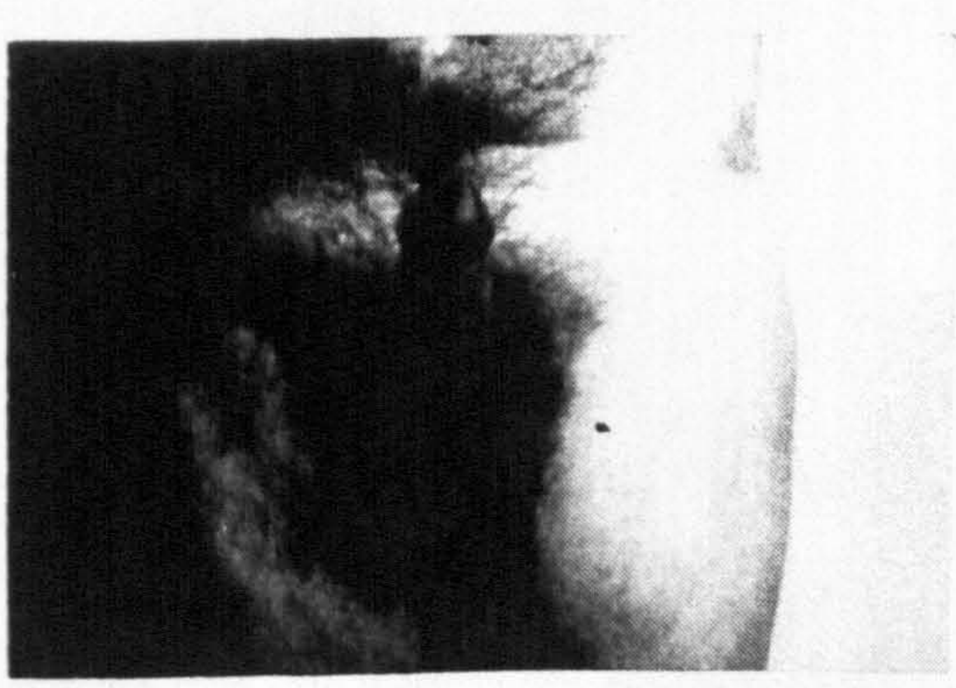
(see footnote to p.151).

