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THE EFFECTS OF OBSERVATIONAL LEARNING ON SEXUAL BEHAVIORS AND ATTITUDES IN ORGASMIC DYSFUNCTIONAL WOMEN.

University of Hawaii, Ph.D., 1974
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THE EFFECTS OF OBSERVATIONAL LEARNING
ON SEXUAL BEHAVIORS AND ATTITUDES IN
ORGASMIC DYSFUNCTIONAL WOMEN

A DISSERTATION SUBMITTED TO THE GRADUATE DIVISION OF THE
UNIVERSITY OF HAWAII IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY
IN PSYCHOLOGY

August 1974

By
Craig H. Robinson

Dissertation Committee:
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Ian M. Evans
THE EFFECTS OF OBSERVATIONAL LEARNING ON SEXUAL BEHAVIORS AND ATTITUDES IN ORGASMIC DYSFUNCTIONAL WOMEN

By Craig H. Robinson

A dissertation submitted to the Graduate Division of the University of Hawaii in partial fulfillment of the requirements for the degree of Doctor of Philosophy

ABSTRACT

The main purpose of the present research was to assess the effects of a specially developed videotape treatment program on the sexual behaviors and attitudes of orgasmically dysfunctional women. All subjects fell within one or more of the following descriptive categories: 1) Had never experienced orgasm under any conditions, 2) had previously, but not currently, experienced orgasm under some conditions, and/or 3) were only infrequently (i.e., rate equal to or less than once per month) experiencing orgasm by any form of sexual stimulation. The following experimental hypotheses were tested: In comparison to untreated control subjects, subjects exposed to a series of videotapes (i.e., observational learning) would experience 1) an increase in certain sexual behaviors (e.g., self-stimulation) discussed and/or modeled on the videotapes, 2) more favorable attitudes toward certain sexual activities presented on the videotapes, and 3) the occurrence of, or an increased frequency of, orgasm. The study further
investigated, relative to each other and an untreated control group, two variations of the videotape treatment program. Both segments of the program consisted of three cassette videotapes ranging in length from 29 to 54 minutes. The first three tapes comprised the "attitudinal" or "A"-series (i.e., A₁, A₂ and A₃). The remaining three tapes constituted the specific suggestions ("behavior") portion or "B" series (i.e., B₁, B₂ and B₃). The basic format for all of the tapes involved a male therapist talking to a couple (role players) who had sought help for the female's difficulty in experiencing orgasm. In the A-series the therapist presented a wide range of sexually related information to the modeling couple. In the B-series, however, most of the information presented was limited to the area of self-stimulation and was accompanied by very specific suggestions given by the therapist to the female of the couple. Twenty three subjects were randomly assigned to one of three groups: 1) E₁ group subjects first viewed the A-series and then the B-series; 2) E₂ group subjects were only exposed to the B-series; and 3) C group subjects served as waiting controls.

Results indicated that a variety of sexual behaviors could be acquired and/or increased in frequency by observational learning procedures. Of particular importance was the finding that both videotape treatment conditions were highly effective in getting subjects to use various methods of self-stimulation for the purpose of enhancing sexual arousal. Of the 6 subjects who initially stated that they had never or were not sure whether they had ever masturbated, 5 began using self-stimulation after exposure to the videotapes. Of the 10 subjects who at the outset stated they did not currently use self-stimulation for sexual arousal, 9 subsequently began engaging in masturbatory
activities. Of the 15 subjects who were exposed to either of the
treatment group conditions, 14 increased their frequency of masturba-
tion. Results further suggested that both videotape conditions (i.e.,
A + B, or B only) were highly effective in promoting more positive
attitudes toward self-stimulation activities. Although the data
strongly supported the first two experimental hypotheses, hypothesis 3
was only partially supported in that the frequency of orgasm most
reliably increased for just those subjects who had experienced orgasm
before. Only one subject who had never experienced orgasm under any
conditions was able to experience orgasm solely as a result of exposure
to the videotapes.

The results were discussed particularly with regard to increasing
treatment program effectiveness, the use of observational learning as
a supplementary therapeutic procedure, and theoretical and research
implications. Emphasis was directed to the apparent lack of effect
that more global sexual attitude change has on specific sexual
attitudes and behaviors. The frequent assumption that clients with
sexual concerns must first develop more positive sexual attitudes
before significantly changing their sexual behaviors was questioned.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>iii</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>ix</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>xi</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Female Orgasm</td>
<td>3</td>
</tr>
<tr>
<td>Historical Perspective</td>
<td>3</td>
</tr>
<tr>
<td>Clarification and Definition</td>
<td>4</td>
</tr>
<tr>
<td>Conflicting Issues</td>
<td>8</td>
</tr>
<tr>
<td>Socio-cultural and Psychological &quot;Correlates&quot; of Orgasm</td>
<td>12</td>
</tr>
<tr>
<td>Female Orgasmic Dysfunction</td>
<td>17</td>
</tr>
<tr>
<td>Incidence</td>
<td>17</td>
</tr>
<tr>
<td>Etiology</td>
<td>19</td>
</tr>
<tr>
<td>Necessity for Treatment and Research</td>
<td>25</td>
</tr>
<tr>
<td>Current Treatment Approaches</td>
<td>27</td>
</tr>
<tr>
<td>Observational Learning</td>
<td>34</td>
</tr>
<tr>
<td>Theoretical Overview</td>
<td>35</td>
</tr>
<tr>
<td>Empirical Support</td>
<td>37</td>
</tr>
<tr>
<td>Clinical Applications</td>
<td>38</td>
</tr>
<tr>
<td>Potential Relevance for Sexual Problems</td>
<td>40</td>
</tr>
<tr>
<td>Sexual Behavior and Attitude Change Through Exposure to Pornography</td>
<td>43</td>
</tr>
<tr>
<td>Theoretical Considerations</td>
<td>48</td>
</tr>
<tr>
<td>Anxiety</td>
<td>48</td>
</tr>
<tr>
<td>A-R-D Theory</td>
<td>49</td>
</tr>
<tr>
<td>Focus of Present Research</td>
<td>55</td>
</tr>
<tr>
<td>METHOD</td>
<td>60</td>
</tr>
<tr>
<td>Subjects</td>
<td>60</td>
</tr>
<tr>
<td>Materials</td>
<td>61</td>
</tr>
<tr>
<td>Sexual Attitude Change Scale (SACS)</td>
<td>62</td>
</tr>
<tr>
<td>Sexual Behavior Inventory (SBI)</td>
<td>63</td>
</tr>
<tr>
<td>Daily Sexual Behavior Checklist (DSBC)</td>
<td>64</td>
</tr>
<tr>
<td>General Information Form (GIF)</td>
<td>65</td>
</tr>
<tr>
<td>Sexual Responsiveness Survey (SRS)</td>
<td>65</td>
</tr>
<tr>
<td>Expectancy Questionnaire (EQ)</td>
<td>65</td>
</tr>
<tr>
<td>Oregon Sex Inventory (OSI)</td>
<td>66</td>
</tr>
<tr>
<td>Problem History</td>
<td>66</td>
</tr>
<tr>
<td>Estimate of Sexual Activity (ESA)</td>
<td>66</td>
</tr>
<tr>
<td>Taxonomy of Sexual Performance (TSP)</td>
<td>67</td>
</tr>
<tr>
<td>Female's Definition of &quot;Orgasm&quot;</td>
<td>67</td>
</tr>
<tr>
<td>Medical History and Contraceptive Questionnaire</td>
<td>67</td>
</tr>
<tr>
<td>Follow-up Questionnaire</td>
<td>68</td>
</tr>
<tr>
<td>Videotapes</td>
<td>68</td>
</tr>
</tbody>
</table>
# Table of Contents

**Procedure** ........................................... 74  
  Group Assignment ....................................... 75  
  Pretreatment Agreement .................................. 77  
  Procedural Guidelines and Design of Study ................. 77  
  Criteria for Acceptance to Program ....................... 78

**RESULTS** ............................................. 83

- Pretreatment Subject Characteristics ...................... 83  
- Pretreatment Measures .................................... 83  
- Between Group Comparisons on Main Dependent Measures .... 86  
- Sexual Attitude Change Scale (SACS) ...................... 86  
- Sexual Behavior Inventory (SBI) .......................... 92  
- Daily Sexual Behavior Checklist (DSBC) .................... 99  
- General Information Form (GIF) ........................... 112  
- Follow-up Questionnaire and Supplementary Information .... 113  
- Females' Definition of "Orgasm" ........................... 116

**DISCUSSION** ........................................... 117

- Summary of Major Findings ............................... 117  
- Main Dependent Measures ................................ 118  
  - Sexual Behavior Inventory (SBI) - Key Items .......... 118  
  - Daily Sexual Behavior Checklists (DSBC) ............. 119  
  - Sexual Attitude Change Scale (SACS) .................. 123  
- Sexual Behavior and Attitudes ............................ 126  
- Methodological Considerations ............................. 129  
  - Videotapes ............................................ 129  
  - Experimental Design .................................... 132  
- Experimental Hypotheses .................................. 133  
  - Hypothesis 1 .......................................... 133  
  - Hypothesis 2 .......................................... 133  
  - Hypothesis 3 .......................................... 134  
- Increasing Treatment Program Effectiveness ............... 135  
  - Observational Learning and Modeling ................... 135  
  - Theoretical and Research Implications .................. 140

**APPENDIX A:** Letter to Colleague ....................... 143

**APPENDIX B:** Letter to All Prospective Applicants .... 144

**APPENDIX C:** Sexual Attitude Change Scale (SACS) Female .... 145  
  Sexual Behavior Inventory (SBI) Female .................... 145

**APPENDIX D:** Sexual Attitude Change Scale (SACS) Key Items .... 150  
  Sexual Behavior Inventory (SBI) Key Items ................ 150

