Review of the Literature on the Treatment of Sexual Dysfunction and a Study of Couples Who Received Treatment at Loyola University Hospital

Catherine Green
Loyola University Chicago

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REVIEW OF THE LITERATURE ON THE TREATMENT OF SEXUAL DYSFUNCTION AND A STUDY OF COUPLES WHO RECEIVED TREATMENT AT LOYOLA UNIVERSITY HOSPITAL

by

Catherine Joy Green

A Dissertation Submitted to the Faculty of the Graduate School of Loyola University of Chicago in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy

May

1978
ACKNOWLEDGEMENTS

The author would like to thank the members of her committee, Dr. Gloria Lewis, Dr. Domeena Renshaw, Dr. Jack Kavanagh, Dr. Frank Kobler and Dr. Theodore Millon for their professional assistance in completing this dissertation. Special thanks to Dr. Manuel Silverman who has been my advisor and guide throughout my graduate career with continuing encouragement and support.

The author is grateful to the couples who completed the program in the Sexual Dysfunction Clinic of Loyola University Medical School, and to the staff and cotherapists at the clinic who gave their time, suggestions and support and helped make this study possible.

Fond thanks go to my fellow students at Loyola University of Chicago and my colleagues at the University of Illinois. Their intellectual clarity and excitement provided an environment that allowed me to grow both as a professional and as an individual.

My children deserve special notice for their encouragement, affection and humanity. Finally, thanks to Robert Green for being supportive and understanding throughout my graduate career.
The author, Catherine Joy Green is the daughter of Stella Pelzmann and Alfred Pelzmann. She was born December 21, 1944 in Chicago, Illinois. She is the mother of Julie, Gerald and Steven.

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CHAPTER I

INTRODUCTION

Chapter One will provide an introduction to the study, including background, purpose, hypotheses, definition of terms and limitations. Chapter Two will review research trends in marital and sexual dysfunction particularly in relation to intervention modalities. Chapter Three will provide a detailed outline of the design of the study, and will further describe the personnel involved. Chapter Four will be a report of the statistical analysis of data, and a discussion of those results. Chapter Five will contain a summary, conclusions, and recommendation for further research.

In sexual behavior the interplay of values, learning and needs is apparent and appears inseparable from the quest for self-understanding and self-respect.\(^1\) Hopefully as quality education in sexuality and communication become increasingly available during the school years, the problems adults

\(^1\) Katchadourian, Herant. Human Sexuality: Sex and Nonsense, (San Francisco: W.H. Freeman, 1974).
face in the marital unit may be handled more effectively, through prevention rather than amelioration. This broadened conceptualization of the role would include those duties mentioned by Mary Calderone, President of SEICUS. Addressing counselors she speaks of services in regard to sexuality as two-fold processes. First, education is a process by which factual information about sexuality if offered and assimilated. Second, counseling is the art of helping the individual transmute this education into fulfilling sexual behavior.

The specific program being studied, Loyola Sex Clinic, was developed as a modification of the brief sex therapy program as delineated by Masters and Johnson. Additional experiential, didactic and therapeutic components have been added within Loyola's setting.

Dual therapist teams are utilized. They are composed of at least one physician, and a cotherapist. The Loyola Clinic serves as a training program and the teams are composed of trainees under

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the supervision of several experienced faculty members. There is a demand for the development of effective training programs such as this one for sex therapists. These programs need to be of quality and clearly delineated.  

This study looks at the issue of the effectiveness of this program as well as reviews other work in the field. The following goals will be addressed in this study.

Goal A: Review the literature on the components of sound sexual functioning and the etiology of sexual dysfunction.

Goal B: Review the literature on past and current methods employed in the education and counseling of adults in their marital relationships with specific reference to sexual dysfunction.

Goal C: Provide a detailed and controlled study of treatment effectiveness and long term effects utilizing information gained at Loyola's Sexual Dysfunction Clinic from couples in the program and couples on the waiting list.

Goal D: Describe the Loyola couples in C on numerous dimensions and assess their relationships as described in self-reports during treatment and follow-up.

Goal E: Seek to identify possible predictors of program outcome.

Goal F: Follow-up the same couples defined in C for additional assessment of outcome and ascertain the degree to which the new behaviors were integrated into the life styles and functioning of the couple.

Goal G: Compare couples described in C with couples on the waiting list for the Loyola x Clinic.

Brief discussions of the relevance of these goals follows.

Goal A: The literature review will address the components of sound sexual function and dysfunction. In speaking of the prevalence of the problem Green contends that half of all married couples have an area of sexual incompatibility which may manifest as marital complaints, vague somatic symptoms and general disease or statement of dysfunction. Sexuality is expressed with another, not to another, or for another, and integrated into the total day's behavior.


8. Masters and Johnson.
Dysfunction is subjectively defined within the confines of an individual's perceptual set. Lobitz and LoPiccolo, define sexual dysfunction in the following fashion.

"In the absence of any physical pathology, sexual dysfunction is viewed as a learned phenomenon, maintained internally by performance anxiety and externally by a non-reinforcing environment, principally the partner. In addition, a lack of sexual skill, knowledge, and communication on the part of one or both partners contributes to the dysfunction."

In reviewing the literature on dysfunction one can best say that any sexual disability has two components: an emotional component related to internalized conflict and a habitual conditioned response mode related to repeated partial gratification. The first issue is delineation of the problem by the individual. Both the therapist and client attempt to define the dysfunction. The question must be asked, "To whom is this a problem?" If the couple doesn't define a dysfunction as such, the therapist should not compel them to do so or attempt treatment.


Given individual differences sexual dysfunction can best be defined in relation to sound sexual function which requires communication, absence of anxiety and maturity. Renshaw, referring to the flowing nature of sexuality states,

"The dynamics of sexuality are the ongoing product of all the changing internal and external stimuli acting on each individual's sex drive at any given moment in time—ever present, ever active, ever in need of comfortable expression or control."\(^{12}\)

Goal B: deals with the treatment of sexual dysfunction. In order to serve their clients, professionals must start to examine and clarify values, and begin utilizing new forms of treatment as well as more traditional ones, in an effort to aid their clients in assessing and growing within their relationships.\(^{13}\) Treatment of sexual issues specifically, is complicated by the interactive processes involved in the marital relationship. Marriage and sexual expression within marriage, is not a union of two separate individuals, but a dynamic interaction. Sex is a form of communication and problems in sexual relationships often are the vehicles by which marital dissatisfaction is expressed.


\(^{12}\) Renshaw, Domeena, "Sex Problems in Medical Practice." (Mimeographed.)

Goal C: deals with the issue of the effectiveness of the particular program under evaluation. Many of the programs utilized for treatment of sexual dysfunction are modifications of programs utilized for gynecology or psychiatry where sex therapy has been effective but untested. Knowing the components of sound sexual function is the first step in developing a program for remediation of sexual dysfunction.

There remains a real need for empirical validation of programs. The few early studies on treatment of sexual dysfunction had no follow-up, and long term effectiveness of the treatment programs often was open to question. In spite of the lack of empirical evidence of effectiveness, programs are continuing. More and more physicians, psychologists, social workers and counselors are being asked to deal with sex-related problems in their daily practice. People seeking this help rely on professionals to be informed, able, and most important, effective.\textsuperscript{14,15} However, poor quality therapy is a reality in a field where demand is great, licensure lacking, and training programs limited. Anyone can hang out a shingle "Sex Therapist." Masters, in a warning to the public about the danger


of phony sex clinics states that there are between 3,000 and 5,000 clinics dealing with sex problems in the country. Of these perhaps one hundred are legitimate.\textsuperscript{16} Even those which are legitimate need more research within the natural setting of operating programs to assess the effectiveness of their approaches to the treatment of sexual dysfunction.\textsuperscript{17}

Goal D seeks to describe the couples studied at the Loyola and assess their relationships. Although other studies have described components of behavior, or aspects of concern, few systematic attempts have been made to assess couples in treatment for sexual dysfunction along numerous dimensions. Hopefully this global approach will clarify some of the actions and interactions involved in the treatment of sexual dysfunction.

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Goal E attempts to identify possible predictors of program outcome. It is known that some people seem more suited to specific treatments than others. A major concern of the therapist is to maximize the possibility of positive outcome for the couple. Unfortunately the tools most effective as predictors are generally used best within the context of a therapeutic relationship. It is hoped that predictors can be developed to suggest those people who will be likely to be helped in this program. Although these might not be very practical outside a therapeutic relationship, they could be used by practitioner involved in therapy with couples, who might then be referred to this program.

Goal F deals with the follow-up of the couples after 3 months for additional assessment of outcome and to ascertain the degree to which the new behaviors were integrated into the life styles and functioning of the couple. The ultimate measure of a treatment program is the integration of new behaviors. By comparing the immediate effectiveness of the program and the continued effectiveness at three month follow-up a measure of this integration can be made.

Goal G would compare couples described in C with couples on the waiting list for the Loyola Sex Clinic. It is hoped that couples who are awaiting an opportunity for treatment will fill out materials that couples going through the program complete. This will serve as a base for comparing those who have simply decided to attempt change.
Purpose of the Study

In relation to the background information that has been presented the purpose of this particular Loyola Sex Clinic study is to a) describe couples and assess their relationship (Selected personality variables, as defined by the Minnesota Multiphasic Personality Inventory; the Millon Illinois-Self Report Inventory Form M; selected medical data; selected biographical data; presenting concerns; observed behavior during educational training and counseling; levels of communication; levels of satisfaction and the self-assessed outcome ratings of these approaches and their long term effectiveness with married couples will be utilized for this purpose), b) to identify possible predictors of program outcome, c) to follow-up the couples for additional assessment of outcome and ascertain the degree to which the new behaviors were integrated into the life styles and functioning of the couple, d) to compare couples in treatment with couples on the waiting list for the Loyola Sex Clinic, e) to aid in the development of improved training programs for sex treatment, f) to analyze responses of the couples on their follow-up questionnaires since such information may indicate modifications in the program that would improve long term effectiveness, resulting in more permanent changes, g) to provide preliminary testing to select a specific modality for a particular couple so as to maximize potential effectiveness and minimize treatment failures.
Hypotheses

1. The first hypothesis is that there is a relationship between a) selected personality variables, selected medical data, selected biographical data, communication, marital satisfaction, presenting sexual problems and b) the immediate and longterm outcome of treatment for couples enrolled in a sexual dysfunction clinic.

2. The second hypothesis is that some of the data in a of the first hypothesis are potential predictors of outcome.

Definition of Terms

Behavior during Program

Behavior during sex counseling is defined as the evaluation of the subject's involvement in specific aspects of the program as evaluated by the cotherapy team.

Long term effectiveness

Long term effectiveness is defined as the degree of success in amelioration of presenting difficulties over the follow-up period.
Presenting sexual concerns

These concerns are defined as those issues which made the couple seek the clinic's help, including premature ejaculation, primary impotence, secondary impotence, primary non-orgasmic, secondary non-orgasmic, dyspareunia, vaginismus and lack of interest in sex.

(see Appendix A)

Selected biographical data

These are defined as those data obtained from the history sheet including details on both the subject's history and the history of the nuclear family.

Selected medical data

These are defined as those data obtained from the history and physical including current state of health, previous health problems and the psychiatric history of the subject.

Selected personality variables

These are defined as specific scale scores on the MMPI and the MI-SRI Form M.

Level of communication

The level of communication is defined as the total score on communication questions in the Marital Adjustment Test, as a pre-test and the total score on the communication questions of the
Self-Report Questionnaire as a post-test.

Reeducation outcome

The outcome of reeducation is defined as the degree of success in the alleviation of presenting complaints.

(see Appendix B)

Assumptions

1. Brief psychobehavioral therapy is a viable way to promote symptom reversal in sexual dysfunction.

2. Couples in the program will evidence different levels of communication, satisfaction, function and presenting problem.

3. Differing levels of communication, satisfaction, and function will be related to the success of the program.

4. Lack of involvement with each other and with the program will influence response to study questions.

Limitations of the Study

1. Volunteers for research on marriage and sexual counseling tend to come from families of higher income levels than non-participants, also they have dated longer before marriage and have higher educational levels. This and the fact that they are self-

18 Murphy and Mendelson.
referred may cause the sample to differ from the general population and therefore the issue of generalizability is a serious problem.

2. Time limits truncate treatment and would leave some couples appearing unimproved in regard to symptoms, but moving in a positive direction. Therefore a simple assessment of symptom removal might not be a valid means of assessing the program in regard to their treatments.

3. The program is spaced over time, so the subjects are involved in daily life activities throughout the program which have both positive and negative impact.

4. Several tests and inventories are given to the couples, and these might serve to have a sensitizing effect.

5. Waiting list couples have as yet not formed a relationship with the program and have hesitation about sharing by telephone or by questionnaire, intimate personal data.
CHAPTER II

REVIEW OF LITERATURE

Introduction

"Sexual health is the integration of the somatic, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love."¹ Sexuality has become an issue of international concern. Nationally this is seen in the burgeoning interest in sexual expression. With this upsurge in interest has come a demand for sexual satisfaction, and if that is not present, the demand for sex education and counseling. People are beginning to realize that today's issues of sexuality in adults have their roots in the learning and lack of education of youth. Many couples find themselves mismated in marriage, and whether the marriage endures or not, psychological separation occurs. Mismating could be prevented through the counseling and education of young people so that they might make their marital decisions more soundly. Those already married could benefit from this type of education by preventing a gap from growing between the partners.² Concern is now turning toward developing effective educational


programs to accomplish this with young people. Pietrofesa, addressing the issue of the role of the school counselor in sex education, states that even today youngsters receive most of their sex information and misinformation from their peer group with emphasis on misinformation.\(^3\) Counselors, both in school and other settings are in a position to provide needed information, guidance and communication training. Individuals would have the opportunity to learn effective methods for building and maintaining relationships. These services could be utilized before, and even during the development of significant relationships, avoiding the need to overcome obstacles created by misunderstandings and long-standing problems.

Sexual function is a product of physiology and information. Sexual function and sexual dysfunction must be viewed within the context of the marital interaction; in relation to the physiology of sexual function; variations of sexual behavior, enhancement of sexual pleasure; and the nature and treatment of sexual malfunction.\(^4\)


This review of the literature will deal with all these aspects of sexual dysfunction. First, the antecedents of dysfunction will be reviewed, including descriptions of couples that seek marital and sexual counseling. Causes of dysfunction must be dealt with, because treatment is often predicated on etiology. Next treatment of both marital and sexual dysfunction treatment will be reviewed, including components of current treatment models. Both of these areas are discussed, because they are in fact often the same. The differences in the statement of presenting problem is more a function of educational level and socioeconomic level, than of the symptomatology.

Several problems arise in connection with reviewing the research relating to treatment of sexual dysfunction.

1. There are few articles evaluating the effects of current programs. Most of the literature is descriptive, delineating methodology, and drawing conclusions as to success, without concrete operational definitions of outcome.

2. The criterion state in much of the marital literature is undefined, or subject to vague global statements in regard to satisfaction, or happiness.

3. Studies often are briefly described, and cannot always be assessed for adequate controls, statistical analysis or methodology and results.

In this report, research results have been considered valid within the above described limitations.
Characteristics of Couples Presenting for Therapy

Many couples seek therapy for marital problems due to unhappiness based on unfulfilled spouse expectancy, which in turn contributes to the continuance of marital dysfunction in attempts to punish the other partner for not fulfilling self-needs. Before one can assess the characteristics of couples who describe their marriages as problematic, an hierarchal system of evaluating levels of marital distress and change must be developed. Vincent, in an attempt to develop such a system examined the behavioral manifestations of marital distress in two settings. The first was in a laboratory problem-solving setting. The second was in a natural setting where the focus was on the exchange of social reinforcement and recreational behavior. The groups being compared were distressed and non-distressed couples. It was found that problem solving behavior tends to be specific to the marital interaction and is not a generalized personality trait. A second result was that all marital partners were more negative in problem solving with spouse than non-spouse, while this discrepancy increased in dissatisfied marital pairs. Fiore studied


the discrepancy between expectations of and reports of actual manifestations of loving behaviors in couples in an effort to empirically derive multiple criteria, on the basis of specific behavioral referents, with which to classify marriages as dysfunctioning or functioning. He found that partners in both types of marriages appear to expect about the same in terms of love expression, but that partners in dysfunctioning marriages report less actual enactment of loving behaviors.\(^8\) In another study on current attitudes and practices in marriage several factors were prominent in couples presenting for marital therapy. In at least fifty per cent of the cases at least one partner had been unfaithful. In addition there was a serious disparity between the ideal of greater equality of role behavior and enactment in terms of family structure.\(^9\)

Couples presenting for sex therapy show characteristics in addition to these. Most couples suffering from a sexually dysfunctional relationship cannot be completely educated in sound sexual functioning until relief of marital conflict has rendered them educable.\(^10\) In reference to symptomatology, women applying to a sexual

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dysfunction clinic complaining of sexual inhibitions were found to be identical to a normal control group in terms of psychological profile, and appeared less neurotic than psychiatric outpatients. Generally couples coming in for sex therapy as opposed to psychological counseling are no less healthy than the general population, with differences arising more strongly in historical antecedents within the nuclear family, and marital relationship than in levels of psychopathology.

**Development of Dysfunction**

Sexual dysfunction is multicaused, and overdetermined. In fact, any number of etiologic factors can contribute to the development of a dysfunction. The relationship between sexual dysfunction and marital satisfaction is of particular importance. Sexual conflict is often a part of overall marital dissatisfaction, depression and unhappiness with one's spouse. In addition, the reported areas of concern, whether marital or sexual, seem more dependent on extraneous factors than on actual symptomology. Frank, et al reported the results of an assessment of twenty-five couples presenting

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for marital therapy and twenty-five couples presenting for sex therapy. Women presenting for marital therapy were bothered by orgasmic dysfunction in over fifty per cent of the cases, with a high incidence of lowered libido and general disinterest. Men presenting for marital therapy were also bothered by lowered libido, erectile difficulties, and reduced interest in affectionate behaviors. Conversely, couples presenting for treatment of sexual dysfunction showed evidence of marital discord and complained of unresolved marital difficulties. Both groups complained of interpersonal problems in which there was a decreased interest in talking to one another, an expression of the feeling that their spouse did not understand them, and did not fill their emotional needs. When the data were analyzed, it was found that whether the couple viewed the problem as one of marital discord, or sexual dysfunction seemed to depend on such factors as the source of referral, socioeconomic class, the length of marriage and the presence of children rather than absolute behavioral differences. Steger did a quasi-experimental time series study designed to investigate the extent of covariation between a couple's daily ratings of marital satisfaction and the daily ratings of the occurrence of sexual behavior and the satisfaction associated with this behavior. The experimental hypothesis was that a significant correlation exists between the subject's daily ratings of mar-

tal satisfaction and the ratings of sexual relationships for the same period, and that these correlations are higher for couples with mildly happy marriages. The results were in the correct direction, but fell short of significance. This may be a function of the limited sample size. It appears that the quality of the marital relationship both reflects and modifies the level of sexual satisfaction and perception of sexual dysfunction.

Specifically, sexual dysfunctions in the male include premature ejaculation, primary impotence, secondary impotence, and lack of interest in sex. In the female the dysfunctions include primary nonorgasmic, secondary nonorgasmic, dyspareunia, lack of interest and vaginismus. Only recently has sexual aversion been considered a dysfunction. Previously this was considered to be solely the product of intrapsychic or severe interpersonal conflict. Not all concerns have equally severe impact. Nonorgasmic response in the female may be problematic, but not necessarily devastating for the individual. A woman suffering from this difficulty is still able to participate in sexual relations while men suffering from erectile


difficulties cannot. Dyspareunia or painful intercourse is more commonly a problem in women than in men. Fink in his study of this complaint found that the two major causes appeared to be psychological, and that these were anxiety and hostility. Varied as these seem, their bases often overlap and include interaction effects, past experiences and prior learning.

Although arguments may polarize, even the earlier statements in regard to sexual function showed an awareness of the dual nature of the etiology of sexual dysfunction. In 1905 Freud stated that it may be possible for sexual disabilities to derive from two sources, internal conflict and inappropriate learning. In analyzing all dysfunctions it must be remembered that these do not exist independent of the relationship, but as a dynamic aspect of the marital interaction. For this reason, the role the dysfunction serves within the relationship becomes a significant aspect in the design of the treatment program.

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Individuals do not enter into a marital relationship untouched by their pasts. The pasts of the couple interact with their present spousal experiences to shape the marital relationship. These historical antecedents are often significant in the development of dysfunctions, and in their maintenance. Historically life experience of patients presenting for the treatment of dysfunction, often reveal high frequencies of gross family pathology. These include psychosis, alcoholism, and abnormal sexual behavior. In one study fifty-seven per cent of the subjects had at least one parent exhibiting such behavior, while thirty-two per cent of the individuals reported some form of bizarre sexual activity in their home during their childhood years. There also was a high incidence of early death in the family, and prolonged separation from one parent or another. It seems evident that the individuals raised in these environments became prone to sexual problems through the lack of effective models. Caution must be taken in drawing these conclusions, since it is unknown how many individuals are exposed to similar environments and do not suffer these particular impairments. Physiology also enters into the development of climactic response. All persons may be born with similar genital apparatus, but the individuals' capabilities to be aroused and respond, vary along a

Turning to female dysfunctions one finds that frigidity is a term used by many researchers to encompass a number of dysfunctions in the female. The study of this is hampered by problems of definition and classification. Often the literature does not clarify if reference is being made to nonconsummation, severe vaginismus, orgasmic inadequacy, or a combination of these. Impairment of female response may be a function of ignorance on the part of the couple as well as other more complex issues. In the former, the couple often respond well to simple directive advice. In other situations where the symptoms prove more recalcitrant, the problem may be that the woman has difficulties in accepting the feminine role, or perhaps the manner in which she deals with conflicts in terms of anxiety or aggression. It is not uncommon for a woman to complain of increasing difficulty with sexual expression that is concurrent with an increasing awareness that her needs are not being

met, or fairly considered in the relationship. Along these lines, Wolpe assumes that in cases of situational frigidity, the inhibition if often a part of a general family conflict, and/or a specific interpersonal relationship. 22 Hogan in his explication of the use of implosive therapy in the treatment of frigidity lists the following dynamic origins of the problem: fears of loss of control; fear of pregnancy; actual traumatic incidents; fear rooted within the interpersonal relationship; fears of sexual assault; cultural training; relationship of sexuality and guilt; violation of the incest taboo; and finally as part of aggressive expression. 23

A man suffering potency problems is more vulnerable. His difficulties are readily apparent, contributing to an increase in anxiety, and a probable decrease in function. Apathognomonic symptom of psychological impotence is that it is selective and occurs under one set of circumstances, and not another. Impotence can also be induced by drugs such as phenothiazines, alcohol, anticholinergic agents, and organic disease. Frequently the first incident of impotence is related to a drug such as alcohol, and the symptom becomes entrenched through ensuing performance anxiety. Cooper defines impotence as


23 Hogan.

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23 Hogan.

one of three types. The first is constitutional impotence where
the individual has low sex drive and responsiveness without demon-
strable organic pathology. The second type is organic pathology,
and this represents perhaps five per cent of cases of impotence.
These result from pathologic lesions or disease. The most common
form of impotence is the final category, psychological impotence.  
Ansari in his study of impotence delineated three individual types.
Group I developed impotence because of anxiety in sexual situations
generally. Group II developed impotence as a reaction to the sexu-
al response and personality of their partners. Group III individu-
als suffer from a gradual decline in potency, which may be attribu-
table to inherent constitutional causes.  
In studies of the rela-
tionship between potency and testosterone blood levels, it was found
that these were not significant in potency. However, a curious re-
sult of the study was the finding that those individuals with normal
or high blood levels of testosterone were more anxious.  

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hormone replacement, or augmentation therapy is sometimes utilized in treatment of impotence, the belief is that their effect is largely that of a placebo. A more likely thesis than strictly physiological causes of impotence is the belief that emotions are prime determinants of impotence. Five hundred years ago impotence was alluded to in the Maleus Malificarum. In this handbook for the conduct of the Inquisition, the following references were made to the causes of impotence. "If a man be impotent with only one woman, he be bewitched. If a man be impotent with all women, he be sick."28

Guilt can also have its effects with both men and women. There is an inverse ratio between sex guilt and sexual behavior to the point of reduction of perceived sexual needs.29 In this way the individual is dealing with the unpleasant feelings by compelling himself to deny the needs that tend to activate these feelings. A final cause of dysfunction is iatrogenic. If a couple comes to a physician with sexual concerns, and are handled inappropriately, their problems may be crystallized. In addition, if an individual is concerned about function and the physician says problems are to be expected, either due to age or physical ailment, the problem has received the medical stamp of approval and becomes far more difficult to eradicate.

28 Hastings.

The knowledge of possible causes of problems aids the therapists in developing effective programs to aid the dysfunctioning couple. Sexual dysfunction is assessed in relation to sound sexual functioning.

Numerous studies have been done in an effort to more clearly elucidate the variables involved in sexual function. Fisher and Osofsky carried out a study on a wide range of variables. They found that sexual responsiveness was not related to the L and K scales of the MMPI, which would indicate that the answers were probably not given in an effort to provide the socially desirable result. Orgasm consistency was found to be inversely correlated with a variety of hostility variables. Sexual responsiveness was positively correlated with orality. Subjective enjoyment of sex and frequency of sexual expression were not related. Heath and Gallant found in their study of brain activity and emotion that disturbing or disrupting ideation extinguishes sexual excitement, and this has been demonstrated objectively by intracerebral encephalography. They found that during sexual arousal high amplitude spindling occurred in paleocortical areas. This could be stopped instantly by interfering neocortical thought processes, such as mathematical calculations.


Emotional stability correlates with both marital and sexual happiness. The converse, that individual psychopathology underlies many if not all marital problems, is also believed to be true. Even Masters and Johnson have become increasingly aware of the presence of underlying psychopathology as a key factor in some cases of sexual dysfunction. One of the more detailed studies of the


relationship of pathology and dysfunction is Cooper's study of the relationship of hostility and impotence. The results proved to be equivocal. There appeared to be no statistical relationship between level of hostility and treatment response, in either the impotent male or in his spouse, however, the issue of level of hostility and appearance of symptoms was not addressed. 37

Sexual responsiveness has been correlated with numerous variables. Fisher and Osofsky found that it was positively correlated with various measures of the adequacy of the woman's marriage and the degree to which the woman felt positively towards her spouse. 38 Maslow stated that sexual responsiveness was greater in women who are ascendent and dominant than in those who are submissive. 39 These results are particularly interesting in the light of the fact that they were found in the early 1940's when the role of women was considered significantly different from the role definitions of the 1970's.

Both partners bring conceptions and misconceptions about sexual expression into their relationship. A prominent cause of sexual dysfunction is the unrealistic, or even destructive components of these beliefs about sexuality. Caplan and Black in dealing with

37 Cooper.
38 Fisher and Osofsky.
this issue say that most sexual problems are centered around unrealistic expectations, particularly distorted conceptions of orgasm. Popular concern with sexuality is beneficial in that taboo subjects may now be discussed. However, not all the popular literature is responsible, and often the impression is that total sexual expression is not an option, but a mandate. This tends to increase the level of aspiration of the readers, and consequently increase their sense of dissatisfaction if these expectations are not met. In addition there are those individuals who continually raise the magnitude of their hurdles. They respond to every success by further raising the "ante" for satisfaction and self-approval. Thus they are continually facing themselves with the threatened loss of self-esteem, and by their perfectionist standards continue to underachieve.