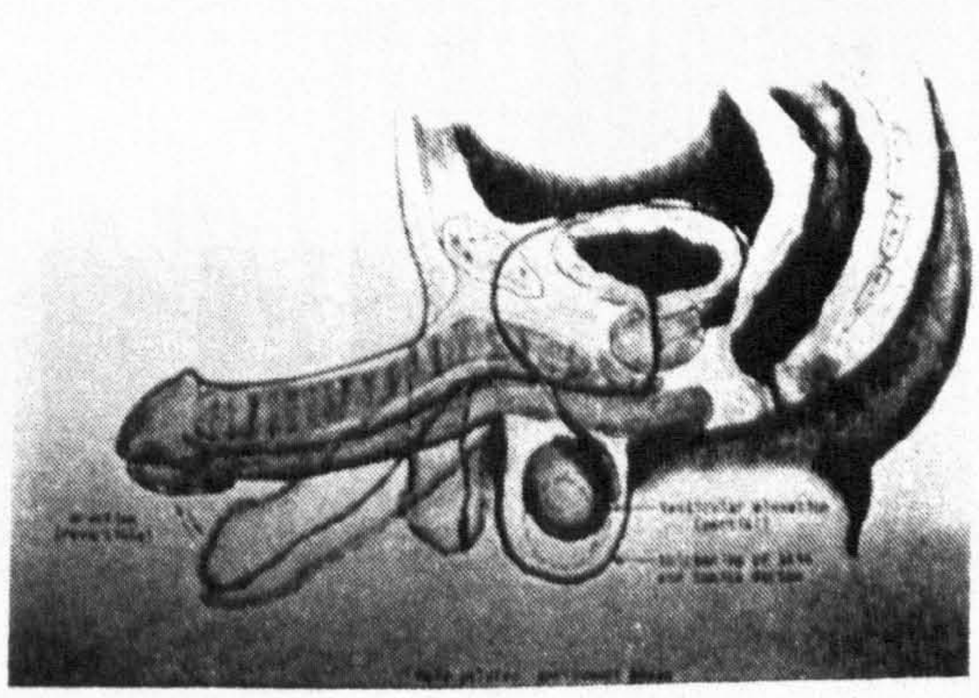


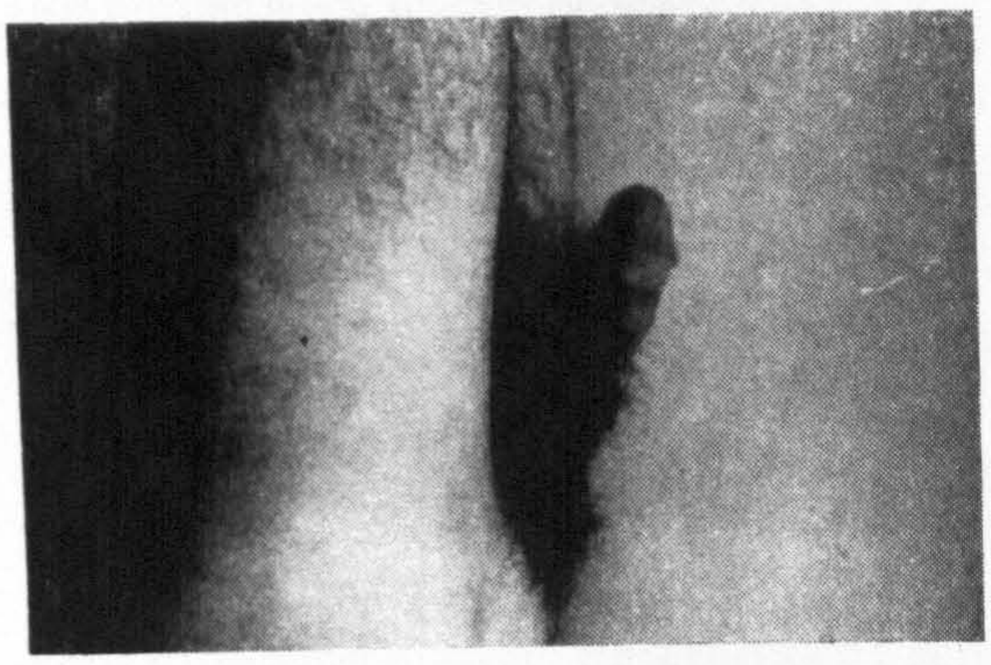


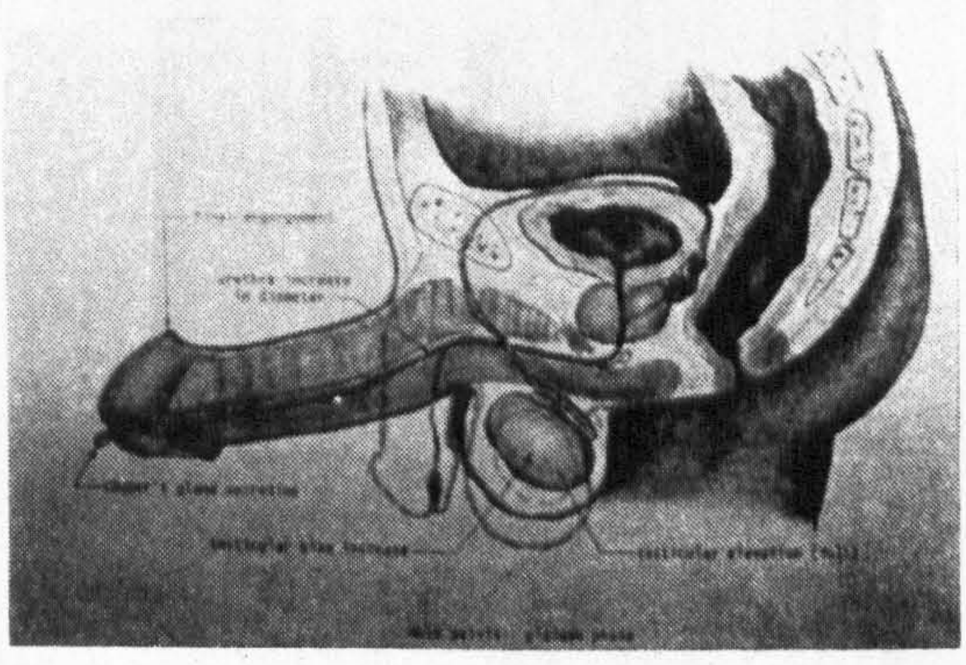


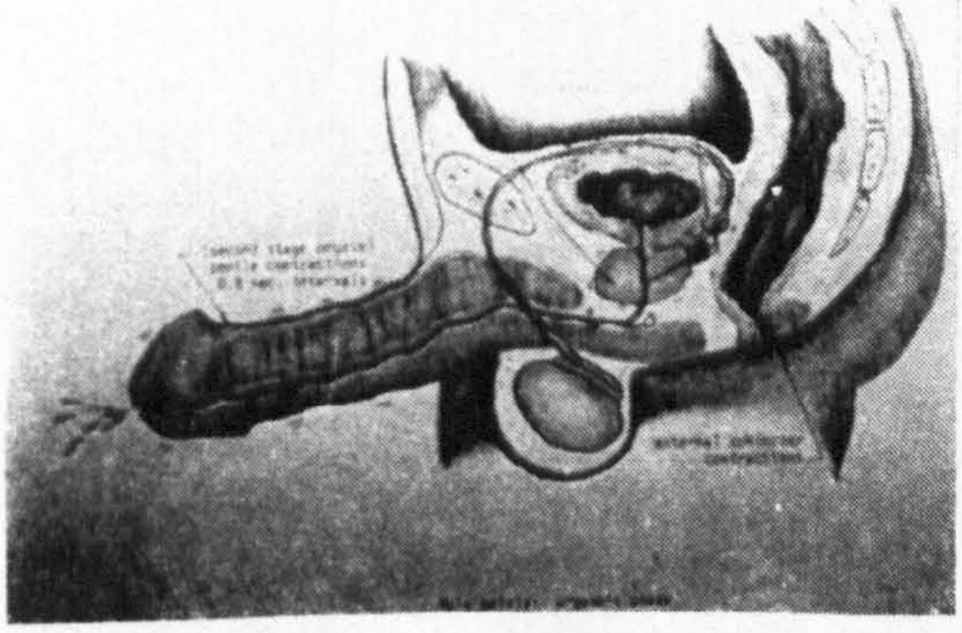


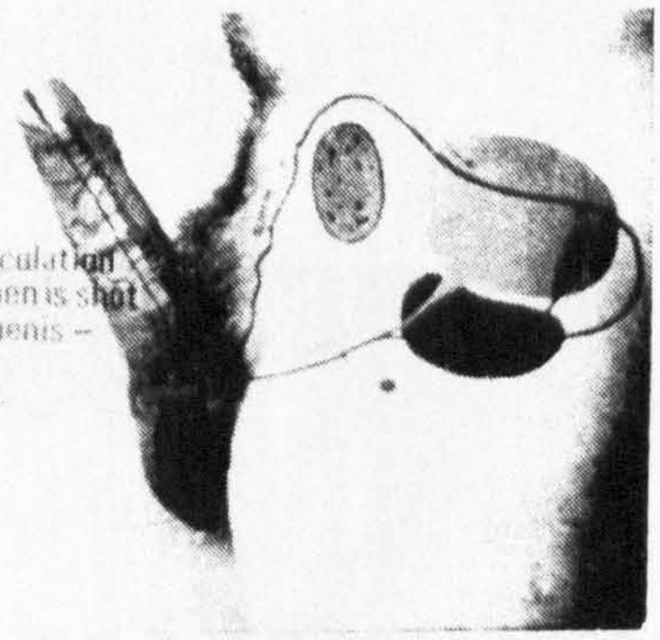






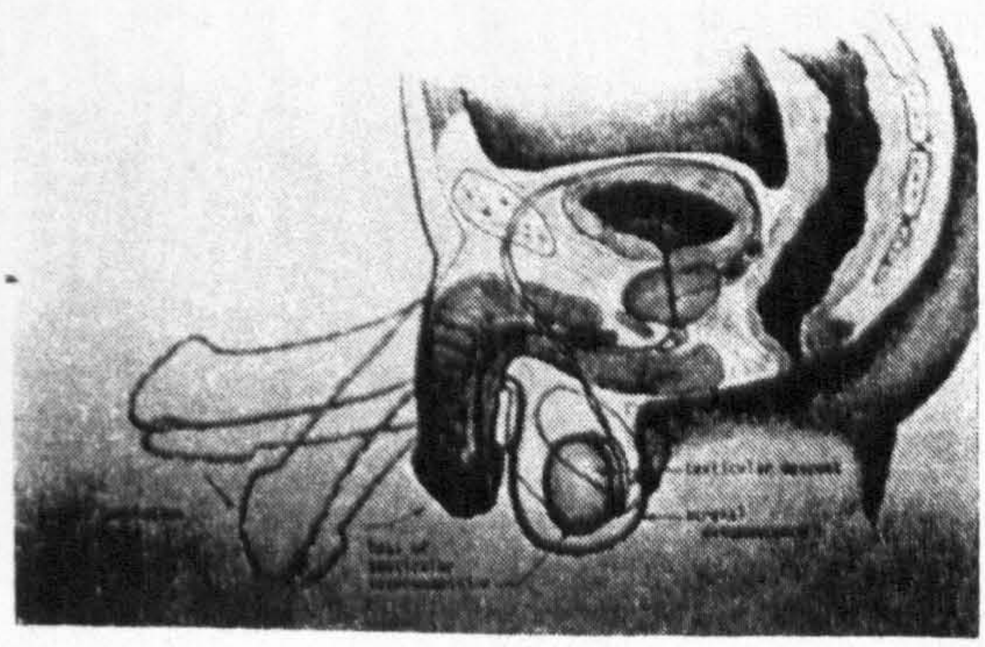


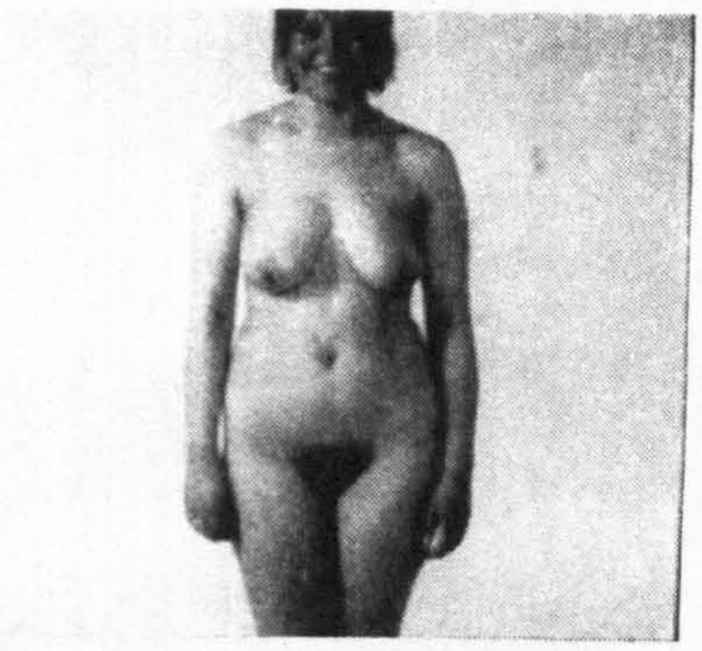


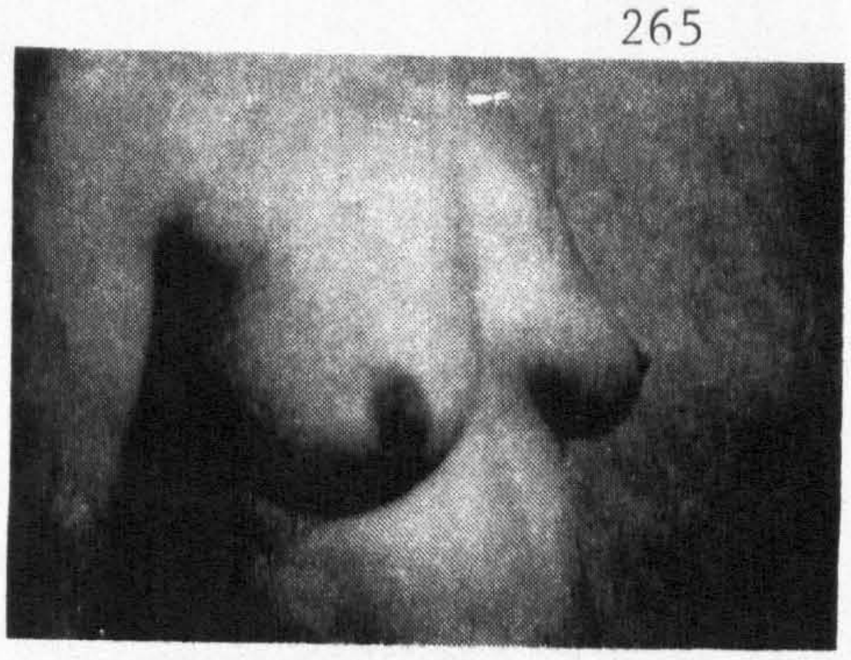


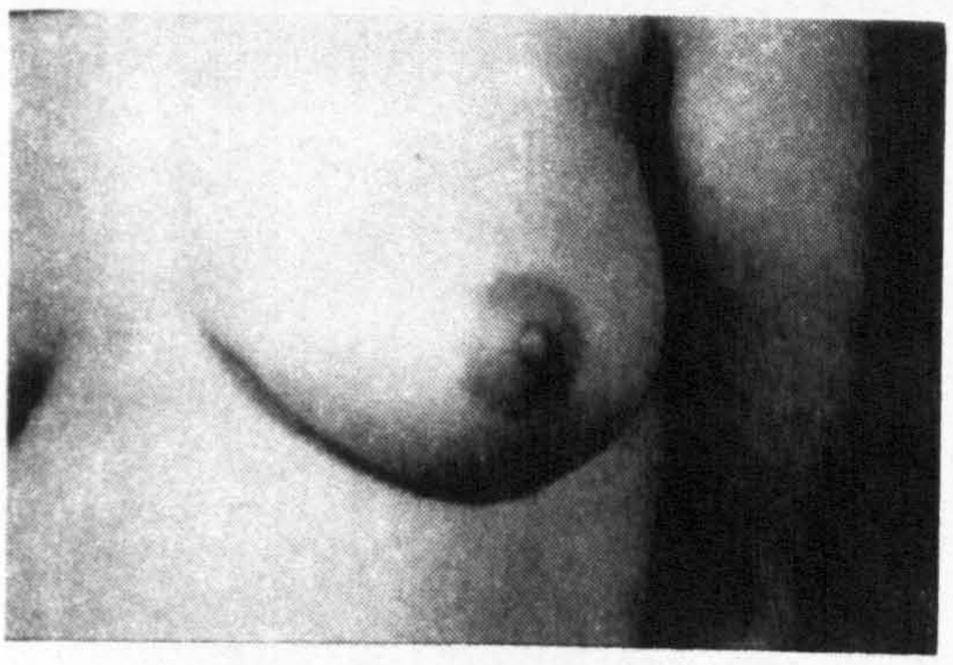
At the moment of ejaculation a teaspoonful of semen is shot from the end of the penis –

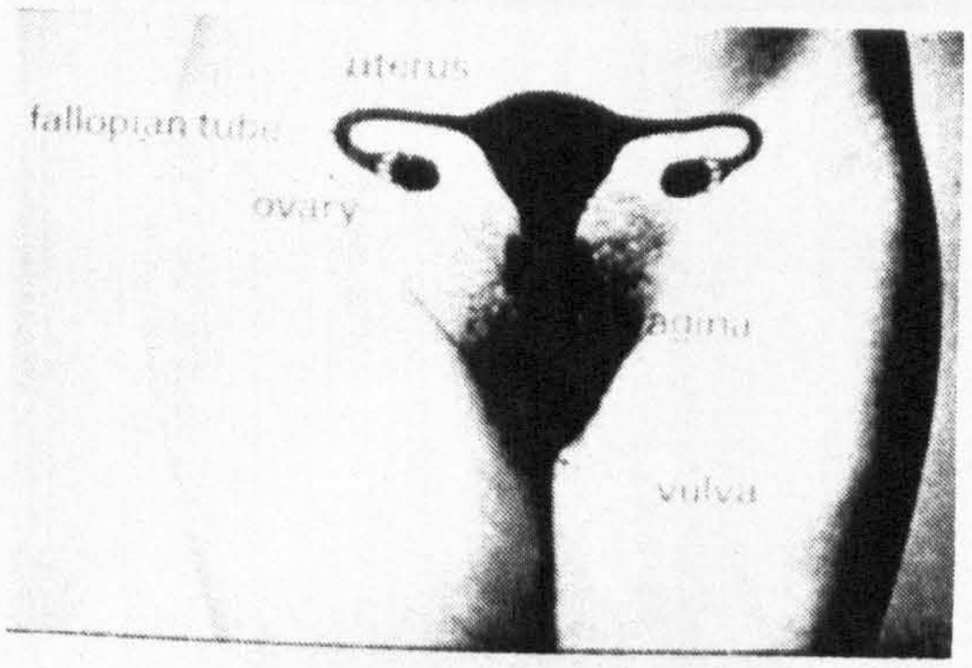
300,000,000 sperm.