**APPENDIX E:** Sexual Attitude Change Scale (SACS) Instructions ... 151

**APPENDIX F:** Sexual Behavior Inventory (SBI) Instructions .... 152
APPENDIX G: Daily Sexual Behavior Checklists (DSBC) Female .... 153
APPENDIX H: Daily Sexual Behavior Checklists (DSBC) Male .... 154
APPENDIX I: General Information Form (GIF) .................. 155
APPENDIX J: Sexual Responsiveness Survey (SRS) .............. 160
APPENDIX K: Expectancy Questionnaire ......................... 169
APPENDIX L: Problem History .................................. 171
APPENDIX M: Estimate of Sexual Activity - Female 
2-Week Period Preceding Initial Interview ................. 173
APPENDIX N: Female's Definition of "Orgasm" ................. 174
APPENDIX O: Medical History and Contraceptive Questionnaire .. 175
APPENDIX P: Follow-up Questionnaire - Female ............... 180
APPENDIX Q: Kegel Exercises (Post B-1) ...................... 182
APPENDIX R: Kegel Exercises (Post B-2) ...................... 183
APPENDIX S: Kegel Exercises (Post B-3) ...................... 184
APPENDIX T: Pretreatment Agreement ......................... 185
APPENDIX U1: Procedure (All Ss - Initial Interview) ........ 186
APPENDIX U2: Procedure (E1 - A1) .......................... 188
APPENDIX U3: Procedure (E1 - A2) .......................... 189
APPENDIX U4: Procedure (E1 - A3) .......................... 190
APPENDIX U5: Procedure (E1 - B1) .......................... 191
APPENDIX U6: Procedure (E2 - B1) .......................... 192
APPENDIX U7: Procedure (E1 & E2 - B2) .................... 193
APPENDIX U8: Procedure (E1 & E2 - B3) .................... 194
APPENDIX U9: Procedure (E1 & E2 - Two Week Follow-up After B3) .. 195
APPENDIX U10: Procedure (C2 - Six Week Follow-up After Initial Interview) . 196
FOOTNOTES .................................................. 197
REFERENCES .................................................. 199
<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Between and Within Group Characteristics of Subjects and Number of Subjects</td>
<td>84</td>
</tr>
<tr>
<td></td>
<td>Per Group Responding to Certain Items on the Sexual Responsiveness Survey</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Pretreatment Group Means and Standard Deviations on SACS - Key Items, SACS</td>
<td>85</td>
</tr>
<tr>
<td></td>
<td>- Total Items, SBI - Key Items, and SBI - Total Items</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Means, Standard Deviations, and Analysis of Variance Results for Initial</td>
<td>87</td>
</tr>
<tr>
<td></td>
<td>Interview, Post A/Pre B Series, Testing, and Follow-up Assessment</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Analysis of Variance of SACS (Key Items)</td>
<td>88</td>
</tr>
<tr>
<td>5</td>
<td>Analysis of Variance of SACS (Total Items)</td>
<td>88</td>
</tr>
<tr>
<td>6</td>
<td>Newman-Keuls Test of SACS - Key Items: Between-Group Means at Initial</td>
<td>90</td>
</tr>
<tr>
<td></td>
<td>Interview</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Newman-Keuls Test of SACS - Key Items: Between-Group Means at Follow-up</td>
<td>90</td>
</tr>
<tr>
<td></td>
<td>Testing</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Newman-Keuls Test of SACS - Key Items: Within-Group Means for E₁ (A + B-</td>
<td>91</td>
</tr>
<tr>
<td></td>
<td>series)</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Newman-Keuls Test of SACS - Key Items: Within-Group Means for E₂ (B-series)</td>
<td>91</td>
</tr>
<tr>
<td>10</td>
<td>Group Mean Scores on SACS - Key Items at Initial Interview, Pre-B₁</td>
<td>94</td>
</tr>
<tr>
<td></td>
<td>and Follow-up Testing</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Group Mean Scores on SACS - Total Items at Initial</td>
<td>94</td>
</tr>
<tr>
<td></td>
<td>Interview, Pre-B₁ and Follow-up Testing</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Analysis of Variance of SBI (Key Items)</td>
<td>96</td>
</tr>
<tr>
<td>13</td>
<td>Analysis of Variance of SBI (Total Items)</td>
<td>96</td>
</tr>
<tr>
<td>14</td>
<td>Newman-Keuls Test of SBI - Key Items: Between-Group Means at Initial</td>
<td>97</td>
</tr>
<tr>
<td></td>
<td>Interview</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Newman-Keuls Test of SBI - Key Items: Between-Group Means at Follow-up</td>
<td>97</td>
</tr>
<tr>
<td></td>
<td>Testing</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Newman-Keuls Test of SBI - Key Items: Within-Group Means for E₁ (A + B</td>
<td>98</td>
</tr>
<tr>
<td></td>
<td>series)</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Newman-Keuls Test of SBI - Key Items: Within-Group Means for E₂ (B series)</td>
<td>98</td>
</tr>
<tr>
<td>Table</td>
<td>Description</td>
<td>Page</td>
</tr>
<tr>
<td>-------</td>
<td>------------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>18</td>
<td>Actual Number of Subjects Per Group Who Engaged in Some or All of the Key DSBC Activities</td>
<td>105</td>
</tr>
<tr>
<td>19</td>
<td>Actual Number of Subjects Per Group Who Engaged in Each of the Key DSBC Activities</td>
<td>108</td>
</tr>
<tr>
<td>20</td>
<td>Analysis of Variance of GIF, Question #8</td>
<td>113</td>
</tr>
<tr>
<td>21</td>
<td>Number of Subjects Per Group (E₁ and E₂) Responding to Certain Items on Follow-up Questionnaire</td>
<td>114</td>
</tr>
<tr>
<td>22</td>
<td>Number of Subjects Per Group (E₁ and E₂) Reporting Various Sexual Activities and Responses</td>
<td>115</td>
</tr>
</tbody>
</table>
# LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Predicted Outcomes Over Time (Treatment Sessions) Based on Initial Attitude and Extent of Behavioral Repertoire</td>
<td>54</td>
</tr>
<tr>
<td>2</td>
<td>Diagram Representing Design of Program</td>
<td>79</td>
</tr>
<tr>
<td>3</td>
<td>SACS - Key Items. Group Mean Scores on SACS - Key Items As a Function of Three Treatment Stages</td>
<td>93</td>
</tr>
<tr>
<td>4</td>
<td>SACS - Total Items. Group Mean Scores on SACS - Total Items As a Function of Three Treatment Stages</td>
<td>93</td>
</tr>
<tr>
<td>5</td>
<td>SBI - Key Items. Group Mean Scores on SBI - Key Items As a Function of Three Treatment Stages</td>
<td>100</td>
</tr>
<tr>
<td>6</td>
<td>SBI - Total Items. Group Mean Scores on SBI - Total Items As a Function of Three Treatment Stages</td>
<td>100</td>
</tr>
<tr>
<td>7</td>
<td>Mean Daily Frequency of All Key DSBC Activities Engaged in As a Function of Each Treatment Stage</td>
<td>107</td>
</tr>
<tr>
<td>8</td>
<td>Mean Frequency of Each Key DSBC Activity Engaged in Per Day As a Function of Treatment Stage</td>
<td>111</td>
</tr>
</tbody>
</table>
INTRODUCTION

Numerous authors over the past decade have been voicing their discontent with traditional views of female sexual responsiveness. Probably no one, however, has drawn such ultimate and extreme conclusions regarding female sexual responsiveness and orgasmic capacity as Mary Jane Sherfey (Brecher, 1969). Incorporating Masters and Johnson's (1966) findings regarding female sexual response with data gathered from her extensive review of a variety of disciplines (e.g., anatomy, physiology, paleontology, evolutionary biology, primatology, ethology, psychiatry, etc.), Sherfey (1966) quite impressively argues for the vital importance of orgasm in fully understanding female sexuality.

The nearly universal sentiment, still very prevalent in our Hebrew-Christian culture, that the female of the species does not, need not, or should not require orgasmic release... can now be said to be biologically unthinkable...

Our myth of the females' relative asexuality is a biological absurdity... (p. 100).

In addition, the popular idea that a woman should have one intense orgasm which should bring "full satisfaction," act as a strong sedative, and alleviate sexual tension for several days to come is simply fallacious.

... the more orgasms a woman has, the stronger they become; the more she has, the more she can have. To all intents and purposes, the human female is sexually insatiable in the presence of the highest degrees of sexual satiation (p. 99). (Author's underscoring.)

In urging re-examination of the concepts of nymphomania and promiscuity without frigidity, Sherfey goes on to state:

It could well be that the "oversexed" woman is actually exhibiting a normal sexuality - although because of it, her integration into her society may leave much to be desired (p. 116).... From the standpoint of normal physiological functioning, these women exhibit a healthy, uninhibited sexuality - and the number of orgasms attained, a measure of human female's orgasmic potentiality (p. 97).... No doubt the most far-reaching hypothesis extrapolated from
these biological data is the existence of the universal and physically normal condition of women's inability ever to reach complete sexual satiation in the presence of the most intense, repetitive orgasmic experiences, no matter how produced. Theoretically, a woman could go on having orgasms indefinitely if physical exhaustion did not intervene (p. 117). (Author's underscoring.)

The validity of Sherfey's (1966) views at this time are obviously open to critical evaluation. Of importance, however, is the impact such scholarly positions have had on directing the attention of researchers and clinicians to the problem of female orgasmic dysfunction (Brown, 1966; Faulk, 1973; Fisher, 1973; Gebhard, 1966; Lobitz & Lo Piccolo, 1972; Masters and Johnson, 1970; Polatin, 1970). Interest in the orgasmic dysfunctional female gained momentum following the contributions of Masters and Johnson (1966, 1970) who provided the most exhaustive scientific and factual knowledge to date regarding human sexual function and dysfunction. The focus on female sexual responsiveness has also been sharpened by such factors as the women's liberation movement (Proctor, Wagner & Butler, 1973), the proliferation of sexual manuals promising the ultimate in technique (Husted, 1972), and the "apparent" contemporary American trend toward sexual permissiveness and liberalism (Hunt, 1973). Western females' increased awareness of their orgasmic capacity (Katchadourian & Lunde, 1972) has undoubtedly led to the current increase in sexual "complaints," ranging from women concerned about their total lack of sexual interest and arousal to those who are frustrated over their consistently high levels of arousal but frequent or total failure to experience orgasm.

Before further investigation into the present body of literature regarding female sexual dysfunction, an examination of what is currently known about "normal" female sexual function will first be made.
Female Orgasm

Historical Perspective

Until the work of Masters and Johnson (1966) the exact nature of females' sexual responsiveness was virtually a neglected topic in both the biological and psychological sciences. Brown (1966) reports: "In a span of 36 years, from 1928 to 1963, the number of specific references to female orgasm in Psychological Abstracts was under 30, an average of less than one per year, and the number of references to female frigidity was under 40, an average of about one per year (p. 127)." The preceding, however, ought not to imply that little has been written about female sexuality.

Indeed, perhaps few topics have been so widely and "authoritatively" discussed with such a lack of scientific and empirical support as that of female sexual behavior. It would appear that only during the past four decades has female sexuality received any close scientific attention, the bulk of which has been generated by the pioneering efforts of investigators such as Havelock Ellis, Alfred C. Kinsey and his associates, and William H. Masters and Virginia E. Johnson.

Havelock Ellis, writing during the English Victorian era, was highly influential in setting the stage for later research in human sexuality attaining scientific legitimacy and respectability. Many of his statements quite profoundly anticipated the empirical findings of subsequent investigators. Brecher (1969) presents some of Ellis' perceptive statements written around 1905:

Masturbation is a common phenomenon at all ages in both males and females. . . . The absence of sexual desire among women is a Victorian myth. Indeed, some women are more
highly sexed than most men and take the active role in initiating sex relations. . . . The orgasm is remarkably similar in men and in women. . . . Multiple orgasm is a common phenomenon among women (p. 37).

With the emergence of female sexuality as a discussible topic, much of the recent focus has been directed to female orgasm which, according to many, appears to be the major component of a female's sexual being. Gebhard (1966) quite cogently states:

It (female orgasm) has become to no small degree a symbol of women's being accepted as a human of equal stature and with her own sexual needs. Orgasm in marital coitus has become not only her goal but her due, and inability to achieve it frequently engenders feelings of personal inadequacy and failure in both the husband and wife. The pendulum has swung from unconcern to over-concern in less than a century (p. 88).

The changes in Western females' awareness of orgasm (Katchadourian & Lunde, 1972) has finally led to the widespread recognition among both men and women that the female is truly capable of both sexual desire and enjoyment; and, for many females the highlight of sexual activity is represented by her orgasmic responsiveness.

**Clarification and Definition**

The desire of females to increase their sexual pleasure (e.g., through orgasm) has been hampered by numerous obstacles, not the least of which has been a general lack of consensus regarding exactly what the female orgasm is. Masters and Johnson's (1966) research did much to dispel many of the myths and fallacies regarding female sexual responsiveness. Their work further resulted in the establishment of reliable (definitional) criteria for the orgasmic response, thus providing one common framework (i.e., physiological) for subsequent investigation of numerous orgasmic related variables. Unfortunately, defining orgasm only in terms of observable physiological and behavioral changes appears
to do an injustice to what is obviously a highly complex, varied and subjective phenomenon.