Marital expectations also enter into the development of sexual dysfunctions. As the marriage fails to provide satisfactions in relation to caring and warmth, as well as more instrumental aspects, sexual pleasure is reduced. It has been found that there is a tendency for women particularly, to move from sexual responsiveness to unresponsiveness as a function of an unsatisfying experience


in marriage. Often the couple settles into a ritualized pattern of behavior, both maritally and sexually. Countermeasures such as promiscuity, infidelity, group sex or wife-swapping may have been tried to alleviate the sameness, but these generally prove unsatisfactory, and the couple present for counseling complaining of lack of enjoyment.

Throughout the literature it is seen that marital and sexual issues are almost inseparable, and to artificially separate their treatment would be simplistic and inaccurate. Marital and sex therapy are clinically interrelated because they deal with different symptoms of overlapping aspects of the couple's total relationship. Often the individual will express a willingness to be involved in sex therapy, but not admit to marital conflict. The converse also occurs, where the individual presents for marital concerns, but does not disclose the presence of sexual dysfunction. The therapist must remember that his role is to remain secondary to the cohesiveness


of the marital unit and not impel an awareness the couple can't accept. Training of therapists must focus on this aspect, as well as on the increase of self-awareness in the therapist. In fact the approach to sexual therapy is such that psychiatrists in continuing education programs for training as sex therapists, often have to unlearn some basic therapeutic habits. To fully deal with the treatment of sexual dysfunction, it becomes necessary to be aware of the etiology of marital conflict, often a component in sexual problems, and the components involved in marital satisfaction, for it will be through the treatment of the marital unit that sexual dysfunction can be dealt with. Sexual dysfunction sometimes can be reversed by behavioral interventions at the level of symptoms alone. In a large percentage of couples this new behavior will not be maintained. The report from the couple is that all behavior in the general marital interactions erodes the therapeutic gains in sexual functioning. Marital satisfaction them becomes a key issue in the treatment of sexual dysfunction.


Marital Satisfaction

Numerous criteria have been proposed to assess marital success, and the choice amongst these criteria determines in large part the interpretation of results in the studies of satisfaction. These criteria include permanence, happiness of mates, satisfaction with the marital relationship, sexual adjustment, marital adjustment, integration of the couple, consensus and the level of companionship.48 One attempt to assess the level of marital integration, is an index which pertains primarily to matters of consensus and interpersonal relationships. It is brief, not overly evaluative, and is explicit. The advantage of this instrument, the Index of Marital Integration is that scores of the couple are analyzed in an effort to assess the dyad, as opposed to the individual alone, as was done in the Burgess, Cottrell and Terman studies.49 Another approach is seen in the Edwards and Klemmack study to determine which variables relate to life satisfaction, and which are most efficient predictors of this satisfaction. The data was derived from a study of health, housing and social participation in the middle-aged and elderly. The Adams Life Satisfaction Index was utilized and it was found that the primary determinant of life satisfaction was socioeconomic status, having


wide-ranging direct and indirect effects. Perceived health status and the intensity of neighboring also predicted satisfaction.

Sinkkonen in his study of modern and traditional marriages found that different aspects of the marital relationship became significant as a function of the age of the individual. Wife's working, educational homogamy and the presence of children were more strongly related to marital satisfaction in young Protestant spouses, than in other groups. Spousal communication and affectional ties were better explanatory variables among younger Catholics, and older spouses in both groups. Orden and Bradburn in their study of marital happiness found that while the presence of loving sex and/or sexual love is a strong satisfier, its absence is a powerful dissatisfier. Returning to the conceptualization of marital satisfaction, much of the marital satisfaction literature appears contradictory, however, Rollins and Cannon found in their study that these apparent contradictions were a function of measurement differences rather than pop-


ulation differences. Regardless of measurement differences, what appears to be occurring is a change in emphasis from survival and security to a focus on companionship, love and communication. This change of focus is often one-sided. Crago hypothesized that fulfillment of marital role causes greater emotional stress for the wife, with the wife's role defined as accommodating, expressive and integrative in contrast to the husband who fulfills a rigid instrumental role. Uhlenberg in his study of variations in family life over the cycle for females found that the most important variables for determining family structure are mortality, marriage, childbearing and marital dissolution. The prototypal pattern at age fifty shows a female who has married, has at least one child, and still is living with her first husband. The women currently at this age have reached the zenith of conformity to this ideal. The decline in mortality, reduction of childlessness and declining ages at marriage have created a situation where more women are currently living this life than ever before, or ever will in the future. Increasing marital instability will serve to reduce the likelihood of survival


of first marriages along with expressions of satisfaction in younger populations. Luckey studying the length of marriage in relation to perceptions of the spouse found that the longer couples were married the less favorable qualities each saw in his mate. This was not associated with self-perception. Subjects in happy marriages saw their spouses as less admirable than formerly, while those in unhappy marriages saw their spouses as being more undesirable than formerly.

Many researchers have posited that the degree of investment in the relationship is directly proportional to the subject's belief that the relationship is a satisfying one. Rollins and Feldman, basing their hypothesis on the theory of cognitive dissonance predicted that wives would distort the evaluation of their marriage in a favorable direction more than husbands would because the marriage was more central to their lives. This hypothesis was supported in their study. Another study found that the wives' marital satisfaction is related to the congruence between the husband's self...


concept and the concept of him held by his wife. Wives appear to be more accepting of disappointment, of noncompliance with their expectations, and are essentially rather stiocal. This expectation of wifely accommodation serves as a self-fulfilling prophecy, for it motivates behavior that is rewarded. Much of this research would indicate that women's marital satisfaction is outside of her control, and her perception of the relationship, and in many ways herself, is totally subject to external control.

Murstein and Beck conducted a study to assess the relationship between self-acceptance, role compatibility and marital adjustment. It was found that similarity and self-acceptance were positively correlated with marital adjustment, as was role compatibility. It appeared that the sexes have unequal roles in determining marital adjustment, in that wives' satisfaction were more related to their perceptions of their husbands, than the reverse.

Numerous studies have been done to determine the relationship between personality variables and marital adjustment. In Griffin's study of the personalities of couples involved in conjoint marital

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therapy, it was found that the 16PF variables could be utilized to form effective predictors of scores on a marriage role questionnaire.  

Kind found that similarity of spouses' personalities with regard to aggression, skepticism and self doubt was related to marital satisfaction. In his study involving personality dimensions as defined by the Myers-Briggs Type Indicator Lindner found that there was a small but significant tendency for intermediate values of personality similarity to be associated with greatest marital happiness. He also found personality similarity between mates to be positively associated with length of marriage. In regard to communication he found a significant tendency for reported feelings of being understood to be positively associated with marital happiness. The MMPI is an instrument developed to assess the level of psychopathology in an individual. In Barrett's study the MMPI was utilized to assess the relation of emotional disturbance, or psychological maladjustment and marital maladjustment in divorced couples, couples in marriage counseling and in control normal couples. Both experimental groups showed substantially more psychological impairment than the control couples, although no specific profile was widely associated with

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marital adjustment. In summarizing the literature on personality and marital satisfaction it is seen that there are no clear-cut personality characteristics associated with either marital satisfaction, or dissatisfaction. A more accurate view is that the level of satisfaction is in large part determined by the nature of the marriage interaction, and the interplay of the personalities of the husband and the wife, rather than by some problematic configuration.

Self-disclosure, and the ensuing vulnerability, are central to a sound dyadic relationship. Webb studied the relationship between an individual's self-acceptance and willingness to disclose to a marital partner, and his empathy and marital satisfaction. He contended that in those couples where openness and comfort with self were prominent, marital satisfaction and empathy would be higher. He found that in couples rated high in self-disclosure and self-acceptance, marital satisfaction was significantly higher than in couples rated low on self-acceptance and self-disclosure. Once again it was demonstrated that comfort with self is concurrent with marital satisfaction.


Dependency is one personality characteristic that has importance in the perception of marital satisfaction. Smith studied the assumption that the level of object need and the perception of that expression within the marital relationship affected the degree of marital satisfaction for the couple. His conclusions were: wives reported higher marital satisfaction as they reported higher dependency needs; husbands and wives reported higher marital satisfaction as they reported higher dependency needs perceived in the partners; Husbands and wives reported higher marital satisfaction as they reported seeing their partners perceiving them as having higher dependency needs; the congruence of self-perceived and partner perceived dependency related to marital satisfaction. Once again it must be remembered that satisfaction is a self-assessed precept. Consequently increased marital satisfaction may not refer to any absolute differences in observable behaviors, but may instead represent an increased need to feel that the relationship in which the partners are invested, is a rewarding one.

In another study on self-disclosure in couples completing an extended marital questionnaire, multiple regression was performed on husband satisfaction, wife satisfaction and joint satisfaction. It was found that the self-report of openness in marriage was related

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to communication satisfaction and marital satisfaction. Self description was also related to marital satisfaction. 67

Recently research has turned to the behavioral explication of marital satisfaction. Wills, Weiss and Patterson studied the relationship between day to day activities and marital satisfaction. The following procedure was utilized. Marriage partners were asked to make two types of measurements for each of fourteen days. The first measure was an observation of the frequencies of specific spouse behaviors. The second was a global rating of the pleasantness of spousal interactions. Both instrumental and affectational behaviors were assessed in this fashion. In an effort to control for intervening variables, an assessment of outside events was also included in the study. In the multiple regression analysis, the following results were obtained. Instrumental and affectational displeasurable behaviors accounted for sixty-five per cent of the explained variance in the criterion variable of marital satisfaction, whereas pleasurable behaviors accounted for only twenty-five per cent of this variability, even though pleasurable behaviors were three times as common. In this study as in others, husbands tended to emphasize the instrumental dimensions of the marriage while wives emphasized the affectional dimensions. There was strong reciprocity between affectional behaviors, particularly the displeasurable ones. 68

67 Kind.

This study emphatically demonstrates the weighting of the perceptions of behaviors. Many marital partners are very confused by their spouse's anger in regard to certain behaviors, stating that they do all sorts of nice things in addition to their more problematic behaviors. What becomes apparent is that good behaviors do not erase negative ones, but a few negative behaviors will significantly damage the spouse's perception of level of satisfaction. Consequently a therapeutic goal in marital counseling is often the reduction of unwanted behaviors, leading to greater changes, rather than the simple increment of positive behaviors.

Another study evaluated marital satisfaction as it related to the evaluation of a spouse versus an opposite-sexed stranger. The experimental procedure involved the observation of spouse and non-spouse reading a selection of poetry, and having the observer rate the two both in process and retrospect. These results were assessed in relation to couple's scores on the Burgess-Wallin Marriage Satisfaction Inventory. It was found that females are significantly more negative in their assessments than males, and that strangers were more negative in their assessments than spouses. As the level of marital satisfaction of the observer increases, the adjective evaluation of the spouse became significantly more positive and the number of negative adjectives applied to the stranger increased significantly. 69 It appears that spousal loyalty creates

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a negative set utilized in the perception and assessment of others. This negative set may serve several functions. First it may interact with positive feelings in regard to the spouse to create a sense of positive isolation of the marital dyad. Even in poor relationships feelings for strangers do not become more positive. In these cases, the failure of marital expectations may be leading to a general disaffection with the behavior of members of the opposite sex. Both these might contribute to a centering on the dyadic relationship as opposed to a movement outward into other interpersonal channels for seeking satisfaction.

Farber developed an index of marital integration to be utilized in marital research. This includes both consensus and role-tension indices. The use of this index enables a comparison of husbands and wives on their perception of domestic values, and an estimation of role coordination on the basis of perceptions by husband and wife of one another. He found that consensus was a key to marital satisfaction, and that marital success was positively correlated to the amount the husband agrees with the wife on the importance of the social-emotional aspects of the interactions. 70

All these studies appear to be dealing with the issue of marital satisfaction from different vantages. What is more accurate is that these assessments are being made with instruments designed within differing conceptual frameworks. What seems to emerge is the

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70 Farber.
importance of the individual's belief that the relationship is important, or one's personal sense of commitment to the relationship. In addition, one notes a distortion of the perception of satisfaction as investment increases. The more important the relationship, the more important it becomes that it be perceived as a happy one. The operationally defined studies show the powerful effects of negative behaviors on perception of satisfaction, as well as the interdependence of daily behaviors and levels of satisfaction. The counselor is faced with this and must decide how to utilize this information in dealing with couples. A sense of investment is a positive force and can be used by the counselor in creating a unified effort for productive change. The sense of couple identification is an effective framework upon which unified activities and communication can be built.

Marital Treatment Models

Just as marital and sexual dysfunction are inseparable, the treatment of sexual dysfunction and marital dysfunction often overlap, and may be equally appropriate regardless of presenting symptom. It is of prime importance for the therapists to understand the multitude of elements influencing a marriage, to effectively plan therapeutic intervention. One distinguishing feature of distressed marriages is the inability of the partners to establish the common interpretations of specific behaviors as accepting or rejecting, be-

71 Greene.
cause of their different backgrounds. If these perceptions are not communicated to the spouse, the day by day repetition of negatively interpreted behaviors leads to disaffection and resultant conflict. The goal of marital therapy is to modify the interaction of a married couple that is in conflict on a variety of parameters; social, emotional, sexual and economic. Included in this therapeutic task is the belief that each partner in the marriage must take responsibility in the relationship, and must be willing to attempt to understand the makeup of his or her personality, and how this in conjunction with the spouse's makeup leads to marital tensions. Marriage counseling emphasizes the relationship per se, and the concern is in developing effective communication patterns within the couple, rather than eliminating or modifying behaviors of just one partner.

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Shane conceptualizes this in a systems framework. His thesis is that marriage is best understood as a system which can get out of balance, creating a dysfunctional marriage. The therapeutic emphasis would be upon the reestablishment of equilibrium.  

Moving from aspects of marital problems to systems for treatment, Olson deals with treatment models viewing them as one of two types. The interactional system of therapeutic intervention focuses on the individual and how this individual interacts with others. In the transactional system the focus is on the process of the family as a system. Olson views the goals of marital therapy as assisting the couple to better understand their marital interaction and attempt to find ways in which needs can be mutually satisfied so that growth and development of each partner can be maximized in the relationship. Assessing treatment modalities it must be asked if individuals can actualize within the marital relationship, or are they only capable of problem solving and conciliation?

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Most therapists begin with a series of evaluation interviews. The model proposed by Greene involves one to three individual initial sessions and a final conjoint session in which the major concerns are enumerated, as perceived by the therapist, and options in treatment are discussed. The options proffered would include supportive therapy, essentially a crisis intervention aimed at eliminating recent imbalances in the system. Intensive therapy would be another alternative, including classical psychoanalytic, collaborative, concurrent, conjoint and combined therapies, aimed at a more extensive restructuring of the marital relationship. Therapeutic interventions would involve retraining in more effective patterns of behavior, and one of the key aspects of this would be the use of therapists, or particularly cotherapists as role models for the couple in therapy.

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78 Greene.


There is a serious lack of empirically tested principles in marital treatment models. In addition, much of the research has shown real methodological weaknesses. Development of therapeutic approaches was often pragmatic and atheoretical. In addition, most marriage counseling research continues as a diffuse area of concern with the majority of individuals producing research, maintaining primary identifications in other more traditional disciplines, rather than within marital therapy. The majority of marital research employs the questionnaire as its primary evaluative tool. The questionnaire approach requires the following limiting assumptions: first, spouses own evaluations of each other's behavior are important in understanding the nature of the couples interaction styles; the descriptive labels on the questionnaire have similar referants for all spouses; spouses recollections reflect the extent of the actual behavior of the spouses; spouses interaction styles are stereotypic, and therefore do not need to be repeatedly evaluated. Glick and Gross in considering means of performing marital research give the assumptions inherent in the use of the simulation approach to the study of the marital dyad; spouse interaction styles are determined by the situation and the behavior of the other partner;

81 Olson.

raters categorization of behavior reflect actual significance of behavior to both spouses; the experimemtal behaviors reflect normal behaviors. They suggest a union of subjective and objective measures which would permit a more complex analysis of couples and their response styles, and would open up new areas of study in which the relations among spouses' perceptions, antecedent conditions and behavior could be systematically explored.  

Gurman in his review of the marital therapy research used the following guidelines. "Marital therapy will be defined as the application of some planned, therapeutic techniques to modify the maladaptive or maladjustive relationships of married couples." Less than twenty-five per cent of the research assessed changes in spouses both as individuals and as part of a dyad. Very few included therapist evaluation along with patient self reports, or behavioral data, generally relying on global ratings of change as outcome criteria. Only one half used multidimensional assessments. Within these limitations the following results were reported. Across treatment modalities and varying outcome criteria, the range of improvement was

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fifty-three to one-hundred per cent, which was similar to Eysenck's reports of forty-one to seventy-seven per cent improvements, and Bergin's forty-two to eighty-seven per cent improvement with psychotherapy in general. Across modalities, it appeared that the briefer therapies had better results. One shortcoming of the research was that very few had a category for deterioration. Gurman's recommendation was that there is a need for multidimensional evaluation of marital therapy outcome, detailing symptom relief, observed behavioral change, social and behavioral change. In Beck's review of marital counseling, deficits of outcome studies enumerated were limited client follow-up, as well as infrequency of multidimensional ratings. Studies such as this point out the need for more controlled, systematized approaches to the study of marital and sexual therapy. The multitrait-multimethod approach employed in the current study answers many of the criticisms of earlier studies.

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85 Gurman.

Turning to specific studies of treatment results, one of the most extensive was Cookerly's. He did a study on 773 former marriage counseling clients. The outcome categories were: divorce with poor outcome; divorce with moderate outcome; divorce with good outcome; marriage with poor outcome; marriage with moderate outcome; marriage with good outcome. Period since termination of treatment ranged from six months to four and one-half years. Treatment modalities were rank ordered for effectiveness, as defined by the above outcome evaluations. Conjoint interview ranked number one for total group and for the still married, but sixth for those divorcing. Conjoint group therapy ranked second for total group and for married, but first for the divorced. Individual interview was generally the next most effective, followed by individual group therapy and concurrent therapy. Twenty-one therapists were involved in these treatment programs and it is possible that some of these differences are attributable to therapist effects, but even so, the results indicated that varying modalities have differential effectiveness in marital counseling, and in fact one of the most common forms of traditional treatment, concurrent therapy, is least effective in effecting positive outcomes, either in divorcing couples, or couples remaining married.  

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Studies have also been done on specific types of treatment and their outcome. Christensen reports the study of the utility of marriage counseling treatment for the training of spouses in interspouse supportiveness. The sample included 27 couples pretested on self-esteem and decisionmaking. Results showed that treatment increased the husbands' intramarriage general self-esteem and the couples' choice fulfillment, but had no effects in decision-making. Couples' self-esteem was increased, but this did not generalize to other aspects of the marital relationship. Ely, Guerney and Stover evaluated the training phase of conjugal therapy, administering pre and post training questionnaires asking about major and minor marital concerns. A major component of their program is the adoption and practice of specific roles within the dyad, as speaker and listener. This training was supplemented by home practice and reading. Tentative positive results were obtained, but it was suggested that a longer program might lead to greater therapeutic gains.


In Cookerly's study on the reduction of psychopathology through therapy, twenty-one couples were placed in concurrent interview, conjoint interview marriage counseling and group marriage counseling. Each of these twenty-one included seven severe, seven moderate and seven mildly maladjusted couples on the basis of a marital adjustment interview. The MMPI was utilized to assess changes in psychopathology after treatment. A significant decrease in depression, paranoia and psychasthenia scales was found in the concurrent interview treatment. It was posited that this might represent a simple reduction in normal bad feelings rather than a reduction in the psychopathology of the individuals.

Several studies have been undertaken to study the effects of group therapy alone. Guerney did a study on conjugal therapy in which a quasi-interaction approach was utilized in training couples to use Rogerian client-centered techniques in their marital interactions. The research results supported the efficacy of training couples to directly express feelings in this fashion. Bruder, in his study of the effects of a marriage enrichment program on improving marital communication and adjustment found that gains were made through treatment, and that these gains were greater for females than males. Individuals changed independently of spouses in

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communication, but in conjunction with spouse on marital adjustment. 91 Ziegler compared two forms of group therapy for the treatment of marital discord. Group A included six couples treated with one and one half hour sessions of group psychotherapy per week over twenty weeks and post tested one week later. Group B was composed of six couples treated in a thirty hour marathon, then tested one week and nineteen weeks later. Group A treatment produced a wider range of changes, while Group B treatment produced more intense changes in a few areas. Neither was uniformly more effective. 92

Studies in behavioral treatment approaches are generally the best designed, on an operational basis. In spite of this, a review of the empirical research in behavioral approaches to marriage therapy showed that the majority of studies had not gone beyond the non-factorial single group design, and that the breadth of treatment populations was restricted. However, the outcomes of treatment, though few, have been almost universally positive and encouraging.


The power of the behavioral methods lie in their theoretical base, observational and treatment relevant assessment, procedural specificity and quantification of outcome.  

It has been demonstrated that behavior modification can be used effectively in the marital dyad. It can be learned easily, and may be applied to one spouse without actively involving the other spouse in the treatment plan, although this is not optimal. Sizable alterations of undesirable behavior have been reported with this approach. Wieman, Shoulders and Farr demonstrated the efficacy of reciprocal reinforcement in altering and maintaining the behavioral patterns of both husband and wife. They found intensive didactic training a useful adjunct to operant interpersonal treatment when the behavior repertoires of the spouses do not include the skills required for adequate performance of the behaviors selected by their mates as significant. Hoshmand reported on an integrative

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94 Liberman.

95 Goldstein and Francis.

behavioral learning model of marital therapy, which was tested for effectiveness through the Kelly-Tharp Marriage Role Questionnaire, and Shostrum's Caring Relationship Inventory. The results showed a significant decrease in dissatisfaction and an increase in caring attributable to the effects of the therapy program. Therapeutic changes correlated positively with learning gains by couples in therapy. In reviewing this research it seems that despite different explanations of human behavior, a common understanding of the dynamics of marital disharmony is present, with the primary differences appearing in how to alleviate these difficulties therapeutically. General studies of treatment, and varied studies of specific modalities show that change can be effected through intervention in the marital system. The degree of success rests on a number of factors including the make-up of the individuals and the treatment modality employed.

**Sexual Dysfunction Treatment Models**

Diagnosis is a major problem in any treatment program. The situation is somewhat different with sexual dysfunction, in that it is the client that determines the problem exists, and actively seeks help to alleviate. The role of the therapist becomes one of identifying issues, working on cohesiveness within the unit and aiding the couple to achieve satisfactory functional response in their home environment, while facing stresses from family, employers and society.

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Schiller views the goals of sex counseling as four fold: the therapist leads the people seeking help to become more comfortable; they are helped to accept sexuality as a natural part of their endowment as human beings; they are provided with a clearer perspective of sex roles, and are given a better understanding of the wide range of forms of sexual expression. Madock and Chilgren stress self-responsibility. One is responsive to his partner, but is responsible for himself. They also add the need for structured behavior change. In fact, much of the treatment of sexual dysfunction is a process of teaching couples to overcome rigid adherence to learned sexual behavior, and to learn and incorporate new and more satisfying behaviors.

Therapy cannot be effective in the absence of specific information on the status of both the individual and the couple. This serves to illuminate possible problem areas and probable etiology. Issues which may jeopardize treatment success are the presence, admitted or otherwise of an extramarital relationship, sham orgasm on the part of the woman, and indifference to the partner.

100 Goldberg, 1967.
Other information useful in this therapy includes the measurement of individual psychopathology, measurement of sexual attitudes and value systems, male and female role identification and expectations, and interpersonal interaction style.  

Numerous clinicians have reported on their work with various models for the treatment of sexual dysfunction. Psychotherapeutic, and specifically psychoanalytic treatment has been utilized for the treatment of sexual dysfunction. Much psychotherapeutic intervention, however was predicated on Freud's early types of female maturation. This was challenged by Sherfey in her work, and refuted by Masters and Johnson. Individual psychotherapy takes into cognizance the motive force of fantasy and conflict. Meyer in supporting the need for this form of therapy states that it is often necessary to employ psychotherapeutic approaches in order to remove conflict so that the patient will be able to benefit from a short term treatment program such as that of Masters and Johnson.

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Group approaches have been utilized in the treatment of sexual dysfunction for a number of reasons. First, most sex problems occur in interpersonal relationships. A group is an ideal place for working through issues of dealing with others, providing an opportunity to deal with problems of intimacy, closeness and dependency, while serving the function of socialization. \(^{105}\) Historically, the first groups designed for the treatment of sexual dysfunction were for couples experiencing fertility problems. \(^{106}\) A major use of the group approach to treating dysfunction is in treating those individuals who have no regular sex partner, and therefore would be excluded from couple therapy. Group therapy has been particularly useful in treatment of impotence and in development of orgasmic responses in women. \(^{107,108}\)

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Behavioral brief therapy for sexual dysfunction is based on the assumption that sexual as well as marital behavior is learned and therefore, if the contingencies and consequences of such behavior are made explicit and are altered, the behavior itself will change. The procedure in behavioral treatment is fairly straightforward. First a behavioral analysis or assessment is conducted. Then a behavioral treatment program that evolves from the behavioral analysis is designed and executed. Specifically, this sequence would include a detailed sex history, counseling in sexual techniques, controlled masturbation and systematic desensitization, as required. Both partners are required to behave like adults when negotiating the treatment contract and must cooperate in the treatment program. There is an emphasis on tailoring the therapeutic approach to the individual dyad's needs, to help them achieve normal, rewarding behavior.


Behavioral treatment, although effective, is not viewed as a panacea, even by behaviorists such as Annan. He states that behavioral methods are effective in the treatment of many sexual dysfunctions, but there are still specific indications for referring clients for more intensive therapy, especially in an effort to modify the underlying base of the problem.112

Not all approaches deal primarily with the sexual behavior. Communication is an integral part of sound sexual functioning, and one approach to the treatment of sexual problems, is the training of couples in the use of effective communication. Rogers, speaking of communication said that in any significant continuing relationship any persistent feeling should be expressed. Every continuing relationship must be worked at, built, rebuilt and continually refreshed by mutual personal growth and sharing. He further stated that couples need education in being partners and that education on a purely cognitive level is not sufficient for a living, changing, growing partnership.113

112 Masters.

Empirical studies of training in communication have been found effective in treating marital problems. Teaching the dys-functioning couple communication skills allows the partners to be understood by their mates and to understand them in turn. Sexual changes occur because sexual pleasure does not exist in a vacuum, but flows from the mutual understanding and fulfillment of wants and needs, by a man and woman who are physically and emotionally committed to one another. Lazarus was the first to report the treatment of a series of frigid patients by desensitization. Nine of the sixteen were fully sexually adjusted after a mean of twenty-eight sessions. Another behavioral approach is implosive therapy, a variant based on the principles of learning and Freudian concepts of psychodynamics, with specific effort aimed at the extinction of anxiety. Jacobsonian relaxation in addition to directed masturbation and sexual assertion training are used to extinguish anxiety in some programs.