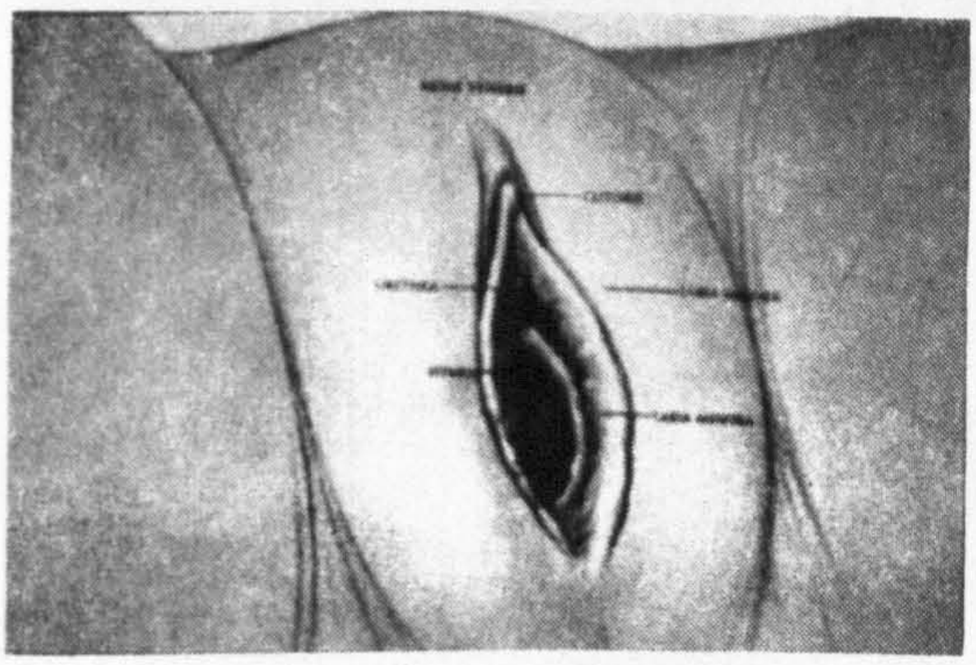


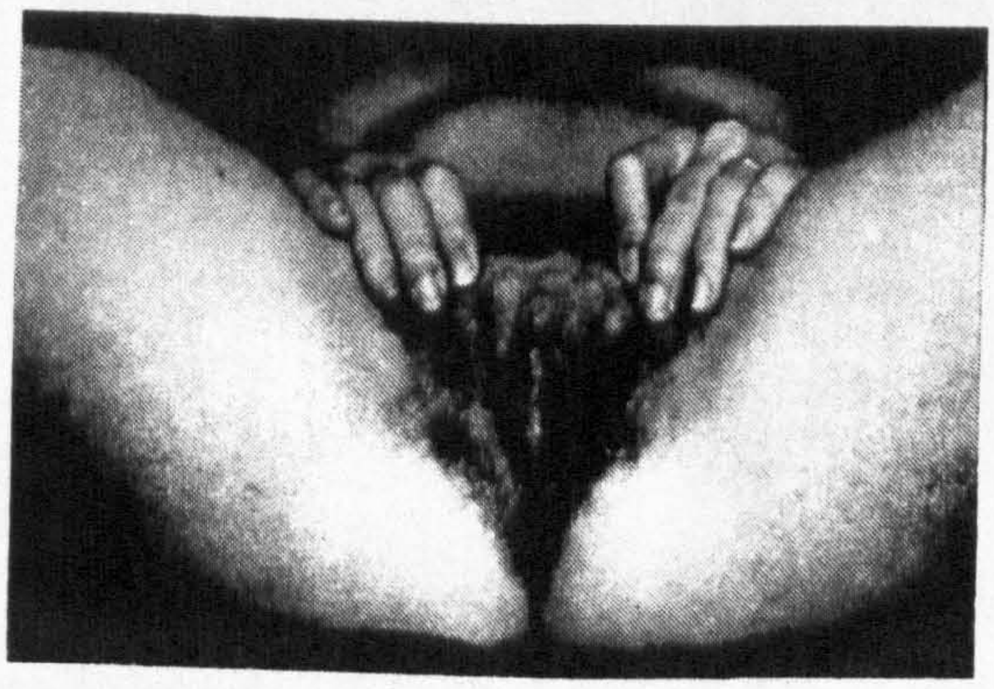


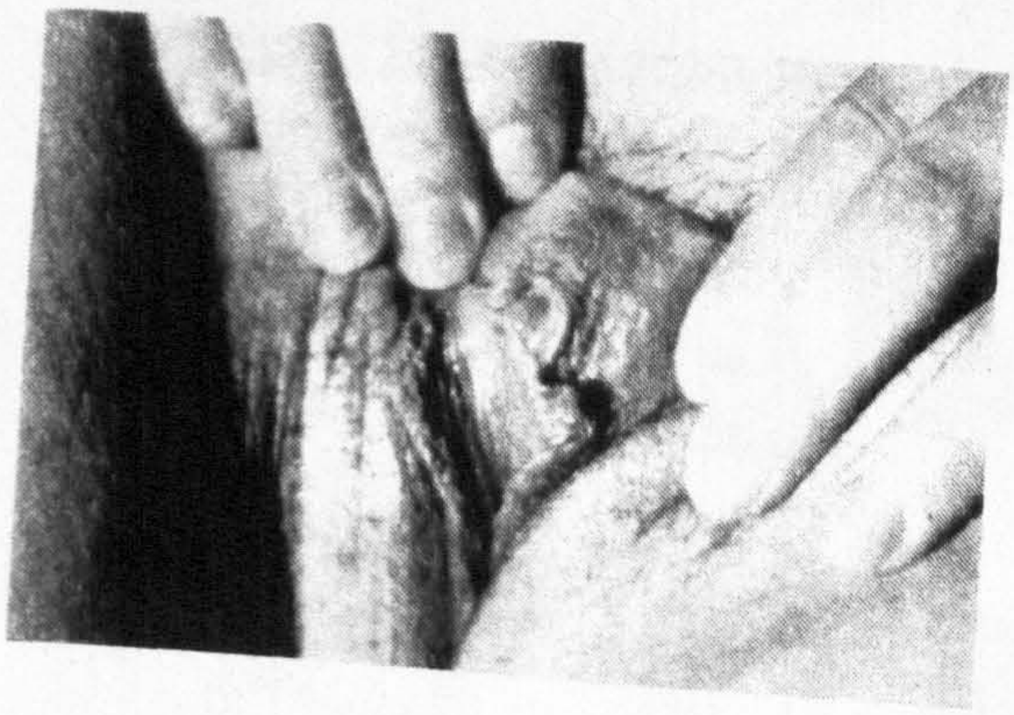


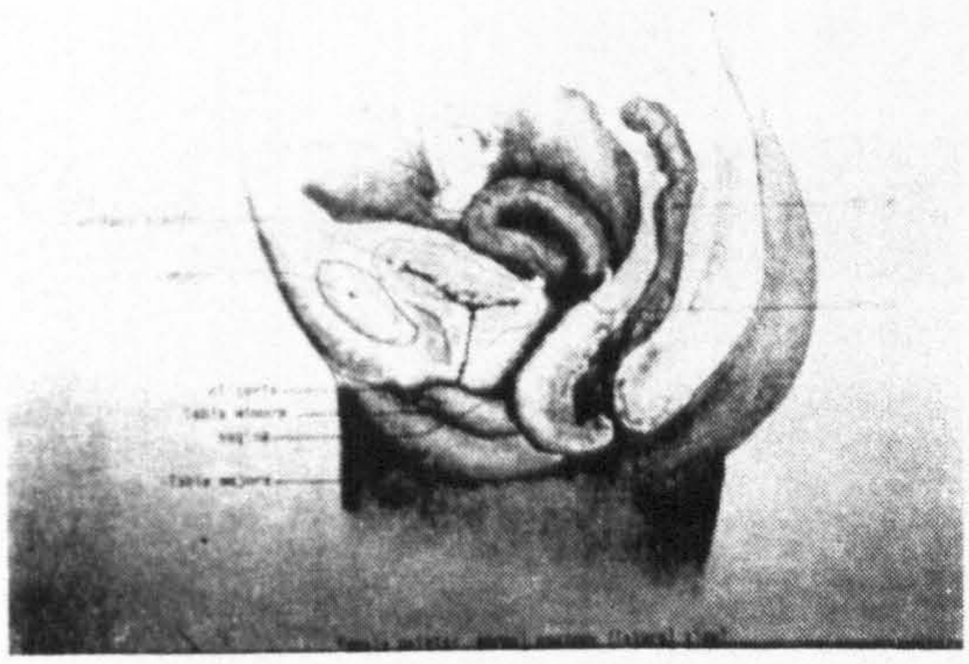


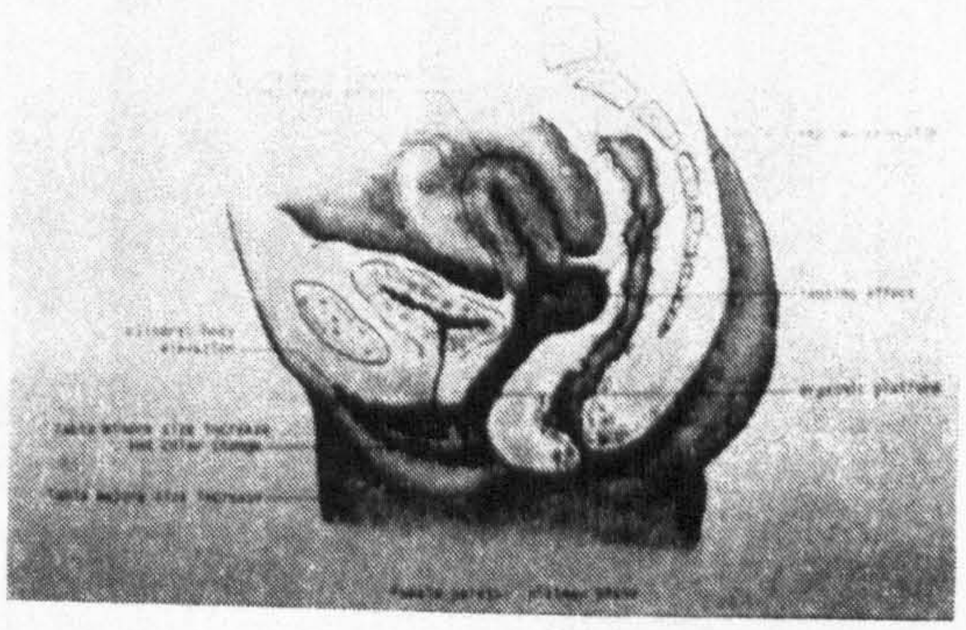

uterus
fallopian tube
ovary
vagina
vulva

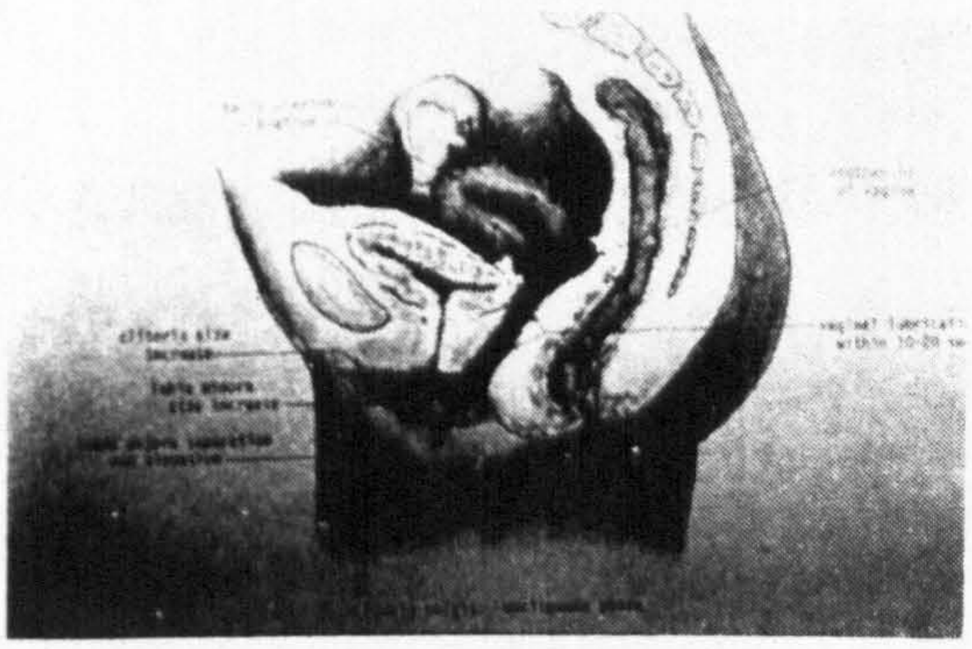


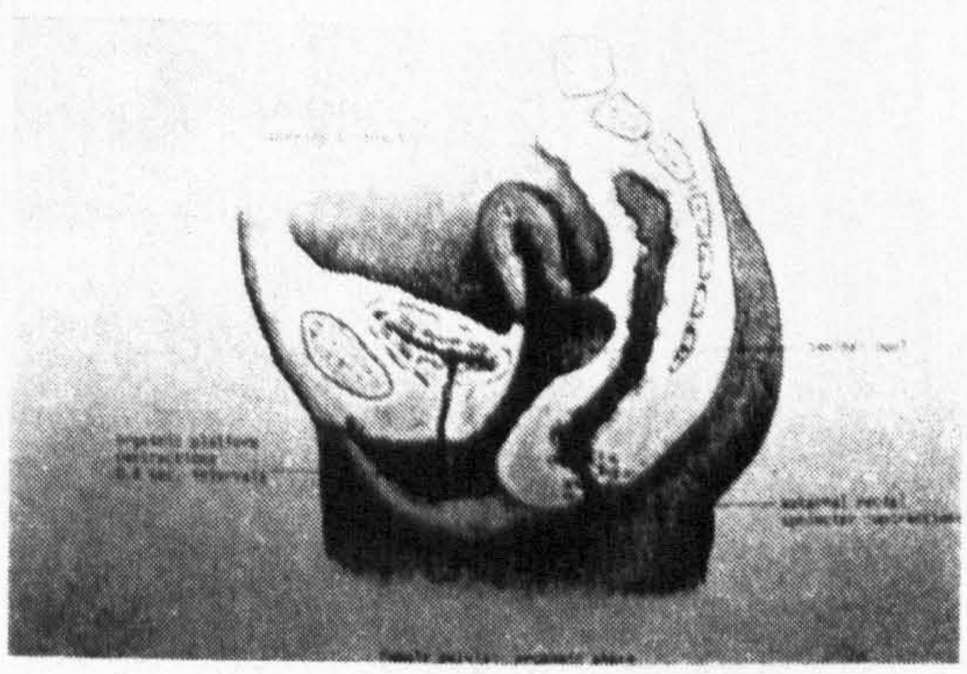


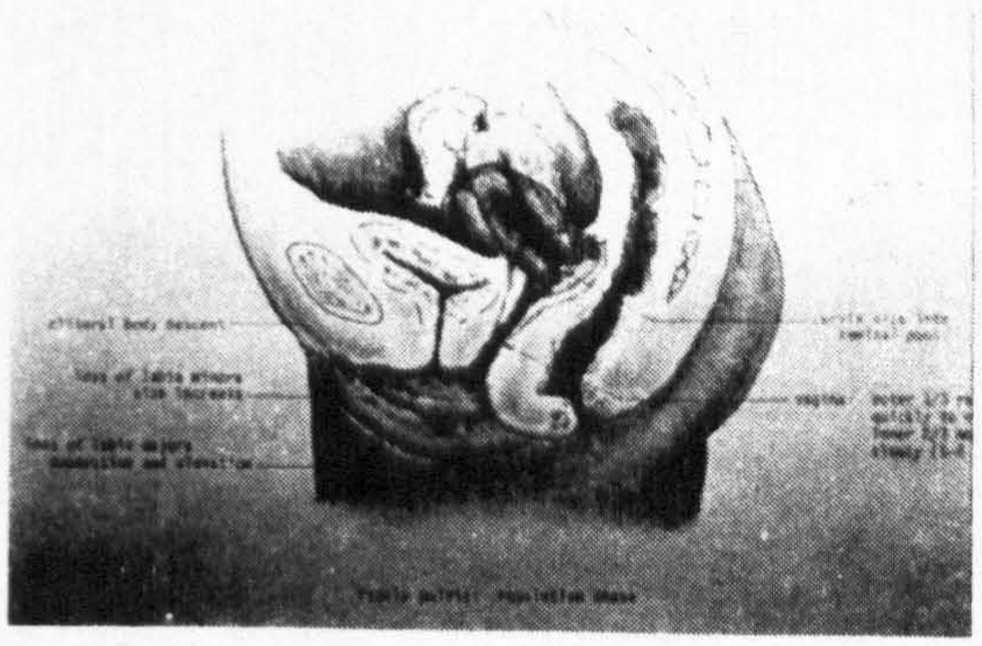


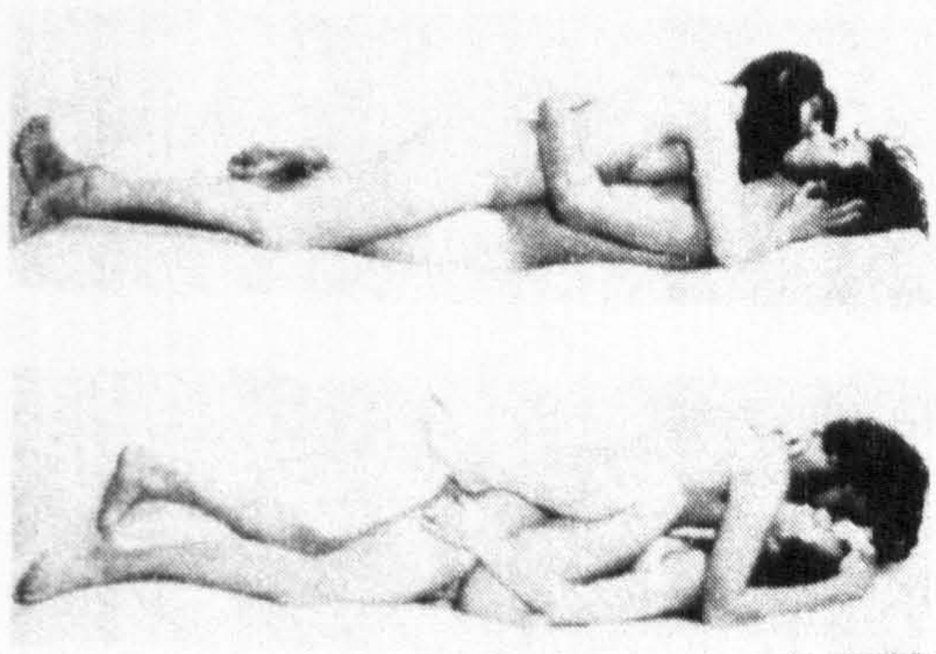












APPENDIX H

Raw data

resulting from Rating Scales and

Factual Data on Couples.

Raw Data

Notes to subscript figures of following tables;

Subscript

1. Odd numbers (e.g., ool) refer to male members of each client couple: even numbers (e.g., oo2) refer to female members of each couple. Male and female members of the same couple are recorded in numerical sequence, with the male of any one couple always preceding the female. The sub-columns m and f of columns 2 and 8 - 15 inclusive therefore record the results for each member of each couple on a single row.

2. Sources of referral: SPE = Specialist

MGC = Marriage Guidance Counsellor

GP = General Practitioner

FPA = Family Planning Association Clinic

SF = Self

SW = Social Worker.

3. In the form in which they were designed and used, the Therapist Rating Sheets, Behavioural Ratings (see Appendix C) started with an assessment of the enjoyment of sexual contact for each member of the presenting couple and then recorded both categories and extent of presenting difficulty by means of a single number

and the sequence of the number. Accordingly the actual numbers of columns 8 and 9 are a mix of codes for categories and for linear judgements of severity of disorder as well as recording the presence or absence of disorder. For instance, the coding for the male partner of the first couple who is numbered ool, with the series 4099 under column 8, shows by reference to the scale of Appendix C and the marking system of numbers there that he enjoys sexual contact on the majority of occasions (4); does not get an erection (0); and that statements regarding premature and retarded ejaculation (9 9) were not applicable in the context of the presentation. Similarly his partner (oo2), for whom the series 1019 is recorded under column 8, gets no pleasure from sexual contact at any time (1); is repulsed by the thought of sexual activity (0); has orgasms in the waking state but not in her partner's presence (1); and statements about difficulty of vaginal entry are not applicable in the context of the presentation(9).