Glenn and Kaplan (1968) point out that any adequate definition of orgasm must take into account three factors: (a) the area of the body that is stimulated (e.g., breasts, clitoris, etc.); (b) the area of the body in which the orgasm is perceived (e.g., vagina, clitoris, etc.); (c) the physiological and anatomical changes that take place in the genitalia. With these three factors in mind, we might judge the adequacy of some commonly used definitions. The following definitions, while not necessarily presented in their entirety, should quickly illustrate that there appears to be almost as many different definitions of the phenomenon as there are authors writing about it.

**ORGASM** Term normally used to describe the climax of sexual pleasure. Satisfaction of sexual excitement, followed by general physical relaxation (Goldstein, Haeberle, & McBride, 1971, p. 126).

These authors additionally point out that orgasm is a highly complex process, is usually accompanied by a variety of behavioral signs (e.g., involuntary movements, groans and sighs, convulsions of the body), and the respondent may become oblivious to her or his surrounding and to their own partner.

Havelock Ellis, in describing how a woman feels when she is having orgasm, speaks of her "... feeling of relieved tension and agreeable repose--a moment when ... together with intense pleasure, there is, as it were, a floating up into a high sphere (cited in Pomeroy, 1969, p. 88)."

In markedly less poetic terms, Kinsey et al. (1953) describe orgasm as follows:
As the responding individual approaches the peak of sexual activity, he or she may suddenly become tense--momentarily maintain a high level of tension--rise to a new peak of maximum tension--and then abruptly and instantaneously release all tensions and plunge into a series of muscular spasms or convulsions which, in a matter of seconds or a minute or two, he or she returns to a normal or even subnormal physiologic state. . . . This explosive discharge of neuromuscular tensions at the peak of sexual response is what we identify as orgasm (p. 627).

*Human Sexuality*, the recent American Medical Association (1972) publication, defines female orgasm strictly in terms of a physiological and anatomical description:

ORGASM . . . During orgasm, the female experiences a series of muscular contractions in the outer third of the vagina. The first contractions are four-fifths of a second apart. . . . Muscles of the neck, face and abdomen sometimes contract severely enough to produce muscular aches the next day. . . . Systolic blood pressure rises by 30 to 80 mm Hg . . . (and) . . . diastolic pressure rises 20 to 40 mm Hg in females (p. 99).

Although accompanied by a lengthy and thorough physiological explanation, at one point Cox (1969) states:

For the human female, orgasm is a psychophysiologic experience occurring within, and made meaningful by her psychosocial environment. Physiologically, it is a brief episode of physical release from the vasocongesture and tonic muscular spasm developed in response to sexual stimuli. Psychologically it is a mental perception of a peak physical (emotional) reaction to sexual stimuli . . . (pp. 62-63).

Wright (1969), in attempting to clarify for females exactly what an orgasm is, resorts to analogy for purposes of description and definition. She equates the orgasmic response with a sneeze and describes four points of similarity:

1. A sneeze occurs in the nose, and only in the nose.

2. Just before the sneeze there is a feeling of tension in the nose which rises to a pitch of sensation carrying with it a peculiar quality of urgent expectation that something must be about to happen.
3. The sneeze itself follows immediately upon the sensation of acutest tension, and is short and explosive in character.

4. When the sneeze is over, there is such a strongly contrasting sensation of relief and release, that it is difficult to remember how acute the tension was, a few seconds ago.

Applying these four points to an orgasm, we get:

1. The sensation of an orgasm is local, and occurs in the region of the sex organs, either externally in the clitoris, or internally in the vagina, or partly in both simultaneously.

2. Leading up to the orgasm there is a sensation of pleasure in the sexual region which is as unmistakably pleasurable as the sensation in the nose just before a sneeze is urgently uncomfortable. However, as the sensation increases, there comes a stage when it is felt that something is about to happen which is similar to the sensation present at that instant but still stronger.

3. The orgasm itself is a sudden heightening of the existing sensation to an extreme limit of pleasure. It is short in duration and is as surprisingly different from the preceding pleasure as a sneeze is different from the tension which precedes it.

4. After the orgasm is peace. The same area, which a second or two ago urgently wanted the sensation to continue, now becomes so different in reaction that the possibilities of sensation are, for the time being, completely satisfied (pp. 50-51).

From the few preceding descriptions one can quickly see the numerous problems inherent in most attempts with direct research dealing with orgasm. Precise, detailed anatomical and physiological descriptions, while perhaps serving the interests of parsimony, validity and reliability, ignore all those factors (i.e., psychological, social, cultural) which are so intimately related to the phenomenon of orgasm. Also, research that uses such definitions is dependent on highly sophisticated measuring devices usually employed under laboratory conditions. At the other extreme we find those "over inclusive"
definitions which, due to their broad generalizations, render any scientific investigation of the presence or absence of orgasmic responsiveness virtually meaningless. An additional problem with most definitions is the fact that the term is defined only according to antecedent and subsequent events. None of the preceding descriptions meet the three suggested definitional criteria proposed by Glen and Kaplan (1968). They also point out that using different definitions from dissimilar frames of reference is indeed akin to the dilemma faced by the blind sages of the East in their attempt to describe the elephant.

It is certainly clear that the evaluation of any one definition of orgasm that will be acceptable to a majority of those researching the area is a long way off. Thus, for purposes of the following discussion and research presentation, unless noted otherwise, the presence of orgasm will simply be defined as: (a) any response that a female has that is labelled, by the female, orgasm, and/or (b) the response is labelled by the female in terms that are commonly considered analogous to orgasm (e.g., climax). Some justification for such a simplistic, and perhaps "unscientific" definition may be found by taking a closer look at some of the current conflicting issues surrounding the female orgasmic response.

Conflicting Issues

1. "Types" of female orgasm--The alleged distinction between types of female orgasms originated in the writings of Freud (e.g., 1933) and were subsequently supported and amplified by such psychoanalytically oriented writers as Deutsch (1945), Fenichel (1945), Knight (1943), Kroger and Freed (1950). With minor variations, these writers essentially maintained that clitoral orgasm was a function of some
combination of immaturity, masculinity, neuroticism, or frigidity while vaginal orgasm was an expression of maturity, normality and femininity (Brown, 1966). Although Kinsey et al. (1953) had earlier questioned the validity of the dual orgasm concept, it was not until the convincing physiological and anatomical data reported by Masters and Johnson (1966) that the clitoral/vaginal orgasm distinction was seriously challenged. It is now widely accepted that, at least biologically, there are absolutely no such separate anatomic entities as clitoral and vaginal orgasms (Brown, 1966; Cox, 1969; Faulk, 1973; Katchadourian & Lunde, 1972; Kogan, 1970; Sherfey, 1966; Wright, 1969).

One may also find in the more recent psychoanalytic literature a shift away from the dual orgasm hypothesis (Salzman, 1968 and Sherfey, 1966; cited in Katchadourian & Lunde, 1972). However, the controversy has not yet been laid to rest. Apparently because of the widely divergent reports of females regarding how and where they subjectively experience orgasm, some writers have recently denied that sexual responsiveness is basically physiological in the first place (e.g., Robertiello, 1970; Shainess, 1973). Although accompanied by no supporting data beyond his clinical experience, Robertiello (1970) quite authoritatively states:

The clitoral orgasm . . . is a very intense, rather short-lasting response which builds to a rapid crescendo and falls just as rapidly. It is closer to the sexual response of the male. The so-called vaginal response . . . rises more slowly, does not reach such a sharp peak, lasts much longer, falls off much more slowly and usually gives a deeper and fuller feeling of satisfaction . . . (p. 308).

In contrast Fisher (1973) reports:

The women who were studied could distinguish differences between the experiential quality of orgasms based upon direct clitoral manipulation versus those primarily induced
through direct penile intromission .... For example, women described the "clitoral" orgasm as producing a greater "ecstatic" feeling than the vaginal type. This was, of course, quite an unexpected finding because it is widely believed ... that the "vaginal" orgasm is the most exciting of all. In any case, there seems to be reason to say that the so-called clitoral and vaginal orgasms, at least in their extreme forms, do differ experientially (pp. 7-8).

Fisher, however, next stresses that orgasm for many women is more than likely "... an indistinguishable blend of vaginal and clitoral elements (p. 8)."

Singer and Singer (1972) have recently made an attempt to reconcile what they consider discrepancies between the physiological and subjective components of orgasm. Reasoning that since emotions have physiological components, and since there are emotional differences between different types of orgasms, then the physiological differences ought to be measurable. The authors first suggest avoiding the terms "clitoral" and "vaginal" orgasm to eliminate the many confusing and value-laden connotations these terms have acquired. Next, three new terms are presented:

1. The "vulval orgasm" is characterised by involuntary, rhythmic contractions of the orgasmic platform, as well as by other physiological changes which have been measured in the laboratory by Masters and Johnson ... . This kind of orgasm does not depend upon coitus since it can be produced by a variety of other procedures, for example, masturbation.

2. The "uterine orgasm" does not involve any contractions of the orgasmic platform, but it involves emotional changes which are certainly measurable. The most notable of these is apnea caused by laryngeal displacement as a consequence of a strong contraction of the circular pharyngeus muscle ... . This kind of orgasm occurs in coitus alone, and it largely depends upon the pleasurable effects of uterine displacement. Subjectively, the orgasm is felt to be "deep," i.e., dependent on repeated penis-cervix contact . . . .
3. The "blended orgasm" combines elements of the previous two kinds. As with the uterine orgasm, it depends upon the female's desire for intromission and is followed by a terminative feeling of satisfaction and fulfillment. It is characterized by contractions of the orgasmic platform, but the orgasm is subjectively regarded as deeper than a vulval orgasm . . . (pp. 259-260).

2. Related Issues--Whether one views the female orgasm as primarily involving physiological or psychological processes, or some combination of both, the interested investigator is confronted with numerous problems, a few of which are summarized below:

   a. Definitions of human sexual arousal cannot practically be restricted to terms only involving observable physiological and behavioral changes. Eliciting stimuli cannot be narrowly specified. Furthermore, many subtle changes in affect which are insensitive to measurement may be identified by an individual as sexual arousal (Mann, 1971).

   b. Attempts to reconcile the relatively consistent physiological and behavioral data with extremely variable emotional responses (e.g., Singer & Singer, 1972) must first demonstrate that different physiological processes accompany different subjective experiences. Current evidence regarding female orgasm points to the contrary (e.g., Faulk, 1973; Fisher, 1973; Masters & Johnson, 1966; Sherfey, 1966).

   c. Subjective reports regarding orgasm may be tremendously influenced and consequently distorted by the intense experiential quality of the response itself (Brown, 1966; Fisher, 1973; Glenn & Kaplan, 1968; Kinsey et al., 1953; Wright, 1969).

   d. Masters and Johnson (1966) described two basic physiologic differences between female and male orgasmic expression. It has also been long assumed that there are fundamental differences between females' and males' subjective experience of orgasm. However, Proctor, Wagner and Butler (1973) have recently shown that "professional judges" could not significantly differentiate descriptions of orgasm written by females from those written by males. Should subsequent research support this data, it would cast serious doubt on the necessity of trying to distinguish different types of orgasms in females, without first being able to show significant experiential differences between males and females.
e. Any attempt to make definitive and generalizable statements regarding female orgasm must take into account the host of sociological and cultural factors that appear to govern the response. A good deal of impressive evidence points to the fact that the percentage of sexual activities that lead to female orgasm is almost certainly a function of cultural determinants (Ford & Beach, 1951; Gebhard, 1971; Mead, 1949). The tremendous variation between groups, between individuals, and within the same individual indeed "... emphasizes how plastic and labile humans are--even in expressing the basic biological sexual imperative (Gebhard, 1971, p. 207)."