115 Masters and Johnson, 1970.
117 Hogan.
Other programs are combinations of several techniques. Not all combination programs for the treatment of sexual dysfunction follow the Masters and Johnson model. Obler used a combination of desensitization and assertiveness, confidence training to treat premature ejaculation, ejaculatory incompetence and secondary impotence in males and orgasmic dysfunction in females. Ellis employs a comprehensive, interlocking cognitive-emotive-behavioral approach to the treatment of dysfunction. This includes corrective information, permission for fantasy, removal of sexual guilt, shame-attacking exercises, non verbal group exercises, and specific homework assignments.

Ellis views most serious sexual problems within a framework of prevailing emotional upset, and strives for a reduction in the general level of disturbance as well as in the sexual dysfunction. Rosenthal and Rosenthal in their paper on correcting the anaphrodesiac effects of long term relationships, stress the need for bringing more affection and romance into the non-sexual aspects of the relationship, while increasing body awareness, and increasing sexual variety.

Masters and Johnson have probably developed the most widely known and emulated program for brief sex therapy. In this program certain steps are followed regardless of symptoms, and additional modifications are introduced specific to symptomatology. The couple is treated together for a two week period. A male and female co-therapy team interpret and help process the couple's reactions. The dual sex team is an important concept, allowing more total perception of the issues, and allowing for support to be given by each therapist to the same sex partner. Extensive histories and individual interviews are used to gather information and create a comfortable therapeutic atmosphere. Medical history and exam are incorporated into the program. Roundtable discussions are utilized to process feelings and present information, while sensate focus exercises are


assigned as homework. The results of this homework are then processed the following day. Murphy and Mikulas reviewing the Masters and Johnson program from the orientation of behavior therapy, found two overlapping components: educative counseling and behavioral assignments. They state that just providing a person with awareness, insight or understanding of his behavioral problems is generally an inefficient way of changing behavior, and that it is more effective to utilize a program that deals with the undesired behaviors and builds in desirable behaviors.

Not all modalities are effective with all dysfunctions. In studies of treatment by dysfunction different aspects of the program, and the dynamics, emerge as significant. Clarke and Parry treated patients for premature ejaculation in a modified Masters and Johnson format. Their success with the technique seemed to derive from the reduction of anxiety in the coital situation and a strengthening of trust and confidence in the relationship between the marital partners.

---


Many men view their impotence as a physical manifestation and therefore physicians are often called upon to treat impotence in urologic practices. There is an increasing selectivity in patients appropriate for urologic counseling. These patients have subjectively delineated their sexual performance as inadequate, defined by the inability to develop penile erection or to maintain the erection to orgasmic completion of coitus. In the physician's office Finkle and Thompson recommend treatment for all medical conditions such as congestive prostatitis along with instructions to abstain from sexual behaviors for one week. At the next appointment the patients are given reassurance that erectile mechanism is intact, and are encouraged to attempt intercourse under non-demand relaxed circumstances. An available cooperative partner is imperative for this, and with this treatment sixty per cent of the men experiences symptom reversal.\footnote{Finkle, Alex and Richard Thompson. "Urologic Counseling in Male Sexual Impotence." \textit{Geriatrics}, 1972, 27 (12): 67-72.} Within a couple therapy mode, one must assess if impotence is a primary or secondary symptom. Would all the ancillary problems fall away if impotence were removed? The Semens technique as modified by Masters and Johnson is used in conjunction with sensate focus to elevate the threshold of excitability, and sense of
Performance anxiety is often a facet of impotence. Hypnotherapy has been employed to give posthypnotic suggestions of pleasing self, that sex is not performance, but pleasure, and that it is irrational to fear the accusation that you failed your partner.

In both sexes the dysfunction is sometimes a lack of desire, rather than inability to perform. Partners vary and covary in their interest in sex, and in their wishes to accommodate the sexual wishes of their partner. In modifying this problem the emphasis is in redeveloping habit patterns of closeness, and building in blocks of time in which the couple actually relate, as opposed to simply coexisting.

Treatment of orgasmic dysfunction has been done in numerous ways. Often it is necessary to follow a series of steps to achieve an end such as coital orgasmic response. Directed masturbation is an integral part of most programs treating pre-orgasmic women. Another means of increasing orgasmic response is exercising the pubococcygeal muscles. Kegel, believed that an orgasm occurs through the stimulation of the proprioceptive nerve endings in the pubococcygeal muscles, and felt that strengthening the muscles increased sexual appreciation. This has been incorporated into the

125 Hastings.
126 Alexander.
treatment of vaginismus, as well as general exercises for the dysfunctioning couple. Directed masturbation has been employed both within the context of a combined program, and by itself. LoPiccolo and Lobitz describe a nine step program to be utilized as an adjunct to behavioral time limited treatment. The steps include increased self-awareness, genital exploration, manual stimulation, and the use of a vibrator, masturbation with the husband watching, then stimulation provided by the husband, and finally intercourse with stimulation. ¹²⁸ Kline-Graber, and Graber suggest a similar program, which is even more explicit in its behavioral stages and involving fantasy as a means of increasing level of excitement. ¹²⁹

Not all therapy is provided by teams devoted exclusively to this problem. Much sex therapy is conducted in the physician's office on a more time limited basis than that which is seen in brief sex therapy. The physician practitioner relies heavily on his interviewing skills to delineate the problems and develop treatment plans. ¹³⁰ The physician must be careful to assess his own attitudes, and be sure that his own misconceptions, or personal beliefs do not


¹²⁹Kline-Graber and Graber.

¹³⁰Committee on Medical Education.
interfere with his professional behavior. Often the treatment consists of reassurance, instruction, supportive therapy and a few suggested techniques for home application. Of prime importance is an open and trusting relationship between the physician and the patient.132

A few studies have appeared on the experimental evaluating of treatment modalities. O'Connor and Stern researched the effects of psychoanalysis and psychotherapy in the treatment of functional sexual disorders. The sample included sixty-one females and thirty-five males. Factors influencing prognosis were sex, psychiatric diagnosis and treatment. Males responded more successfully than females. With analytic treatment seventy-seven per cent improved, while forty six per cent improved with psychotherapy. It must be remembered that the criterion is improvement, not symptom reversal, and that this improvement is subjectively evaluated.133

Biofeedback has achieved great success in the treatment of certain psychophysiological problems. Biofeedback was successfully

131 Abse, Nash and Loden.
132 Fink.
133 O'Connor and Stern; 1972.
used in the treatment of psychogenic impotence by Csillag, and he found that it was possible to create and maintain penile tumescence to a significant degree through the use of biofeedback techniques. Obler's study utilized a treatment of invivo sexual stimuli in combination with an imagined hierarchy of items, assertion and confidence training in systematic desensitization for treatment dysfunctions. The first control group utilized traditional insight approaches, while the second control had no contact with the experimenter at all. The subjects were assessed pre and post on psychological, cognitive, and observable measures of anxiety, as well as maintaining a record of sexual behavior. The control groups both showed about two to three per cent improvement, while the experimental treatment showed significantly greater improvement. It was also found that anxiety level was inversely proportional to the success of treatment. Husted reported on the use of imaginal or invivo desensitization in the treatment of vaginismus, negative personal reaction to sexual contact and lack of interest, while Wincze and Caird described a study using systematic or videodesensitization in a study of twenty-one females complaining of sexual dysfunction. Videodesensitization proved more effective with symptom reversal occurring in twenty-five per cent of


Meyer, et al. studied the interaction of psychiatric issues and sexual symptomatology in couples seeking help for sexual dysfunction. Treatment involved seeing couples weekly for a period of ten weeks, with a post-treatment follow-up. Four of the sixteen couples showed symptom reversal at the conclusion of treatment, with improvement in another twenty-five percent, equivocal improvement in thirty-one percent, and no improvement or deterioration in nineteen percent. The seven-month follow-up showed a failure rate of thirty-seven percent with the strength of alliance between sexual and neurotic or character problems a crucial factor in outcome and maintenance. This was one of the few studies to assess follow-up systematically and the recidivism is disappointing.


In an attempt to deal with the problem of maintaining therapeutic gains, Lobitz and LoPiccolo suggested a program in which an active attempt was made to involve the couples in the development of the maintenance program. The success rate was one hundred percent with primary nonorgasmic females and premature ejaculation, sixty-seven percent in erectile failure and only thirty-three percent in the treatment of secondary non-orgasmic females.\textsuperscript{139}

Increased awareness doesn't necessarily lead to symptom reversal, but other benefits may appear. Caplan found in her study that participation in a treatment program resulted in significant positive changes in attitudes towards themselves and their partners in the sexual area, without regard to whether they benefited from the treatment in regard to the dysfunction.\textsuperscript{140}

Results on Masters and Johnson type treatment programs are generally favorable. Rosenthal and Rosenthal reported on the results of a modified version of the program, with four to six sessions per week, plus telephone contacts over three weeks. Seventy-eight per


cent of the women rated satisfaction as significantly higher at the end of the program, with this dropping to seventy-one per cent at the end of three months. Seventy-four per cent of the women rated themselves as achieving orgasm in one half or more of their sexual encounters at the end of the program. Eighty-four per cent claimed increased marital satisfaction. Less positive results were obtained by Lansky and Davenport in their program at a military hospital. Only twenty-five per cent of the couples achieved symptom reversal, and here it appeared that the underlying agenda extended far beyond the symptoms or its consequences. In fact the symptom tended to reinforce or justify this agenda.

There are numerous advantages to group treatment, both interactionally and economically. Group treatment has been utilized for individuals as well as couples. In the group treatment of pre-orgasmic women in Barbach's study, a five week treatment program of home masturbation and group process of feelings, ninety-two per cent of the women became able to masturbate to orgasm regularly. Within eight months, the majority of subjects in satisfactory relationships transferred this orgasmic capability to the partner relationship.

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143 Murstein and Glaudin.
Zilbergeld reporting on the group treatment of sexual dysfunction in men found that the group was successful in achieving the goals of many group members in the sexual sphere, with favorable changes observed in other areas of functioning as well.\textsuperscript{144}

Group sessions have also achieved good results for couples. Leiblum, Rosen and Pierce found marked increase in marital satisfaction, orgasmic attainment, ejaculatory control and enhanced self-acceptance in a ten-session group for couples with a variety of sexual dysfunctions.\textsuperscript{145} An additional option is the use of extended group meetings in a setting outside the normal setting, as an adjunct to ongoing treatment groups. Reckless, in describing this option finds the intensification of emotions allows for increased growth, but as in other marathon groups also allows for the possibility of negative reactions due to the instability of defenses and coping mechanisms in both therapists and members.\textsuperscript{146}

Numerous therapeutic modalities have been applied to the treatment of sexual dysfunction. It appears that a psychobehavioral approach provides the greatest improvement over the total spectrum of


dysfunctions. One of the major functions of this study will be to assess the impact of a specific psychobehavioral program, and the relationship among various components of the program and treatment outcome.
Summary

The characteristics of couples presenting for sex therapy are often not substantially different from those of couples presenting for marital therapy. Sex is one amongst a series of concerns. This series may include dissatisfaction with the spouse, concerns about both instrumental and affectional behaviors, money and quarrels about children. Numerous studies have found that these couples do not have more psychological problems than the general population, but rather that their marital and personal histories vary from those who do not seek this type of help.

Sexual dysfunction is caused by a variety of factors, singly and in combination. The quality of the sexual and marital relationship both reflect and modify the level of sexual satisfaction and the perception of a sexual dysfunction. The client is the one who determines that the problem exists, and it is the client who goes on to seek help to alleviate discomfort. The perceived dysfunction can develop in many ways. Some may be the product of incomplete or incorrect sexual learning. Others may occur through an interaction between psychological concerns, interpersonal reactions and sexual learning. Other dysfunctions may occur as a sign of disaffection or conflict between the sexual partners. Another major cause of sexual dysfunction is guilt, and the sense of shame that some individuals feel in regard to sexual expression
Marital satisfaction is a major component of the perception of sexuality within a marriage. It is generally described in relation to the meeting of emotional needs, while dissatisfaction relates more often to instrumental failures. Marital satisfaction varies over the lifetime of the relationship and is interdependent on other changes in the family group. In fact the level of satisfaction is determined by the nature of the marriage interaction, and the interplay of the personalities of the husband and wife rather than by some specifically problematic psychological configuration.

The goal of marital counseling is to modify the interaction of a couple that is in conflict along social, emotional, sexual or economic parameters. This counseling is carried forth within a number of modalities. These include individual, conjoint, group, and concurrent therapy, employing both psychodynamic and behavioral approaches, or a combination of both. Studies have found differing levels of success with these approaches, largely as a function of the criterion definitions of successful treatment.

Similar approaches have been utilized in the treatment of sexual dysfunction. Not all methods are effective with all dysfunctions. The range of treatment extends from simple reassurance and education to an integrated psycho-behavioral approach involving instruction, education, structured exercises, psychodynamic material, as is deemed pertinent as well as encouragement and training in communication.
CHAPTER III

RESEARCH DESIGN

This chapter outlines the research design of the study, including: (1) subjects (2) personnel (cotherapists and supervisors) (3) procedure. Briefly this study involves a sample of seventy-seven couples who have participated in the Loyola Sexual Dysfunction Treatment Program and couples on a waiting list for the same program at Loyola University School of Medicine's Sexual Dysfunction Clinic.

The subjects in the treatment program had a series of seven three to five hour meetings with their cotherapists over a seven week period. A variety of didactic and experiential techniques were utilized in these sessions.

Waiting list couples were to be contacted first by preliminary letter (Appendix P), then phoned, then questionnaires were to be mailed to them followed by another phone call. The waiting list component of the study went through screening by the Human Investigation Committee of Loyola University Hospital to ensure that couples would be adequately protected within the study (Appendix Q).

The cotherapists were trainees in the same program under the supervision of experienced faculty sex educators. Following the Masters and Johnson model, one trainee cotherapist was a physician or medical student, while the other could be a physician,
social worker, psychologist, nurse, minister of religion or physician spouse. Pre-test and post-test data on level of sexual function, marital satisfaction and communication allowed analysis of change as a function of treatment. Historical and personality data, as well as cooperation with the program were also analyzed in relation to presenting problem and treatment outcome in efforts to establish predictors of treatment outcome.
Subjects

a) Treatment couples:

Seventy-seven couples, 154 subjects included all the couples enrolled in the Sexual Dysfunction Treatment Program at Loyola University School of Medicine from October, 1976 through May, 1977. The subjects were aware that Loyola is a teaching and research institution, and that the program in which they were enrolled was under constant evaluation.

The ages of the subjects fell in categories "20 - 24" through "55 through 59." The median category for males were "30 - 34." The median for women fell in category "30 - 34."

b) Waiting List couples:

It was decided that an initial group of ten couples were to be contacted followed by others. However, the responses were so few (two) that a decision was made to exclude them from this study.
TABLE 1

Frequency Distribution of Subjects by Age

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Females Absolute Frequency</th>
<th>Females Relative Frequency</th>
<th>Males Absolute Frequency</th>
<th>Males Relative Frequency</th>
<th>Couple Absolute Frequency</th>
<th>Couple Relative Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 20 - 24</td>
<td>1</td>
<td>1.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 25 - 29</td>
<td>23</td>
<td>29.9</td>
<td>12</td>
<td>15.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 30 - 34</td>
<td>26</td>
<td>33.8</td>
<td>27</td>
<td>35.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 35 - 39</td>
<td>13</td>
<td>16.9</td>
<td>8</td>
<td>10.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 40 - 44</td>
<td>5</td>
<td>6.5</td>
<td>16</td>
<td>20.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 45 - 49</td>
<td>4</td>
<td>5.2</td>
<td>7</td>
<td>9.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 50 - 54</td>
<td>4</td>
<td>5.2</td>
<td>6</td>
<td>7.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 55 - 59</td>
<td>1</td>
<td>1.3</td>
<td>1</td>
<td>1.3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Heterogamy: defined as more than two levels of difference in age within the couple

7 9.1
The distribution of subjects by religion was: Catholic women 35, Catholic men 35, Protestant women 19, Protestant men 18, Jewish women 15, Jewish men 15, Fundamentalist or 7th Day Adventist women 4, Fundamentalist or 7th Day Adventist men 3, Hindu women 1, Hindu men 1, No religion stated women 3, No religion stated men 5. Seventeen couples had a mixed religious background.
### TABLE 2

**Frequency Distribution of Subjects by Religion**

| Religion              | Females | | | | | | Males | | | | | | Couple | | | | |
|-----------------------|---------|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
|                       | Absolute Frequency | Relative Frequency | Absolute Frequency | Relative Frequency | Absolute Frequency | Relative Frequency |
| Catholic              | 35      | 45.5 | 35 | 45.5 | |
| Protestant            | 19      | 24.7 | 18 | 23.4 | |
| Jewish                | 15      | 19.5 | 15 | 19.5 | |
| Fundamentalist        |         |      |   |      |   |   |   |   |   |   |   |   |   |   |   |
| 7 Day Adventist       | 4       | 5.2  | 3  | 3.9  | |
| Hindu                 | 1       | 1.3  | 1  | 1.3  | |
| None                  | 3       | 3.9  | 5  | 6.5  | |
| Couples of Mixed      |         |      |   |      |   |   |   |   |   |   |   |   |   |   |   |
| Religious Background  |         |      |   |      |   |   |   |   |   |   |   |   |   |   |   |
|                       |         |      |   |      |   |   |   |   |   |   |   |   | 17 | 22.1 |
The distribution of the sample by highest level of education achieved was: 8th grade 2 (1 was functionally illiterate), some high school 5, high school graduate 24, some college or two year technical program 38, college graduate 48, some graduate training 24, terminal graduate degree 13. Amongst the couples showed a moderate degree of educational disparity, as defined by more than two levels difference between the educational level of the husband and wife. These results are shown in Table 3.
<table>
<thead>
<tr>
<th>Education</th>
<th>Females Absolute Frequency</th>
<th>Females Relative Frequency</th>
<th>Males Absolute Frequency</th>
<th>Males Relative Frequency</th>
<th>Couple Absolute Frequency</th>
<th>Couple Relative Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>8th grade attended h.s.</td>
<td>2</td>
<td>2.6</td>
<td>3</td>
<td>3.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>graduated h.s.</td>
<td>15</td>
<td>19.5</td>
<td>9</td>
<td>11.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>some college or 2 year tech.</td>
<td>18</td>
<td>23.4</td>
<td>20</td>
<td>26</td>
<td></td>
<td></td>
</tr>
<tr>
<td>college graduate</td>
<td>26</td>
<td>33.8</td>
<td>22</td>
<td>28.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>some grad. school</td>
<td>13</td>
<td>16.9</td>
<td>11</td>
<td>14.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>graduate degree</td>
<td>3</td>
<td>3.9</td>
<td>10</td>
<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educational heterogamy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7</td>
<td>9.1</td>
</tr>
</tbody>
</table>
The distribution of the subjects by occupation showed unemployed outside of home 33, manual laborer 9, sales, waitress 14, teaching 14, clerical, retailing 25, health professional 11, business, accounting 30, engineers 6, college trained advanced degree professionals (MD, JD, PhD, DDS) 12. The results showed 33 husbands working with wives remaining at home without outside employment. These frequencies are shown in Table 4.
<table>
<thead>
<tr>
<th>Occupation</th>
<th>Females</th>
<th></th>
<th>Males</th>
<th></th>
<th>Couple</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Absolute Frequency</td>
<td>Relative Frequency</td>
<td>Absolute Frequency</td>
<td>Relative Frequency</td>
<td>Absolute Frequency</td>
<td>Relative Frequency</td>
</tr>
<tr>
<td>unemployed outside home</td>
<td>33</td>
<td>42.9</td>
<td>0</td>
<td>0</td>
<td>33</td>
<td>44</td>
</tr>
<tr>
<td>manual labor</td>
<td>1</td>
<td>1.3</td>
<td>8</td>
<td>10.4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>sales, waitress</td>
<td>1</td>
<td>1.3</td>
<td>13</td>
<td>16.9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>teacher</td>
<td>12</td>
<td>15.6</td>
<td>2</td>
<td>2.6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>clerical, retail</td>
<td>16</td>
<td>20.8</td>
<td>9</td>
<td>11.7</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>health profession</td>
<td>8</td>
<td>10.4</td>
<td>3</td>
<td>3.9</td>
<td>0</td>
<td>0</td>
</tr>
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The distribution by presenting complaint was: premature ejaculation 34, primary impotence 2, secondary impotence 16, lack of interest in sex 12, primary non-orgasmic 12, secondary non-orgasmic 38, vaginismus or dyspareunia 4, none 34. In 55 of the couples both partners had presenting complaints.
<table>
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<th></th>
<th>Males</th>
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<th>Couple</th>
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<td>Relative Frequency</td>
<td>Absolute Frequency</td>
<td>Relative Frequency</td>
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<td>16.9</td>
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<td>couples in which both partners have complaint on presenting</td>
<td></td>
<td>55</td>
<td></td>
<td>71.5</td>
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</table>
A "typical couple" in this sample might be described as having some college education, caucasian, with children, and both partners in their thirties. Their presenting complaints would be of two dysfunctions. However, there was a range of difference as noted, including one illiterate male who also benefited, with modification of the program to offer verbal exchange and exclude (for both partners) written tests.
Personnel

This section will describe the personnel used in the study, including cotherapists and supervisors. Their backgrounds as well as their orientation to the program will be described.

Cotherapists

Seventy-seven pairs of cotherapists were utilized for this study. The Sexual Dysfunction Clinic of Loyola University's Medical School is run primarily as a physician's training program. Each couple is assigned a dual-sex cotherapist pair. Consequently all the subject couples in this study were seen by a pair of trainee cotherapists under the supervision of one or more of four experienced faculty psychotherapists or physicians with particular expertise in the treatment of sexual dysfunction. The cotherapists remained together as partners throughout the program and saw the same couple throughout their seven weeks of treatment.

The cotherapist trainee included physicians both during and post residency, medical students, psychologists, social workers, nurses and religious personnel. Each dual-sex team included at least one medical student or physician who was medically responsible for physical examination and care. The level of experience of the trainees ranged from sophomore medical students through individuals who had been involved in the practice of psychotherapy or medicine for many years.
The training program for the cotherapists included three, five hour workshops, as well as supervisory training periods throughout the seven weeks of clinical sessions. The program is described in detail in Appendix C.

Supervisors

One supervisor remained constant throughout this study. This supervisor was the faculty psychiatrist who was the major developer of the program at Loyola. Generally another supervisor was present as well, since training supervisors is another goal of this program. The additional trainee supervisors were either physicians, psychologists or psychiatric social workers who had already trained in the program and had gone through the rotation as cotherapists several times. They were all experienced psychotherapists, with a strong interest in the treatment of sexual dysfunction, and a belief in the effectiveness of brief sex therapy. Their role was two-fold. First, they served to supervise and direct the cotherapist trainees behavior throughout the treatment program, and to guide them through treatment intricacies. Their more sensitive and demanding role was to help the cotherapists remain aware of their own feelings during the psychotherapeutic process and to help the trainees work through some of these feelings, so these do not interfere with therapeutic movement on the part of the couples. This is a particular problem, when husband and wife teams go through as co-therapists. The dynamics of their own marital relationship may be
reflected in their couple. Sometimes the therapists tend to over-identify and find similarities. The supervisor's task is to provide perspective during supervision, prevent the therapists (both of husband-wife teams and of others) from using their clients as a vehicle for working out problems within the therapists' own relationships. The specific components of the supervisory tasks will be explained later in this chapter when the procedure is described.

Procedure

This study is not experimental. The treatment program has existed since July, 1972. It uses the framework of the medical model. The sexual treatment is only one aspect of the procedure (see Appendix D for a detailed explanation of this treatment).

The following were taken from the subject's week one answers to four hours of face to face questions from the Loyola University Hospital Sexual Dysfunction Clinic History Sheet: biographical data; pertinent medical and psychiatric history; family history, both of the current nuclear family and the family life of the subject's childhood; marital history; sexual history including attitudes and frequencies of expression.

During the second weekly session the therapists asked the subjects to fill out the Loyola University Marital Adjustment Test and the Loyola University Sex Clinic Sentence Completion Test. While one partner filled out the tests the other partner underwent a physical and sexological examination.
In week three one partner was asked to complete the MMPI while the spouse was participating in the Fantastic Voyage exercise with both cotherapists present. The roles were then reversed for the other partner.

Both partners were asked to complete the MI-SRI Form M during a supervision break in the fifth week.

Additional information on the progress of the subjects throughout the program, was obtained from the Loyola University Hospital Sexual Dysfunction History Sheet including: statement of symptom reversal as based on self-reports of couple; motivation to be involved in clinic; therapist assessment of the participation of the individuals in the various aspects of the treatment program.

Two and one-half months after the couples completed the clinic the author contacted each couple by phone and after introducing herself requested their cooperation in a study authorized by the Sexual Dysfunction Clinic. Her name had previously been given to the couples so that this call was not unexpected. Following this the following questionnaires were mailed to the couples along with a cover letter (see Appendix L and Appendix M), and a stamped envelope addressed to the author of the study. Those couples who had not returned their questionnaires in two weeks were called again, and generally agreed to mail in the questionnaire. If they wished they were given the option of answering the questions over the phone at this time.
Initially it had been decided to do a study of couples on the waiting list for the Loyola Sexual Dysfunction Clinic. This was to serve as a means of assessing the effects of being on the waiting list itself, and also the effects of testing without treatment. It was impossible to achieve compliance with these goals. Couples on a waiting list are not actually involved in a therapeutic relationship and have not made a contract for such a relationship. It appeared consequently, that however motivated they were to eliminate their problem, they were unwilling to be involved with the clinic without the human therapeutic component of treatment being present.
The following data were coded and punched onto computer cards:

1. Biographical data
2. Pertinent medical and psychiatric history
3. Family history, both of the current nuclear family and the family life of the subject's childhood
4. Marital history
5. Sexual history including attitudes and frequency of expression
6. Individual responses on the Marital Adjustment Test
7. Scale scores on the MMPI
8. Scale scores on the MI-SRI Form M
9. Individual replies on the Self Report Questionnaire
10. Statement of symptom reversal as based on the self-reports of the couple
11. Motivation to be involved in the clinic as assessed by the cotherapists in the initial interviews
12. Therapist assessments of the participation of the individuals in the various aspects of the treatment program.

The following procedures were utilized to analyze these data:

1. The individuals were divided into groups on the basis of symptom reversal. First this was done by symptom, then the symptoms were grouped.

2. Following these divisions, frequencies were run on those data which were interval, while percents were found on the categorical data. This was done in an effort to determine which variables appeared to correlate with symptom reversal.

3. Those not appearing to be involved were eliminated from
further appraisal.

4. Profiles were developed on the groups divided as a function of their symptoms, as well as on groups divided by symptom reversal.

5. Discriminant analysis was done on MMPI and MI-SRI Form M variables, and predictors developed from this function.

6. Partial correlations controlling for marital satisfaction and marital communication were utilized to assess symptom reversal.

7. Symptom reversal was analyzed as a function of the couple's levels of satisfaction and communication.
CHAPTER IV

RESULTS AND DISCUSSION

This chapter reports the findings obtained through analysis of the following data: the medical histories, motivation and performance during the clinic program, the Loyola University Marital Adjustment Test, the Self Report Questionnaire, the Minnesota Multiphasic Personality Inventory, and the Millon Illinois-Self Report Inventory Form M of 154 subjects (77 couples) in Loyola Sex Therapy Clinic between October 1976 - May 1977.