In order to make the tabulation appropriate for data analysis, only those scores which were related to severity of disorder were retained; scores were re-coded on a 1 to 5 basis in order to abolish zeros in the summing; and the direction of all scores was established as the same for all scores, with 1 being marked presence of a dysfunction and 5 being its absence, as assessed. Columns 10 and 11 are the re-coding of columns 8 and 9 respectively.

							Therapist rating sheet, behavioural ratings: see Appendix C				Assessor's rating Sheet: Appendix D			Couples' Rating sheet: Appendix B
1	2		3	4	5	6	7	8	9	10	11	12	13	14	15
Couples' Reference number	Age in years to nearest month		Source of referral	Weeks, referral to treatment	Weeks, assess-mt. to treatmt.	No. of treatmt. sessions	No. of weeks in treatment	Therapist ratings, pre-treatment	Therapist ratings post-treatment	Therapist ratings, pre-trtmt. re-coded	Therapist ratings, post-trtmt. re-coded	Therapist ratings pre-trtmt.	Therapist ratings post-trtmt.	Assessor's ratings post-trtmt.	Couples' independent ratings, post-treatment
	m	f						m f	m f	m f	m f	m f	m f	m f	m f
C01/002	30	28	SPE	63	15	09	23	4099 1019	4999 4449	51-- 212-	5--- 555-	34 01	44 44	-- --	777777 777777
003/004	25	22	MGC	31	31	10	17	2099 0329	4097 3239	31-- 143-	51-- 434-	31 10	33 33	43 44	656755 755767
005/006	33	29	MGC	13	11	09	08	0099 0000	0099 0000	11-- 1111	11-- 1111	30 00	20 00	-- --	------ ------
007/008	31	29	MGC	22	13	20	45	0929 1939	2938 4939	1-3- 2-4-	3-4- 5-4-	10 30	42 22	43 44	766766 665666
009/010	25	24	MGC	10	09	15	15	2099 2229	4499 4349	31-- 333-	55-- 545-	21 31	44 44	44 44	777777 767777
011/012	34	33	MGC	03	07	15	21	0929 2939	0929 2949	1-3- 3-4-	1-3- 3-5-	20 11	31 11	-- --	523633 521772
013/014	27	25	MGC	24	09	11	10	2099 0929	4192 3999	31-- 1-3-	52-3 4---	11 11	33 22	-- --	665666 655677
015/016	47	49	MGC	22	10	14	21	0999 2029	4999 4039	1--- 313-	5--- 514-	22 21	43 42	-- --	745766 443755
017/018	48	53	GP	20	13	11	10	0909 1249	0909 1249	1-1- 235-	1-1- 235-	31 11	21 11	-- --	511445 444555
019/020	42	39	SPE	23	14	08	07	2099 4329	4999 4949	31-- 543-	5--- 5-5-	44 22	44 44	44 44	777777 766666
021/022	40	38	GP	18	13	10	09	2199 2229	3099 2239	32-- 333-	41-- 334-	01 11	23 33	33 33	776777 777777
023/024	28	21	SPE	29	22	13	17	2999 0231	4999 4444	3--- 1342	5--- 5555	20 30	44 44	44 44	665676 677767
025/026	28	27	GP	37	25	15	17	2099 1019	4999 4349	31-- 212-	5--- 545-	21 11	44 44	44 44	532433 731663
027/028	21	22	SPE	44	24	04	03	WITHDRAWN							

029/030	22	23	GP	31	25	14	24	0909	0929	0909	0929	1-1-	1-3-	1-1-	1-3-	20	20	20	20	40	40	177245	411444
031/032	26	25	GP	34	25	11	13	2199	1919	2999	2339	32--	2-2-	3---	344-	02	01	23	13	--	--	776664	766666
033/034	45	46	GP	38	25	11	12	00390139		2039	2139	114-	124-	314-	324-	31	00	33	12	40	40	643655	744765
035/036	38	33	GP	37	26	11	13	0999	2129	4999	4449	1---	323-	5---	555-	11	11	44	44	34	33	765777	777777
037/038	39	35	SPE	29	19	20	36	0929	0339	2939	4849	1-3-	144-	3-4-	5-5-	10	01	31	32	20	20	552635	411643
039/040	59	59	GP	35	24																		
041/042	24	21	SPE	37	30	06	07	4299	0000														
043/044	26	26	SPE	42	33	10	18	4099	2229	4199	4339	51--	333-	52--	544-	33	21	44	44	44	44	765776	666777
045/046	26	23	SPE	37	31	07	10	1999	0000	4199	4449	2---	1111	52--	555-	30	30	44	44	--	--	666777	777777
047/048	48	47	FPA	24	19	03	03	2939	2029														
049/050	42	38	SPE	41	35	04	04	0828	W I T H D R A W N														
051/052	44	37	GP	70	63	20	30	1899	1000	2899	0000	2---	2111	3---	1111	10	10	00	00	--	--	422435	421564
053/054	31	32	SPE	41	36	07	09	4099	1219	4999	4349	51--	232-	5---	545-	32	32	44	44	--	--	766777	777777
055/056	25	23	GP	40	36	04	04	0898	0000														
057/058	31	26	GP	08	02	04	04	0899	0010														
059/060	29	27	GP	17	03	12	14	0099	0014	4199	4449	11--	1125	52--	555-	31	31	44	44	--	--	676577	677777
061/062	53	52	SPE	49	42	14	19	0919	0129	2099	2239	1-2-	123-	3-1-	3-4-	40	40	21	31	--	--	766766	744777
063/064	38	40	SW	39	31	11	23	0889	2349														
065/066	44	35	GP	30	22	08	10	0909	0329														
067/068	36	35	SPE	24	18	16	17	2292	0839	3094	3439	32-3	1-4-	41-5	454-	21	11	22	23	--	--	655755	555555
069/070	32	31	SPE	57	52	10	12	2099	2329	4099	4449	31--	343-	51--	555-	31	11	44	44	43	44	776777	777777

071/072	45	46	SPE	49	40	13	15	4999	0023	3999	3833	5---	1134	4-—	4-44	31	31	33	43	44	43	771777	777776
073/074	29	26	SPE	32	26	13	18	4099	0018	4999	3844	51--	112-	5—-	4-55	13	21	43	43	--	--	756777	766777
075/076	25	27	GP	41	37	--	--	2999	0809	4439	3339	3---	1-1-	545-	444-	10	10	44	44	--	--	666766	655766
077/078	29	29	GP	14	06	10	12	0193	0339	4444	4444	12-4	144-	5555	5555	22	22	44	44	--	--	765777	776677
079/080	39	34	MGC	42	38	22	31	0943	1113	4049	3333	1-54	2224	515-	4444	33	01	44	43	43	43	666656	666777
081/082	37	37	GP	36	29	16	26	4049	0433	4049	4449	515-	1544	515-	555-	24	22	44	44	--	--	755676	677777
083/084	40	32	GP	28	20	19	30	0049	2323	4449	4449	115-	3434	555-	555-	33	22	34	34	04	04	766676	766767
085/086	24	23	GP	51	44	14	32	2349	1319	4449	4449	345-	242-	55--	555-	22	11	44	44	--	--	776777	777777
087/088	28	28	NGC	53	52	19	28	4049	2224	4999	4239	515-	3335	5---	534-	41	43	44	44	--	--	665566	766766
089/090	38	36	MGC	43	37	--	--	4049	1018			515-	212-										
091/092	35	31	GP	36	26	11	16	2099	2039	4999	2039	31--	314-	5---	314-	11	11	23	23	--	--	411522	423413
093/094	42	39	GP	22	17	14	22	0084	3039	3999	3039	11-5	414-	4---	414-	20	20	44	44	--	--	545565	666446
095/096	28	25	GP	26	23	11	27	4999	2323			5---	3434			20	20						
097/098	38	38	GP	19	17	11	14	4049	3349			515-	445-			22	03						
099/100	22	21	GP	21	20	14	23	4099	0409	4099	3239	51--	151-	51--	434-	30	10	44	34	43	43	766777	665776
101/102	42	41	GP	29	19	10	16	4049	1439	4099	4849	515-	254-	51--	5-5-	12	11	44	44	43	43	766656	766766
103/104	51	42	SF	38	33	08	08	4049	4349	4999	4999	515-	545-	5---	5-5-	33	31	44	44	--	--	755466	553465
105/106	30	28	SPE	29	25	10	14	4990	4449	4990	4449	5--1	555-	5--1	555-	44	44	44	44	44	44	447444	446444
107/108	30	28	GP	33	25	14	16	0429	0139	0919	4139	153-	124-	1-2-	524-	40	40	40	30	--	--	541444	443444
109/110	30	25	GP	10	05	04	06	2222	0109	.		3333	121-			40	30						
111/112	54	48	GP	13	05	11	14	0921	0949	0929	2049	1-32	1-5-	1-3-	315-	40	40	40	40	--	--	521422	711744
113/114	29	26	SPE	29	26	24	29	0319	0000	4999	2033	142-	1111	5---	3144	20	20	43	42	43	43	655554	642754

115/116	23	22	GP	16	12	14	22	4999	2223	4999	3034	5---	3334	5---	4145	43	41	43	43	--	--	766777	766777
117/118	29	23	GP	40	32	21	37	2133	2249	4133	4349	3424	335-	5244	545-	41	42	43	44	43	44	666766	766777
119/120	32	27	GP	37	30	09	14	4044	0024			5155	1135			32	11						
121/122	51	44	GP	15	10	12	13	4119	2139	4049	4149	522-	324-	515-	525-	41	42	44	44	40	40	655675	555655
123/124	33	32	GP	17	07	09	09	4049	2919			515-	3-2-			24	21						
125/126	50	49	MGC	27	26	08	09	4049	2239	4999	4249	515-	334-	5---	535-	14	23	34	44	--	--	555676	777777
127/128	24	26	SPE	73	64	16	21	4049	1819	4999	4939	515-	2-2-	5---	5-4-	34	31	44	44	--	--	777767	677777
129/130	27	23	GP	21	17	17	18	4049	1819	0999	0910	515-	2-2-	1---	1-21	04	11	10	10	--	--	522521	411521
131/132	44	35	SPE	83	69	23	39	2992	4449	2991	4949	3--3	555-	3--2	5-5-	42	43	32	33	--	--	421662	511533
133/134	52	45	SF	28	23	07	12	3099	1119	3099	2229	41--	222-	41--	333-	11	12	22	21	--	--	653665	644555
135/136	56	53	SF	22	14	23	39	2049	1209	4199	3939	315-	231-	52--	4-4-	22	11	33	33	--	--	655666	777767
137/138	24	26	SPE	30	27	09	17	2099	2029	2099	0010	31--	313-	31--	1121	20	20	20	20	--	--	653766	411474
139/140	28	29	MGC	27	26	08	12	0999	0219	4999	4449	1---	132-	5---	555-	20	00	44	44	44	44	775676	777747
141/142	26	24	SPE	11	03	18	23	4999	0010	4999	4844	5---	1121	5---	5-55	40	40	44	34	--	--	766777	755777
143/144	56	33	GP	38	27	08	13	0420	0839	4930	4249	1531	1-4-	5-41	535-	31	31	43	44	43	43	765666	766566

APPENDIX I

History-taking Proforma.