Socio-cultural and Psychological "Correlates" of Orgasm

Before directing our attention to the problem of female orgasmic dysfunction, it would appear worthwhile to first consider some of the many variables or conditions which have been frequently thought related to female orgasmic responsiveness. The present section will provide a brief overview of several sociological, cultural and psychological variables which are commonly assumed to be correlates and/or determinants of female orgasm. Unless otherwise indicated, the following will only pertain to the female experience of orgasm as it appears within the broad parameters of contemporary American society.

Of particular interest in Fisher's (1972) investigation, which will be given more attention in a later section, is the number of major sexual variables which revealed little or no relationship to the consistency with which orgasm is experienced. There was no significant correlation between orgasmic consistency and how frequently a woman wants intercourse, the quality of her feelings during and after orgasm, or her preference for clitoral versus vaginal stimulation.

Several studies have more specifically focused on the relationship between the existence and frequency of orgasm to a woman's enjoyment of intercourse, the common assumption being that orgasm is necessary for
coital enjoyment. Wallin and Clark (1963) found, however, that although there was a positive correlation between frequency of orgasm and enjoyment of intercourse, approximately 17% of the women in their sample reported enjoying coitus very much despite experiencing orgasm very infrequently or not at all. The consistency of orgasmic responsiveness has often been evaluated within the context of the quality and/or duration of marriage and sexual experience (Clark & Wallin, 1965; Gebhard, 1966; Kinsey et al., 1953; Shope & Broderick, 1967). Kinsey et al. (1953) reported that the ability of wives to experience orgasm increased with the duration of marriage. Clark and Wallin (1965) found that marriages consistently described as positive tended to be accompanied by increased sexual responsiveness up until the point of being married five years. However, marriages which initially were rated negative in quality with a later shift to positive in quality were not accompanied by wives' increased sexual responsiveness. Thus, these authors suggested qualifying Kinsey's findings to be mainly relevant only to those marriages which were positive in quality during the early years of marriage. Investigating several possible factors in marital orgasm, Gebhard (1966) found:

... a strong correlation between female orgasm and marital happiness (presumably causal in both directions); a definite correlation between female orgasm rate and length of marriage; a moderate correlation between female orgasm rate and duration of pre-coital foreplay, and a moderate (and complex) correlation between female orgasm rate and duration of penile intromission (p. 95).

In a study involving the level of sexual experience and predicted adjustment in marriage, Shope and Broderick (1967) found little difference between orgasmic and non-orgasmic non-virgins and sexual adjustment or marital happiness.
The relationships between female sexual responsiveness and marital satisfaction are complexly intertwined and few, if any, firm conclusions regarding functional relationships can be drawn from the results of such correlational studies. The absence of orgasmic responsiveness does not necessarily preclude a happy marriage nor enjoyment in sexual activity (Faulk, 1973). To make matters more complex, Masters and Johnson's (1966) data have suggested that even when orgasm is present, there is no direct relationship between the intensity and duration of orgasm and the woman's sense of sexual gratification. Apparently orgasm of relatively low intensity and short duration may be described as a completely fulfilling experience if occurring with a partner who is cared for and loved (Kogan, 1970).

Of the numerous possible orgasmic related factors investigated by Kinsey et al. (1953), the following conditions were found to correlate with higher incidences of orgasm:

1. The percentage of females experiencing orgasm within any five-year period tended to be higher among those with upper educational backgrounds.

2. The number of females who responded with orgasms in all or nearly all of their coital contacts tended to be greater among those who were married after 20 years of age.

3. The incidence and frequency of orgasm during the first year of marriage was much higher for females who had pre-marital experience in orgasm. More specifically, females who had pre-marital coital orgasm were 10 to 20 times more responsive during the first year of marriage than females who had pre-marital coitus without orgasm.

4. Females who had pre-marital experience in masturbation which led to orgasm represented a higher percentage of those who were orgasmic during the first year of marriage than females without such experience.
While females are frequently considered to be generally less responsive to psychologic factors (e.g., erotic stories, movies, etc.) than males (Kinsey, et al., 1953), the variability among females in the degree of sexual responsiveness is much greater than among men (Kogan, 1970). Of the Kinsey et al. (1953) female sample, the percentage of females who reported "definite and/or frequent" erotic responses to certain psychologic factors which might be considered as facilitative of orgasmic responsiveness under certain conditions were as follows:

1. 17% - observing the opposite sex (n = 5772)
2. 21% - observing genitals of the opposite sex (n = 617)
3. 9% - observing moving pictures (n = 5411)
4. 14% - observing portrayals of sexual action (n = 2242)
5. 22% - fantasies concerning the opposite sex (n = 5772)
6. 16% - reading literary materials (n = 5699)

It should be noted that the above only represents the percentage of females who reported a definite and/or frequent erotic response to the various situations. Furthermore, while the percentages of males who reported erotic responses to such stimuli was typically higher than females, the results of this data might reflect more in the way of differences in experience with psychosexual stimuli than sex specific differences (Sigusch, Schmidt, Reinfeld, & Wiedermann-Sutor, 1971).

Females interviewed in Fisher's (1973) study were able to enumerate various conditions which they felt inhibited or facilitated their sexual responsiveness. Those categories mentioned most frequently as contributing to responsiveness were:

1. 18% - privacy and freedom from intrusion
2. 18% - good relationship between self and husband
3. 8% - something "good" or "successful" occurred that day
4. 8% - not tense or depressed
5. 8% - not tired

Other less frequently made references concerned conditions such as room
temperature, time of day, activities preceding sexual activity, etc.
In addition to these situational or environmental variables, Fisher
also attempted to find sexual indices which might correlate with orgasm
response consistency. The most common correlates of a woman's orgasm
consistency were high self-ratings in sexual responsiveness, feelings
of satisfaction after orgasm, orgasms being described as of high
strength, and experiencing more than one orgasm in an hour period. It
should be noted here, however, that of Fisher's seven different samples,
all of which were relatively homogeneous as to age, education, marital
experience and socio-economic level, there was never a totally reliable
finding of any of the orgasm consistency correlates across all the
samples. For example, the correlation between consistency of orgasm
and the tendency to experience more than one orgasm in an hour period
was found in only three out of six groups sampled.

There are indeed numerous psychological, sociological and cultural
factors which appear to be associated with female orgasmic responsive­
ness. However, until more precise experimentation can demonstrate
specific functional relationships, the results of studies which simply
yield correlations between female arousal and/or orgasm and a host of
variables does little to further our understanding of how to facilitate
the female orgasmic response. The assumption that there is some
meaningful continuity or a typical way of responding sexually across a
variety of situations is widely held. The evidence, however, points to
the contrary. In summarizing the results of his extensive review of the psychological dimensions of responsiveness and orgasm, Fisher (1973) states:

Retracing the results, one is not left with the impression that there is a unitary, consistent quality about a woman's responses to sexual stimulation. It is, in most instances, difficult to predict one aspect of her sexual response pattern to another aspect. . . . The prime impression that emerges is that large sectors of what we call sexual behavior are relatively independent of each other. Sexual behavior is apparently a mixture of diverse elements, not infrequently having in common only their shared semantic designation (pp. 221-222).

**Female Orgasmic Dysfunction**

**Incidence**

Information regarding the number of females having difficulty in experiencing orgasm is extremely varied and often misleading. Knight (1943) states:

Gynecologists and psychiatrists especially, however, are aware that perhaps seventy-five percent of all married women derive little or no pleasure from the sexual act. Many women not only experience no pleasure but actually suffer pain and revulsion (p. 32).

Hastings (1963) and Kroger and Freed (1950) provide similar estimates. It is important to note, however, that these estimates along with many others are undoubtedly exaggerated because they are typically derived only from patients seen by clinicians—usually obstetricians, psychiatrists, psychoanalysts, psychologists, social workers, or marriage counselors (Brown, 1966; McCary, 1973; Polatin, 1970).

More realistic estimates of orgasmic inadequacy are reported in studies or literature review articles by Brown, 1966; Brady, 1966; Clark and Wallin, 1965; Faulk, 1973; Husted, 1972; and Polatin, 1970. After combining data obtained in several questionnaire studies over the
past 30 years, Brown (1966) makes the following estimates and
generalizations obtained from some 2,500 married women:

... between 60 and 70 percent of married women
experience orgasm "usually or always," about 25 percent
"some of the time," and between 5 and 10 percent "rarely
or never" (p. 136).

These findings are roughly comparable to the Kinsey et al. (1953) data
which indicated that 25% to 30% of married women have an impaired
orgasmic response to coitus. The incidence of orgasmic inadequacy fell
from 25% at the end of one year of marriage to 11% by 20 years of
marriage. It also tended to be less common in younger generations.

More recent data suggests that the rates of orgasm for females
have increased. Hunt (1973, 1974) compared women whose marriages
averaged 15 years with women in the Kinsey et al. (1953) sample who were
married at the 15th year. He reports a distinct increase in the number
of wives who always or nearly always have orgasm (53%) and a sharp
decrease in the number of wives who seldom or never do (15% compared
to Kinsey's et al. (1953) 28%. Hunt (1973) further reports that
considerable more young single females who are having coitus are also
having orgasm. Approximately three quarters of these females sampled,
compared with about half of Kinsey's related sample, are having orgasms
and a larger proportion of these than Kinsey's have orgasm at least
half the time. Hunt (1973) also points out that the median frequency
of more than one coital orgasm every two weeks is three times as high
as in Kinsey's sample.

In studying the females' ability to reach orgasm in relationship
to both length of foreplay and intromission, Gebhard (1966) found that
about three-fifths of his female sample almost always experienced
orgasm if foreplay lasted longer than 20 minutes. Expressed differently, only 7% of these females never experienced orgasm when foreplay continued for more than 20 minutes.

We might thus conclude from the preceding surveys that approximately 5% to 15% of all married women seldom or never experience orgasm during coital activity. Furthermore the incidence of non-orgasmic response appears to decrease significantly with experience, assuming that duration of marriage is directly related to increasing numbers of coital contacts. Also it appears that of all women, married or single, who experience orgasm at least sometimes during intercourse, the frequency of orgasmic responsiveness has definitely been increasing particularly during the past 30 years. Such increases in female sexual responsiveness are not especially dramatic, however, when one considers that the best estimates currently available seem to indicate that around 10% of all females in American culture seldom or never experience orgasm during coitus. (The female's ability and desire to have orgasm under conditions not involving sexual intercourse will be considered in a subsequent section).

Etiology

Any meaningful discussion of etiological factors involved in female orgasmic problems would seem to preclude some consensus regarding definition of the problem under investigation. Yet, considering the wide range of varying and conflicting definitions of what orgasm actually is, the lack of agreement as to factors involved in the absence of orgasm is not hard to understand. Orgasmic difficulties, as well as other problems like dyspareunia and vaginismus, are most frequently considered within the rubric of frigidity. Thus, the following
A discussion of possible causal factors will frequently make reference to the term "frigidity," despite the fact that the present research still centers on the problem of females who are specifically concerned with absent or infrequent orgasmic responsiveness.

As was the case with the term "orgasm," the term "frigidity" appears to have almost as many definitions as there are authors writing about it. At one extreme we find simple restrictive definitions such as failure to experience "vaginal" orgasm in coitus (Fenichel, 1945; Knight, 1943). The other extreme is represented by broad, general statements such as "abnormally averse to sexual intercourse" (Webster's Third New International Dictionary, 1961). A more commonly accepted definition (Husted, 1972) is "that condition wherein the female is unable to initiate or maintain the heterosexual arousal pattern" (Hastings, 1963, p. 7). Avoiding the label of frigidity, Lazarus (1969) divides the most common forms of female sexual inadequacy into several categories:

1. Complete or partial absence of sexual arousal;
2. Total or partial aversion to sex (despite feelings of arousal);
3. Loss of sexual interest or arousal before achieving orgasm;
4. Inability to have an orgasm . . . ;
5. Absence of pleasure during sex;
6. Various degrees of pain or discomfort during coitus, not due to organic disorders . . . (pp. 53-54).