This chapter will discuss these data and their analysis in the following order: selection of variables, the construction of aggregate variables, profiles of groups divided by symptom, comparison of groups that completed the follow-up questionnaire and those that did not, symptom reversal for each symptom and for the total sample, profiles of groups divided on the basis of symptom reversal, symptom reversal at three month follow-up compared to symptom reversal at end of clinic program, discriminant analysis of MMPI and MI-SRI Form M to develop predictors of symptom reversal, classification of subjects through the use of the discriminants developed, partial correlations on symptom reversal, satisfaction with program, marital satisfaction and communication.

Selection of Variables

The initial pool of variables encompassed all those demographic,
medical, questionnaire and scale scores available for each individual. In addition it included all the replies on the Loyola University Adjustment Test and the Self Report Questionnaire.

The subjects were divided by sex into two groups on the basis of change in the status of presenting symptom. Those showing total correction of symptom or substantial improvement formed one group, while those who did not show any change formed another. This assessment of symptom change was based on the therapists' conclusions at the end of the seven week program at Loyola University's Sex Clinic. These groups were then compared on all the variables. Per cents were computed on categorical data while frequencies were calculated for ordinal and interval data. The decision rule for studying a variable further was a difference of 15% or more between the group that improved and the group in which there was no change.

The nominal variables that were considered for further examination were occupation, whether husband or wife called the clinic, the subject's sexual complaints, and the subject's reactions to the physical examinations. Ordinal variables included motivation to attend the program, commitment to the marriage, the duration of the husband's problem, husband's relationship to his father, the following questions from the Loyola University Marital Adjustment Test:
1. (a.) Do you think your marriage is happy/unhappy

4. Do you ever wish you had not married?
   (a.) (my opinion)
   (b.) (partner's opinion)

6. (a.) I want my partner to be a special kind of person
   (b.) My partner wants me to be a special kind of person

10. (a.) I can be critical of him/her without being upset myself

11. (b.) I disapprove of my partner

12. (a.) I think my partner does not like me for myself

and the following questions from the Self Report Questionnaire:

1. How do you feel about having come to Loyola's clinic?


8. Has there been a change in your emotional relationship in this marriage?

Age, duration of marriage and scale scores on the MMPI and the MI-
SRI Form M were the interval variables that were analyzed further.

Only these selected variables were analyzed further.
Marital satisfaction at follow-up was defined as the sum of the following items on the Self Report Questionnaire:

8. Has there been a change in your emotional relationship in this marriage?

35. What do you think of your own capacity to handle emotional problems now?

36. What do you think of your own capacity to handle emotional problems with your mate now?

A quantitative assessment of the level of sexual behavior was defined as the total of stated levels of affectionate behavior, intercourse and masturbation on the medical history.

A quantitative assessment of level of sexual behavior at follow-up was defined as the total of the following items on the Self Report Questionnaire:

28. How often do you express affection per month?

29. How often do you have intercourse per month?

30. How often do you masturbate per month?

Level of sexual function at follow-up was defined as the sum of the following items on the Self Report Questionnaire:

5. Current status of the sexual condition

33. What do you think of your own capacity to handle sexual problems now?

34. What do you think of your own capacity to handle sexual problems with your mate now?
It was hoped that these aggregated scales would more clearly indicate the relationship among communication, marital satisfaction and symptom reversal, than would the individual replies on the questionnaires. After the scores were tabulated for each subject on these scales, frequencies were calculated. When the scores on these aggregate variables were compared for the group in which symptoms were improved or eliminated, and the group in which no change occurred, the following merited further evaluation: level of communication at beginning of the program; level of communication at follow-up; conflict in communication at follow-up; level of marital satisfaction at beginning of program; level of marital satisfaction at follow-up; status of sexual function at follow-up; and quantitative assessment of sexual expression at follow-up. Scores on these scales for both groups are shown in Table 18 for husbands and Table 19 for wives.
DESCRIPTIONS OF GROUPS BY SYMPTOM
Individuals were grouped on the basis of symptoms for the following analyses. If they complained of only one symptom they were considered a member of just that group. However, husbands or wives complaining of two symptoms were considered members of both individual groups and members of the group of combined symptoms. Consequently the total number of subjects could exceed the total number of subjects in the study. Some of the individuals complained of symptoms that were included in none of the major categories. When two or fewer subjects had a complaint the statistical analyses were not reported, because individual variation was far too great to use for any, even preliminary conclusions. Dyspareunia and vaginismus for women and lack of interest for men, were treated in this fashion. In addition, information was sometimes incomplete for specific individuals on various variables. Consequently the number of subjects in a particular analysis could fall below the total number of individuals in the study.
profiles of groups divided by symptoms compared to subjects without presenting symptoms on the Minnesota Multiphasic Personality Inventory

The MMPI is an empirically derived 566 item self-report inventory. Ten clinical scales and four validity scales are generally considered in assessing the personality profile. A T-score of 50 corresponds to the average number of items on a scale responded in the keyed direction by "normal" persons. T-scores of 70 or higher are considered to indicate presence of pathological signs that characterize the clinical population with which the scale was developed (see Appendix N for scale descriptions).

Husbands: Although the range of means across groups is small as seen in Table 6, the three symptom group means were either all higher, or lower than the mean for the group of husbands without presenting symptoms. The normal group had lower means than symptom groups on hypochondriacal trends, symptomatic depression and psychasthenia. More modest differences but still lower than the symptom groups' are seen on hysteroid tendencies, resentful attitudes towards authority, masculinity-femininity, schizoid mentation and social introversion. The mean for hypomania was slightly higher for normal subjects than for the symptom groups. Graph 1 pictorially represents this.

Wives: The profiles of wives across symptom groups is less clear than with the husbands, as seen in Table 7. In fact the symptom group means seem more different than similar. Both of the non-
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<th>Scale</th>
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<th>Premature Ejaculation</th>
<th>Secondary Impotence</th>
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<td>44.6</td>
<td>46.3</td>
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### TABLE 6 (continued)

**HUSBANDS GROUPED BY PRESENTING SYMPTOM**

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<td>( \sigma )</td>
<td>( \bar{x} )</td>
<td>( \sigma )</td>
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<tr>
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<td>54.2</td>
<td>9.7</td>
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GRAPH 1
HUSBANDS GROUP BY PRESENTING SYMPTOM

- Premature ejaculation
- Secondary impotence
- Premature ejaculation and secondary impotence
- No symptom
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<th>N = 38 Non-orgasmic</th>
<th>N = 12 Primary</th>
<th>N = 12 Non-orgasmic</th>
<th>N = 7 Lack of Interest</th>
<th>N = 7 No Symptom</th>
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<td>Hysteroid tendencies</td>
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<td>60.5</td>
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<td>Psychopathic deviance</td>
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<td>65.1</td>
<td>15.0</td>
<td>46.8</td>
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<tr>
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<td>58.6 ± 10.5</td>
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<td>Psychasthenia</td>
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<td>Schizoid mentation</td>
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<tr>
<td>Social introversion</td>
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<td>51.9 ± 5.7</td>
<td>55.5 ± 13.9</td>
<td>50.8 ± 8.8</td>
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</tr>
</tbody>
</table>
WIVES GROUPED BY PRESENTING SYMPTOM

MMP1

- Primary non-orgasmic
- Secondary non-orgasmic
- Lack of interest
- No symptom
orgasmic groups are fairly alike, with the group expressing lack of interest deviating from both, being higher on depression, lower on hypochondriasis, psychopathic deviance, masculinity-femininity, psychasthenia and schizoid mentation, often with the mean for the normal group falling among the symptom group means. This may be a function of real differences, or an artifact of the small number (n = 7) of subjects with this symptom. Graph 2 shows this.

Profiles of groups divided by symptoms compared to subjects without presenting symptoms on the Millon Illinois-Self Report Inventory Form M

The MI-SRI Form M is a 150 item self report inventory designed mainly for adults undergoing evaluation and treatment for physical ailments in which behavioral or emotional components may play a role.

The twenty scales of the MI-SRI Form M are divided into three main sections: the first eight scales pertain to the subject's basis style of coping; the second group of six scales reflect a series of attitudes and feelings associated with an increase in the probability of psychosomatic pathogenesis; the final set of six scales represent measures which correlate with emotional and social factors that complicate the course of several established disease syndromes. A BR score of 50 corresponds to the average number of responses on the scale by an individual. A BR score of 75 would suggest this characterizes the subject.

Husbands: As with the MMPI, the MI-SRI Form M profile for normals varied from those of all the symptom groups. The normal
<table>
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</tr>
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<td>41.7 8.2</td>
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GRAPH 3
HUSBANDS GROUPED BY PRESENTING SYMPTOM
MI-SRI FORM M

- Introverted
- Inhibited
- Cooperative
- Sociable
- Confident
- Forceful
- Respectful
- Sensitive
- Chronic tension
- Recent stress
- Premorbid pessimism
- Future despair
- Social alienation
- Somatic anxiety
- Allergic inclination
- Gastrintestinal
- Cardiovascular
- Pain proneness
- Life-threat react.
- Emotional vulnerability

*Premature ejaculation N=38  ▲Secondary impotence N=21  ■Premature ejaculation & secondary impotence N=11  ➥No symptom N=20
group was substantially higher on Sociable and Confident scales, while being substantially lower on Inhibited, Sensitive, Recent stress, Premorbid pessimism, Future despair, Social alienation and Somatic anxiety and slightly lower on Cooperative, Respectful and Chronic tension scales than the symptom groups (Table 8 and graphically in Graph 3).

Wives: As with the MMPI, the MI-SRI Form M profiles for wives are less uniform than for husbands as seen in Table 11. In fact there appear to be two very different patient populations (Table 9), with the primary and secondary non-orgasmic being somewhat alike, as Cooperative and Sociable, while those stating a lack of interest were Sensitive, Inhibited and Forceful with elevated problem scales. The non-symptom subjects were lower than all symptom groups on Sensitive and Inhibited while showing higher scores than all groups on Sociable and Confident scales. These are shown pictorially in Graph 4.
<table>
<thead>
<tr>
<th>Scale</th>
<th>MI-SRI Form M</th>
<th></th>
<th>MI-SRI Form M</th>
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<th>MI-SRI Form M</th>
<th></th>
<th>MI-SRI Form M</th>
<th></th>
</tr>
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<td>Primary Non-orgasmic BR</td>
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<td>Lack of interest BR</td>
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<td>Non-orgasmic BR</td>
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<td>16.8</td>
<td>33.3</td>
<td>25.0</td>
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<td>26.9</td>
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<td>48.8</td>
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<td>65.4</td>
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<td>34.0</td>
<td>25.8</td>
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<tr>
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<td>48.3</td>
<td>17.1</td>
<td>61.4</td>
<td>20.0</td>
<td>49.7</td>
<td>31.0</td>
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<tr>
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<td>15.7</td>
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TABLE 9 (continued)

WIVES GROUPED BY PRESENTING SYMPTOM

**MI-SRI FORM M**

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<tr>
<th>Scale</th>
<th>N = 38 Secondary Non-orgasmic</th>
<th>N = 12 Primary Non-orgasmic</th>
<th>N = 7 Lack of interest</th>
<th>N = 10 No symptom</th>
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<td>BR</td>
<td>BR</td>
<td>BR</td>
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<td>19.5</td>
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GRAPH 4
WIVES GROUPED BY PRESENTING SYMPTOM
MI-SRI FORM M

Introvertsve
Inhibited
Cooperative
Sociable
Confident
Forceful
Respectful
Sensitive
Chronic tension
Recent stress
Premorbid pessimism
Future despair
Social alienation
Somatic anxiety
Allergic inclination
Gastrointestinal
Cardiovascular
Pain proneness
Life-threat react.
Emotional vulnerability

Secondary non-orgasmic N=38 ▲Primary non-orgasmic N=12 ■Lack of interest N=7 ◇No symptom N=10
All male groups (see Table 10), both with and without symptoms were represented in several occupational categories. However, the modal category for all the symptom groups was business-accounting, while the no symptom group of males had the largest number in sales with slightly lower representation in teaching and business-accounting. Education was relatively even across groups except that those men presenting with both premature ejaculation and secondary impotence had no subjects with postgraduate or professional training.

In all groups of males the majority had had thoughts of divorce. However in the group presenting with both premature ejaculation and secondary impotence the percentage was substantially higher. Sexual satisfaction was variable across groups with those with premature ejaculation being the least dissatisfied.

For wives (Table 11), the occupational picture is quite different. The modal group for those without symptom, and for primary and secondary non-orgasmic, was no employment outside the home. For those expressing lack of interest teaching and clerical-retailing were the modal classifications. Educationally the no symptom, primary and secondary non-orgasmic groups were modal in the category of some college, or college graduate, while the group expressing lack of interest was bimodal with high school education and graduate school education education the modal groups.

As occurred with much of the personality data the no symptom
group was not discrete from all symptom groups on these variables. Women presenting with complaints of primary and secondary non-orgasmic symptoms had the lowest incidence of stated thoughts of divorce, although still in the majority, while the group expressing lack of interest was highest with the no symptom group falling among them. The large majority of all groups defined themselves as sexually dissatisfied.
TABLE 10

DESCRIPTION OF GROUPS DIVIDED BY SYMPTOMS COMPARED TO SUBJECTS WITHOUT PRESENTING SYMPTOMS: HUSBANDS

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<th>Secondary Impotence</th>
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<td>51.4</td>
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<tr>
<td>No</td>
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<td>48.6</td>
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TABLE 10 (continued)

DESCRIPTION OF GROUPS DIVIDED BY SYMPTOMS COMPARED TO SUBJECTS WITHOUT PRESENTING SYMPTOMS: HUSBANDS

<table>
<thead>
<tr>
<th></th>
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<th>Secondary Impotence</th>
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<td>N</td>
<td>%</td>
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TABLE 11 (continued)

DESCRIPTION OF GROUPS DIVIDED BY SYMPTOMS COMPARED TO SUBJECTS WITHOUT PRESENTING SYMPTOMS: WIVES

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Comparison of subjects who completed the Self Report Questionnaire and subjects who did not complete the questionnaire

Fifty-one of the seventy male subjects on whom both MMPI and MI-SRI Form M were available completed the follow-up questionnaire (SRQ). T-tests employing Fisher's pooled variance estimates were done on all available interval data. These data included subject's age, number of years married, and the scale scores on the MMPI and MI-SRI Form M. This was done to ascertain if those individuals who responded on follow-up were different in any significant fashion from those who did not respond. Table 12 shows that of the 36 t-tests run for the males only one was significant at \( p < .050 \). Random chance would allow for one of 20 t-tests to be significant at this level. Consequently it appears that the two groups are not substantially different, at least in regard to personality variables, and that one might extrapolate from the results of those who completed the follow-up to the entire study sample.

Forty-seven of the seventy female subjects on whom both MMPI and MI-SRI Form M scores were available, completed the follow-up questionnaire (SRQ). T-tests employing Fisher's pooled variance estimates were done on all available interval data. These data included subject's age, number of years married, and scale scores on the MMPI and MI-SRI Form M. Table 13 shows that only one of the 36 t-tests run for the females was significant at \( p < .05 \). As with the male subjects, it seems safe to extrapolate from the results of those who completed the follow-up to the entire study sample.
### TABLE 12

**COMPARISON OF FOLLOW-UP AND NON-FOLLOW-UP GROUPS**

**HUSBANDS**

**t-TESTS**

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### TABLE 12 (continued)

#### COMPARISON OF FOLLOW-UP AND NON-FOLLOW-UP GROUPS

#### HUSBANDS

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### TABLE 12 (continued)
COMPARISON OF FOLLOW-UP AND NON-FOLLOW-UP GROUPS

HUSBANDS

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**TABLE 13 (continued)**

**COMPARISON OF FOLLOW-UP AND NON-FOLLOW-UP GROUPS**

**WIVES**

**t-TESTS**

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IMPROVEMENT OF SUBJECTS AT END OF PROGRAM AND THREE MONTH FOLLOW-UP
The following analyses deal with improvement at the termination of the program, and at follow-up. As in the first series of analyses, individuals were grouped on the basis of presenting symptoms. In addition data were presented for the total group. Not all individuals come to the clinic with a symptom. Consequently, the total does not equal the number of subjects. Percentages were calculated on the number of subjects for whom there were data. Those subjects who did not reply at follow-up were not calculated in percentage totals, but were listed as missing in the appropriate categories.
Subjects improvement at the end of the program and at three month follow-up

Clinical programs are developed to treat specific problems. The initial test of efficacy is the status of the condition at the end of the treatment program. The ultimate test is the status of the condition after a period of time. A difference between these two indicates the need for helping the subjects to integrate their newly learned behaviors more effectively.

As one looks at subject's level of improvement grouped by husband's presenting symptom (Table 14), it is seen that some improvement or better is found in 84% of the total sample with even those presenting with both premature ejaculation and secondary impotence, combined; showing improvement in 72% of the cases. The wives of these subjects improved as well with 75% being improved or initially asymptomatic.

Results at follow-up are equally encouraging. Three months after the end of the program 72% of the husbands reporting stated that the condition was either eliminated or improved, with only 3% stating that the condition was worse. These figures remain fairly even across all symptom groups with only about 25% reporting no change. The wives of these men, who also had symptoms claimed some or total improvement in their own symptoms in 79% of the replies. Only the wives of husbands with both premature ejaculation and secondary impotence reported lower improvement, and they still reported
in 60% of the cases that there was some improvement in their own conditions.

75% of the wives reported some or total improvement (see Table 15). The only group reporting substantially lower success, was the group of women presenting with lack of interest, and they reported 57% improved. Husbands of the total group of subjects were either asymptomatic or improved in 88% of the cases.

At follow-up 72% of the wives reported some or total improvement. Only those expressing lack of interest were lower with only 25% acknowledging any improvement at three month follow-up. Seventy per cent of the husbands of the wives in these groups reported some or total improvement at follow-up. The only group of husbands reporting, substantially less positive results (40% improvement) were those of wives expressing lack of interest.

Overall, the results of follow-up are encouraging showing that new behaviors are integrated and maintained over a period of time following the completion of the clinic.
### Table 14

**Level of Improvement of Subjects Grouped by Husband's Symptom at End of Program and at Three Month Follow-Up**

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<th>Secondary Impotence</th>
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TABLE 14 (continued)

LEVEL OF IMPROVEMENT OF SUBJECTS GROUPED BY HUSBAND'S
SYMPTOM AT END OF PROGRAM AND AT THREE MONTH FOLLOW-UP

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<td>total improvement</td>
<td>3</td>
<td>13.0</td>
<td>10</td>
<td>71.4</td>
<td>3</td>
<td>60.0</td>
<td>3</td>
<td>8.6</td>
</tr>
<tr>
<td>some improvement</td>
<td>13</td>
<td>56.5</td>
<td>10</td>
<td>71.4</td>
<td>3</td>
<td>60.0</td>
<td>23</td>
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</tr>
<tr>
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<td>26.1</td>
<td>4</td>
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<td>2</td>
<td>40.0</td>
<td>8</td>
<td>22.9</td>
</tr>
<tr>
<td>worse</td>
<td>1</td>
<td>4.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>2.9</td>
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<tr>
<td>missing</td>
<td>15</td>
<td></td>
<td>9</td>
<td></td>
<td>6</td>
<td></td>
<td>20</td>
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</tbody>
</table>
## TABLE 15

**LEVEL OF IMPROVEMENT OF SUBJECTS GROUPED BY WIFE'S SYMPTOM AT END OF PROGRAM AND AT THREE MONTH FOLLOW-UP**

<table>
<thead>
<tr>
<th></th>
<th>Primary Non-orgasmic</th>
<th>Secondary Non-orgasmic</th>
<th>Lack of Interest</th>
<th>Total Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Wife's level of improvement at end of program:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>total</td>
<td>9</td>
<td>75.0</td>
<td>19</td>
<td>47.3</td>
</tr>
<tr>
<td>substantial</td>
<td>2</td>
<td>4.9</td>
<td>2</td>
<td>3.2</td>
</tr>
<tr>
<td>some</td>
<td>1</td>
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<td>25.4</td>
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<tr>
<td>unchanged</td>
<td>2</td>
<td>16.7</td>
<td>9</td>
<td>22.7</td>
</tr>
<tr>
<td>missing</td>
<td>3</td>
<td>17.7</td>
<td>1</td>
<td>22.2</td>
</tr>
<tr>
<td>Husband's level of improvement at end of program:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>total</td>
<td>6</td>
<td>54.5</td>
<td>18</td>
<td>43.9</td>
</tr>
<tr>
<td>substantial</td>
<td>3</td>
<td>7.3</td>
<td>1</td>
<td>14.3</td>
</tr>
<tr>
<td>some</td>
<td>1</td>
<td>9.1</td>
<td>7</td>
<td>17.1</td>
</tr>
<tr>
<td>unchanged</td>
<td>2</td>
<td>18.2</td>
<td>5</td>
<td>12.2</td>
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<tr>
<td>no symptom</td>
<td>2</td>
<td>18.2</td>
<td>8</td>
<td>19.5</td>
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<td>2</td>
<td>2</td>
<td>3</td>
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</table>
### TABLE 15 (continued)

LEVEL OF IMPROVEMENT OF SUBJECTS GROUPED BY WIFE'S SYMPTOM AT END OF PROGRAM AND AT THREE MONTH FOLLOW-UP

<table>
<thead>
<tr>
<th>Wife's status at follow-up:</th>
<th>Primary Non-orgasmic</th>
<th>Secondary Non-orgasmic</th>
<th>Lack of Interest</th>
<th>Total Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>total improvement</td>
<td>3</td>
<td>37.5</td>
<td>2</td>
<td>7.1</td>
</tr>
<tr>
<td>some improvement</td>
<td>3</td>
<td>37.5</td>
<td>19</td>
<td>67.9</td>
</tr>
<tr>
<td>unchanged</td>
<td>2</td>
<td>25.0</td>
<td>5</td>
<td>17.9</td>
</tr>
<tr>
<td>worse</td>
<td>2</td>
<td>7.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>unsure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>missing</td>
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<td>15</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Husband's status at follow-up:</th>
<th>Primary Non-orgasmic</th>
<th>Secondary Non-orgasmic</th>
<th>Lack of Interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>total improvement</td>
<td>2</td>
<td>20.0</td>
<td>2</td>
</tr>
<tr>
<td>some improvement</td>
<td>5</td>
<td>50.0</td>
<td>16</td>
</tr>
<tr>
<td>unchanged</td>
<td>3</td>
<td>30.0</td>
<td>6</td>
</tr>
<tr>
<td>worse</td>
<td>2</td>
<td>7.4</td>
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</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>missing</td>
<td>2</td>
<td>16.7</td>
<td>2</td>
</tr>
</tbody>
</table>
DESCRIPTION OF GROUPS BY CHANGE IN STATUS OF SYMPTOM
Profiles of groups divided by change in status of symptom

Differences between subjects who improved, and subjects who did not improve are a major concern in clinical research. The final clinician's statement of symptom status at the end of the program was used to define subjects in regard to improvement. Those subjects whose symptoms were considered substantially improved, or totally corrected were designated as members of the improvement group. Subjects whose symptoms were unchanged were designated as the unchanged group. Scores for these groups were then compared across variables. Others were not grouped.

Profiles of ordinal variables are plotted separately for males and females (Tables 17 and 17). Tables 18 and 19 list the aggregated scale scores on communication, marital satisfaction and sexual function. Inventory profiles for males and females on the MMPI and MI-SRT Form M are found on Graphs 5, 6, 7 and 8 followed by Tables 18, 19, 20 and 21 listing standard score means and standard deviation by scale.

As in many studies evaluating the effectiveness of an ongoing clinical program, variables are often inexactely measured, or assessed with a high variability across subjects. In a descriptive evaluative study such as this, the major concern is to develop an idea of the nature of differences between those subjects who respond positively to treatment, and those whose symptoms remain unchanged.
Later studies could then be developed to evaluate these differences more critically. Several patterns emerge as one examines the ordinal variables for males (Table 16). Those subjects who improved appear slightly more motivated to attend the clinic than those who were unchanged, as well as more committed to the marriage than the group that did not change. In addition the presenting problem appeared to be of shorter duration in the group that improved. The husband's relationship to his father seems substantially better in the improved group than in the other. The wish to have not married varied as did the husband's commitment to the marriage with the unchanged group expressing expressing slightly higher levels of regret than the successful group. The unchanged group expressed a stronger feeling that their wives did not like them for themselves than did the successful group.

Responses from the SRQ showed those in the change group as substantially more satisfied with coming to the clinic, although the difference in actual status of condition at follow-up wasn't as great, with both groups showing improvement. At follow-up the no change group showed a more positive attitude about emotional level within the marriage than did the group that was defined as improved.

Table 17 shows the wives responses on certain ordinal variables. As with the males, the groups of improvement and no change were based on the therapists assessment of the status of the wives condition at the termination of the program. Contrary to the re-
<table>
<thead>
<tr>
<th>Variable</th>
<th>N = 34 Substantial or Total Improvement</th>
<th>N = 8 Unchanged</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motivation to attend clinic</td>
<td>1.367 0.718</td>
<td>1.286 0.488</td>
</tr>
<tr>
<td>Commitment to marriage</td>
<td>1.226 0.617</td>
<td>1.000 0.0</td>
</tr>
<tr>
<td>Duration of problem</td>
<td>1.632 0.761</td>
<td>1.750 0.886</td>
</tr>
<tr>
<td>Relationship to father</td>
<td>2.400 0.770</td>
<td>1.875 0.354</td>
</tr>
<tr>
<td>Wish he had not married</td>
<td>2.621 0.561</td>
<td>2.750 0.463</td>
</tr>
<tr>
<td>Thinks partner does not like him</td>
<td>2.172 0.711</td>
<td>2.375 0.518</td>
</tr>
<tr>
<td>Satisfaction with clinic program</td>
<td>4.043 1.065</td>
<td>3.000 1.633</td>
</tr>
<tr>
<td>Status of condition</td>
<td>3.818 0.733</td>
<td>3.500 0.577</td>
</tr>
<tr>
<td>Change in emotional relationship</td>
<td>3.864 0.710</td>
<td>4.250 0.500</td>
</tr>
<tr>
<td>Variable</td>
<td>N = 34 Substantial or Total Improvement</td>
<td>N = 14 Unchanged</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>----------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Motivation to attend clinic</td>
<td>1.68 (1.08)</td>
<td>2.00 (0.91)</td>
</tr>
<tr>
<td>Initial level of marital happiness</td>
<td>3.47 (0.82)</td>
<td>2.71 (1.07)</td>
</tr>
<tr>
<td>Wishes partner to be a special person</td>
<td>2.80 (0.93)</td>
<td>3.07 (0.83)</td>
</tr>
<tr>
<td>Partner wishes her to be special</td>
<td>2.73 (1.05)</td>
<td>3.36 (0.72)</td>
</tr>
<tr>
<td>Disapproval of partner</td>
<td>1.97 (0.41)</td>
<td>2.57 (0.65)</td>
</tr>
<tr>
<td>Satisfaction with clinic program</td>
<td>4.18 (0.91)</td>
<td>3.38 (1.30)</td>
</tr>
<tr>
<td>Change in emotional relationship</td>
<td>4.09 (0.79)</td>
<td>4.43 (0.54)</td>
</tr>
</tbody>
</table>
sults for males, the wives showing no change appeared somewhat more motivated to attend the clinic than those who improved. However, the wives who improved expressed substantially higher levels of marital happiness than the unchanged group. The unchanged group showed higher expectations of their spouse and also believed that their spouse had higher expectations of them than the group that improved. In addition the wives who didn't improve expressed a substantially higher level of disapproval of their partners than did the group that improved. As was the case with husbands at follow-up on the SRQ, those wives who improved expressed greater satisfaction with the program than those who did not. Also, in spite of lack of symptom reversal, wives in the no change group felt more strongly than the successful wives, that the emotional relationship within the marriage had improved.