NATIONAL MARRIAGE GUIDANCE COUNCIL

MARITAL SEXUAL DYSFUNCTION PROJECT

Draft systematic interview
for co-therapy enquiry

1. First Interview (Joint). This is essentially a "Hello" meeting. Very brief biographical data is taken, and under 'Presenting problem' the couple are encouraged to make a brief first statement of the presenting difficulty in their own words, with some minimal relevant detail.

2. At the Second Interview the male therapist and male client work together, and similarly female and female, and the main protracted interview takes place here. This interview is followed by a conference between the therapists, who discuss their individual conclusions and prepare together the areas that, in the cross-over interviews of male-female/female-male, each therapist feels it would be most helpful for the other to pursue.
Notes of this discussion are made in the left-hand column of the

3. Third Interview sheet (page 10), and conclusions arising in the right hand column. The therapists then confer again, and summarise their findings for each other, establishing the information basis of

4. the fourth stage, the Round Table discussion, which is noted on Page 1 under Summary of Round Table.

Subsequent interview sheets are used in repeat appointments, an example being enclosed.

It should be stressed that this is a first draft of a systematic enquiry, and it will be seen that this form is essentially a developmental history, with particular emphasis upon the development of sexual understanding and experience. Comments following use will be much appreciated. Additional copies can be had at cost from the address below. Revisions will be made available to colleagues on our mailing list as and when they appear.

P.T. Brown

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FIRST INTERVIEW (JOINT)

Presenting problem

a) Nature of current sexual difficulties

b) Circumstances of onset

c) Possible precipitant

d) Immediate reaction of partnership to problem

e) General trend since onset

f) Present sexual functioning of partnership

g) Current reaction of partnership to problem

h) Frequency of sexual intercourse:- (i) before problem

(ii) now

i) Own and partner's efforts to improve situation

j) Referral to helping agency.

FIRST INTERVIEW (JOINT)

Date

Co-therapists

	Own	Partner's	Children	Ages
Name				
Age				
Address				
Occupation				
religion				
Civil status				
Nationality				
G.P.				
Source of referral				

Presenting Problem

a)

b)

c)

d)

e)

f)

g)

h) (i)

(ii)

i)

j)

SECOND INTERVIEW

1. CHILDHOOD

a) Place of birth
b) Any known difficulty at birth
c) Infantile illnesses
d) Neurotic traits, e.g., nailbiting, bedwetting
e) Sociability
f) Preferred games
g) Schooling:- (i) enumerate schools
(ii) level of education and academic achievement
(iii) peer group relationships
(iv) recreational preferences
(v) own expectations at school
(vi) parental expectations of you at school
(vii) attitude to school
h) Sexual experience as a child:- (i) games
(ii) observed activity in others
(iii) verbal or visual material
(iv) traumatic experiences
(v) pleasant experiences
(vi) parental attitude to either (if discovered)

2. FAMILY BACKGROUND

Mother (or mother substitute)
a) age
b) state of health or date and cause of death
c) description of personality
d) relationship with you
e) relationship with partner
f) her effect on you in marriage

Father (or father substitute)
a) age
b) state of health or date and cause of death
c) occupation
d) description of personality
e) relationship with you
f) relationship with partner
g) his effect on you in marriage.

SECOND INTERVIEW

Co-therapist

Client:

Date

1. CHILDHOOD

a)
b)
c)
d)
e)
f)
g) (i)
(ii)
(iii)
(iv)
(v)
(vi)
(vii)
h) (i)
(ii)
(iii)
(iv)
(v)
(vi)

2. FAMILY BACKGROUND

Mother (mother substitute)
a)
b)
c)
d)
e)
f)

Father (or father substitute)
a)
b)
c)
d)
e)
f)
g)

Siblings:-
a) ages
b) relationships in childhood
c) relationships now
d) their current marital situations

a) Early socio-economic background
b) Early religious background
c) Geographical movements
d) Details of parental separation or divorce
e) Home atmosphere
f) Details of physical illness in family
g) Details of nervous illness in family
h) Demonstration of emotion in family
i) Family attitude to sex
j) Family discussion of sex.

ADOLESCENCE

a) Age at puberty or menarche
b) Degree of sex education
c) Source of such education
d) Reaction to it
e) Sexual fantasies or daydreams
f) First physical sttractions, crushes, heterosexual or homosexual
g) Early casual ineractions with opposit sex
h) Age at onset of dating
i) Details of first and subsequent relationships with opposite sex.

j) Self-image during adolescence
k) Masturbation:- (i) age at onset
(ii) any specific cause of onset
(iii) feelings about it then
l) Nocturnal emissions
m) First heterosexual intercourse:- (i) age
(ii) with whom
(iii) occasion
(iv) physical reaction
(v) emotional reaction

Siblings:-

a)
b)
c)
d)

a)
b)
c)
d)
e)
f)
g)
h)
i)
j)

3. ADOLESCENCE

a)
b)
c)
d)
e)
f)
g)
h)

i)	age	duration	nature of physical relationship	extent of sexual experience	reason why relationship ended	feelings about it ending

j)
k) (i)
(ii)
(iii)
l)
m) (i)
(ii)
(iii)
(iv)
(v)

n) subsequent premarital sexual experience(s) not with partner:-

o) premarital pregnancies or terminations
p) homosexual relationships or sexual experiences

4. DETAILS OF MARRIAGE OR PRESENT RELATIONSHIP

a) Age of self at marriage (or start of present relationship)
b) Age of partner " " " "
c) Own previous marriage(s)
d) Partner's previous marriage(s)
e) First meeting with partner
f) length of courtship
g) Details of courtship
h) Basis of choice (attractive attributes of partner)
i) Description of partner
j) Partner's parents
k) Partner's family generally
l) Partner's occupation and ambitions
m) Common interests of you and partner
n) different " " "
o) Time spent together with other people
p) Time spent together alone
q) Communication between you
r) any periods of separation for whatever reason?
s) details of first sexual encounter with partner:- (i) when
(ii) where
(iii) own physical reactions
(iv) own emotional reactions
(v) partner's physical reactions
(vi) partner's emotional reactions
t) details of honeymoon
u) any problems then?
v) any masturbation since then?
w) any children?
x) were they planned?
y) were they wanted?
z) what effect did they have on relationship?
aa) if no children now, what plans for future?

n)	age	duration	extent of sexual experience	reactions to sexual experience	reasons why relationship ended	feelings about it ending

o)
p)

4. DETAILS OF MARRIAGE OR PRESENT RELATIONSHIP

a)
b)
c)
d)
e)
f)
g)
h)
i)
j)
k)
l)
m)
n)
o)
p)
q)
r)
s) (i)
(ii)
(iii)
(iv)
(v)
(vi)
t)
u)
v)
w)
x)
y)
z)
aa)

bb) feelings about future of the marriage
cc) expectation of role of wife
dd) expectation of role of husband
ee) any extramarital relationships of own?
ff) any extramarital relationships of partner?
gg) effects of either on marriage
hh) any illegitimate children of either partner out side the relationship?

5. SEXUAL FUNCTIONING IN PRESENT RELATIONSHIP

Has presenting problem been present throughout duration of relationship (If it has, then just use section A, and then go on to Section C. If it has developed at some time during the relationship, use B also).

A) Usual pattern of sexual intercourse
(before onset of presenting problem if going on to use section B).

a) frequency
b) timing
c) whose initiative?
d) under what circumstances?
e) typical encounter
f) preferred position (own)
g) preferred position (partner's)
h) details of foreplay
i) details of vaginal lubrication
j) reliability of erection
k) reliability of ejaculatory control
l) details of own orgasm
m) details of partner's orgasm
n) does love-making always end in intercourse?
o) feelings about this?
p) contraceptive measures
q) attitude to them
r) effectiveness of them
s) whose choice?
t) what factors in intercourse :- (i) give you pleasure?
(ii) give partner pleasure?
(iii) arouse you?
(iv) arouse partner?
(v) do you dislike?
(vi) does partner dislike?
u) factors which prevent or delay arousal:- (i) in you
(ii) in partner
v) means of sexual pleasure other than intercourse attempted or enjoyed/disliked by either partner:-

(i) cunnilingus
(ii) fellatio
(iii) visual stimuli
(iv) verbal stimuli
(v) anal stimulation
(vi) fantasy
(vii) vibrator
(vIII) others - specify

bb)
cc)
dd)
ee)
ff)
gg)
hh)

5. SEXUAL FUNCTIONING IN PRESENT RELATIONSHIP

A) Usual pattern of sexual intercourse
(before onset of presenting problem if going on to use section B).

a)
b)
c)
d)
e)
f)
g)
h)
i)
j)
k)
l)
m)
n)
o)
p)
q)
r)
s)
t) (i)
(ii)
(iii)
(iv)
(v)
(vi)
u) (i)
(ii)
v) (i)
(ii)
(iii)
(iv)
(v)
(vi)
(vii)
(viii)

w) any methods you would like to try and have not?
x) what reasons have prevented you from trying?