Polatin (1970), while supporting Lazarus' (1969) avoidance of the term "frigidity," suggests that the word "inadequacy" might be unacceptable to otherwise "adequate women" and advances the word "hyposexual" . . .
"as perhaps the best term to use in describing frigidity and other
sexual difficulties in women . . . (p. 13)." Annon (1971) cites
references to other forms of frigidity including relative, temporal,
situational, true, and pseudo.

Masters and Johnson (1970) have discarded the term "frigidity" in
favor of "female orgasmic dysfunction." The latter category is further
divided into primary (never having attained orgasm during any condi­
tions) and situational (having experienced at least one orgasm through
some mode of stimulation). McGovern and Stewart (1972) have divided
the problem of secondary (i.e., situational) orgasmic dysfunction into
several categories, with the first two being the most common:

1. Female is orgasmic in masturbation, but not during
sexual activity with a partner (either through genital
manipulation or intercourse).

2. Female is orgasmic in masturbation or via partner
genital manipulation, but not during intercourse.

3. Female is orgasmic with a partner other than her mate,
but not with her mate.

4. Female was orgasmic with her mate in the past, but not
with her mate at present.

5. Female is orgasmic with her mate during intercourse,
but she is dissatisfied with her low frequency of
orgasmic response (p. 1).

From the preceding definitions, descriptions, groupings and
categories, it becomes readily apparent that to advance possible etio­
logical factors to account for a problem that is not even defined or
mutually agreed upon by authorities to be a problem appears quite
unproductive. For purposes of the present discussion, etiological
variables will only pertain to those factors which are thought to
contribute to female orgasmic dysfunction, further defined as any
problem a female reports regarding the absence or frequency of orgasm.

Preceding their discussion of etiological influences, Masters and Johnson (1970) state:

It is extremely difficult to categorize female sexual dysfunction on a relatively secure etiological basis. There is such a multiplicity of influences within the biophysical and psychosocial systems that to isolate and underscore a single major etiological factor in any particular situation is to invite later confrontation with pitfalls in therapeutic progression (p. 229).

Katchadourian and Lunde (1972) also point out that the psychological causes of sexual malfunctioning are innumerable and not specific to types of disturbances. The same conflict may cause any number of dissimilar sexual complaints. There is, however, widespread agreement that the vast majority of female orgasmic difficulties are caused by psychological or psychogenic factors (American Medical Association, 1972; Brown, 1966; Marmor, 1963; Polatin, 1970). That such problems are learned or acquired is seldom debated--although the conflict as to how such learning takes place continuously goes on. It might also be noted that some authorities (e.g., Annon, 1971; Vincent, 1973) place much emphasis on the individual's failure to learn as a common etiological factor.

Hypotheses to account for female orgasmic difficulties range from psychological blocks, fostered by society's archaic and fallacious attitudes (McCary, 1973) to "psychological inhibition wherein the female learns by conscious or unconscious processes to inhibit receptivity and desire, or responsiveness and drive, or orgasm and satisfaction (Polatin, 1970; p. 16)."
Other factors frequently mentioned are underlying personality disorders (Smith, 1956) and interpsychological and intrapersonal problems relating to the marriage (Shainess, 1973). Faulk (1973) suggests that the acquisition of female sexual inhibitions comes from personal and social experience, and whether such inhibitions will be overcome depends on their strength, the personality of the individual, and the current experiences of the subject. Polatin (1970) claims that inhibition leading to sexual dysfunction is based on the dimensions of fear-anxiety, hostility-aggression, and conflict-guilt. Fears and hostility are particularly apt to prevent an individual from "letting go" because of the fear of bodily disintegration and loss of ego control. Additional etiological influences often cited include anxiety and depression, lack of sexual identity, loss of control, and interpersonal conflicts (Katchadourian & Lunde, 1972). More extensive reviews of other psychological determinants of orgasmic difficulties are presented by Annon (1971) and Husted (1972).

Many current authorities have expressed strong support for the role of conditioning, learning, and experience in determining female erotic responsiveness (e.g., Annon, 1973; Brown, 1966; Masters and Johnson, 1970; Newton, 1973). The role of anxiety and conditioned inhibition in orgasmic problems have been discussed by behaviorally oriented researchers such as Brady (1966), Lazarus (1963, 1971) and Wolpe (1969). The importance of learning and experience to female orgasmic responsiveness has received added support from cross-cultural research (e.g., Marshall & Suggs, 1971). Gebhard (1971) concludes from numerous anthropological studies that:
... the proportion of coital acts which result in orgasm for the female varies widely; almost certainly it is largely culturally determined. In some societies, ... females rapidly learn to achieve orgasm and thereafter experience orgasm in most of their coitus. In other societies wherein sex is viewed negatively, ... females seldom achieve orgasm (p. 214).

From his study of Mangaians, Marshall (1971) reports:

... there is a complete consensus among informants that all Polynesian women achieve orgasm, and that they definitely expect to be brought to climax during intercourse. Similarly, there is a complete consensus that the orgasm is learned by women, and that a "good man" will bring them to it (p. 155).

Despite the overwhelming support for linking female orgasmic problems to psychogenic factors, a few authors are still attempting to incorporate biological, anthropological, and evolutionary data to account for the "problem." In discussing the relationship of coitus to caretaking behavior, an essential element in successful reproduction, Newton (1973) states: "Operant conditioning, reinforced through coital pleasure, may be the biologic foundation upon which patterns of family life are built (p. 92)." Others feel that female orgasmic ability may still be developing from an evolutionary standpoint (Brown, 1966). Grant (1972) suggests that "... it is possible that 'anxiety about orgasm' and psychosexual inhibition have their roots in prehistory, and are remnants of a tract which was necessary for the development of civilization (p. 46)."

Some of Kinsey's et al. (1953) data also indicated that basic innate constitutional differences among females in physical and physiologic structures might effect sex drive, arousal threshold, and orgasmic capacity. Kane, Lipton, and Ewing (1969) have stressed the potential role of female hormones as an important factor for "... (1) the early developmental organization of the neural substructures subserving
sexual behavior and (2) activation of these neural substructures to adult functional levels at puberty (p. 208)." Kinsey et al. (1953) have also pointed to between sex differences in responsiveness to psychologic stimulation as possibly accounting for problems involving female orgasm. The male's greater dependence on various modes of psychologic stimulation (e.g., fantasy) to facilitate arousal in contrast to the female's ability to achieve orgasm without fantasy may lead to difficulty if the male does not appreciate his partner's greater dependence upon physical and physiologic sources of erotic arousal. Finally, again we find the extreme position held by Sherfey (1966) who proposes an almost total biological etiology of coital frigidity. Drawing heavily on the earlier unpublished data of Masters and Johnson, Sherfey flatly states:

On the basis of these observations, it seems that the vast majority of cases of coital frigidity are due simply to the absence of frequent, prolonged coitus (p. 117). . . . The inordinate sexual, orgasmic capacity of the human female will fall in line with that of the other higher primates--and the magnitude of the psychological and social problems facing modern mankind is difficult to contemplate (p. 119).

Necessity for Treatment and Research

In comparison to Kinsey's et al. (1953) data, Hunt (1973) reports an increase in rates of orgasm for females along with increased frequencies of intercourse. Nevertheless, despite the concomitant decrease in the percentages of those married females who only sometimes or never have orgasm (i.e., Kinsey et al.--28%; Hunt--15%), there still remains a sizeable number of women who are frequently dissatisfied with their sexual responsiveness. The literature regarding the effects of lack of orgasm shows considerable confusion. Husted (1972) presents some evidence to suggest that among sexually dysfunctional women there are positive correlations with feelings of low-self-esteem, lack of
confidence, and perceived inadequate body image. Some investigators claim that infrequent or lack of orgasm in females is a cause of chronic anxiety, tension, marital unhappiness, frustration, and some psychophysiological complaints such as fatigue, restlessness, insomnia, poor appetite and gastric disturbances (Polatin, 1970). Masters and Johnson (1966) have supported earlier findings that with numerous repeated periods of sexual stimulation and arousal not followed by orgasmic release, over the years a syndrome of chronic pelvic congestion may develop. McCary (1973) and Gebhard (1966) have pointed to the increasing concern on the part of both men and women over the females' ability to experience orgasm. Failure to achieve orgasm may engender in both husband and wife profound feelings of personal inadequacy and failure.

"There is good evidence that the capacity for orgasm or sexual climax is a natural birthright of almost every healthy adult human being (cited in Kogan, 1970, p. 99)." Yet despite impressive anatomical and physiological evidence pointing to similar capacities for orgasmic responsiveness between men and women, females in American society are much more frequently orgasmically impaired than males (Kinsey et al., 1953; Marmor, 1963; Masters and Johnson, 1970; Sherfey, 1966). Although certain estimates of female orgasmic difficulties are obviously biased upwards (e.g., Hastings, 1963; Knight, 1943; Kroger & Freed, 1950) the frequency of this complaint is more than sufficiently high to warrant continued research attention. As presenting complaints, sexual problems are still infrequent in mental health and counseling centers, although they frequently emerge during the course of therapy or marriage counseling (Husted, 1972). This is not the case, however, with
physicians, particularly obstetricians and gynecologists. In discussing a study involving 514 doctors, Lobsenz (1973) indicated that most doctors ranked "poor sexual adjustment" as the main complaint brought to them. Furthermore, only one out of four of these doctors reported that they discussed sexual problems with their patients, and most of these said the topic was avoided unless first raised by the patient. Lobsenz also describes another study of how physicians typically dealt with their patient's sexual worry. The three most commonly mentioned strategies were to "talk generally," "give reassurance," or to say "can't help at all."

The current preoccupation with sex (Katchadourian & Lunde, 1972) and the "modern interest in the orgasm" (Kogan, 1970) has undoubtedly led to many frustrated failures in experiencing orgasm. One psychiatrist notes:

An emphasis on orgasm pervades all age groups of our society . . . among university students the search for the ultimate orgasm has become almost a competitive matter . . . the ultimate confession . . . I have seen girls who admitted cheating, stealing . . . and promiscuity with little shame but who wept violently when they confessed that they could not have orgasms (cited in Kogan, 1970, p. 98).

From his study of Mangaian sexual behavior and cultural factors with regard to the female orgasm, Marshall (1971) concludes:

The fact that the orgasmic reaction can apparently be universally achieved in one society implies that such achievement could be learned in other societies by those individuals who now do without such an experience. Whether this general achievement of the climax would--in the long run--be socially cohesive or socially disruptive is a problem that must be left for another discussion.

**Current Treatment Approaches**

A little over two decades ago, Bergler (1951) asserted that the success of Freudian psychoanalysis in restoring orgasmic capacity proved
that neurotic inhibition, and nothing else, was involved and therefore every other form of therapy was a waste of time.

Cure is possible with Freudian psychoanalysis, but the amount of time one must give to the individual patient (an appointment several times a week for a minimum of eight months and a maximum of two years) is so enormous and the knowledge of the physician in treating this disease is so specialized, requiring a period of years for acquisition, that mass treatment is out of the question. As a mass problem, the question of frigidity is unfortunately not to be solved (cited in Brown, 1966, pp. 158-159).