When looking at the aggregated scales, it must be remembered that they are merely a preliminary effort at elucidating some global aspects involved in sexual dysfunction and its treatment. Differences on these scales merely indicate possible differences, and some promising avenues to be explored. Table 18 shows the means and standard deviations for the male subjects. Level of communication before the program seemed about the same for both groups while showing high variability within the groups. Conflict in communication was higher for the no change group. The level of marital satisfaction at the beginning of the program was higher for those who im-
proved, but in the follow-up the stated level of marital satisfaction was substantially higher in the unchanged group, than in the group that improved. Sexual function as reported in the follow-up was slightly higher in both status of function and quantitative evaluation of function for the symptom reversal group than for the no change group.

The aggregate variables of the wives (Table 19) showed a somewhat different and more diffuse pattern than those of the husbands. Levels of communication at both the beginning of the program, and at follow-up were slightly higher for those who showed improvement than for those whose symptoms were unchanged. Conflict in communication, however, was a great deal higher for those who improved than for those who were unchanged. Initial marital satisfaction appeared slightly higher in the no change group than in those wives that improved.
<table>
<thead>
<tr>
<th>Variable</th>
<th>Husbands N = 34</th>
<th>Substantial or Total Improvement</th>
<th>N = 8</th>
<th>Unchanged</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( \bar{x} )</td>
<td>( \sigma )</td>
<td>( \bar{x} )</td>
<td>( \sigma )</td>
</tr>
<tr>
<td>Initial level of communication</td>
<td>12.22</td>
<td>2.34</td>
<td>12.25</td>
<td>3.24</td>
</tr>
<tr>
<td>Conflict in communication</td>
<td>11.650</td>
<td>1.63</td>
<td>12.75</td>
<td>1.71</td>
</tr>
<tr>
<td>Initial level of marital satisfaction</td>
<td>10.18</td>
<td>1.16</td>
<td>9.71</td>
<td>1.11</td>
</tr>
<tr>
<td>Status of symptom at follow-up</td>
<td>10.59</td>
<td>2.50</td>
<td>9.25</td>
<td>2.50</td>
</tr>
<tr>
<td>Quantitative level at follow-up</td>
<td>8.32</td>
<td>1.62</td>
<td>8.00</td>
<td>1.41</td>
</tr>
<tr>
<td>Level of marital satisfaction at follow-up</td>
<td>10.68</td>
<td>2.38</td>
<td>12.75</td>
<td>2.06</td>
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</table>
### TABLE 19

**AGGREGATE VARIABLES**

**WIVES**

<table>
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<tr>
<th>Variable</th>
<th>N = 34</th>
<th>Substantial or Total Improvement</th>
<th>N = 14</th>
<th>Unchanged</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial level of communication</td>
<td>13.16</td>
<td>2.20</td>
<td>12.93</td>
<td>2.50</td>
</tr>
<tr>
<td>Level of communication at follow-up</td>
<td>17.16</td>
<td>2.41</td>
<td>16.83</td>
<td>3.25</td>
</tr>
<tr>
<td>Conflict in communication</td>
<td>12.16</td>
<td>1.67</td>
<td>9.60</td>
<td>1.19</td>
</tr>
<tr>
<td>Initial level of marital satisfaction</td>
<td>10.21</td>
<td>1.37</td>
<td>10.43</td>
<td>1.09</td>
</tr>
</tbody>
</table>
Couples scores on Communication and Marital Satisfaction based on status of subject's sexual symptom

Sexual satisfaction and function generally are developed and evaluated in a dyad. The literature addresses the issue of the interdependence of couple satisfaction and improvement in the status of the sexual symptom of the individual. Combined scores for the couple were developed on the aggregate scales. These were then compared for husbands grouped by status of sexual symptom, and for wives divided in the same way.

Examining these variables for the husband (Table 20), very few show differences between groups. However the level of marital satisfaction at follow-up appears slightly higher for the couple in the unchanged group of husbands than in the group where the husband improved. The largest difference was found in communication problems level at the beginning of the program. The score for couples where husbands improved was higher than for those where he did not improve.

For wives (Table 21) conflict in communication was higher for the couple where the wife improved, than for the couple where the wife did not change. This variable approaches issues similar to those of the communication problems scale. Marital satisfaction was higher for the couples where wives improved, than for the unchanged group. Even though these scales are merely a primitive attempt at elucidating relationships they indicate a possible direc-
tion for further, more definitive inquiry in the area of communication, problem identification and solving in the dyad, as related to the treatment of marital and sexual dysfunction.
TABLE 20

AGGREGATE VARIABLES OF COMMUNICATION AND MARITAL SATISFACTION
FOR THE COUPLE GROUPED ON THE BASIS OF STATUS OF HUSBAND'S
SEXUAL SYMPTOM AT COMPLETION OF THE PROGRAM

<table>
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<tr>
<th>Variable</th>
<th>N = 34</th>
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<td>Total or Substantial</td>
<td>No Change</td>
</tr>
<tr>
<td></td>
<td>Improvement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( \bar{x} )</td>
<td>( \sigma )</td>
</tr>
<tr>
<td>Couple's initial level of communication</td>
<td>25.2 3.6</td>
<td>25.6 6.6</td>
</tr>
<tr>
<td>Level of communication at follow-up for couple</td>
<td>34.7 4.1</td>
<td>33.3 4.9</td>
</tr>
<tr>
<td>Level of couple's conflict in communication</td>
<td>24.4 2.5</td>
<td>24.8 2.9</td>
</tr>
<tr>
<td>Couple's initial level of marital satisfaction</td>
<td>20.7 1.9</td>
<td>20.0 1.4</td>
</tr>
<tr>
<td>Couple's level of marital satisfaction at follow-up</td>
<td>22.8 1.9</td>
<td>24.0 3.5</td>
</tr>
<tr>
<td>Couple's initial level of communication problems</td>
<td>15.8 3.1</td>
<td>12.7 2.9</td>
</tr>
</tbody>
</table>
### TABLE 21

AGGREGATE VARIABLES OF COMMUNICATION AND MARITAL SATISFACTION FOR THE COUPLE GROUPED ON THE BASIS OF STATUS OF WIFE'S SEXUAL SYMPTOM AT COMPLETION OF THE PROGRAM

<table>
<thead>
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<th>Variable</th>
<th>N = 34</th>
<th>N = .14</th>
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</thead>
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<td>No Change</td>
</tr>
<tr>
<td></td>
<td>$\bar{x}$</td>
<td>$\sigma$</td>
</tr>
<tr>
<td>Couple's initial level of communication</td>
<td>25.3</td>
<td>4.0</td>
</tr>
<tr>
<td>Level of communication at follow-up for couple</td>
<td>33.8</td>
<td>3.9</td>
</tr>
<tr>
<td>Level of couple's conflict in communication</td>
<td>23.8</td>
<td>3.0</td>
</tr>
<tr>
<td>Couple's initial level of marital satisfaction</td>
<td>20.4</td>
<td>2.1</td>
</tr>
<tr>
<td>Couple's level of marital satisfaction at follow-up</td>
<td>22.7</td>
<td>3.5</td>
</tr>
<tr>
<td>Couple's initial level of communication problems</td>
<td>15.1</td>
<td>2.3</td>
</tr>
</tbody>
</table>
Profiles of groups divided on basis of symptom change on the Minnesota Multiphasic Personality Inventory

When one examines the personality inventory profiles of the two groups some differences are observed. Table 22 gives the MMPI standard scores as well as the standard deviations for the sample of males divided as a function of improvement. The scores were not widely disparate and the variance was small. All scale means were within the normal range. It must be remembered that the MMPI is a test of psychopathology normed on a psychiatric population, not a general medical population. This is pictorially represented in Graph 5.

The mean scores for the female groups were more widely separated (see Table 23, Graph 6) but the standard deviations were also larger for the females. The group showing change scored consistently higher than the no change group on all MMPI scales. Again, all mean scores were well within the normal range.
<table>
<thead>
<tr>
<th>Scale</th>
<th>Substantial or Total Improvement N = 30</th>
<th>Unchanged N = 7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>STSC</td>
<td>STSC</td>
</tr>
<tr>
<td>Hypochondriacal trends</td>
<td>52.0</td>
<td>10.7</td>
</tr>
<tr>
<td>Symptomatic depression</td>
<td>55.9</td>
<td>12.0</td>
</tr>
<tr>
<td>Hysteroid tendencies</td>
<td>59.5</td>
<td>7.5</td>
</tr>
<tr>
<td>Psychopathic deviance</td>
<td>60.1</td>
<td>8.8</td>
</tr>
<tr>
<td>Masculinity-femininity</td>
<td>64.7</td>
<td>7.8</td>
</tr>
<tr>
<td>Paranoid mentation</td>
<td>54.6</td>
<td>7.2</td>
</tr>
<tr>
<td>Psychasthenia</td>
<td>57.6</td>
<td>9.2</td>
</tr>
<tr>
<td>Schizoid mentation</td>
<td>57.0</td>
<td>11.3</td>
</tr>
<tr>
<td>Hypomania</td>
<td>57.9</td>
<td>11.2</td>
</tr>
<tr>
<td>Social introversion</td>
<td>52.6</td>
<td>12.0</td>
</tr>
</tbody>
</table>
GRAPH 5
HUSBANDS' MMPI PROFILE

- ▲ - Substantial or Total Improvement
- □ - Unchanged
### TABLE 23

**WIVES’ MMPI**

<table>
<thead>
<tr>
<th>Scale</th>
<th>Substantial or Total Improvement</th>
<th>Unchanged</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>STSC (N = 30)</td>
<td>STSC (N = 14)</td>
</tr>
<tr>
<td>Hypochondriacal trends</td>
<td>49.8 16.8</td>
<td>43.5 20.0</td>
</tr>
<tr>
<td>Symptomatic depression</td>
<td>53.5 19.7</td>
<td>48.6 22.0</td>
</tr>
<tr>
<td>Hysteroid tendencies</td>
<td>53.6 17.4</td>
<td>51.9 22.8</td>
</tr>
<tr>
<td>Psychopathic deviance</td>
<td>41.4 18.2</td>
<td>34.9 24.1</td>
</tr>
<tr>
<td>Masculinity-femininity</td>
<td>54.5 13.6</td>
<td>49.1 15.9</td>
</tr>
<tr>
<td>Paranoid mentation</td>
<td>54.4 17.3</td>
<td>49.3 22.0</td>
</tr>
<tr>
<td>Psychasthenia</td>
<td>55.0 17.7</td>
<td>51.8 22.5</td>
</tr>
<tr>
<td>Schizoid mentation</td>
<td>48.5 17.8</td>
<td>46.0 23.5</td>
</tr>
<tr>
<td>Hypomania</td>
<td>49.5 16.2</td>
<td>46.8 22.6</td>
</tr>
<tr>
<td>Social introversion</td>
<td>42.8 15.7</td>
<td>42.5 21.9</td>
</tr>
</tbody>
</table>
Profiles of groups divided on basis of symptom change on the Millon-Illinois-Self Report Inventory Form M

The MI-SRI Form M is a self report inventory normed on a general medical population. The scale scores highlight styles of interaction and problem issues rather than inherent pathology. When examining the profiles of symptom reversal and no change groups, certain interpersonal patterns emerge as characteristic of the groups. Males (Table 24) in the improved group showed substantially higher scale means on Sociable, Confident and Forceful scales with an elevation in Recent Stress. The males who did not show improvement exhibited substantially higher scale means on the Cooperative, Inhibited and Respectful scales. In addition they showed higher scores than the other group on Premorbid pessimism, Future despair and Social alienation. It must be remembered that these are measures of styles of interaction and outlook, not psychopathology. Graphically this is seen in Graph 7.

The profiles of the improved and unchanged female groups showed major differences in scale elevations (Table 25). The group showing substantial or total improvement displayed a Cooperative, Sociable and Confident constellation, while the other group was higher on Sensitive, Inhibited and Forceful scales. In addition, the no change group was much higher on Premorbid pessimism, Future despair and Social alienation pictured in Graph 8.
# TABLE 24

## HUSBAND'S MI-SRI PROFILE

<table>
<thead>
<tr>
<th>Scale</th>
<th>Substantial or Total Improvement</th>
<th>Unchanged</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BR</td>
<td>☐</td>
</tr>
<tr>
<td>Introversive</td>
<td>44.3</td>
<td>22.2</td>
</tr>
<tr>
<td>Inhibited</td>
<td>43.5</td>
<td>32.6</td>
</tr>
<tr>
<td>Cooperative</td>
<td>51.5</td>
<td>28.0</td>
</tr>
<tr>
<td>Sociable</td>
<td>61.5</td>
<td>31.1</td>
</tr>
<tr>
<td>Confident</td>
<td>46.1</td>
<td>28.9</td>
</tr>
<tr>
<td>Forceful</td>
<td>45.2</td>
<td>25.8</td>
</tr>
<tr>
<td>Respectful</td>
<td>35.7</td>
<td>23.0</td>
</tr>
<tr>
<td>Sensitive</td>
<td>44.6</td>
<td>27.9</td>
</tr>
<tr>
<td>Chronic tension</td>
<td>49.8</td>
<td>23.9</td>
</tr>
<tr>
<td>Recent stress</td>
<td>41.8</td>
<td>22.6</td>
</tr>
<tr>
<td>Premorbid pessimism</td>
<td>32.3</td>
<td>29.2</td>
</tr>
<tr>
<td>Future despair</td>
<td>36.8</td>
<td>29.5</td>
</tr>
<tr>
<td>Social alienation</td>
<td>42.5</td>
<td>29.0</td>
</tr>
<tr>
<td>Somatic anxiety</td>
<td>34.5</td>
<td>25.5</td>
</tr>
<tr>
<td>Allergy</td>
<td>45.8</td>
<td>24.6</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>42.3</td>
<td>19.3</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>48.4</td>
<td>20.6</td>
</tr>
<tr>
<td>Pain proneness</td>
<td>42.8</td>
<td>21.3</td>
</tr>
<tr>
<td>Life-threat react.</td>
<td>42.7</td>
<td>25.6</td>
</tr>
<tr>
<td>Emotional vulner.</td>
<td>19.2</td>
<td>26.5</td>
</tr>
</tbody>
</table>
Introverted
Inhibited
Cooperative
Sociable
Confident
Forceful
Respectful
Sensitive
Chromic tension
Recent stress
Premorbid pessimism
Future despair
Social alienation
Somatic anxiety
Allergic inclination
Gastronintestinal
Cardiovascular
Pain proneness
Life-threat react.
Emotional vulnerability

GRAPH 7
HUSBANDS PROFILES BY SYMPTOM CHANGE
MI-SRI FORM M

Substantial or total improvement  Unchanged
<table>
<thead>
<tr>
<th>Scale</th>
<th>Substantial or Total</th>
<th>Unchanged</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Improvement N = 30</td>
<td></td>
</tr>
<tr>
<td></td>
<td>BR</td>
<td>BR</td>
</tr>
<tr>
<td>Introversive</td>
<td>42.8</td>
<td>22.3</td>
</tr>
<tr>
<td>Inhibited</td>
<td>39.3</td>
<td>26.0</td>
</tr>
<tr>
<td>Cooperative</td>
<td>66.3</td>
<td>22.6</td>
</tr>
<tr>
<td>Sociable</td>
<td>63.7</td>
<td>25.8</td>
</tr>
<tr>
<td>Confident</td>
<td>48.0</td>
<td>25.7</td>
</tr>
<tr>
<td>Forceful</td>
<td>32.1</td>
<td>21.1</td>
</tr>
<tr>
<td>Respectful</td>
<td>37.7</td>
<td>22.9</td>
</tr>
<tr>
<td>Sensitive</td>
<td>43.0</td>
<td>27.3</td>
</tr>
<tr>
<td>Chronic tension</td>
<td>44.4</td>
<td>20.4</td>
</tr>
<tr>
<td>Recent stress</td>
<td>37.4</td>
<td>20.2</td>
</tr>
<tr>
<td>Premorbid pessimism</td>
<td>38.2</td>
<td>21.7</td>
</tr>
<tr>
<td>Future despair</td>
<td>44.9</td>
<td>22.3</td>
</tr>
<tr>
<td>Social alienation</td>
<td>36.2</td>
<td>19.9</td>
</tr>
<tr>
<td>Somatic anxiety</td>
<td>40.9</td>
<td>21.8</td>
</tr>
<tr>
<td>Allergy</td>
<td>47.6</td>
<td>21.1</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>45.4</td>
<td>18.8</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>44.9</td>
<td>17.2</td>
</tr>
<tr>
<td>Pain proneness</td>
<td>60.0</td>
<td>15.2</td>
</tr>
<tr>
<td>Life-threat react.</td>
<td>43.8</td>
<td>17.2</td>
</tr>
<tr>
<td>Emotional vulner.</td>
<td>21.6</td>
<td>22.8</td>
</tr>
</tbody>
</table>
Introversive
Inhibited
Cooperative
Sociable
Confident
Forceful
Respectful
Sensitive
Chronic tension
Recent stress
Premorbid pessimism
Future despair
Social alienation
Somatic anxiety
Allergic inclination
Gastrointestinal
Cardiovascular
Pain proneness
Life-threat react.
Emotional vulnerability

\[ \Delta \text{ Substantial or total improvement} \quad \square \text{ Unchanged} \]
PREDICTORS OF SYMPTOM REVERSAL
Data from seventy husbands and seventy wives were available for the discriminant analysis. Subjects were grouped in the same manner as for the preceding series of analyses. Those who were totally or substantially improved were defined as members of Group I. Those who were unchanged were in Group II.
Discriminant analysis of MMPI and MI-SRI Form M to develop predictors of symptom reversal

Discriminant analysis is a technique used to statistically divide two or more groups. The mathematical objective of discriminant analysis is to weight and linearly combine discriminating variables in some fashion so that the groups are forced to be as statistically distinct as possible. The functions produced can then be used to predict group membership.

In this analysis a stepwise procedure utilized Wilks criterion. This criterion is the overall multivariate F ratio for the test of differences among group centroids. The variable which maximizes the F ratio also minimizes Wilks' Lambda, a measure of group discrimination.

It must be remembered these data were collected within the context of an ongoing therapeutic relationship. It would be presumptuous to assume that these predictors could be used for couples who had not established a therapeutic bond.

The male and female subjects were separately treated in the development of discriminants. The combined MMPI and MI-SRI Form M instrument scales were weighted and placed in the analysis based on Wilks' Lambda formula. When the analysis of the independent variables was completed a set of standardized discriminant coefficients was established as shown in Table 26 for the males. One function was developed to differentiate the two groups of males. The dis-
### TABLE 26

**DISCRIMINANT ANALYSIS**

**HUSBANDS' GROUP I**  
**GROUP II**

**MI-SRI FORM M**  
**MMPI**

#### Standardized Discriminant Function Coefficients

<table>
<thead>
<tr>
<th>MMPI</th>
<th>Function 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypochondriacal trends</td>
<td>0.569</td>
</tr>
<tr>
<td>Psychopathic deviance</td>
<td>-0.301</td>
</tr>
<tr>
<td>Paranoid mentation</td>
<td>0.345</td>
</tr>
<tr>
<td>Psychasthenia</td>
<td>-1.115</td>
</tr>
<tr>
<td>Social introversion</td>
<td>0.483</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MI-SRI FORM M</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inhibited</td>
<td>2.302</td>
</tr>
<tr>
<td>Respectful</td>
<td>0.789</td>
</tr>
<tr>
<td>Recent stress</td>
<td>-0.505</td>
</tr>
<tr>
<td>Social alienation</td>
<td>-0.899</td>
</tr>
<tr>
<td>Allergic inclination</td>
<td>-0.507</td>
</tr>
</tbody>
</table>

#### CENTROIDS OF GROUPS IN REDUCED SPACE

<table>
<thead>
<tr>
<th>Group</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Group I</td>
<td>-0.353</td>
</tr>
<tr>
<td>Group II</td>
<td>1.514</td>
</tr>
</tbody>
</table>
**TABLE 27**

**DISCRIMINANT ANALYSIS**

**HUSBANDS' GROUP I**  **GROUP II**

<table>
<thead>
<tr>
<th>MI-SRI FORM M</th>
<th>MMPI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Discriminant Function</strong></td>
<td><strong>Eigenvalue</strong></td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>1</td>
<td>1.22068</td>
</tr>
</tbody>
</table>
TABLE 28

PREDICTION RESULTS

HUSBANDS’ MI-SRI FORM MMPI

<table>
<thead>
<tr>
<th>Actual Group</th>
<th>Number of Cases</th>
<th>Predicted Group Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Group I</td>
</tr>
<tr>
<td>Group I</td>
<td>30</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td></td>
<td>86.7%</td>
</tr>
<tr>
<td>Group II</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.0%</td>
</tr>
<tr>
<td>Ungrouped cases</td>
<td>33</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td></td>
<td>72.7%</td>
</tr>
</tbody>
</table>

Percent of "grouped" cases correctly classified: 89.19%
criminant function has been listed for an analysis of significance for the combined tests in Table 27. The chi-square of the function with 10 degrees of freedom was statistically significant with \( p < .008 \). The results presented in Table 28 indicated that the discriminants found did differentiate the two groups and predict group membership. The percent of "grouped" cases correctly classified by this function was 89.19%.

The combined MMPI and MI-SRI Form M instrument scale scores for the women were weighted and placed in the discriminant analysis based on Wilks' Lambda formula. When the analysis of the independent variables was completed a set of standardized discriminant coefficients was established as shown in Table 29. One function was developed to differentiate the two groups of females. The discriminant function has been listed for an analysis of significance for the combined tests in Table 30. The chi-square of the function with 7 degrees of freedom was statistically significant with \( p < .001 \). The results presented in Table 31 indicated that the discriminants found did differentiate the two groups and predict group membership. The percent of "grouped" cases correctly classified by this function was 93.18%.
### Table 29

**Discriminant Analysis**

**Wives' Group**  
**Group II**

<table>
<thead>
<tr>
<th>MMPI</th>
<th>Function 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychasthenia</td>
<td>-0.802</td>
</tr>
<tr>
<td>Schizoid mentation</td>
<td>1.018</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MI-SRI Form M</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sociable</td>
<td>-0.897</td>
</tr>
<tr>
<td>Forceful</td>
<td>1.097</td>
</tr>
<tr>
<td>Chronic tension</td>
<td>-0.856</td>
</tr>
<tr>
<td>Future despair</td>
<td>-0.391</td>
</tr>
<tr>
<td>Allergic inclination</td>
<td>0.419</td>
</tr>
</tbody>
</table>

**Centroids of Groups in Reduced Space**

<table>
<thead>
<tr>
<th>Group</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Group I</td>
<td>-0.482</td>
</tr>
<tr>
<td>Group II</td>
<td>1.032</td>
</tr>
</tbody>
</table>
TABLE 30

DISCRIMINANT ANALYSIS

WIVES' GROUP I  GROUP II

<table>
<thead>
<tr>
<th>Discriminant Function</th>
<th>Eigenvalue</th>
<th>Relative Percentage</th>
<th>Canonical Correlation</th>
<th>Functions Derived</th>
<th>Wilks' Lambda</th>
<th>Chi-Square</th>
<th>df</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1.03503</td>
<td>100.00%</td>
<td>0.713</td>
<td>0</td>
<td>0.4914</td>
<td>27.365</td>
<td>7</td>
<td>0.001</td>
</tr>
</tbody>
</table>
### TABLE 31

**PREDICTION RESULTS**

<table>
<thead>
<tr>
<th>Actual Group</th>
<th>Number of Cases</th>
<th>Predicted Group Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Group I</td>
</tr>
<tr>
<td>Group I</td>
<td>30</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td></td>
<td>93.3%</td>
</tr>
<tr>
<td>Group II</td>
<td>14</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7.1%</td>
</tr>
<tr>
<td>Ungrouped cases</td>
<td>26</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>46.2%</td>
</tr>
</tbody>
</table>

Percent of "grouped" cases correctly classified: 93.18%
ANALYSES OF PARTIAL CORRELATIONS
Partial correlation is a statistical method utilized to detect spurious correlations. In addition, it can serve to tease apart the effects of several variables to find which variables relate, but whose relationship is clouded by cancelling effects of other variables. The effects of the control variables are considered to be linear throughout the range.

It is assumed that some of the relationships among variables in this study are clouded. The relationships among marital satisfaction after the clinic, type of symptom, improvement, satisfaction with coming to the clinic, satisfaction of initial expectations and communication level at follow-up were of particular interest. Partial correlations were run on these variables to assess the relationships.

The first correlation studied for the males (Table 32) was that between marital satisfaction at follow-up and the feeling that initial expectations of the husbands in regard to the clinic, had been met. Before partialing out other variables the relationship appeared significant. However, after partialling out status of the condition at follow-up, original presenting problem, and communication at follow-up, the relationship was no longer significant.

Treatment programs are always concerned about meeting the needs of the patients that seek them out. The relationship between
status of the condition and the feeling that initial expectations have been met addresses part of this issue. If in fact the couples seek symptom reversal and their satisfaction with the program is predominantly based on this, the program emphasis on symptomology is validated. Before partial correlation the relationship between these two variables was 0.6359 and was significant at $p < .001$. After controlling for level of marital satisfaction at follow-up, presenting concern, and level of communication at follow-up, the correlation was reduced a little, but was still significant at $p < .001$.

Another issue is the relationship between level of marital satisfaction and change in the status of the symptom. Without partial correlation the relationship was seen as weakly negative and not significant. After partialling out satisfaction with initial expectations, presenting concern and status of condition the correlation became even weaker.

Change in status of the presenting symptom and how it related to satisfaction with coming to the clinic, were correlated. Before partialling out other variables it was positive and significant at $p < .001$. After partialling out level of marital satisfaction at follow-up, presenting problem and level of communication at follow-up it remained significant at $p < .01$.