B. Usual pattern of sexual intercourse (since onset of presenting problem)

Any changes in any of those, and when did these changes occur?

a) frequency
b) timing
c) whose initiative?
d) usual circumstances
e) typical encounter
f) preferred position (own)
g) preferred position (partner's)
h) details of foreplay
i) details of vaginal lubrication
j) reliability of erection
k) reliability of ejaculatory control
l) details of own orgasm
m) details of partner's orgasm
n) does love-making always end in intercourse?
o) feelings about this
p) contraceptive measures
q) attitude to them
r) effectiveness of them
s) whose choice?
t) factors in intercourse which:-
  (i) give you pleasure
  (ii) give partner pleasure
  (iii) arouse you
  (iv) arouse partner
  (v) you dislike
  (vi) partner dislikes
u) means of sexual pleasure other than intercourse attempted and enjoyed/disliked by either partner:-
  (i) cunnilingus
  (ii) fellatio
  (iii) visual stimuli
  (iv) verbal stimuli
  (v) anal stimulation
  (vi) fantasy
  (vii) vibrator
  (viii) others - specify

C.(i) Concept of sexual organs and feelings about them
a) own
b) partner's

(ii) Concept of desired sexual functioning for self and partner or man and woman in general
a) positive expectations
b) negative expectations

w)
x)

B. Usual pattern of sexual intercourse (since onset of presenting problem)

a)
b)
c)
d)
e)
f)
g)
h)
i)
j)
k)
l)
m)
n)
o)
p)
q)
r)
s)
t)
(i)
(ii)
(iii)
(iv)
(v)
(vi)
u)
(i)
(ii)
(iii)
(iv)
(v)
(vi)
(vii)
(viii)

C.(i) Concept of sexual organs and feelings about them

a)
b)

(ii) Concept of desired sexual functioning for self and partner or man and woman in general

a)
b)

6. OCCUPATIONAL AND SOCIAL HISTORY

a) age leaving school
b) higher education
c) work record:-
d) current work situation
e) future prospects
f) career ambitions
g) hobbies and interests
h) social life and activities:- (i) involving partner
(ii) not involving partner
i) religious belief systems:- (i) own
(ii) partner's

7. GENERAL HEALTH AND PAST MEDICAL HISTORY

a) serious illnesses
b) accidents
c) hospitalisations
d) psychiatric treatment
e) current illness or disability
f) details of treatment and medication
g) details of investigations and/or treatment for:-
(i) gynaecological complaints
(ii) urogenital complaints
(iii) infertility
h) menstrual history:- (i) age at onset
(ii) regularity
(iii) premenstrual tension or depression
(iv) dysmenorrhea
(v) attitude to menstruation:- (aa) own
(bb) partner's
i) obstretic history
j) any history of venereal disease
k) current physical symptoms
l) current psychiatric symptoms
m) tobacco consumption
n) alcohol consumption
o) use of illicit drugs
p) use of proprietary drugs

8. CURRENT OTHER PROBLEMS, OWN, PARTNER'S OR BOTH

a) financial
b) health
c) accommodation
d) employment
e) family
f) religious
g) dietary
h) others - specify

6. OCCUPATIONAL AND SOCIAL HISTORY

a)
b)
c)
d)
e)
f)
g)
h) (i)
(ii)
i) (i)
(ii)

7. GENERAL HEALTH AND PAST MEDICAL HISTORY

a)
b)
c)
d)
e)
f)
g) (i)
(ii)
(iii)
h) (i)
(ii)
(iii)
(iv)
(v)
i)
j)
k)
l)
m)
n)
o)
p)

8. CURRENT OTHER PROBLEMS, OWN, PARTNER'S OR BOTH

a)
b)
c)
d)
e)
f)
g)
h)

9. PERSONALITY AND SELF-PERCEPTION

a) self description
b) opinion of own physical attributes
c) opinion of own general attributes
d) social functioning
e) ease of emotional expression

10. PERCEPTION OF PARTNER

a) description of partner
b) opinion of partner's physical attributes
c) opinion of partner's general attributes
d) social functioning of partner
e) partner's ease of emotional expression

11. SPECIAL SENSES

a) erotic imagery and fantasy
b) preferred sensual stimuli:- (i) touch
(ii) taste
(iii) smell
(iv) sight
(v) sound
(vi) other?
c) disliked stimuli:- specify

12. ANY OTHER IMPORTANT POINTS NOT ALREADY COVERED WHICH COULD POSSIBLY BE CAUSING A PROBLEM OR WHICH WOULD CLARIFY ANYTHING?

13. PRACTICALITIES OR DIFFICULTIES IN ARRANGING APPOINTMENTS

9. PERSONALITY AND SELF-PERCEPTION

a)
b)
c)
d)
e)

10. PERCEPTION OF PARTNER

a)
b)
c)
d)
e)

11. SPECIAL SENSES

a)
b) (i)
(ii)
(iii)
(iv)
(v)
(vi)
c)

12. ANY OTHER IMPORTANT POINTS NOT ALREADY COVERED WHICH COULD POSSIBLY BE CAUSING A PROBLEM OR WHICH WOULD CLARIFY ANYTHING?

13. PRACTICALITIES OR DIFFICULTIES IN ARRANGING APPOINTMENTS

THIRD INTERVIEW

Co-therapist

Client

Date

Areas to be pursued after initial co-therapist discussion

SUBSEQUENT INTERVIEW SHEET

Interview No.:-

Date

Progress towards previously set goals

Generalised changes in relationship

Nature of block (if any)

Goals for next interview

Observations

Signature(s)

.....

.....

APPENDIX J

The Sexual Knowledge Inventory,

SKI.

File No._____

Sex Knowledge Inventory VOCABULARY AND ANATOMY

Developed by Gelolo McHugh

Author of Training for Parenthood for FAMILY LIFE PUBLICATIONS, INC.

DIRECTIONS: This inventory is for confidential use with you by your teacher, doctor, minister, or other counselor. It is to help you understand better the constructive part sex may play in life. This is not an intelligence test. It is a measure of what you know about sex. Be sure to read carefully all directions. *Answer every question.* If you do not know, *guess.* If you are guessing, place an X by your answer. If you want more information about any question, draw a circle around your answer. Complete the blanks on this page: then turn the page and begin.

DO NOT WRITE YOUR NAME ON ANY PART OF THE INVENTORY

Age:_____*years.* Sex: (*Check one*) ☐ *Male* ☐ *Female*

Marital Status: (*Check one*) ☐ *Single* ☐ *Married* ☐ *Widowed* ☐ *Divorced* ☐ *Separated*

How many brothers?_____*older*_____*younger.* How many sisters?_____*older*_____*younger.*

Education completed: (*Circle highest grade completed*) *High School*- 1 2 3 4 *College*- 1 2 3 4

Other-_____

Your occupation:_____

Your father's occupation:_____

Type of community in which childhood was spent:

☐ *Country* ☐ *Small Town* ☐ *Small City* ☐ *Suburban* ☐ *Large City*

Childhood religious training:

☐ *Catholic* ☐ *Protestant* ☐ *Jewish* ☐ *None* ☐ *Other*_____

Are you a parent? ☐ *Yes* ☐ *No* If so, how many children do you have?_____

What is your state of health? ☐ *Excellent* ☐ *Good* ☐ *Fair* ☐ *Poor*

What physical handicaps, if any, do you have?_____

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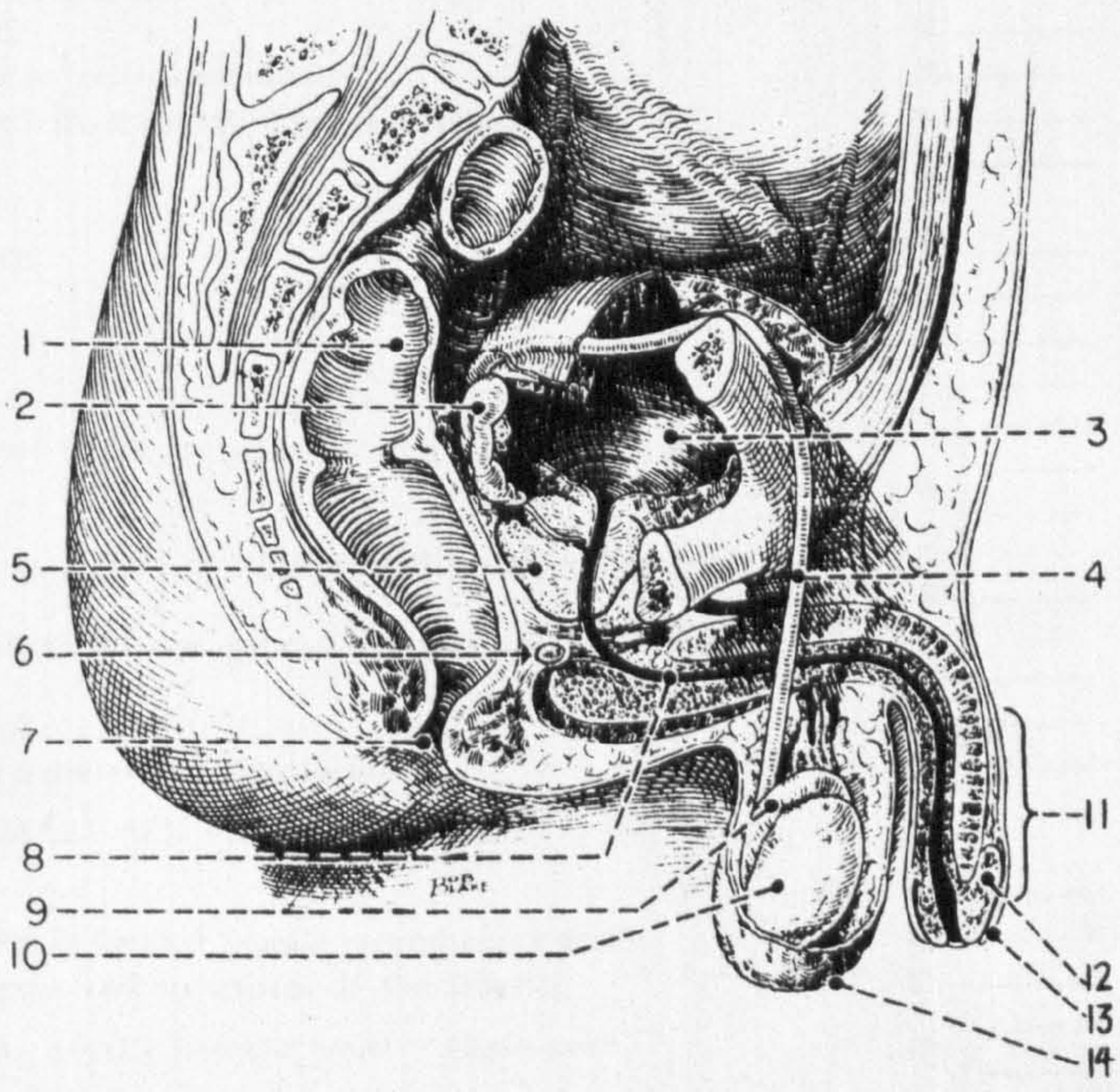
PART I

DIRECTIONS: How well do you know the proper names for male and female sex parts? Given the proper name, you are to identify each part by its number. In the blank space by each name write its number from the drawing. Be sure to fill all spaces. If you do not know, guess. If you are guessing, place an X by your answer. If you want to know more, draw a circle around your answer. The term *sex part* is used here to mean either sex *organ* or sex *structure*. Each drawing shows one half of a human body which has been divided through the center from front to back.