Approximately one year ago, psychiatrist Natalie Shainess, in her critical review (1973) of Masters and Johnson's research (1966, 1970) stated:

Sexual problems can be explored and treated. But unless they are caused by simple ignorance, which is rare, they are likely to require long psychological, and not always successful, treatment. In my professional experience, sexual difficulties are the last of all symptoms to improve. I do not like this; I simply accept it as reality (p. 25).

A number of authorities (Annon, 1971; Ince, 1973; Yates, 1970) have pointed out that many psychotherapeutic orientations have considered orgasmic problems refractory to treatment. However, with the emergence of new procedures during the past 15 years, particularly behavioral approaches, it is indeed puzzling as to why such pessimism (e.g., Shainess, 1973) still exists, especially in light of the overwhelming evidence to the contrary (e.g., Brady, 1966; Brown, 1966; Kraft & Al-Issa, 1967; Lazarus, 1963; Masters and Johnson, 1970).

The first comprehensive diagnostic and treatment program concerned with female orgasmic dysfunction, as well as numerous other sexual problems, was developed in 1959 by Masters and Johnson (1970). Their current therapeutic focus for the nonorgasmic female is directed toward the creation or restoration of sexual feeling to its appropriate
psychosexual context. Through a series of sensate focus exercises, physical communication between the female and her partner is gradually increased. Constant stress is given to helping the female to communicate, both verbally and nonverbally, what she prefers as opposed to what her partner may think she prefers. Throughout the various phases of stimulation, the female is encouraged to develop an awareness of all positive feelings but not focus on orgasmic release as the goal. When success has been achieved at a particular level, the couple proceeds to the next step which consists of increasingly more direct and coitally related sexual stimulation. By 1970, Masters and Johnson reported a failure rate in reversal of orgasmic dysfunction of 19.3%. Their two clinical divisions of orgasmic problems (i.e., primary orgasmic dysfunction and situational orgasmic dysfunction) only differed minimally with respect to treatment failure or success rate.

As of March, 1973, Taylor (1973) lists over 20 treatment centers and/or sex therapy teams that specialize in the treatment of sexual dysfunction. Treatment approaches for nonorgasmic females may range anywhere from training in sensory awareness to comprehensive, intensive programs such as the "Bio-Psycho-Social Approach" taken by Hartman and Fithian (1972). Unfortunately, the data regarding the efficacy of many current programs is typically either in short supply or confined to a highly select patient population consisting of both motivated and economically advantaged individuals.

One of the few comprehensive treatment approaches that has been developed on the basis of a well-organized theoretical framework accompanied by supporting empirical evidence is that of Lobitz and Lo Piccolo (1972). Their theoretical orientation closely follows
Wolpe's desensitization model. Sexual dysfunction is viewed as a learned phenomenon and is treated through systematically training changes in the couple's behavior. Patients are gradually exposed, in vivo, to a number of graded tasks designed to inhibit internally maintained performance anxiety. While many of the Masters and Johnson (1970) techniques are incorporated into this program, other clinical innovations include the following:

1. Procedures designed to allow the therapists to obtain regular data on the client's sexual behavior and to ensure that the clients carry out the "homework" assignments.

2. Procedures which enhance the client's desire and arousal towards his or her partner.

3. Procedures which teach interpersonal sexual skills.

4. Procedures which disinhibit clients towards displaying their own sexual arousal and responsiveness.

5. Procedures designed to maintain treatment gains after therapy has ended (p. 266).

Applying Masters and Johnson's (1970) success criterion, Lobitz and Lo Piccolo have reported generally good results, i.e., 13 out of 13 treated cases of primary orgasmic dysfunction, and 3 out of 9 cases of secondary orgasmic dysfunction have been considered successes. The effectiveness of each of the major treatment program components is currently under evaluation.

Many of the newer brief treatment approaches have depended upon some form of systematic desensitization to alleviate anxiety which is assumed to be inhibiting sexual responsiveness (Brady, 1966; Husted, 1972; Kraft & Al-Issa, 1967; Lazarus, 1963; Madsen & Ullmann, 1967; Wincze, 1971; Wincze & Caird, 1973; Wolpe, 1969). Other procedures which have basically followed the systematic desensitization model have
typically employed some form of successive approximation, graded exposure, or in vivo desensitization to alleviate performance anxiety (Lazarus, 1969; Lobitz & Lo Piccolo, 1972; McCarthy, 1973; Masters & Johnson, 1970; Prochaska & Marzilli, 1973). The therapeutic use of masturbation, sometimes in conjunction with one or more of the desensitization related procedures, has been reported by Annon (1973), Hastings (1963), Lo Piccolo and Lobitz (1972), and Wright (1969).

Other successful short-term procedures discussed in the literature include dynamic counseling and direct instruction (Bauer & Stein, 1973), the use of vibrators (Dengrove, 1971), anxiety reduction and sexual skill training (McGovern, Stewart & Lo Piccolo, 1973), and group didactics and instruction (Lazarus, 1969). The use of films and videotapes for purposes of desensitization, direct instruction, and changing negative attitudes about masturbation have recently been reported by Lehman (1974), More (1973a, 1973b), Renick (1973), and Wincze and Caird (1973). Richardson (1964) quite successfully used hypnotherapy to increase the percentage of orgasmic response in 72 of 76 patients, and Geisinger (1969) reported a successful outcome in a difficult case using a combination of techniques including assertive training, behavior rehearsal, thought stopping, flooding and systematic desensitization.

It is quite clear from the variety of approaches currently available and successfully employed that problems involving orgasmic dysfunction no longer have to (and should not) be viewed as especially difficult cases requiring long-term psychotherapy. All of the approaches previously described require relatively few sessions and with one exception (Bauer & Stein, 1973), all are mainly geared toward accepting the symptom as the problem and dealing with it directly.
Most of these treatment strategies use one or more behavior therapy approaches which are, in many cases, more amenable to empirical scrutiny than former therapeutic procedures. It should, however, be noted that many studies claiming successful outcomes are based on a limited number of cases, and all too frequently are single case presentations. It would also appear that therapeutic failures, whatever the actual percentage may be, are less likely to be reported in the literature (cf. Kaplan & Kohl, 1972). Despite the promising and encouraging results obtained so far from the behaviorally oriented approaches, many problems yet remain to be solved (Annon, 1971; Dengrove, 1967; Franks, 1967; Rachman, 1961; Yates, 1970).

A uniform treatment approach to the problem of female orgasmic dysfunction is seriously open to question, despite the contention of Masters and Johnson (1970). For example, Masters and Johnson maintain that the differences in failure rate they found between primary (16.6%) and situational (22.8%) orgasmic dysfunction would have been statistically negligible had they been more successful in treating random orgasmic inadequacy, a sub-category of situational orgasmic dysfunction.

The close approximation of failure rates in the two arbitrary clinical divisions of woman's nonorgasmic status supports the concept of uniformity of treatment approach, regardless of whether the woman has ever had previous orgasmic experience (p. 315).

On the other hand, several investigators have consistently found higher success rates for primary orgasmic problems and have gone on to suggest somewhat different treatment strategies for secondary orgasmic dysfunction (McGovern & Stewart, 1972; McGovern, Stewart & Lo Piccolo, 1973). McGovern et al. (1973) reported that while cases of primary and secondary orgasmic dysfunction did not differ significantly in most
aspects of their sexual behavior prior to treatment, before treatment there was a tendency for secondary (but not primary) orgasmic females to be associated with disturbed marital relationships. Following a behavioral treatment program involving anxiety reduction and sexual skill training, orgasm in coitus was attained by the primary cases but not the secondaries. In contrast, Brinton (1972, cited in McGovern, et al., 1973) has indicated that the Marriage Council of Philadelphia has a higher rate of success with cases of secondary orgasmic dysfunction.

The preceding suggests that whatever mode of therapy is to be used it most likely should consider besides the frequency or prior existence of orgasm, a host of other related variables such as extent of sexual repertoire, frequency of orgasmic related activities, and attitudinal or emotional responses to various sexual behaviors. The "cautious optimism" regarding behavioral approaches to sexual disorders urged by Rachman (1971) over a decade ago is still warranted until further research suggests otherwise. In a more recent discussion of the treatment of sexual disorders, Franks (1967) states:

Behavior therapy, as currently practiced, must not be viewed as a panacea for all disorders, even those which are clearly "behavioral" (p. 218).

... Or perhaps one solution lies in treating the whole man by diverse behavioral techniques, including every aspect of the patient's personality, and not just his presenting sexual anomaly (p. 220).

... He (the therapist) must also be a skilled clinician who cares about people, knows his topic (in this case sexual deviation) and is sophisticated with respect to clinical matters (p. 220).
Of the many therapeutic approaches to orgasmic dysfunction currently employed, those that have attempted to closely follow some theoretical framework have mainly fallen within the parameters of Wolpe's (1958, 1969) concept of reciprocal inhibition. More specifically, the assumption that anxiety inhibits sexual responsiveness is widely held and most treatment strategies focus on anxiety reduction through a variety of means. Systematic, in vivo, and variants of desensitization are utilized, along with direct instruction to terminate overt behaviors at the first sign of anxiety. Other approaches use some form of graded exposure or successive approximation. These procedures assume that with appropriate performance hierarchies, attempting and completing each step has a high probability of success, which in turn both reinforces the accomplished task and serves as a motivating influence to proceed on to the next. The implicit assumption of course is that there is little or no anxiety prior to embarking on any one step of the performance hierarchy. Maintaining a high probability of successful task completion thereby reduces or eliminates inhibiting anxiety regarding the next performance or behavioral goal.

Few, if any, current treatment procedures for female orgasmic dysfunction or other sexual disorders make any explicit mention or systematic attempts to effect sexual behavior and attitude change through any of the powerful vicarious learning processes. Bandura (1969) quite convincingly argues that:

... virtually all learning phenomena resulting from direct experiences can occur on a vicarious basis through observation of other persons' behavior. . . .
Modeling procedures are, therefore, ideally suited for effecting diverse outcomes including elimination of behavioral deficits, reduction of excessive fears and inhibitions, transmission of self-regulating systems, and social facilitation of behavioral patterns on a group wide scale (p. 118).

The process of observational learning, also referred to as vicarious learning, imitation, identification, modeling, social facilitation, etc., is "... taken to mean a change in behavior which is acquired as a result of observing the behavior of another person(s)--it is by definition a social phenomenon (Rachman, 1972; p. 382)."