Satisfaction with coming to the clinic and level of marital satisfaction at follow-up appeared positively and significantly re-
### TABLE 32

PARTIAL CORRELATIONS HUSBANDS

<table>
<thead>
<tr>
<th>Variables correlated</th>
<th>Correlation</th>
<th>df</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>* POSMSATH BY SRQ2H</td>
<td>0.3773</td>
<td>47</td>
<td>0.004</td>
</tr>
<tr>
<td>* POSMSATH BY SRQ2H controlling for SRQ5, MSEXPH, ACOMH</td>
<td>0.1745</td>
<td>37</td>
<td>0.144</td>
</tr>
<tr>
<td>* SRQ2 BY SRQ5H</td>
<td>0.6359</td>
<td>46</td>
<td>0.001</td>
</tr>
<tr>
<td>* SRQ2H BY SRQ5H controlling for POSMSATH, MSEXPH, SCOMH</td>
<td>0.5692</td>
<td>37</td>
<td>0.001</td>
</tr>
<tr>
<td>SYMREVH BY POSMSATH</td>
<td>-0.1388</td>
<td>46</td>
<td>0.173</td>
</tr>
<tr>
<td>SYMREVH BY POSMSATH controlling for SRQ3H, SRQ5H, MSEXPH</td>
<td>-0.0157</td>
<td>42</td>
<td>0.460</td>
</tr>
<tr>
<td>* SRQ1H BY SRQ5H</td>
<td>0.4965</td>
<td>48</td>
<td>0.001</td>
</tr>
<tr>
<td>* SRQ1H BY SRQ5H controlling for POSMSATH, MSEXPH, ACOMH</td>
<td>0.4559</td>
<td>48</td>
<td>0.002</td>
</tr>
<tr>
<td>* SRQ1H BY POSMSATH</td>
<td>0.2284</td>
<td>49</td>
<td>0.053</td>
</tr>
<tr>
<td>SRQ1H BY POSMSATH controlling for SRQ5H, MSEXPH, ACOMH</td>
<td>0.0202</td>
<td>38</td>
<td>0.451</td>
</tr>
</tbody>
</table>

POSMSATH = level of marital satisfaction at follow-up
SRQ2H = belief that initial program expectations were met
SRQ5H = status of condition at follow-up
SYMREVH = degree of symptom reversal at end of program
MSEXPH = presenting symptom or symptoms
ACOMH = level of communication at follow-up
SRQ1H = satisfaction with having come to clinic

* significant correlations
lated for the males at $p < .05$. However, after partialling out current status of condition at follow-up, specific symptom and level of communication at follow-up the relationship was very weak and not significant. It would appear that for the male subjects satisfaction with the clinic as well as satisfaction of initial expectations is primarily related to the correction of the presenting symptom.

Table 33 shows the partial correlations for the wives in the study. As with the husbands, the relationship between satisfaction of initial program expectations and level of marital satisfaction at follow-up is significant and positive. However, after partialling out for status of the condition at follow-up, the correlation was greatly reduced and no longer significant.

The relationship between satisfaction of initial expectations and status of condition was significant at $p < .001$. The relationship remained significant after partialling out level of marital satisfaction at follow-up, presenting symptom and level of communication at follow-up.

As with husbands, change in status of condition and marital satisfaction at follow-up related in a weak, negative fashion, and after partialling out satisfaction of initial expectations, specific symptom and level of communication at follow-up, the relationship became stronger, but still did not reach significant levels.
Marital satisfaction at follow-up was correlated with satisfaction with having attended the clinic. The results for wives, in contrast to those of the husbands showed an initial correlation significant at $P < .003$. When the status of condition at follow-up, specific sexual complaint and level of communication at follow-up were partialled out the relationship remained significant at $P < .05$.

Replies of wives on satisfaction with having come to the clinic correlated very strongly and positively with the status of condition at follow-up, significant at $P < .001$. Even after partialling out symptom, level of marital satisfaction at follow-up and level of communication at follow-up, the relationship remains strongly significant at $P < .001$.

In wives as in the husbands' follow-up replies, both satisfaction with coming to the clinic and satisfaction of initial expectations are significantly related to correction of presenting symptom. In contrast to the husbands, satisfaction of wives also correlated with level of marital satisfaction at follow-up, even after other effects were partialled out. This would point to a differential perception of what the clinic represents to men and women.
TABLE 33

PARTIAL CORRELATIONS WIVES

<table>
<thead>
<tr>
<th>Variables correlated</th>
<th>Correlation</th>
<th>df</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>* POSMSATW BY SRQ2W</td>
<td>0.2943</td>
<td>45</td>
<td>0.022</td>
</tr>
<tr>
<td>POSMSATW BY SRQ2W controlling for SRQ5W, MSEXPW, ACOMW</td>
<td>0.1194</td>
<td>34</td>
<td>0.244</td>
</tr>
<tr>
<td>* SRQ2W BY SRQ5W</td>
<td>0.5663</td>
<td>47</td>
<td>0.001</td>
</tr>
<tr>
<td>* SRQ2W BY SRQ5W controlling for POSMSATW, MSEXPW, ACOMW</td>
<td>0.5113</td>
<td>34</td>
<td>0.001</td>
</tr>
<tr>
<td>SYMREVWPW BY POSMSATW</td>
<td>-0.0236</td>
<td>40</td>
<td>0.441</td>
</tr>
<tr>
<td>SYMREVWPW BY POSMSATW controlling for SRQ2W, MSEXPW, ACOMW</td>
<td>-0.1781</td>
<td>30</td>
<td>0.165</td>
</tr>
<tr>
<td>* SRQ1W BY POSMSATW</td>
<td>0.3995</td>
<td>44</td>
<td>0.003</td>
</tr>
<tr>
<td>* SRQ1W BY POSMSATW controlling for SRQ5W, MSEXPW, ACOMW</td>
<td>0.2794</td>
<td>34</td>
<td>0.050</td>
</tr>
<tr>
<td>* SRQ1W BY SRQ5W</td>
<td>0.6523</td>
<td>46</td>
<td>0.001</td>
</tr>
<tr>
<td>* SRQ1W BY SRQ5W controlling for POSMSATW, MSEXPW, ACOMW</td>
<td>0.6131</td>
<td>34</td>
<td>0.001</td>
</tr>
</tbody>
</table>

POSMSATW = level of marital satisfaction at follow-up
SRQ2W = belief that initial program expectations were met
SRQ5W = status of condition at follow-up
SYMREVWP = degree of symptom reversal at end of program
MSEXPW = presenting symptom or symptoms
ACOMW = level of communication at follow-up
SRQ1W = satisfaction with having come to clinic

* significant correlations
Summary

A survey of the literature in the area of modes of sex therapy and outcome was done preliminary to proceeding with the project under study. The review is covered in Chapter II.

The first step in analyzing the data gathered during this study, was to reduce the number of variables being evaluated. The major concern was program effectiveness. Consequently, the criterion for retaining variables, was that they differed as a function of improvement in the symptoms. Subjects were divided by sex on the basis of improvement in symptom. If a given variable varied more than fifteen per cent, between those who showed total or substantial improvement, and those who showed no change, the variable was retained for further analysis. In addition, a number of aggregate variables were developed on the basis of theoretical commonalities. These were then evaluated on the same criterion as the single variables.

Another issue addressed in this study was differences and commonalities amongst groups divided on the basis of presenting symptoms. Real differences were found among the groups. Not only did the groups vary in certain perceptions of marriage and their partners, but in their involvement in the relationship. In addition there were marked differences among the groups on a number of the personality measures.

The key concern of the study was effectiveness of the program. It was found that the initial rate of improvement was quite high, and that this level was generally maintained at the three month follow-up.
The only groups which showed reduced levels of improvement at follow-up were those women who presented with lack of interest, and those males who present with both premature ejaculation and secondary impotence.

Predictors of successful treatment are based on differences between those individuals who improved and those who did not improve. Differences existed between these groups on a number of variables. The personality variables were utilized to develop predictors. The discriminant functions developed for this purpose were very powerful. These predictors could be used to effectively select the program that would be of greatest benefit to a given couple.

The partial correlations clarified some similarities and some differences between the husbands in the sample and the wives. Satisfaction with coming to the clinic was significantly correlated with improvement in the presenting symptoms, for both husbands and wives. In addition, marital satisfaction was significantly correlated with satisfaction with the program for the wives in the sample, but not for the husbands. The important conclusion was that the clinic program was meeting the needs of the couples, including an increased sense of closeness, understanding and comfort with each other and symptomatic improvement was not the only need that was being met.
CHAPTER V
SUMMARY

This study addressed sexuality issues and methods employed in the education and counseling of adults in the realm of interpersonal relationships with specific references to treatment and outcome of sexual dysfunction. Review of the literature reveals a need for empirical validation of techniques utilized in the remediation of sexual dysfunction. A variety of programs are already established for sex treatment. Practitioners as well as researchers have expressed a wish for research within the natural setting of operating programs to assess program effectiveness and the degree to which new behaviors are maintained. Since sexual expression is a major part of human existence and more counselors are becoming involved in the area of sexual concerns, both as educators and counselors, this study was implemented to join the skills and expertise of various disciplines.

Sexual functioning occurs within a relationship. Marriage and sexual expression within marriage form a dynamic interaction. This interaction is expressed on a number of levels involving verbal and non-verbal communication as well as sexuality. Therapists must be prepared to operate on all these levels of patient needs. This is graphically defined for the therapists in the "Roles and Tasks of Trainee Therapists" (Appendix R). In fact, problems in sexual relationships often are the vehicles by which marital dissatisfaction is expressed. Professionals continually utilize new
forms of treatment as well as more traditional ones to aid clients in assessing and growing within their relationships. The Loyola Training program is multi-mod 1 and utilizes sex education, brief behavioral sex therapy plus marital (relationship) counseling and psychotherapy.

The results of this study of the Loyola Program could aid in the development of improved programs for the treatment of sexual dysfunction. 1) The components of an effective program have been validated. 2) Possible avenues for modifying the program have been illuminated, both in regard to initial outcome, and in long-term effectiveness. 3) Information gained from this study could improve the method of selection of modality for specific couples to maximize potential effectiveness of treatment. 4) The follow-up aspect of the study was significant in ascertaining the degree to which newly learned behaviors were integrated into life styles and the daily functioning of the couple. 5) Effective predictors of outcome can aid professionals. If couples are already involved in a therapy relationship, it would be possible to utilize these predictors (MMPI, MI-SRI Form M) for selecting persons for a specific type of program or perhaps in suggesting alternatives.
Subjects and Symptoms

The one hundred and fifty-four subjects involved in the study included all the couples (77) who enrolled in and completed the Sexual Dysfunction Treatment Program at Loyola University School of Medicine from October, 1976 through May, 1977. Presenting symptoms for the husbands were premature ejaculation \( (n = 27) \), secondary impotence \( (n = 10) \), a combination of premature ejaculation and secondary impotence \( (n = 11) \), and no symptoms \( (n = 20) \). The remaining husbands had a variety of symptoms or combination of symptoms. Presenting symptoms for the wives were primary non-orgasmic \( (n = 12) \), secondary non-orgasmic \( (n = 38) \), lack of interest \( (n = 7) \), no symptoms \( (n = 10) \). The remaining wives had symptoms such as dyspareunia, vaginismus, or these in combination with other symptoms.

Personnel

The seventy-seven pairs of cotherapists utilized for this study were participants in the Physician's Training Program in the Sexual Dysfunction Clinic. All cotherapist pairs were under the supervision of one or more experienced faculty psychotherapists. Cotherapists included physicians, medical students, psychologists, counselors, social workers, nurses and religious personnel.

Instruments

Testing was administered throughout the program. These were administered in the following order: Loyola University Marital Ad-
justment Test, Minnesota Multiphasic Personality Inventory (MMPI), Millon Illinois-Self Report Inventory Form M (MI-SRI Form M). In addition information was drawn from the Loyola University Hospital Sexual Dysfunction Clinic Sheet. The follow-up Self Report Questionnaire (SRQ) was mailed to the couples two and one half months after the completion of the program.

Research Design

After approval by the Human Investigation Committee of the hospital this study was done on and during the ongoing Sex Clinic of Loyola University's Medical School. Testing was done within the framework of the treatment program and further information utilized in the study was drawn from responses on the follow-up Self Report Questionnaire.

Assumptions and Hypotheses

The investigator made several assumptions when undertaking this study. First, brief psychobehavioral therapy is a viable way to promote symptomatic improvement in sexual dysfunction. It is believed that couples being educated evidence different levels of communication, satisfaction and functioning, and have a variety of presenting problems. It is also assumed that differing levels of communication, satisfaction and functioning as well as specific presenting problem will be related to the success of treatment.

The following hypotheses were tested:
1. There exists some relationship among personality variables, biographical data, communication, marital satisfaction, presenting problem and the outcome of treatment and long term effectiveness in the Sexual Dysfunction Clinic.

2. Some of these data are effective predictors of outcome.

Data Analysis

The MMPI scoring was done by Roche Scoring Service. The MI-SRI Form M was done at the University of Illinois Medical Center. The data drawn from medical records of the Sexual Dysfunction Clinic and SRQ were coded at Loyola University, and all data were punched at University of Illinois Medical Center. The data were analyzed at the University of Illinois Medical Center utilizing the Statistical Package for the Social Sciences for descriptive statistics, frequency distributions, t-tests, partial correlations and discriminant analyses.

Results

Although profiles of groups as a function of presenting symptom all were within the normal range, differences were found. For males, the MMPI showed lower scale means for subjects without symptoms on all scales except Hypomania on which they were slightly higher.

The MI-SRI Form M profile for males showed the no symptom group as substantially higher on Sociable and Confident, while much
lower on Inhibited, Sensitive, Recent stress, Premorbid pessimism, Future despair, Social alienation and Somatic anxiety than all symptom groups.

For wives the picture was more diffuse on the MMPI. On the MI-SRI Form M, scale scores for the no symptom group were higher on Sociable and Confident and lower on Sensitive and Inhibited than in all symptom groups.

Seventy-one per cent of the subjects completed the follow-up questionnaire (SRQ). When t-tests were run on personality scale scores, age and duration of marriage, for those who returned the follow-up and those who did not, only two of the 72 were significant. Since this would be expected merely on chance, it is assumed that there are no significant differences, and the replies of those who completed follow-up are generalized to all subjects in the study.

Improvement in the status of subject's condition was evaluated at two points. Therapists recorded their assessment to symptomatic improvement at termination of the program. The subjects themselves evaluated the status of the condition in the SRQ. At the end of the program improvement was 84% for males, with 75% of their wives improved or asymptomatic. At follow-up these figures fell only slightly to 72% for the males, with their wives remaining constant. There was some variation across symptom groups with those presenting with both premature ejaculation and secondary impotence less successful.
For wives, 75% of those with symptoms were improved at the termination of the program with 88% of their husbands asymptomatic or improved at termination. The group complaining of lack of interest had lowest improvement with 57% at termination. At follow-up 72% of all wives with symptoms still reported improvement. Only 25% of the lack of interest group reported continued improvement at follow-up. Seventy per cent of the husbands reported continued improvement at follow-up, with only 40% of the husbands of the lack of interest group reporting improvement at this point.

Subjects were also contrasted by groups as a function of symptom improvement. Improved males with a problem of shorter duration appeared more motivated than those who did not improve. The couple score for communication problems was also at a higher level for those who improved than for those who did not. The profiles on MI-SRI Form M showed male subjects who improved were higher on Sociable, Confident, Forceful and Recent stress while the group of males who did not change were higher on Cooperative, Inhibited, Respectful, Premorbid pessimism, Future despair and Social alienation (see Appendix O).

Wives whose symptoms improved reported a higher level of marital happiness than those who did not change, although the unchanged appeared more motivated to attend the clinic. All seemed to feel that the emotional relationship within the marriage had improved. The scores for the couple of wives who improved were higher on com-
communication conflict than for the unchanged group. The profiles on MI-SRI Form M showed the improved subjects as higher on Cooperative, Sociable and Confident scales, while the group that did not change was higher on Sensitive, Inhibited, Forceful, Premorbid pessimism, Future despair and Social alienation.

When discriminant analyses were separately performed for males and females on the scales of both the MMPI and the MI-SRI. Form M constellations of weighted scale discriminants were found which were able to predict treatment outcome at impressively high levels for those involved in this type of program.

Analysis of the data with partial correlation showed that the correlation of satisfaction with coming to the clinic and status of the condition was significant for all subjects as was the belief that initial expectations were met and the status of the condition. In addition, for wives there was a significant correlation between satisfaction with coming to the clinic and level of marital satisfaction at follow-up.

Conclusions

1. Results indicated substantial differences among the profiles of the no symptom and all the symptom groups. These are particularly illuminating on the MI-SRI Form M in regard to self-perception and styles of interaction. Both male and female subjects with no presenting symptoms had higher scores on Sociable and Confident scales than all symptom groups, indicating individuals who
are active, concerned with appearing talkative and charming as well as fairly comfortable with their own sense of worth. The no symptom groups were lower than all symptom groups on Sensitive and Inhibited. They would be seen as less fearful, hurt and distrustful as well as less likely to be unpredictable, moody and troublesome.

2. In addition to differing from no symptom groups, the symptom groups differed among themselves. These differences are significant both in maintaining and improving relationships. Males presenting with premature ejaculation and secondary impotence seemed least equipped with social skills and feelings about self that would promote sound sexual relationships. In addition they tended to be pessimistic, socially alienated and expressed many feelings which indicate the possibility of serious emotional problems. Females presenting with lack of interest appeared tense, fearful, distrustful, unpredictable, domineering and often hostile. These traits make lasting relationships very difficult. In addition these subjects exhibit higher levels of stress, feelings that life is a series of troubles for them, and that situations are unlikely to improve in the future.

3. The most important aspect of this study was its assessment of improvement, both at the end of the program and at follow-up. Improvement was impressive with both males and females showing high levels of improvement at the end of the program. Lowest levels of improvement among males were found in males presenting with both
premature ejaculation and secondary impotence. In addition their wives did less well in the program than the wives of males with other problems. This pattern was magnified (with none claiming total improvement, and 80% reporting some improvement), at the three month follow-up. Females presenting with lack of interest showed lowest level of improvement among female symptom groups, and immediate gains were not well maintained at three month (75% unchanged, 25% some improvement) follow-up. Their spouses also fare more poorly than those of other groups, with even these modest gains reduced at three month follow-up.

4. A variety of differences exist between those individuals who improved and those who did not. Husbands who improved appeared more motivated and committed to their marriage than the unchanged group. In wives, those who did not change appeared more motivated, but also more critical and demanding of their spouses. Both improved groups reported higher satisfaction with the program than those who did not improve. Communication appears to be a key factor in improvement in the program, and type of communication is not the key but that communication goes on.

On the MI-SRI Form M both males and females who improved were higher on Sociable and Confident scales, while those who did not improve were higher on the Inhibited scale. There are very real differences in concepts of marital role, spouse expectations and personality styles of individuals who improved during the treatment program, and those who did not improve.
5. The discriminant analysis developed useful predictors of those individuals who would, or would not improve, on the basis of their personality scale scores. Assuming these predictors hold in cross-validation studies, they will be of great value in selecting treatment programs for couples already involved in a therapeutic relationship who wish treatment of a sexual dysfunction. Those who would be unlikely to improve with this type of program could be referred for other, hopefully more effective modalities, or perhaps for additional treatment before entering the Sexual Dysfunction Clinic Program.

6. Our poor response (2/20) from the Loyola Sex Clinic Waiting List indicates that in the absence of a face to face therapeutic contact, persons are unwilling to take risks of exposing the self in tests for an unknown professional. Therefore attempts to utilize the MMPI and MI-SRI as predictors of modality will be grossly limited by this factor.

7. Partial correlation of variables studied showed both similarities and differences between male and female subjects. In both males and females it was found that the belief that initial expectations were met was significantly correlated with improvement in the condition. One major difference did appear. Satisfaction of wives with the program was significantly correlated with level of marital satisfaction at follow-up, even after partialing out specific sexual symptom improvement and the level of communication at follow-up. In
analyzing this it appears that wives and husbands had different goals in attending a sexual dysfunction clinic. To the wives marital satisfaction appeared as important in assessing satisfaction with the clinic as symptomatic sexual improvement itself.

Recommendations

This study may serve as a basis for further studies on sexual dysfunction, its treatment and long term effectiveness. Specifically, the following may be proposed to cross-validate and extend the findings:

1. Increase the size of the sample through continuing this study at Loyola University Medical School. This would serve to increase discrimination and in addition serve as a cross-validation of the earlier study.

2. Replicate this study in other programs for the treatment of sexual dysfunction and compare the similarities and differences among programs. These studies could lead to improved utilization of therapeutic approaches through modifying programs to employ the most effective components of a variety of treatments.

3. Plan follow-up cross-validation and predictive studies with the weighted discriminants. This would perhaps allow programs to screen patients seeking treatment and direct the couples appropriately.
4. Develop refinements of scales assessing communication and marital satisfaction and further evaluate their relationship to sexual dysfunction and its treatment. These could then be used both in sexual dysfunction treatment programs and marital counseling programs.

5. Continue to follow the subject's progress over a longer period of time than the three month follow-up. This would provide information on longer term integration of new behavior, within the context of changes occurring in the family group.
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APPENDIX A

DEFINITIONS OF DYSFUNCTION
## Appendix A

<table>
<thead>
<tr>
<th>Dysfunction</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premature ejaculation</td>
<td>Inability to exert voluntary control over the ejaculatory reflex.</td>
</tr>
<tr>
<td>Primary impotence</td>
<td>Never has been capable of erection, penetration and ejaculation in a woman's vagina.</td>
</tr>
<tr>
<td>Secondary impotence</td>
<td>Previously, or selectively capable of erection, penetration and ejaculation in a woman's vagina.</td>
</tr>
<tr>
<td>Primary nonorgasmic</td>
<td>Lifetime lack of orgasmic response as defined by a brief episode of physical release from the vasocongestive and myotonic increment developed in response to sexual stimuli.</td>
</tr>
<tr>
<td>Secondary nonorgasmic</td>
<td>Situational nonresponse, or absolute, where the woman was formerly capable of orgasmic response, and now is not capable.</td>
</tr>
<tr>
<td>Dyspareunia</td>
<td>Subject's report of pain during intercourse.</td>
</tr>
<tr>
<td>Lack of interest</td>
<td>Subjective report of lack of interest in participating in sexual activities.</td>
</tr>
<tr>
<td>Vaginismus</td>
<td>Involuntary spasm in the outer third of the vagina as assessed by clinical examination.</td>
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APPENDIX B

DEFINITION OF SYMPTOM REVERSAL
### Appendix B

<table>
<thead>
<tr>
<th>Dysfunction</th>
<th>Symptom reversal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premature ejaculation</td>
<td>Expressed statement of control over ejaculatory process.</td>
</tr>
<tr>
<td>Primary impotence</td>
<td>Capacity for erection, penetration, and ejaculation with a female at least once.</td>
</tr>
<tr>
<td>Secondary impotence</td>
<td>Capacity for erection, penetration, and ejaculation at least 75% of sexual encounters.</td>
</tr>
<tr>
<td>Primary nonorgasmic</td>
<td>Orgasmic response by masturbation or Orgasmic response within the context of sexual expression, including foreplay, coital or post-coital.</td>
</tr>
<tr>
<td>Secondary nonorgasmic</td>
<td>Orgasmic response by masturbation or Orgasmic response within the context of sexual expression, including foreplay, coital or post-coital.</td>
</tr>
<tr>
<td>Dyspareunia</td>
<td>Absence of pain during intercourse.</td>
</tr>
<tr>
<td>Lack of interest</td>
<td>Reversal of lack of interest.</td>
</tr>
<tr>
<td>Vaginismus</td>
<td>Absence of involuntary spasm.</td>
</tr>
</tbody>
</table>

All statements of symptom reversal are based on subject's self report.
APPENDIX C

WORKSHOP PROGRAM
Forty cotherapists and a trainer were involved in each of these workshops. These workshops were conducted by one of the supervisors who is an experienced sex therapist, instrumental in the development of the Loyola program. She is a psychiatrist who has been actively in practice for a number of years. The training program included didactic presentations, experiential exercises and role playing.

In the beginning of the first workshop the cotherapists are introduced to one another so that they may become acquainted with each other, and share their feelings throughout the workshop experiences. The workshop program may be divided into two sections, an educational aspect, and a treatment aspect. These components are further divided into didactic and experiential parts. Although they may be separated for purposes of description, they are not separated into individual components during the workshops.

Until now there has been little training beyond the mechanics of reproduction, even in medical school programs. Therefore many professionals who wish to treat clients with sexual dysfunctions have compiled their knowledge through reading, an occasional lecture and their own early learning, which often was a collection of misconceptions. In addition, the therapist trainees come from disciplines which have varied concepts of what therapy is supposed to accomplish, and how to implement these changes.
The philosophy of the program is given at the beginning of the workshop. The relationship is the patient. The members of the partnership are considered equally responsible for making this relationship a satisfying one for themselves. Although the therapists may have opinions as to the relative health of the partners, they are not treated as identified patients, and one of the strengths of the cotherapist modality, is that it avoids the two against one constellation that might otherwise occur. The couple, by seeking out the clinic has established a contract. They have invited the therapists into their lives in an effort to create changes. The therapists will use various techniques to create these changes. These include behavioral and psychodynamic techniques. The psychodynamic material is only used as a means to create behavioral change. There is no attempt to change those aspects of the individual's functioning, which although problematic, do not directly contribute to the sexual dysfunction.

Information on sexual functions is given as well. Since the cotherapists vary in their awareness of the mechanics of function, this information is presented assuming no knowledge on the part of the participants. This information includes the anatomical descriptions of genitalia, and how they relate to orgasm, along with illustrations of these. Masturbation and intercourse are both discussed, and the physiology of orgasm, regardless of whether it is coital, non-coital or masturbatory is discussed. An orgasm is an orgasm is an orgasm, and the clinic does not promise, or even attempt to follow
the myth, that the ultimate goal of sexual expression is simultaneous coital orgasm of the partners. These materials are covered through lectures, slide presentations and movies.

Having covered the basic anatomy of function the workshop turns to sexual options. An open accepting attitude on the part of the cotherapists is encouraged in regard to options of sexual expression in the dyad. Particular emphasis is placed on the non-genital aspects of sexual gratification. Although the couples have come to the clinic complaining of a sex problem, there is more to their difficulties than the physiology of orgasmic release. In addition, there is more to the resolution of their difficulties than successful genital coupling. Homosexual options are also discussed. This often leads into one of the more emotionally charged parts of the workshop, where the cotherapists are encouraged to state their feelings about homosexuality, and in fact any form of sexual expression they find personally unacceptable.

The experiential components are mixed into the educative aspects of the program. Therapists must be aware of their own sexuality and their feelings about sexual expression. One of the more difficult aspects of working in this area is admitting to one's own feelings. During the workshops the trainer often asks if the therapists find the material arousing. It is only with great reluctance that the majority of the therapists admit their very evident reactions. Another issue is that of countertransference.
There is no question that people take a sexual dysfunction rotation for a number of reasons. Besides being an area of growing interest, a number of the therapists have issues around sexuality that they wish to resolve for themselves. Because of this, countertransference is common. Besides suggesting this as a possibility, the supervisors are constantly working with the therapists, and dealing with these countertransference reactions. This is handled in the workshops through the use of pictures and discussions of feelings about the pictures. These cover sexual behavior, both seriously and comically, normal and divergent. The slides range from photographs of old cartoons, and art to photographs of male homosexuals fondling each other's exposed genitals. The trainer strives to show the workshop participants that the closer the representation is to our time and life, the stronger the response of the individuals. There is a constant effort to increase the awareness of one's personal comfort and discomfort with sexuality and the expression of sexuality. With an increased awareness of their own discomforts and the opportunity to work some of these through, the cotherapist is less likely to rigidly adhere to a belief that is inappropriate, or to act in a therapeutically dogmatic fashion.

Although most trainees enter the program with some ideas of what sexual therapy is, the specifics of the Loyola program and their rationale may not be known. Consequently one of the major aspects of the program is the description of the treatment. This will be included in detail in Appendix D.
Once again the emphasis on the treating of the relationship is stated. This also provides an opportunity to state that the skills and treatment techniques of the individual cotherapists are used in conjunction with the basic techniques of the program, when this appears consistent with the development of the treatment plan.