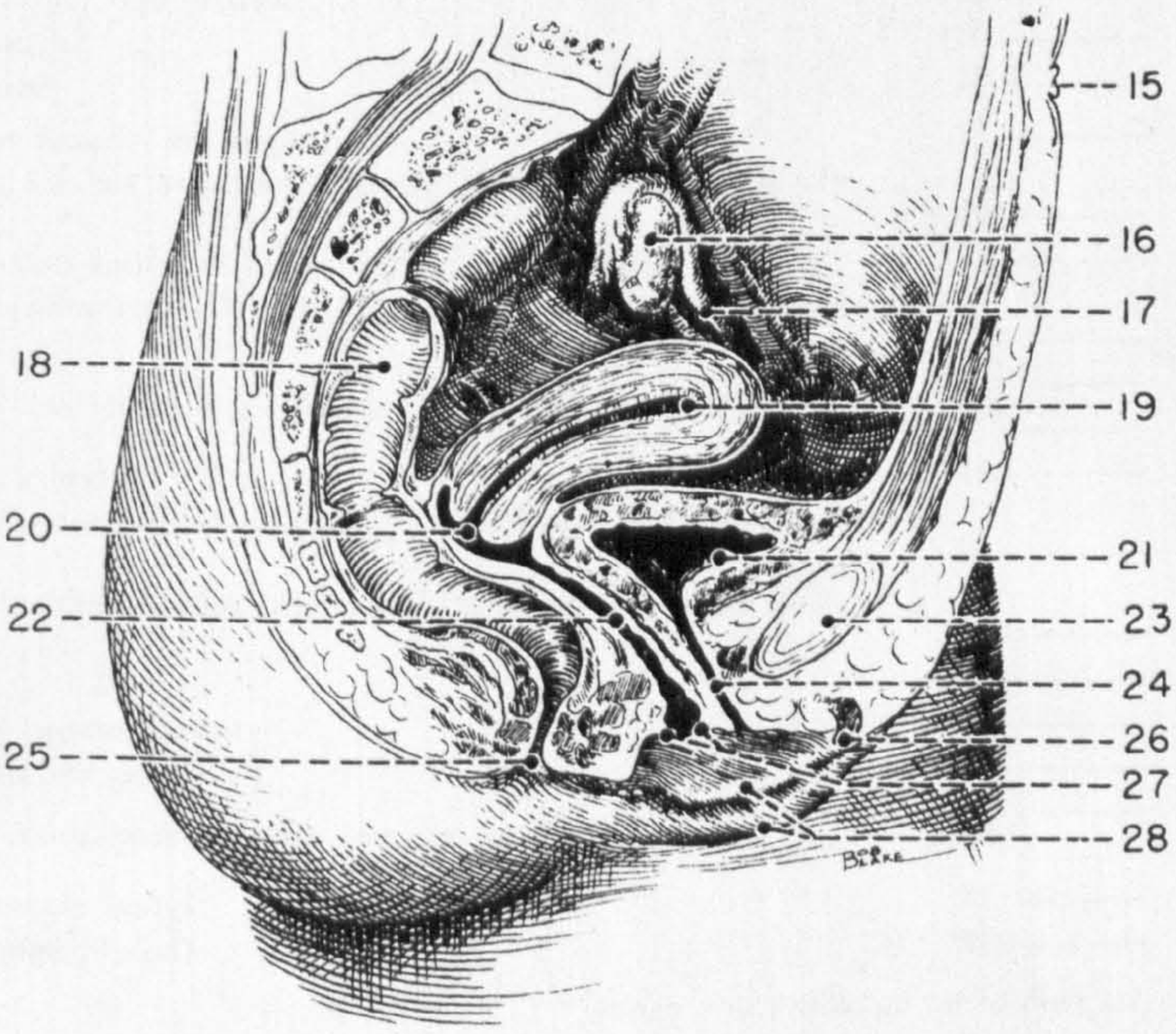
	Cowper's gland
	epididymis
	foreskin
	glans penis
	penis
	prostate gland
	scrotum
	seminal vesicles
	testicle
	urethra
	vas deferens

MALE SEX PARTS



	cervix
	clitoris
	Fallopian tube
	hymen
	labia
	ovary
	urethra
	uterus *or* womb
	vagina

FEMALE SEX PARTS



Now go on to the next page.

PART II

DIRECTIONS: You may understand much about male and female sex parts without knowing their names. Answer the questions below with numbers *only*. Select a number from the drawing to fill in each blank space. Be sure to fill *all* spaces. If you do not know, *guess*. If you are guessing, place an X by your answer. If you want to know more, draw a circle around your answer. The term *sex part* is used here to mean either sex *organ* or sex *structure*. Each drawing shows one half of a human body which has been divided through the center from front to back.

MALE SEX PARTS

1. What covers and protects the male reproductive glands? 1._____
2. Where are the male reproductive cells formed? 2._____
3. Where do the newly formed male reproductive cells accumulate? 3._____
4. Which is the male sex organ or structure used in sex relations and urination? 4._____
5. What male organ holds urine? 5._____
6. During sexual excitement:
   a. What male sex part becomes larger and firmer: 6a._____
   b. Where is the male most sensitive to touch? 6b._____
   c. Which male sex part becomes moist? 6c._____
7. Which is the male organ for sex relations? 7._____
8. At the highest point of male sexual excitement fluids are added to the male reproductive cells by three glands. These *three* glands are: 8._____ _____ _____
9. Which male sex part, if it is closed by disease, injury or surgery, will make it impossible for the male to become a parent? 9._____
10. Which male sex gland supplies the male bloodstream with products important to physical growth and health? 10._____
11. What male sex part is removed in castration? 11._____
12. Which is the male sex part that is partially removed in circumcision? 12._____

FEMALE SEX PARTS

13. Where are female reproductive cells formed? 13._____
14. Which female sex part first receives the completely formed female reproductive cell? 14._____
15. What covers and protects the outside sex organs and structures of the female? 15._____
16. During sexual excitement two female sex parts usually become moist. These are: 16._____ _____
17. During sexual excitement:
    a. What female sex part usually becomes larger and firmer? 17a._____
    b. Where is the female most sensitive to touch? 17b._____
18. Which is the female organ for sex relations? 18._____
19. Where does the male sex organ enter the female sex organ? 19._____
20. At what place inside of the female organ for sex relations does the male sex organ usually discharge male reproductive cells? 20._____
21. Where does a male reproductive cell meet and unite with the female reproductive cell? 21._____
22. Where do the united male and female reproductive cells continue to grow until the baby is ready to be born? 22._____
23. In being born a baby must pass through two female sex parts. These are: 23._____ _____
24. Where does a baby come out of its mother's body? 24._____
25. Which female sex part, if it is closed by disease, injury or surgery, will make it impossible for the female to become a parent? 25._____
26. What female sex gland supplies the female bloodstream with products important to physical growth and health? 26._____
27. What female organ holds urine? 27._____
28. Which is the female part or structure for urination only? 28._____
29. The menstrual flow comes from what female sex part? 29._____
30. In leaving the female body menstrual flow must pass through two sex parts. These are: 30._____ _____
31. Where does the menstrual flow leave the female body? 31._____
32. In douching where is the nozzle of the syringe placed? 32._____

When you finish, go on to Part III.

PART III

DIRECTIONS: In the blank space beside each definition below, write the *number* of the word that *best* fits the definition. Be sure to fill *all* spaces in both columns. If you do not know, *guess*. If you are guessing, place an X by your answer. If you want to know more about the meaning of a word, draw a circle around your answer.

1. Caesarean	5. labor	9. puberty
2. hanian	6. menstruation	10. senility
3. conception	7. menopause	11. semen
4. douche	8. pregnancy	12. sterilization

_____ The stage of physical growth during which boys and girls become able to have children.

_____ Flushing the vagina with a liquid.

_____ The birth of a baby through the abdomen by a surgical operation.

_____ Fluid containing male sex cells.

_____ The shedding of a lining of blood cells by the womb.

_____ A surgical operation which prevents a person from becoming a parent.

_____ That time when a woman is losing her ability to have children.

_____ The joining of a male and a female cell.

_____ The physical effort of giving birth to a baby.

_____ The condition of a woman from the time her baby begins to develop until it is born.

13. climax	17. ejaculation	21. orgasm
14. coccyx	18. erection	22. ovulation
15. copulation	19. fervent	23. ovum
16. coitus	20. intercourse	24. sperm

_____ The separation of the female egg from the gland where it forms.

_____ } The highest point of sexual excitement in male
_____ } or female.
(Write two numbers.)

_____ The reproductive cells of the male.

_____ }
_____ } Sex relations.
_____ } *(write three numbers.)*

_____ Discharge of fluid by the male at the highest point of sexual excitement.

_____ The enlarged and firm condition of the male sex organ during sex arousal.

_____ The reproductive cell of the female.

25. adultery	29. gonads	33. mistress
26. fornication	30. hirsute	34. rape
27. frigidity	31. impotence	35. travesty
28. genitals	32. masturbation	36. vulva

_____ Low degree of sex desire—especially in women.

_____ Male and female sex parts.

_____ Sex relations of an unmarried male with an unmarried female.

_____ Sex relations forced upon another.

_____ Sex relations of a married person with someone other than husband or wife.

_____ The outside, visible parts of the female sex organs.

_____ Self-stimulation of one's sex organs.

_____ Lack of ability to perform normal sex relations—especially in men.

_____ Male and female sex glands.

_____ A woman who usually limits her sex relations to one man to whom she is not married.

37. abortion	41. infamy	45. prostitute
38. gonorrhea	42. miscarriage	46. syphilis
39. homosexual	43. prophylactic	47. taboo
40. incest	44. promiscuity	48. Wassermann

_____ A disease of the blood which usually enters the body through the sex organs.

_____ The birth of a baby before it can live.

_____ A disease of the inside lining of male or female sex organs.

_____ A blood test for a venereal disease.

_____ Natural or intentionally caused birth of a baby before it can live.

_____ Sex relations with a close relative.

_____ A woman who offers to have sex relations for pay.

_____ A person who has sex relations with a member of the same sex.

_____ A device or chemical used to keep one from catching a venereal disease through sex contacts.

_____ Sex activities with more than one person during the same period.

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STATEMENT made by the Secretary of State for Social Services, the Rt. Hon. Davis Ennals, M.P., on 23 March 1977, following the presentation of a Report to the DHSS upon the completion of the work presented in this thesis :

Mr Patrick Jenkin asked the Secretary of State for Social Services what reply he has sent to the National Marriage Guidance Council to its request for financial support for a nationwide sex-therapy service.

Mr Ennals said: The National Marriage Guidance Council recently submitted a detailed programme of its two year pilot project, largely funded by my Department, in the training of counsellors to treat sexual difficulties as part of their general marriage guidance work. The Report concluded that suitably trained volunteer marriage guidance counsellors can successfully counsel clients with certain sexual problems. After careful consideration of the Report and the National Marriage Guidance Council's proposals to develop this aspect of its work, my Department has agreed in principle to support a development of this work up to March 1980.

Hansard, 23 March 1977, p.578