Theoretical Overview

While some authors attempt to distinguish between the various terms relating to observational learning (e.g., Rachman, 1972), Bandura (1971a) seems to regard most as essentially synonymous, particularly since it has not been demonstrated that different forms of observational learning or modeling are governed by separate determinants or mechanisms. Bandura maintains that observational learning produces three major effects: 1) observers may acquire new behavior patterns not previously existing within their behavioral repertoires; 2) observers' behavior may be either inhibited or disinhibited as a result of viewing a model's behavior; and 3) the expression of already existing responses may be facilitated by watching a model emit those same responses. While numerous attempts have been made to explain modeling phenomenon, including instinctual interpretations, reinforcement theories, associative theories, and affective-feedback theories, there is still considerable confusion regarding the exact theoretical underpinnings and operations involved in observational learning (Bandura, 1969, 1971b).
From a social learning theory viewpoint, Bandura (1969) hypothesizes four main interacting subsystems governing observational learning. Perhaps the most important subsystem involves attentional processes, i.e., procedures which increase the probability that an observer will attend to, recognize, and discriminate the various features of the observed model or event. Variables that are commonly thought to influence attentional processes include physical and interpersonal qualities of the model, incentives provided for learning observed behavior, and the motivational characteristics of the observer. A second subsystem involves retention processes which include those processes by which a person can acquire a response, even though the response is occurring only in representational or symbolic form. Imaginal and verbal representational systems may influence observational learning so that an observer can later perform in the absence of the model. Also, rehearsal operations, both cognitive and behavior, tend to increase retention of acquired behavior. The third observational learning component involves motoric reproduction processes. Here the concern is to what extent the observer's behavioral repertoire is sufficient to allow reproduction of the observed or modeled behavior. Instructed or directed performance can facilitate novel response acquisition (cf. Masters & Johnson, 1970). The fourth major subsystem includes reinforcement and motivational processes. An observer will only tend to model responses that are prompted and/or followed by some form of external, vicarious or self-reinforcement. Reinforcement variables may also affect observational learning by influencing those modeled or observed events to which the observer is most likely to attend.
Empirical Support

The effects of observational learning have been demonstrated under many different conditions and across a wide range of problems. Since the initial studies of vicarious learning processes by Bandura (1962, 1965), the research on modeling has accelerated tremendously. In his annotated behavior therapy bibliography, Morrow (1971) lists over 75 studies during the past 15 years that have employed modeling or some form of observational learning as a modification procedure. Much of the research attention has been devoted to demonstrating the efficacy of modeling as a means of vicariously extinguishing fears and reducing avoidance behavior (Bandura & Menlove, 1968; Bandura & Rosenthal, 1966; Bandura, Blanchard & Ritter, 1969; Bandura, Grusec & Menlove, 1967; Litvak, 1969; Rimm & Mahoney, 1969; Ritter, 1968). Bandura (1965) and Flanders (1968) have presented impressive evidence documenting the acquisition of behavior prior to its reproduction or performance. Bandura, Ross, and Ross (1963) demonstrated how children could be taught novel responses, not previously existing in their behavioral repertoires. The power of modeling procedures to modify moral judgment orientations has been shown by Bandura and McDonald (1963) and Le Furgy and Woloshin (1969). Modeling procedures have also been successfully employed to teach certain interpersonal skills to college students (Rappaport, Gross, & Lepper, 1973), to teach assertive behavior to coeds (Rathus, 1973; Young, Rimm & Kennedy, 1973) and to modify hypnotic susceptibility (Diamond, 1972).

While earlier observational learning procedures typically used live models, many studies have since demonstrated the equal efficacy of modeling through symbolic representation, e.g., films, videotapes,
pictures (Bandura & Menlove, 1968; Bandura & Mischel, 1965; Bandura, Blanchard & Ritter, 1969; Bandura, Ross & Ross, 1963; Flanders, 1968; Marshall & Hahn, 1967; O'Connor, 1969; Spiegler, Liebert, McMains & Fernandez, 1969). Kazdin (1972) has also reported success with covert modeling, where neither live nor symbolic (film) models were employed.

There can be little doubt about the modifying affects of observational learning on a wide range of emotional responses and behaviors. The bulk of the research, however, has been similar to the analog studies used in the investigation of systematic desensitization (Rachman, 1972) and much less emphasis has so far been directed toward the extension of observational learning procedures to psychotherapeutic settings. Considering the evidence about modeling, it is indeed surprising that "... in spite of the sheer number, diversity, and robustness of such successful demonstrations of the efficacy of modeling interventions, their systematic use and evaluation in clinical contexts has been minimal (Goldstein, Martens, Hubben, Van Belle, Schaaf, Wiersma & Goedhart, 1973, p. 31)."

Clinical Applications

Some work with modeling has been done using adult psychotic or psychiatric inpatient populations. Sherman (1965), using a combination of response contingent reinforcement and modeling, was able to reinstate verbal behavior in mute psychotics. Wilson and Walters (1966) also were able to increase verbal productivity of near-mute schizophrenics by both reinforced modeling and modeling alone. Rachman, Hodgson and Marks (1971) showed both a modeling and flooding procedure to be equally successful in the treatment of chronic, obsessional inpatients. Using modeling procedures with two samples of neurotic
outpatients and one sample of psychiatric inpatients, Goldstein et al. (1973) reported significant increases in independent behavior.

As a media for facilitating behavior and attitude change through observational learning, films and videotapes have recently been employed by several investigators (e.g., Persons & Persons, 1973). Muzekari and Kamis (1973) were able to increase task-oriented verbal behavior (but not performance behavior) in a group of chronic psychotics through a combination of videotape feedback and modeling. There was, however, no change in those patients who were exposed to a modeling only condition. Sarason and Ganzer (1973) demonstrated the effectiveness of a modeling procedure in producing positive changes on a number of attitude, self-concept, and behavior ratings in a group of institutionalized male juvenile delinquents. A second treatment condition involving group discussion which closely paralleled the modeling sessions as to sequence and content was equally effective in prompting more positive attitude change, behavior change, and less recidivism. Fryrear and Werner (1970), using a videotaped modeling technique, successfully treated an incapacitating fear of the dissection of live animals in a prenursing student. Employing a videotaped vicarious desensitization procedure, Mann (1969, 1972) showed a significant reduction of test anxiety in a group of counselor-referred junior high school students.

It would appear that the dearth of studies extending the principles of observational learning to clinical populations cannot be explained by the ineffectiveness of the procedures. In discussing the lack of systematic work with modeling in chronic psychiatric cases, Bandura (1969) quite succinctly states:
The relative neglect of this powerful approach probably results in large part from therapists' strong allegiances solely to operant conditioning methods or to interview procedures in which a great deal of time is devoted to analyzing patients' ineffectual behaviors (p. 158).

Fortunately, there is increasing recognition that modeling theory and practice does have profound therapeutic implications, and it is quite likely that this new therapeutic tool will soon receive much more attention from researchers regarding its clinical utility (Heller, 1971; Meichenbaum, 1973; Rachman, 1972).

Potential Relevance for Sexual Problems

Considering the demonstrated effectiveness of observational learning procedures to evoke a wide range of behaviors, it is curious why this therapeutic modality has not yet received much attention from clinicians working with sexual problems. The practicality of using modeling procedures would seem much more realistic now considering the present availability of films depicting a wide range of sexual activities and behavior. One of the first attempts to employ modeling procedures with sexual problems was reported by Wincze (1971). A 29 year old female with a frigidity problem was treated by both systematic desensitization and a vicarious extinction procedure, the latter of which involved showing the patient films of heterosexual behavior. Improvement was only noted during systematic desensitization. In speculating about the ineffectiveness of the vicarious extinction procedure, Wincze suggested that the films involving fearful stimuli might have been incompatible with the patient's anxiety level or perhaps inappropriate as they didn't include all stimuli relevant to the patient's complaint. In a subsequent study involving 21 females complaining of sexual frigidity, Wincze and Caird (1973) compared the
relative effectiveness of systematic desensitization and video desensitization to an untreated control condition. Both experimental groups received identical treatments except that in the video group, all hierarchy scenes were presented via videotapes. Both groups showed decreases in heterosexual anxiety immediately after treatment. Although the final results only minimally supported the effectiveness of desensitization (per se) as a treatment approach for sexual frigidity, the video desensitization procedure did appear to be somewhat more effective overall than the standard desensitization procedures.

More (1973b) and Renick (1973) have also employed videotapes and films in treating sexual dysfunction. However, several additional therapeutic procedures were concomitantly used with the visual materials and neither report makes any attempt to supply data, other than clinical impression, to assess the therapeutic contribution of the videotapes and films. Finally, Lehman (1974) has recently described a procedure employing slides as instructional aids for orgasmically dysfunctional women. Since initial treatment emphasis is on teaching the women to experience orgasm through self-stimulation, the slides are presented prior to the introduction of specific homework assignments with the hope of alleviating learned negative attitudes about masturbation. The alleged disinhibiting effects of the visual material are thought to facilitate movement into and through the "self-pleasuring" phase of therapy. While this approach sounds most reasonable and worthy of further investigation, no supportive empirical data have as yet been presented.

It would appear that any attempt to systematically employ and evaluate observational learning with sexual problems is immediately
confronted with two major problems. First, the use of live models to demonstrate sexual behaviors is for quite obvious reasons out of the question. Secondly, there is considerable difficulty in obtaining appropriate films that are non-pornographic (Wincze, 1971). Furthermore, of the relatively few good films that are currently available through such organizations as Behavioral Alternatives, Atascadero, California and the Glide Foundation in San Francisco, they are still apt to be judged by many observers (particularly clients) as pornographic, regardless of the environment and context in which they are presented. We might speculate, however, that if sexually explicit films were presented within a well structured and defined therapeutic setting, a client's judgement of whether or not the visual material was technically pornographic would be of little or no consequence. Of more importance would be using the therapeutic milieu to enhance, or inhibit, the impact of such materials in a direction that was consistent with the treatment goals. For example, because of precise control over presentation of the visual material, a sexually anxious and avoidant client might be afforded the opportunity to both learn and/or be desensitized in marked contrast to the predicted reactions if such a client were to see the same material at a local X-rated theater. We might further speculate on the effects of sexually explicit films on the client who complains of low levels of sexual arousal but expresses no particular anxiety or aversion to many sexual activities. Such a client, if viewing pornography in the usual theater setting, might be expected to join with her fellow patrons in the frequently seen reactions of laughing, gesturing, and verbally expressing disgust and revulsion. Any revelation of sexual arousal is quite obviously not a
socially acceptable response in this type of setting. On the other hand, our hypothetical client viewing the same material in a therapeutic setting might conceivably experience some feelings of arousal either during or following exposure to such material. This, of course, assumes that the therapist or therapeutic setting either explicitly and/or implicitly encouraged, supported, and "permitted" such sexual responsiveness if and when it occurred.

The extension of observational learning procedures to the treatment of sexual problems (i.e., orgasmic dysfunction) does seem to be a potentially powerful therapeutic strategy. The delineation of those conditions under which such procedures might be expected to be most therapeutically effective would, however, require some examination of the relevant literature concerning the effects of pornography on sexual behavior and attitudes.

**Sexual Behavior and Attitude Change Through Exposure to Pornography**

It is quite obvious that the use of modeling procedures in the treatment of most any sexual difficulty must inevitably lead the researcher into the realm of what is presently considered pornography. It is fortunate, however, that there currently exists a wide body of literature which may serve as a guide in the selection of materials suitable for the therapeutic task at hand. Of particular relevance for the present study is the potential or actual effects of exposure to, and observation of, pornography on sexual behavior and attitudes. Due to the limited scope of this study, the following discussion will mainly involve findings regarding the effects of pornography (slides and films only) on the sexual behavior and attitudes of women. Unfortunately, many of the more extensive and well designed studies
available have only used males as subjects (e.g., Ameroso, Brown, Ware, & Pilney, 1971; Davis & Braucht, 1971; Howard, Reifler & Liptzin, 1971; Schmidt, Sigusch & Meyberg, 1969). However, several recent studies have included females in their samples (e.g., Byrne & Lamberth, 1971; Kutchinsky, 1971; Mann, Sidman & Starr, 1971; Mosher, 1971).

Because of the thorough literature reviews incorporated into each of these studies, as well as the exhaustive and frequent replicative nature of the results, with a few exceptions, the following will mainly consist of summarizing the findings potentially relevant to the present investigation.