Learning new techniques is not just a cognitive experience. New techniques require practice, and create a degree of discomfort within the therapists. Role playing is utilized to dispel some of this discomfort, and to give practice in the techniques of the program. The physical and sexological examination are known to the physicians, but often their cotherapists have never been present at a physical other than their own, let alone the physical of their clients, one of whom is of the opposite sex. During the role playing of this there is much joking and teasing in an effort to dispel some of the anxiety around the examination. The cotherapists also work on dealing with the couples' feelings in regard to the physical exam, and possible client reactions are put forward. These may include feelings in regard to vulnerability and the privacy of one's genitals, even from the spouse. They are dealt with in "fishbowl" role playing. In this type of role playing, two individuals play the couple, two play the cotherapists, and the audience makes suggestions and alternative therapist replies, as they feel appropriate. Role playing is also utilized in regard to interviewing techniques, the use of "I language", and particularly in the processing of roundtable discussions which go on throughout the seven week
program. These are handled in a two on two mode, employing the fishbowl technique described earlier.

Training does not end with the three workshops. The cotherapists continue to get further training, of about one hour each week during supervision. This covers both the specifics of treatment and guidance in the dynamics of the relationship being treated, as well as an occasional nudge towards self-awareness for the therapists.

The cotherapists were strongly committed to the program. They showed stress and anxiety at the beginning of the program, and most cotherapists were heavily invested in the success of the couple that they treated throughout the program. Identification between the cotherapists and the couple was often strong, with both feeling that they got the best couple and most interesting one available. One of the problems in assessing the outcome of this program is that symptom reversal is based on the statements of the couple, as is the degree of marital comfort, which is rated by both therapists and the couple. Because of the high level of personal investment, the subjects feel they must get better, or their cotherapists would be disappointed. When the identification with the cotherapists is positive the couple is likely to report a higher degree of harmony and success than might exist, while if the feelings towards the cotherapists are negative, for whatever reasons, the couple may underreport their progress.
APPENDIX D

TREATMENT PROGRAM
APPENDIX D

Treatment Program

Week 1: When the couples have arrived at the clinic, registered as hospital patients, and paid their fee for the session, the supervisors come out with the cotherapists, greet and introduce self and team to the couple they will be associated with for the next seven weeks. The supervisors state that they are available for consultation as needed. This is done, in part, to overcome the couple's possible resistance to having "students" handle their case. It is not uncommon for a couple to say that "real" therapists could have fixed them. From week one the couple are told they are responsible for change within themselves, and 95% of the changes occur in their relationship. After a ten or fifteen minute get acquainted roundtable (the two cotherapists and the couple) the female therapist begins the interview with the female partner. The Loyola University Hospital Sexual Dysfunction Clinic History Sheet is used to collect these data (see Appendix E). This history covers biographical data, motivation to attend the clinic, pertinent medical history including any psychiatric history, family history, both of the current nuclear family, and the family life of the subject's childhood, marital history, as well as detailed sexual history including attitudes on and frequency of masturbation,
and other specific forms of sexual expression. After about two hours, the couple is given a break and the cotherapists return for consultation and supervision. This gives the cotherapists an opportunity to share their early impressions of the couple as well as focus further questions for the second half of the history taking session. The cotherapists switch for the second half of the history taking, with the female cotherapist interviewing the male partner, while the male cotherapist interviews the female partner. Once the interviewing is completed the therapists meet to confer again. They then return to their couple to instruct them in the home activities for the week. Many of the couples are concerned that they will be asked to perform at the clinic, and are relieved to hear that sexual behavior prescriptions are for home. This roundtable with the couple provides an opportunity to articulate problem areas, as they are now perceived, propose solutions, outline treatment plans and confirm the contract with the couple. The contractual basis of this therapy is emphasized throughout the program. Without the full cooperation of both partners, the relationship cannot be treated. Home activities are outlined for the first week. Coitus is deemphasized for the first week, in fact is prohibited. There is an emphasis on the understanding of the erotic potential of the entire body through the use of massage and sensate focus, and through erotic evenings. The goal of this approach is intimacy through trust and openness. The couple is assured throughout the program that their values will be respected. Although they may be asked to do things they find uncomfortable at first, a sensi-
tivity to their feelings is both expressed verbally, and through the sympathetic support of the cotherapists. They are also taught "I language" in this session. At this point the couple and the cotherapists are feeling overwhelmed by the sheer quantity of input, as well as the intensity of feelings surrounding the history taking. In an effort to help the couple remember their instructions, a booklet is given to them (see Appendix F) to take home as well as two Home Sheets (see Appendix G) which they are to fill out during the week and bring back for the following week's session. These home sheets, to be filled out in "I language" cover the individual's own reaction and observations about their spouse in regard to activity done, level of enjoyment, level of sexual arousal and any comments. The first week these would be reports of the sensate focus exercises, and perhaps erotic evenings which are thought of by the partners in an effort to bring variety, lightness and stimulation to the relationship. The couple is dismissed, having been reminded that for these seven weeks they must make time for sexuality, and to allow one hour per day to overcome difficulties that have taken a lifetime to develop.

Week 2: The second week's session begins as do all succeeding week's sessions with both cotherapists and the couple in a roundtable to discuss the past week's experiences, and the statements written on the home sheets. The cotherapists are particularly alert to the nature of the interaction the couple show during the sessions, and reflect back current interaction patterns, as well as impressions of their statements about what has been going on at home. This is fol-
followed by a brief consultation in which the cotherapists summarize the behaviors and reactions of their couple for the preceding week. The supervisors use this opportunity to point out impressions of the dynamics which the cotherapists might not have been aware of, as well as suggest the activities for the couple for the following week. Although the program follows the same format during the sessions for all couples, the home assignments vary, both as a function of the presenting symptom, and the progress of the couple. After this, both cotherapists return to the couple and ask one partner to use the time to fill out the Loyola University Marital Adjustment Test (see Appendix H), and the Loyola University Sex Clinic Sentence Completion Test (see Appendix I). The other partner has a complete physical and sexological examination with both cotherapists in attendance. The last ten minutes of the examination the partner is brought in so that both may see and touch the genitalia as they are being described to the couple. In the female this includes the breasts, vagina, clitoris, anus and the surrounding tissues, along with their innervation. During the woman's examination the vaginal clamp, holding and flicking exercises are explained as needed. In the male the physical includes penis, testes, cremasteric reflex, frenulum and anus. All these anatomical structures are pointed out to the partners, and first the partner being examined is guided to feel them, then the other partner. The squeeze technique is described to the couple at this point. After both partners have had their physical and completed the tests, the therapists go for a conference with
their supervisor. At this time they discuss the couple's reactions
to the physicals and any unusual findings. Next the couples and the
teams get together for a slide presentation on the sexual anatomy
and how this anatomy functions in the majority of individuals. Com-
ments and discussion are invited from the participants. The couples
and cotherapists then go back to their rooms for roundtable. Gen-
erally the home exercise prescription is for sensate focus with geni-
tal touching and still no intercourse. The couples are encouraged
to become more self-responsible and to continue their efforts in the
use of "I language". After this session the cotherapists confer once
again with their supervisors and review the responses of their cou-
ples on the test. This material is fed back to the couple as is ap-
propriate. Particular care is taken by the supervisors to keep the
cotherapists from overreacting to the replies, or behaviors of the
couples. As with other novices, the tendency is to label deviation
within the norm, as pathology. The cotherapists are reminded that
they are treating the relationship, and if it is appropriate, made
aware of their overidentification with a given partner.

Week 3: This session begins with a roundtable. In addition to re-
viewing the previous week the cotherapists take this time to explain
the session's activity, the Fantastic Voyage. It is explained that
the therapists are human mirrors reflecting the feelings of the in-
dividuals. Following this explanation one partner is given an MMPI
to fill out while the other is asked to undress while the cothera-
pists remain outside. Nudity is encouraged for this exercise be-
cause it tends to make the individual more aware of his or her body, and the comfort or discomfort with which they view it. The cotherapists then return to the room with the lights dimmed, and in a soft voice set the scene for the Fantastic Voyage (see Appendix J). The client is standing in front of a full length mirror through a series of questions in part specifically designed for the individual. The subject is asked their feelings about the outside of their body. After this the following statement is read to the individual.

"Pretend you are able to become tiny and able to enter your body for a journey to your inside parts and can take us with you by explaining as you go. Let the "little self" tell the "big self" how it feels in each place when: tense/relaxed; angry/happy; sad/sexy."

The individual is encouraged to spend a fair amount of time on his voyage and is not allowed to escape examining feelings, particularly in regard to genetalia. Following both Fantastic Voyages the cotherapists return for supervision, where the couple reactions are discussed and homework assignments are formulated. This is often the point at which masturbation is prescribed for particularly reluctant primary non-orgasmic women. If her Voyage has shown a real reluctance to face her own body and her responsibility for sexuality, masturbation may prove the key in both overcoming the lack of response, and some of her aversion to bodily functions. If deemed necessary, a prescription is actually written out, specifying what is to be done and how often. However, moral values of the individual are respected. If an exercise suggested is beyond their range of acceptability it is respected. If there is misinterpretation of dogma
they may be referred to a priest, rabbi or minister for consultation. The cotherapists then return to their couple for a wrap up roundtable and discussion of the week's assignments. These generally include continuation of sensate focus, with the squeeze technique as needed, and vaginal containment. The emphasis remains directed away from coital orgasm. In fact this is deemphasized throughout the program.

Week 4: Once again the session begins with a roundtable. The significance of the week's nonverbal exercise, titled the Marcel Marceau, is explained to the couple at this time. After the roundtable the cotherapists go for supervision. As the weeks go by, and the comfort of the couples with the therapists increases, materials emerge that may have been hidden earlier. This is utilized within the context of whatever activities are going on during the sessions each week being linked to earlier weeks. Consequently as the weeks go by the assignments and interactions become more meaningful to each individual couple. After supervision the cotherapists return to their couple. The couple has been encouraged to undress for the Marcel Marceau, although this is not mandatory. It has been found that whether the couple undresses or remains clothed is more a function of the cotherapists comfort with nudity, than a function of the level of reluctance in the couple. The following statement is then read to the couple.

"This session is to help you understand and facilitate your own awareness of the non-verbal messages and cues you give and are capable of giving each other. This is a session where we will ask you not to talk. Pretend you are mute, you have no voice, but active expressive faces and bodies. We will give you verbal cues."
It is essential that we the therapists can see you, so that later we may feed back to you how we see and understand your exchange. For optimum openness with each other we have suggested nudity. We have asked you to take off your shoes at least so that you can not run away from each other. We want you to relate."

A series of directives are then given to the couple, first one partner, then the other (see Appendix K). Additional directives, that seem appropriate to the individual couple are also given. After this exercise is completed, the therapists go for supervision. By now it is often apparent that the clients have unresolved issues with significant others in their past or present. Letters written as if they could be sent, in regard to these unresolved feelings are often prescribed, example: to a dead parent, a former lover etc. These letters are generally written during supervision breaks throughout the program. After supervision, the therapists rejoin their couple for a roundtable and assignment. Generally full intercourse is being encouraged now, still with no demand or expectation of coital orgasm for either partner. The continued emphasis is on the reports of improvement and positive change, rather than disappointment in the rate of progress, or the difficulties that still remain. The emphasis remains on communication, on making the partners aware of each other's feelings, and establishing a pattern of communication in the home setting.

Week 5: This session begins with the roundtable, followed by supervision. All couples and their teams then gather for explicit sexual films and a discussion of these films. The films are on sexual re-
sponse in the female, and the "squeeze technique," with women on top for coitus. This position is used in the treatment of both premature ejaculation and impotence, also for vaginismus, dyspareunia and orgasmic difficulties of women.

A supervisory session follows this, with guidance being given to the cotherapists in regard to their specific couples, as well as a general sharing among the cotherapists. The couple returns to their room to fill out the MI-SRI at this time. The couple is rejoined by the cotherapists for a roundtable, a review of any questions they might have after the movies and assignments for the coming week. If thought necessary one of the supervisors may participate in roundtable if they feel the couple is experiencing exceptional difficulties, or appears to be extremely negative towards their therapists. Following the roundtable the cotherapists dismiss their couple for the day and return for supervision. It is during these final wrap up supervisions that cotherapist feelings are dealt with most extensively. The fact that the program is almost over is introduced in this session, and both the couple and the cotherapists must begin to work through the separation.

Week 6: Roundtable begins this session, and the program is reviewed to date. The cotherapists process with the couple, in regard to progress and their feelings about the program. The couple are generally given an assignment of a letter at this time, if they haven't done any before this time, while the therapists go for supervision.
After this the couple and cotherapists get together in male-male, female-female dyads for feedback on the MMPI and sentence completion tests. Then they roundtable for home assignments and are given the home sheets which they are asked to fill out and return the following week. It is often thought that any test, or procedure that elicits a response from a client serves as a sensitizer and therefore confounds the effect of the therapy itself. In this program all the tests or questionnaires which the couples fill out are utilized in either feedback sessions or in the development of the treatment program. Consequently they are a part of the treatment, as opposed to simply a means of assessing the feelings, concerns, or level of functioning of the individuals involved. The session ends with a supervision session.

Week 7: This week is devoted primarily to separation and recapitulation. Both the couples and the therapists mobilize separation anxiety at this time. The therapists are alerted to the possibility of a variety of responses to the separation. These range from indifference, to anger, to a reactivation of symptoms, to open anxiety. This must be recognized and dealt with. One way is by discussing the possible options for further therapy if this is deemed advisable. These include follow-up appointments with the cotherapist team, generally in one month. Conjoint marital groups are also available at Loyola Outpatient Clinic as are both men's and women's sex therapy groups and regular psychotherapy. The cotherapists are reminded to
tell the couple that the aim of good treatment is no treatment, with the couple managing effectively on their own. The therapists then go for supervision, returning to the couple for a final round-table and farewell.

Throughout the program the therapists have been writing progress notes, while a set of master "extract" notes on cards have been kept on each couple by the supervisors. The data utilized in this study were taken from these records as well as the history, and test results of the couples.
APPENDIX E

SEXUAL DYSFUNCTION CLINIC HISTORY SHEET
LOYOLA UNIVERSITY HOSPITAL, SEXUAL DYSFUNCTION CLINIC,
Dorameena C. Renshaw, M.D., Dir.
2160 South First Avenue, Maywood, Illinois 60153

HISTORY SHEET

DATE:____________________

NAME:____________________ SPouse:____________________

Address:____________________________________________________________

Phone: Home____________________ Work____________________
Age:____________________ Age of spouse:____________________
Occupation:____________________ Of Spouse:____________________
Education:____________________ Of Spouse:____________________
Religion:____________________ Of Spouse:____________________

How did you feel about coming to the Sexual Dysfunction Clinic?

How did your spouse feel about coming here?

Which of you suggested it?____________________
Who made the first call?____________________
Did you or your partner feel any pressure from the other to come?____________________

What discussion did you have in the car coming here?

How do you think we can best be of help to you personally?

How do you think we can best be of help to your partner?

How do you think we can best be of help to your relationship?

Are you committed to this marriage?____________________
Is your spouse?____________________

I. MEDICAL HISTORY

Family Doctor:____________________
Present state of health:____________________
Last check-up:____________________
Serious medical illnesses:____________________
Surgery:____________________
Medications:____________________
Cigarettes: daily:____________________
Alcohol (daily intake):____________________
Problem due to alcohol (self or spouse):____________________
Psychiatric illness: self:____________________ Describe:____________________
Spouse:____________________ Describe:____________________
Child:____________________ Describe:____________________
<table>
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<tr>
<th>Family member:</th>
<th>Describe:</th>
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<td>Suicide attempt: Self:</td>
<td>Describe:</td>
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<tr>
<td>Spouse:</td>
<td>Describe:</td>
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<td>Child:</td>
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<td>Family member:</td>
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<td>Violent episode: Self:</td>
<td>Describe:</td>
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<td>Spouse:</td>
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<td>Child:</td>
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<td>Family member:</td>
<td>Describe:</td>
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**FAMILY HISTORY**

Duration of this marriage: [ ]

Children: [ ]

Names and ages of children: [ ]

Problems: [ ]

---

Previous marriage/s [ ]

Duration [ ]

Children [ ]

Description (including sexual adjustment) [ ]

---

Spouse's previous marriage/s [ ]

Duration [ ]

Children [ ]

Sexual problem: Self [ ] Spouse [ ]

What do you see as your own greatest problem? [ ]

---

How long has it existed? [ ]

Why are you now seeking help? [ ]

---

Previous help: [ ] From: [ ]

---

In this marriage, how are these handled:

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<th>Self</th>
<th>Spouse</th>
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<td>Communication</td>
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<td>Religion</td>
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Children
Decisions
Leadership

How did you meet your partner?
What did you like best?
What do you now like least?

Courtship:
Duration:
Any Sex?
Love:
First sexual encounter: (with spouse)

First sexual encounter (with other)

Honeymoon: Duration:

Has there been a change in your relationship in this marriage?
Describe:

How do you account for this?

How do you fight? (fair/unfair)
Details: (recurrent issues of conflict)

ORIGINAL FAMILY:

Father: age
Occupation:
Background (educational and cultural)

Type of relationship with his wife:

Attitude toward sex:

Type of relationship with you:

Mother: age
Occupation:
Background (educational and cultural)

Type of relationship with her husband:

Attitude towards sex:

Type of relationship with you:

Parents' sex life:

Home sex education:
brothers and sisters, type of relationship with you and their adjustment to marriage and life:

Age: Name:

Who was most important to you as a child?
Did you feel part of your family?
What kind of a family were you?
How was discipline handled?
Did anything about your family trouble you as a child or teenager?

Childhood sex exploration and sex play

First menstruation: age: feelings:
Parental attitude:
Instructions at onset:
Prior education/preparation:

Was contraception discussed?
Specific fears regarding menses:

PRESENT NUCLEAR FAMILY:

Own children and how you relate to them:

What kind of family life do you have now?

What kind of parent are you?
How do you handle discipline?
What kind of parent is your spouse?
How does he/she handle discipline?
How do you handle sex education for your children?

PERSONAL:

Education: Level
Problems:
Grades:
Sports:
Social activities:
Problems:
Civic activities:
Problems:
Hobbies:
Problems:
Job Description:

Satisfaction:
Problems: holding changing coping
Supervisors: Co-workers:

MILITARY SERVICE:

EMOTIONAL:
What kind of a person are you?
Feelings of inferiority
Sensitivity
Anxiety
Depression
Appetite
Weight loss
Insomnia (duration and details)
Self-confidence
Influence of religion on your marriage
Influence of religion on yourself (seminary, convent, etc.)
Influence of religion on your sexuality
Influence of religion on your partner's sexuality
How would you describe your marriage?

What would you change about your marriage?
What would you change about your partner?

Do you think your partner loves you?
Do you love your partner?
Do you fear/wish the loss of your partner?
Does your partner fear/wish the loss of you?

How did you resolve above conflict?

What do you consider your most significant sexual problem?

SEXUAL HISTORY:
Have you ever thought of/threatened/attempted separation or divorce?

Details:

Extramarital activity:
Details:

Miscarriages
Details:

Does spouse know?
Details:

Do you consider your most significant sexual problem?
How does this affect your spouse's sexual function?

How does he/she view your sexuality?
How do you view his/her sexuality?
How have you as a couple tried to handle the sexual problem so far?

Own remedies: alcohol? other partners? etc.
Reading: sex manuals, magazines, etc.

What is your concept of the optimum sexual function for a woman?

Should she approach him for sex?
For a man?
Should he always make sex advances?

What is your concept of marital roles for a wife?
    in bed conflict?
    socially conflict?
    financially conflict?
    with children conflict?
    other conflict?

What is your concept of marital roles for a husband?
    in bed conflict?
    socially conflict?
    financially conflict?
    with children conflict?
    other conflict?

Own sexual satisfaction: yes no comment
Frequency of affectionate expression per week:
Frequency of intercourse per week:
Difficulties: irregular climax no climax

Repulsion: Why?

Pain: Where? What?
Erection difficulty: Frequency per week:
Morning erections? Frequency per week:
with masturbation? with specific partner?
Describe in detail first episode of erection problem (alcohol/anxiety/anger):

**masturbation**:

Age first masturbated: Frequency pre-marriage:
Frequency per week now: Does partner know?
Feelings: Masturbatory fantasies:
Ejaculation: premature: Delayed:
Kissing: yes/no Who initiates? Preference Aversion Conflict
Foreplay: yes/no Who initiates? Preference Aversion Conflict

**oral sex**:

Fellatio: yes/no Who initiates? Preference Aversion Conflict
Cunnilingus: yes/no Who initiates? Preference Aversion Conflict

Anal intercourse: yes/no Who initiates? Preference Aversion Conflict
Reading sexual material: yes/no   Who initiates: Preference:  Aversion: Conflict:
Venereal disease: yes/no   Type:
Method of contraception:
B.C. pill   Duration   Feelings:
brand   Symptoms:
intrauterine device   vaginal cap   foam   jelly   rhythm   condom
Conflict in this area:
Rape (real):
Rape (fantasies):
Specific fears about sex:
Specific guilts about sex:
Specific hang-ups about sex:
Incest: (details - touch/full coitus. How much alcohol involved?)
Specific sexual enjoyment:
Homosexual fears:
Homosexual episode/s:
Can you have sexual discussions with partner?
Any special comments:
MENTAL STATUS:

DIAGNOSIS:

PHYSICAL EXAMINATION:
General:

Respiratory:

Cardiovascular. Pulse __________ Blood Pressure _________
   Heart
   Peripheral pulses
   Abdominal:

Central Nervous System:

Genitourinary:

Other:

H.D. Comment:
APPENDIX F

MALE AND FEMALE SEXUAL FUNCTIONING
This is a twelve page booklet describing sexual development, coital response, diagrams of genital and extra-genital responses. In addition expected changes after 50 years of age are briefly listed. Positions are shown for sensate focus, and training positions for ejaculatory control as well as a conceptual model for the development of self-esteem.
APPENDIX G

HOME SHEET
MAKE YOUR COMMENTS IN "I" LANGUAGE - Your own reactions and observations about your spouse - negative, positive, questions, thoughts, etc. Be specific about activity. Example: "touching fact", etc. Report each time Sensate Exchange took place.

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<th>Day</th>
<th>Activity Done To Me</th>
<th>Enjoyment 1-10</th>
<th>Sexual Arousal 1-10</th>
<th>Comments</th>
<th>Day</th>
<th>Activity Done By Me</th>
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APPENDIX H

MARITAL ADJUSTMENT TEST
LOYOLA UNIVERSITY MARRITAL ADJUSTMENT TEST

CRISS-CROSS

Domena C. Renshaw, M.D., 1941.

1. (a.) Do you think your marriage is

<table>
<thead>
<tr>
<th>Very unhappy</th>
<th>Unhappy</th>
<th>Happy</th>
<th>Very happy</th>
<th>Perfectly happy</th>
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</table>

(b.) Does your partner think your marriage is

<table>
<thead>
<tr>
<th>Very unhappy</th>
<th>Unhappy</th>
<th>Happy</th>
<th>Very happy</th>
<th>Perfectly happy</th>
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2. When disagreements arise, they usually result in

(a.) (I think)
me giving in/partner giving in/mutual agreement

(b.) (partner thinks)
him/her giving in/me giving in/mutual agreement

3. Regarding social/sports activities together:

(a.) (I think)
we do enough/we don't do any/we should do more

(b.) (partner thinks)
we do enough/we don't do any/we should do more

4. Do you ever wish you had not married?

(a.) (my opinion) always/frequently/sometimes/never

(b.) (partner's opinion) always/frequently/sometimes/never

5. If you could have your lives over, I think:

(a.) I would marry: the same person/a different person/not at all

(b.) my partner would say he or she would marry:
the same person/a different person/not at all

6. I want my partner to be a special kind of person

(a.) always/frequently/sometimes/never
Details:

(b.) My partner wants me to be a special kind of person
always/frequently/sometimes/never
Details:
7. Do you think you confide in each other

(a.) about finances (my opinion) - always/frequently/sometimes/never
    about finances (partner's opinion) always/frequently/sometimes/never

(b.) about angry feelings (my opinion) always/frequently/sometimes/never
    about angry feelings (partner's opinion) always/frequently/sometimes/never

(c.) about sexual fantasies (my opinion) always/frequently/sometimes/never
    about sexual fantasies (partner's opinion) always/frequently/sometimes/never

(d.) about appreciation of thoughtfulness (my opinion) - always/frequently/sometimes/never
    about appreciation of thoughtfulness (partner's opinion) - always/frequently/sometimes/never

(e.) about holding a grudge (my opinion) always/frequently/sometimes/never
    about holding a grudge (partner's opinion) always/frequently/sometimes/never

8. In arguments, do you think you fight fairly?

   (my opinion) always/frequently/sometimes/never
   (partner's opinion) always/frequently/sometimes/never

   Details: __________________________________________________________

9. In arguments, do you think your partner fights fairly?

   (my opinion) always/frequently/sometimes/never
   (partner's opinion) always/frequently/sometimes/never

   Details: __________________________________________________________

10. (a.) I can be critical of him/her without being upset myself
     always/frequently/sometimes/never

    (b.) He/she can be critical of me without my being upset
        always/frequently/sometimes/never

11. (a.) I think my partner disapproves of me - always/frequently/sometimes/never
    Details: __________________________________________________________

    (b.) I disapprove of my partner - always/frequently/sometimes/never
    Details: __________________________________________________________
12. (a.) I think my partner does not like me for myself
always/frequently/sometimes/never

(b.) I don't like my partner for himself/herself
always/frequently/sometimes/never

13. (a.) My partner's outward response is quite different from what I think he/she feels inside. - always/frequently/sometimes/never

Details: ____________________________________________

(b.) My outward response to my partner is quite different from what I feel inside. - always/frequently/sometimes/never

Details: ____________________________________________

14. (a.) I feel a risk in being open and honest with my partner about inside feelings - always/frequently/sometimes/never

Details: ____________________________________________

(b.) I think my partner feels it is a risk to be open and honest about inside feelings - always/frequently/sometimes/never

Details: ____________________________________________

15. What other people think of me affects the way my partner feels about me - always/frequently/sometimes/never

(b.) What other people think of him/her affects the way I feel about my partner - always/frequently/sometimes/never

16. (a.) When I'm honest about my feelings with my partner, I pay a high price later - always/frequently/sometimes/never

Details: ____________________________________________

(b.) When my partner's honest about his/her feelings, I feel upset of withdraw later - always/frequently/sometimes/never

Details: ____________________________________________

17. (a.) I get uneasy when he/she talks about certain things - always/frequently/sometimes/never

Details: ____________________________________________

(b.) My partner gets uneasy when I talk about certain things - always/frequently/sometimes/never

Details: ____________________________________________

18. Other Comments: ____________________________________________________________
APPENDIX I

SENTENCE COMPLETION TEST
LOYOLA UNIVERSITY SEX CLINIC  SENTENCE COMPLETION TEST

NAME: ___________________________ Age: __________ Date: __________

Directions: Work quickly. There are no wrong or correct answers. Give spontaneous replies. Important: Try to be open. This is confidential.

1. My very first memory of being a person (how old, who was with you, what happened) is ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

2. My earliest memory of sex is _______________________________________
   ____________________________________________________________

3. Women are ______________________________________________________

4. Men are _________________________________________________________

5. I like women who _______________________________________________

6. I like men who __________________________________________________

7. Darkness _______________________________________________________

8. Shame is _______________________________________________________

9. Sex is __________________________________________________________

10. Intimacy means _________________________________________________

11. Love means ____________________________________________________

12. Fun is _________________________________________________________

13. Pain is _________________________________________________________

14. It makes me angry when __________________________________________

15. It makes me upset when __________________________________________

16. I am ashamed of ________________________________________________

17. I feel guilty about ______________________________________________

18. It is sinful to ___________________________________________________

19. Divorce is ______________________________________________________

20. Marriage is _____________________________________________________

21. My greatest problem is __________________________________________

22. The anus is _____________________________________________________

23. Obscenity is _____________________________________________________

24. Touch is ________________________________________________________

25. Comfort is _____________________________________________________

26. My face is ______________________________________________________

27. My body is _____________________________________________________

28. My mind is _____________________________________________________

29. I wish I could change ____________________________________________

30. My good points are _____________________________________________

31. My weaknesses are ______________________________________________

32. My ideal is _____________________________________________________
APPENDIX J

FANTASTIC VOYAGE
Therapists are the human mirrors to feedback the patient's attempts to get in touch with his/her own body.

**Fantastic Voyage into Self:**

(Made - clothed if severe inhibitions - in front of mirror, standing or sitting. Lights dimmed. Team in room. Keep voice down. Listen carefully. Leave silences.)

What do you like most about your body?

Why do you like that best?

What do you like least about your body?

Why do you like that least?

Anything you want to tell us about the outside of your body?

Anything you want to tell us about your face?

Anything you want to tell us about your feet?

Anything you want to tell us about your hands?

"Pretend you are able to become tiny and able to enter your own body for a journey to your inside parts and take us with you by explaining as you go. Let "little self" tell "big self" how it feels in each place when: tense/relaxed; angry/happy; sad/sexy.

Where have you entered?

How does it look inside?

How does it feel inside?

Keep going........

Where are you now?
How does it feel when tense/relaxed, angry/happy, sad/sexy?

Brain:

Breasts:

Heart:

Chest:

Anus:

Bladder:

Genitals: Penis:

What would an orgasm feel like there?

Vagina:

What would an orgasm feel like there?

What would it be like with your husband's penis there?

What would it be like when you're not interested in sex?

What would it be like if you're pregnant?

Anything else?

Now come out, telling us how:

What did this whole experience mean to you?
APPENDIX K

MARCEL MARCEAU SESSION
Therapists are the human mirrors to understand, reflect, and facilitate awareness of couples' behavioral non-verbal cues or messages. Both partners are asked to refrain from speech - "pretend you're mute" and express with body language.

Lights dimmed, therapists in room with voices low (alternate male/female therapist voice). Toss for who will record notes. Full view of couple is essential. Nudity of couple is entirely optional. Hospital gown, undies, or clothing (shoes off!) indicated.

Therapists should include special questions relevant to obtained history of strengths/difficulties of couple's interactions (*)

Note: Also criss-cross these questions (same to each partner).

- How would you like _______ to greet you when you get home from work?
- How do you usually say goodbye in the morning?
- How would you like _______ to behave when getting ready for bed?
- How do you think _______ would like you to behave when getting ready for bed?
- Special questions from history: (*)

- Express to _______ your feelings about him/her joining you for this Sex Clinic experience.
- Show with body expression only, your greatest problem.
- Show with body expression only, your own greatest asset.
- Show how you'd like him/her to react to you when you feel angry.
- Show how you'd like him/her to react to you when you feel sad.
- Show how you'd like him/her to react to you when you feel loving.
- With your whole body, express how you feel about your future together.
- With your hands only, express your feelings about this past week.
- With your foot only, express your feelings about the worst part of this past week.
- With your head only, express your feelings about the best part of this week.
With your whole body, express how you feel right now, this moment.

Use any kind of non-word expression to give any message to him.

Reflect back what you think she expressed.

Repeat above for other partner.

Touch part of partner you like best.

Express warmth:

Express affection:

Say non-verbally: "I love you."

Say non-verbally: "I'm mad at you."

Say non-verbally: "I hate you."

Say non-verbally: "I'm sorry."

Say farewell forever.

Greet after a long separation.

Any other special non-verbal message you (he/she) want to send in any way?

Show non-verbally what you think he/she expressed:

Together, give us a non-verbal message of what this body language session has meant to you.
APPENDIX L

SELF REPORT QUESTIONNAIRE
Self Report Questionnaire

PLEASE CHECK THE APPROPRIATE ANSWER.

1. How do you feel now about having come to Loyola's clinic?

__ very satisfied
__ satisfied
__ not sure
__ somewhat displeased
__ very displeased

Comments: _________________________________

2. Have your initial expectations been satisfied?

__ yes
__ unsure
__ no

3. Criticisms of the program:

4. Problem that brought you to the clinic:

__ premature ejaculation
__ primary impotence
__ secondary impotence
__ lack of interest in sex
__ primary non-orgasmic
__ secondary non-orgasmic
__ vaginismus
__ dyspareunia
__ other, please specify ____________________


__ eliminated
__ improved
__ the same
__ worse
__ don't know

6. Have you participated in any other experiences, workshops, etc., since the completion of the program?

__ yes
__ no

If yes, what were they? ____________________
7. Do you feel these experiences had an effect on sexual function?

___ yes-positive
___ no
___ yes-negative
___ not applicable

8. Has there been a change in your emotional relationship in this marriage?

___ very positive
___ positive
___ no change
___ negative
___ very negative

Comments: ____________________________________________

___________________________________________________

9. Has there been a change in sexual function since you completed the clinic?

___ yes
___ no

In what way? __________________________________________

___________________________________________________

10. Have you continued the exercises you've learned in the clinic?

___ yes
___ no

11. If yes, which?

___ sensate focus
___ homework
___ erotic evenings
___ squeeze technique
___ other: specify please ________________________________

12. Was medication prescribed in the clinic?

___ yes
___ no

If yes, please specify ________________________________.

13. If so, are you still taking it?

___ yes
___ no
___ not applicable
14. New learning: Check if you feel you gained learning in any of these areas.

___ about dysfunctions
___ about own attitudes
___ about own feelings
___ about body functions
___ about body structure

15. Do you confide in spouse about children?

___ always
___ frequently
___ sometimes
___ never

16. Is this an area of conflict?

___ yes
___ no
___ unsure

17. Do you confide in spouse about finances?

___ always
___ frequently
___ sometimes
___ never

18. Is this an area of conflict?

___ yes
___ no
___ unsure

19. Do you confide in spouse about angry feelings?

___ always
___ frequently
___ sometimes
___ never

20. Is this an area of conflict?

___ yes
___ no
___ unsure

21. Do you confide in spouse about sexual fantasies?

___ always
___ frequently
___ sometimes
___ never
22. Is this an area of conflict?
   ___ yes
   ___ no
   ___ unsure

23. Do you confide in spouse about appreciation of thoughtfulness?
   ___ always
   ___ frequently
   ___ sometimes
   ___ never

24. Is this an area of conflict?
   ___ yes
   ___ no
   ___ unsure

25. Do you confide in spouse about holding a grudge?
   ___ always
   ___ frequently
   ___ sometimes
   ___ never

26. Is this an area of conflict?
   ___ yes
   ___ no
   ___ unsure

27. Are there any sexual concerns still unresolved?
   ___ yes
   ___ no

Comments:__________________________________________

28. How often do you express affection per month?
   ___ 0
   ___ 1-4
   ___ 5-9
   ___ 10 or more

29. How often do you have intercourse per month?
   ___ 0
   ___ 1-4
   ___ 5-9
   ___ 10 or more
30. How often do you masturbate per month?

- 0
- 1-4
- 5-9
- 10 or more

31. Have you had any extramarital affairs since the completion of the clinic program?

- yes
- no

If yes, number of partners______________________.

32. Have you been involved in any homosexual incidents since you completed the clinic program?

- yes
- no

If yes, number of partners______________________.

33. What do you think of your own capacity to handle sexual problems now?

- no problem
- more confident
- a little better
- same
- worse

34. What do you think of your own capacity to handle sexual problems with your mate now?

- no problem
- more confident
- a little better
- same
- worse

35. What do you think of your own capacity to handle emotional problems now?

- no problem
- more confident
- a little better
- same
- worse

36. What do you think of your own capacity to handle emotional problems with your mate now?

- no problem
- more confident
- a little better
- worse
37. Anything else you would like to add?
APPENDIX M

FOLLOW-UP LETTER
Dear ____________________________:

As explained in our recent conversation, Loyola's Sex Clinic is asking for some of your time in order to evaluate and improve our program. Dr. Domeena Renshaw has authorized this study. The investigation currently under way is important in understanding sexual problems and treatment effectiveness, and also to help you and other couples. As former participants in the clinic, your responses, criticisms and suggestions are of particular value.

All replies will be confidential. For this purpose, the questionnaires have been coded by number. The only requirement is that the husband fill out the form marked male, and the wife fill out the form marked female. To make your answers as accurate as possible, please fill out these forms independently. Please do not discuss your answers with your partner until after you both have completed the questionnaires.

The questionnaire has been especially designed to obtain information necessary to evaluate our program, so it is important that all the questions be answered. However, if you feel uncomfortable with any specific question, do not answer it.

When both the questionnaires are completed, please put them in the stamped return envelope and mail it. If you wish feedback on this study, please indicate so by writing your name on the questionnaire. Many thanks for your co-operation.

Very sincerely yours,

Ms. Kitty Green, M.Ed.
Co-ordinator,
Loyola Follow-up Study

KG:jmg
APPENDIX N

MMPI
The inventory is composed of a series of items with responses keyed to validity and clinical scales. The total on each scale is converted into standard scores, known as T-scores. A T-score of 50 corresponds to the average number of items on a scale responded to in the keyed direction by "normal" persons; T-scores of 70 or higher are considered to indicate the presence of pathological signs that characterize the clinical population with which the scale was developed. The following are brief descriptions of the major scales.

Validity Scales

? This scale is an indication of cautiousness or defensiveness; too high a score invalidates the test.

L This scale addresses the extent to which the subject was motivated to put himself in a good light, to avoid admission of even the mildest of personal defects or conflicts.

F This scale detects the degree to which the test has been invalidated by carelessness or by tendencies to exaggerate complaints and to give an unduly "bad" picture of the subject.

K This is a more subtle measure than L or F of test-taking attitudes. The higher the K-score, the more defensive is the subject.
Clinical Scales

Hs  This scale assesses hypochondriacal trends. All the major organ systems and physical complaint areas are sampled by the items scored on this scale.

D  Symptomatic depression is addressed on this scale.

Hy  This scale assesses hysteroid trends. These include denial of conflicts, claims of superior personal adjustment, and the presence of certain somatic complaints.

Pd  This scale indicates a mixture of rebellious, resentful attitudes toward authorities, lack of positive emotional experiences, asocial trends and interpersonal conflicts.

Mf  This addresses psychological masculinity-femininity as revealed by interests and preferences.

Pa  This denotes trends toward ideas of reference and influence, including both subtle and more obvious paranoid mentations.

Pt  This scale detects the presence of obsessive-compulsive trends, worries, phobias and extreme anxiety symptoms.

Sc  This scale refers to schizoid mentation and affect, including delusional trends.

Ma  Self-confidence, morale and manic trends are indicated.

Si  This refers to the degree the subject remains withdrawn from others.
APPENDIX O

MI-SRI FORM M
Description of Scales:

The twenty scales of the MI-SRI Form M are divided into three main sections: the first eight scales pertain to the patient's basic personality style of coping, and can be analyzed either separately or as a profile configuration; the second group of six scales reflect a series of attitudes and feelings associated with an increase in the probability of psychosomatic pathogenesis; the final set of six scales represent measures which correlate with emotional and social factors that complicate the course of several established disease syndromes.

Scale 1: Introversive Style

High scorers are rather colorless and emotionally flat, tending to be quiet and untalkative. They are often unconcerned about their problems. Typically, they are lacking in energy and just plod along through life in a dull way.

Scale 2: Inhibited Style

High scorers tend to be fearful of others and are often shy and ill-at-ease. Since they are distrustful of what others may do to them, the physician will have to devote extra effort in establishing rapport. They have low opinions of themselves, and may keep their problems to themselves although they want understanding and attention.

Scale 3: Cooperative Style

High scorers tend to be good natured, gentle and generous with others. They are very eager to attach themselves to another person. They will rarely take the initiative in treatment, but will expect to be told exactly what to do. They tend to belittle themselves and are inclined to deny the existence of real problems.
Scale 4: Sociable Style

High scorers are superficially very sociable, talkative and charming. However, these individuals are rather changeable in their likes and dislikes. They may appear to be very cooperative in following a treatment plan, but this alliance and cooperation is often short-lived. They are often more concerned with "appearing nice and attractive" than with solving their problem.

Scale 5: Confident Style

High scorers act in a calm and confident manner. However, they have a great fear of bodily injury and will thus be motivated to follow any treatment plan that will ensure their well-being. They expect to be given special treatment and will take advantage of others.

Scale 6: Forceful Style

High scorers tend to be domineering, tough-minded and are often hostile and angry. Given their tendency not to trust others, these individuals may not follow the planned treatment program, doing just what they want.

Scale 7: Respectful Style

High scorers are very prompt, efficient and disciplined. They hold their feelings inside and will try to impress the physician as being well-controlled, serious-minded and responsible. They follow all therapeutic recommendations very carefully. There is a strong tendency, however, to deny symptoms.

Scale 8: Sensitive Style

High scorers tend to be unpredictable, moody and troublesome. They are often erratic in following a treatment plan. They often seem displeased and dissatisfied with their physical and psychological state. At times, they will complain a lot about treatment, but this can quickly switch to expressions of guilt. Mood changes seem to occur for no clearcut reason.
Scale A: Chronic Tension

High scorers are disposed to suffer various psychosomatic and physical ailments. They seem constantly on the go, live under considerable self-imposed pressure and have trouble relaxing.

Scale B: Recent Stress

High scorers have an increased susceptibility to serious illness for the year following test administration. Recent marked changes in their life predicts a significantly higher incidence of poor physical and psychological health than in the population-at-large.

Scale C: Premorbid Pessimism

High scorers are disposed to interpret life as a series of troubles and misfortunes and are likely to intensify the discomforts they experience with real physical and psychological difficulties.

Scale D: Future Despair

High scorers do not look forward to a productive future life and view medical difficulties as seriously distressing and potentially life-threatening.

Scale E: Social Alienation

High scorers are prone to physical and psychological ailments. They possess tenuous family and social support and may not seek assistance until the situation is extremely discomforting.

Scale F: Somatic Anxiety

High scorers tend to be hypochondriacal and susceptible to various minor illnesses. They experience an abnormal amount of fear concerning bodily function.

Scale MM: Allergic Inclination

High scorers among patients with allergic disorders—urticaria,
dermatitis, asthma—experience emotional factors as significant precipitants of their disease process. The role of these influences among low scorers is likely to be minimal.

Scale NN: Gastrointestinal Susceptibility

High scorers among patients with gastrointestinal disorders—ulcer, colitis, dyspepsia—are likely to react to psychological stress with an increase in the frequency and severity of symptomatology. Stress is not a significant precipitant among low scorers with these ailments.

Scale OO: Cardiovascular Tendency

High scorers among patients with cardiovascular symptoms—hypertension, angina pectoris—are susceptible to a significant increase in complaint symptomatology under conditions of psychic tension. Emotional factors are not likely to contribute significantly to such symptomatology among low scorers.

Scale PP: Pain Proneness

High scorers among patients with periodic or persistent pain syndromes—low back pain, tension headache, TMJ dysfunction—are prone to experience especially intense discomfort in reaction to emotional stress. Low scorers appear to be less influenced by the impact of psychic tension.

Scale QQ: Life-threat Reactivity

High scorers who are currently suffering a chronic or progressive life threatening illness—metastatic carcinoma, renal failure, congestive heart disease—are likely to deteriorate more rapidly than is typical among patients with a comparable physical illness.

Scale RR: Emotional Vulnerability

High scorers facing major surgery or other life dependent treatment programs—open heart procedures, hemodialysis, chemotherapy—are vulnerable to severe disorientation, depressions or frank psychotic episodes.
Loyola Hospital is a University teaching and research institution. Ongoing evaluations of clinic programs are one aspect of this affiliation. As explained in our recent conversation, Loyola’s Sex Clinic is asking for some of your time in order to evaluate and improve our program. Dr. Domeena Renshaw has authorized this study. The investigation currently under way is important both directly, as an aid to understanding sexual dysfunction, delay in treatment and treatment effectiveness, and indirectly, this study may help other couples on waiting lists. As couples signed up for this clinic, your "before therapy" responses are of particular value to this study.

The purpose of this Waiting List Study is to assess the basic concerns of people on the waiting list for the Loyola Sex Clinic, and how the delay affects them. All replies will be confidential and will be received and analyzed anonymously. Neither your replies nor your participation will affect your place on the clinic waiting list.

Three questionnaires and a follow-up will be mailed out in two separate mailings. The first packet will arrive in a few weeks. The second some weeks thereafter. Prepaid envelopes will be enclosed with the materials so that they can be mailed back as soon as they are completed. Detailed instructions will be enclosed with each packet. I will be calling you as well during this period of time. You may call me at any time at 729-4468 in the event that you have any questions concerning the study, the clinic program or your own reactions. Also, for immediate help, Ms. Ann Shannon may be contacted at 531-3750.

Sincerely yours,

Ms. Kitty Green, M.Ed.
Co-ordinator,
Loyola Waiting List Study
APPENDIX Q

WAITING LIST PROPOSAL
AN INVESTIGATION OF COUPLES ON THE WAITING LIST
OF THE LOYOLA SEX CLINIC

Submitted by: Kitty Green, M.Ed.
Objectives

The first objective of this study is to assess the basic concerns of people on the waiting list for the Loyola Sex Clinic. The second is to ascertain how their presence on the waiting list affects them.

Methodology

In order to obtain this information a series of telephone and mail contacts will be made with all couples currently on the waiting list of the Loyola Sex Clinic with the exception of the first twenty couples, who are expected to enter treatment in the March, 1977 rotation. Participants suffer no delay in treatment by their involvement in this study. Care will be taken at every step to insure the subjects' full understanding of the study and their freedom to refuse participation without jeopardy.

The first contact will be a letter from Dr. Renshaw (see Appendix 1) stating the presence of a follow-up study, and introducing the investigator, Kitty Green.

The next contact will be a telephone call from the investigator. At this time the study will be explained and the cooperation of the subjects will be requested.

This phone call will be followed by the letter marked Introductory Letter (Appendix 2) and the consent form (Appendix 3), which is to be returned by mail. This letter restates the purpose of the study, while explaining that neither the individual's replies nor participation will have an effect on the couple's place on the waiting list. The participants are told in each subsequent contact, that they are free to discontinue their participation in the study at any time. This letter
briefly details the nature of further participation in the study.
The investigator's phone number is enclosed in case the participants
wish additional information.

Four weeks later the first packet of test materials are mailed
to the couples along with the letter labeled Packet 1(Appendix 4).
The instruments to be utilized are the Minnesota Multiphasic Personality
Inventory (MMPI), the Millon Illinois-Self Report Inventory Form M
(MI-SRI), and the Loyola University Marital Adjustment Test. The
couples are offered feedback on the study, at this time.

Fourteen weeks later the final research material will be sent
out with a letter labeled Packet 2(Appendix 5). This is a follow-
up Self-Report Questionnaire.

Instruments

Minnesota Multiphasic Personality Inventory: MMPI This inventory
purports to give measures, in terms of scale scores, of the strength
of certain components in an individual's personality in the form
of psychiatric classifications. Different areas of life experience
are covered in the inventory, and on the basis of response, scale
scores are determined.

Millon Illinois-Self Report Inventory Form M: MI-SRI The MI-SRI
Form M has scales encompassing eight personality styles or inter-
personal coping strategies. These are determined by one, the type of
interpersonal reinforcements one receives; two, whether they are
gained actively or passively; and three, whether received mainly
from oneself, or from others. The test also includes scales on
various attitudes relevant to health care. The test has been normed
with samples of both medical and non-medical populations.
Loyola University Marital Adjustment Test is a seventeen item test that involves subject ratings on a continuum, in which the subject is asked to state both his/her view as well as what he/she thinks the partner feels. This test has not been validated against external measures.

Self-Report Questionnaire is a thirty seven item questionnaire designed by the investigator to assess current feelings, attitudes and level of function, both sexual and communicatory in the subjects.

Data Analysis

These data will be subjected to preliminary analysis in the following fashion. Path analysis techniques will be used to assess variables that are largely concurrent. Correlations will be made on personality scale scores and change during presence on the waiting list. Canonical correlations will be run on personality scale scores and sex data. These preliminary statistical analyses are expected to illuminate further avenues of analysis.

A more detailed description of this study and its rationale are available in the form of the investigator's dissertation proposal. Attached is the bibliography utilized in the development of this proposal.
Dear __________________:

If you remember, I told you you would be hearing from us - for better or for worse - for 5 years. Follow-up is difficult (for us as well as a bit of a nuisance for you). Yet it may also be of value - a moment in the busy day to pause and reflect on how things are/were, and could be ..... For us it is of great consequence - namely to evaluate whether what we have done and still continue to do is lasting and meaningful.

Therefore, each of you please take a few minutes to complete the attached form and mail it back as soon as you can.

A Loyola staff member, Ms. Kitty Green, may phone you for follow-up in the next few months.

With best regards,

Sincerely,

Domeena Renshaw
Domeena C. Renshaw, M.D.
Associate Professor
Loyola University
Dear 

Loyola Hospital is a University teaching and research institution. Ongoing evaluations of clinic programs are one aspect of this affiliation. As I explained in our recent conversation, Loyola's Sex Clinic is asking for some of your time in order to evaluate and improve our program. Dr. Domena Renshaw has authorized this study. The investigation currently under way is important both directly, as an aid to understanding sexual dysfunction and treatment effectiveness, and indirectly in helping other couples. As couples signed up for the clinic, your "before therapy" responses are of particular value to this program.

The purpose of this study is to assess the basic concerns of people on the waiting list for the Loyola Sex Clinic, and how the delay affects them. All replies will be confidential and will be received and analyzed anonymously. Neither your replies nor your participation will affect your place on the clinic waiting list. You are free to discontinue your cooperation at any time.

Materials will be mailed out two separate times. The first packet will arrive in approximately four weeks, the second fourteen weeks later. Please fill these out and return them in the enclosed envelopes as soon as possible. Detailed instructions will be enclosed with each packet. Thank you for the courtesy of your assistance.

I am enclosing my card, so that you can call me in the event that you have any questions concerning either the study or the clinic program.

Sincerely yours,

Ms. Kitty Green, M.Ed.
Appendix 3

Consent Form

This is to state that I agree to participate over a period of twenty weeks in a telephone and written study on the waiting list for the Loyola Sex Clinic. The participation will only be by telephone and written replies. I am aware that there will be no cost to me and that neither my replies nor participation will affect my place on the clinic waiting list.

I have read the above and agree to consent to participate in this study. I am free to withdraw my cooperation at any time.

Husband ______________________

Wife ______________________

Witness ______________________
Appendix 4
Packet 1

Enclosed is your first of two packets of materials. These materials will be utilized in a study authorized by Dr. Domeema Renshaw to evaluate the waiting list of the Loyola Sex Clinic. As stated previously this study is a part of Loyola's research and program improvement.

All replies will be confidential. To maintain anonymity, the questionnaires and the personality inventories are coded by number. The only requirement is that the husband fill out the forms marked male, and the wife fill out the forms marked female. To make your answers as accurate as possible, please fill in these forms independently. Please do not discuss your answers with your partner until after you have completed them.

There are three forms in this group. The Minnesota Multiphasic Personality Inventory and the Millon Illinois-Self Report Inventory have answer sheets attached. These must be filled out with pencils. Please write your answers directly on the Loyola University Marital Adjustment Test. When both these forms and the inventories are completed, please put all the forms and answer sheets in the stamped return envelope and mail it. If you wish feedback on this material, please indicate so by writing your name on the Marital Adjustment Test. Thank you again for your cooperation in this important study. You are free to discontinue at any time.

Very truly yours,

Ms. Kitty Green, M.Ed.
This is your final questionnaire in the study being done under the direction of Dr. Domeena Renshaw of Loyola's Sex Clinic. Some of the questions on this form refer directly to the program. Please answer all questions as you feel at this time. The questionnaire has been especially designed to obtain information necessary to evaluate couples reactions to a long waiting list. It is important that all the questions be answered. However, if you feel uncomfortable with any specific question, or if it doesn't have meaning for you, do not answer it.

Please complete these forms as you did the previous forms with the husband filling out the form marked male and the wife filling out the form marked female. Return these questionnaires in the enclosed envelope.

Thank you again for collaborating in this study to improve the program of the Loyola Sex Clinic. Your comments and participation will be a valuable addition to the study. However, you may discontinue at any time.

Very sincerely yours,

Ms. Kitty Green, M.Ed.


APPENDIX R

ROLES AND TASKS OF TRAINEE THERAPISTS
### Evaluation of Sex Problem Level

<table>
<thead>
<tr>
<th>Evaluation of Sex Problem Level</th>
<th>Patient Need</th>
<th>Physician-Trainee Task</th>
<th>Physician-Trainee Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Unknown</td>
<td>To be understood</td>
<td>Active (creative) listening i.e. understand and evaluate</td>
<td>Evaluator-Inquirer</td>
</tr>
<tr>
<td>2. Sexual Ignorance</td>
<td>Sexual Knowledge</td>
<td>Provide accurate information and suggest specific sexual behavior. Follow-up.</td>
<td>Sex Educator</td>
</tr>
<tr>
<td>3. Sex Discomfort/Dysfunction</td>
<td>Comfortable Sexual Function</td>
<td>Rule out organic pathology; reduce or remove discomfort/dysfunction; make contract ex. 5x visits; suggest specific sexual behavior. Follow-up.</td>
<td>Physician; Sex Educator and Counsellor; refer to helpful professional if own intervention not enough.</td>
</tr>
<tr>
<td>4. Interpersonal conflict and sex problem</td>
<td>Assistance with sexual conflict</td>
<td>Review, direct, restore bonding; make contract ex. 5x visits; suggest specific sexual behavior. Follow-up.</td>
<td>Sex Educator and Marital Therapist; refer if indicated.</td>
</tr>
<tr>
<td>5. Sex problem and intrapsychic conflict</td>
<td>Explore internal conflicts and interpersonal conflicts</td>
<td>Correlate internal conflicts with sex problem for perspective and resolution</td>
<td>Sex Educator and Psychotherapist</td>
</tr>
<tr>
<td>6. All of above</td>
<td>Comfortable use of newly learned sex knowledge/attitudes/skills</td>
<td>Recognizing hierarchy of patient needs to be addressed in rational brief treatment</td>
<td>Sex Educator and Marital and Psychotherapist - Sex Therapist</td>
</tr>
</tbody>
</table>
The dissertation submitted by Catherine Joy Green has been read and approved by the following committee:

Dr. Manuel S. Silverman, Director
Associate Professor, Guidance and Counseling, Loyola

Dr. Jack Kavanagh
Associate Professor, Foundations, Loyola

Dr. Frank Kobler
Professor, Psychology, Loyola

Dr. Gloria Lewis
Assistant Professor, Guidance and Counseling, Loyola

Dr. Theodore Millon
Professor, Psychology, University of Miami

Dr. Domeena Renshaw
Professor, Psychiatry, Loyola Medical School

The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the Committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

Date: 4-24-78
Director's Signature: [Signature]