One well established finding regarding even brief exposure to pornography indicates that such material produces some degree of psychosexual stimulation in most males and females (Mann, 1971). However the extent to which pornographically induced sexual arousal relates to subsequent sexual behavior and attitudes is somewhat less clear. Mosher (1973) studied the reactions of 183 single undergraduate females (and also 194 males) to viewing two films, one involving minimal pre-coital foreplay and then intercourse, and the other showing a variety of "petting" activities including kissing, manual genital stimulation, cunnilingus, and fellatio to ejaculation. Overall results indicated that females reported increases in negative affects and little change in sexual activity 24 hours following the films. Additional analyses, controlling for level of sex-guilt and sex experience, revealed that only the low sex-guilt and/or more experienced females among women showed much of an increase in the affect, "eager for contact." Furthermore, the high sex-guilt and low experienced females tended to rate the "petting" film on the abnormal
side of a rating continuum. There were no significant sexual behavior changes between 24 hours prior to and 24 hours following exposure to either of the films. Of the minority of subjects who exhibited some changes, the only significant ones were talking more about sex and an increase in sexual fantasies. No changes were found in the frequency of masturbation, petting or coitus. The results thus supported the frequent findings (cf. Schmidt & Sigusch, 1970) that erotic films tend to lead to increased sexual activity following the films only if there is a well established behavior pattern involving these activities.

Mann, Sidman and Starr (1973) compared attitudinal and behavioral changes over a twelve-week period in 51 married couples who viewed erotic films, 17 couples who viewed non-erotic films, and 15 couples who viewed no films. While those couples in the erotic film group reported significantly more sexual activity on film viewing nights, no group exhibited significant stable changes in sexual behavior. The authors also point out that even though the erotic film group tended to engage in coitus on film viewing nights, there were still no increases in the weekly frequency of intercourse. Also, with the exception of attitudes toward the legal dissemination of visual erotica, attitudes toward various aspects of sexual behavior remained remarkably stable. It was further noted regarding the acquisition of new sexual behaviors or the regeneration of former ones, that few subjects added new behaviors to their repertoires and that subjects' performance of low frequency behaviors tended to remain at the same levels given at the start of the study. These authors thus conclude:

The pattern of results completely failed to demonstrate even an attenuated relationship between viewing the
erotic films and an appreciable increase either in low frequency sexual behaviors or in the more conventional sorts of sexual innovations (p. 125).

In a study designed to test the effect of erotic stimuli on sexual arousal, evaluative responses, and subsequent behavior, Byrne and Lamberth (1971) exposed 42 married couples to one of three conditions each containing a variety of erotic stimuli. Among several non-significant findings, there were no effects attributable to the experimental conditions on sexual behavior in the week following the experimental session. One of the more unexpected findings was that instructions to imagine the activities of various sexual themes led to much greater arousal than exposure to either pictorial or prose presentations of these same themes.

In a pilot experiment involving the effects of pornography on perception, behavior, and attitudes, Kutschinsky (1971) used 72 Danish university students, mostly married couples, as subjects. Bearing in mind the pilot nature of this project, several interesting findings were presented. Eleven percent of the female subjects either "somewhat" or "strongly" increased their masturbation activity within 24 hours after the pornography session. However, 41% of the females reported increases in coital activity during the same period. According to Kutschinsky (1971), this is apparently the only study so far to have shown a substantially higher increase in heterosexual activity over autosexual activity. Another interesting finding concerned the relationship between "interest in 'deviant' sexual practices" and coital frequency. Increases in intercourse occurred considerably more often among both subjects who indicated they would like to try many of the 17 examples of 'deviant' practices and subjects who were very
restrictive in this respect. Subjects expressing only medium interest in 'deviant' practices rarely displayed an increase in coital frequency. It should, however, be stressed that those behaviors that did increase rapidly decreased or disappeared by the second week, or sooner, following the pornography session. Of perhaps equal importance is the fact that "interest in 'deviant' sexual practices" markedly dropped within four days following the session.

A nationwide survey conducted by Abelson, Cohen, Heaton and Suder (1971), of public attitudes toward and experience with erotic materials also revealed much evidence consistent with some of the preceding data. Among a host of other findings, these investigators reported that 1) more experience with erotica was related to higher frequencies of intercourse; 2) experience with erotica was correlated with a permissive attitude toward masturbation; and 3) both men and women thought that providing information had been the effect of erotic materials on them, more than any other effects suggested as possibilities.

From the current data regarding the effects of erotic visual materials on sexual behaviors and attitudes, the following conclusions seem justified:

1. No study has convincingly shown any long-term effects of pornography on sexual behavior and attitudes.

2. With the exception of more favorable attitudes toward the legal dissemination of pornography, attitudes regarding various sexual behaviors appear to remain quite stable following exposure to erotic visual material.

3. Many males and females exposed to erotic films frequently report various degrees of short-term sexual arousal.
4. There tends to be increases in the frequency of coital activity within 24 hours after viewing pornography, however there still is no significant increase in the overall rates of intercourse.

5. Exposure to visual sexual stimuli often increases the frequency of masturbation among minorities of various subject populations; however, these increases tend to disappear within 48 hours.

6. It is relatively rare that novel sexual activities are tried, or low-frequency sexual behaviors are increased, following exposure to erotica. The most reliable behavioral effect is an increase in masturbation during the 24 hours following exposure.

7. The majority of individuals who increase masturbation following exposure tend to be individuals with already established masturbatory patterns.

8. Another predictable (yet still unreliable) behavioral effect of exposure to pornography seems to be temporary increases in sexual fantasy, dreams, and conversation about sex during the first 24 hour period following exposure.

While there are numerous other tentative conclusions one can draw from the available literature, the preceding seem to potentially have the most relevance for the present study. Of particular importance is the hypothesis that given an appropriate therapeutic setting, coupled with therapeutic instructions, the minimal or non-existent behavior and attitudinal changes currently displayed following exposure to sexually explicit films might be greatly enhanced or instigated. That there are so many consistent "minimal" effects when pornography is viewed under natural or laboratory conditions would appear to justify this hypothesis.

**Theoretical Considerations**

**Anxiety**

The theorized reciprocal roles of anxiety and sexual responsiveness (Wolpe, 1958) have been very influential in the development of
several treatment programs for sexual difficulties (e.g., Husted, 1972; Lobitz & Lo Piccolo, 1972; Masters and Johnson, 1970). However it is quite clear that the reduction or elimination of anxiety does not, in and of itself, always lead to increased sexual responsiveness. Husted (1972) has recently provided evidence in support of the notion that decreases in anxiety can lead to increases in sexual behaviors as well as more favorable sexual attitudes. She does point out, though, that her results "... strongly suggest that such anxiety reduction does not automatically lead to orgasmic release, however, even with complete anxiety reduction (p. 147)."

While there is little argument against the interfering effects of anxiety on sexual arousal, it is also clear that many long term and/or intensive treatment approaches (e.g., Annon, 1971; Hartman & Fithian, 1972) may serve to reduce sexual anxiety (whether intentional or not) merely by the client's repeated exposure to sexually related assessment, conversation, activities, etc. The failure of anxiety reduction alone to produce orgasmic responsiveness suggests that many orgasmic dysfunctional females may tend to avoid some sexual activities, not because of anxiety, but simply do to the lack of positive consequences they derive from their emotional and physical sexual efforts.

A-R-D Theory

Annon (1971) has made excellent use of Staats' (1968) A-R-D human motivational system as a conceptual scheme for the ordering of sexual problems and the development of appropriate treatment procedures. While no published material presently exists regarding the actual use of the A-R-D system with female orgasmic problems, Annon's (1971) use of the system with other sexual difficulties has important implications
for the present research. Of particular interest is the A (attitudinal or emotional function of a single stimulus) segment of the system. Annan suggests that if an individual has the necessary instrumental behaviors in his current repertoire, but had a negative attitude toward these instrumental behaviors, alteration of his attitudinal or emotional response might be sufficient to change both the discriminative and reinforcing functions of a given stimulus. Thus, a positive attitudinal response to a previously negative stimulus might change the discriminative function to elicit more 'approach' behaviors, which in turn would increase as a function of the increased reinforcing value of the stimulus. In the example used above, if the 'approach' behaviors referred to were either inadequate or absent from the individuals' behavior repertoire, alteration of the attitudinal response would, theoretically, only facilitate the subsequent acquisition of the desired instrumental behaviors. Annan (1971) goes on to state:

It would appear that attempts to teach such new behaviors through modeling and operant principles without working with the A-R-D system would be much more difficult. The therapeutic implication in such cases is clear; work to alter the A-R-D system prior to teaching new instrumental behaviors (p. 356).

If we somewhat liberally extend Annan's interpretation of A-R-D theory to outcome predictions for different therapeutic approaches to female anorgasmia, we would expect quite different results depending upon whether or not orgasm had ever occurred under any conditions. This of course would also be related to the individual's current attitudinal response to orgasmic related behaviors. Consider the female who in the past has been orgasmic but is currently unable to experience sufficiently high levels of sexual arousal to reach orgasm
and has a negative attitudinal response to certain sexual behaviors associated with orgasm. Such an individual clearly has (or had) the necessary repertoire of sexual behaviors which, at one time produced orgasm. A-R-D theory would suggest that a treatment program designed to produce more positive attitudinal and emotional responses to relevant sexual stimuli (e.g., masturbation) might be sufficient alone to produce the necessary sexual behavior, and reinforcing consequences, leading toward the desired goal.

In contrast, take the female who has never experienced orgasm by any means. Obviously such an individual would eventually have to learn certain sexual behaviors (e.g., masturbation) which would logically precede and/or accompany sexual arousal and subsequent orgasmic release. However, here Annon (1971) would likely argue that any attempt to teach new instrumental behaviors (e.g., masturbation) through modeling or operant principles would be fraught with difficulty if the individual's present A-R-D system (e.g., negative attitudinal and emotional response toward masturbation) were not altered first.

From the preceding we might conclude that there are at least three general dimensions (continua) which would be of prime importance for any treatment program of orgasmic dysfunction:

1. An individual's attitudinal and emotional response to sexual stimuli, ranging from highly positive reactions to most sexual stimuli (ATTITUDE POSITIVE) to very negative responses to most sexual stimuli (ATTITUDE NEGATIVE).

2. The number or variety of sexual behaviors actually existing within the individual's repertoire, i.e., sexual activities which an individual has at one time or another actually engaged in, regardless of consequences (REPERTOIRE LARGE through REPERTOIRE SMALL).

3. The frequency of sexual behaviors currently engaged in by the individual (FREQUENCY HIGH through FREQUENCY LOW).
While there are obviously many possible complex interactions between these three dimensions, for the sake of conceptual clarity let us just consider the arbitrary extreme points of the above dimensions. For example in a clinical setting it is common to see an orgasmic dysfunctional female who has a very negative attitude about a wide range of sexual activities. She also may have a rather limited repertoire of sexual activities, and the frequency of engaging in those existing sexual behaviors is low. However, it is not uncommon to find individuals who have fairly positive attitudinal and emotional responses, a rather extensive sexual repertoire, but a relatively low frequency of engaging in some or many sexual activities. The first example might be more characteristic of the primary dysfunctional female while the latter pattern might be seen in females who have in the past at least experienced orgasm under certain conditions. Referring again to the extreme points of the above three dimensions we would find any one of the following eight combinations or situations:

1. Attitude Positive, Repertoire Large, Frequency High
2. Attitude Positive, Repertoire Large, Frequency Low
3. Attitude Positive, Repertoire Small, Frequency High
4. Attitude Positive, Repertoire Small, Frequency Low
5. Attitude Negative, Repertoire Large, Frequency High
6. Attitude Negative, Repertoire Large, Frequency Low
7. Attitude Negative, Repertoire Small, Frequency High
8. Attitude Negative, Repertoire Small, Frequency Low

Returning to Annon's (1971) position on A-R-D theory discussed earlier, the above extreme situations might yield certain outcome predictions given the therapeutic program for each situation was held
constant. For example, a therapeutic program (e.g., observational learning) which emphasized masturbation as a desirable step toward increased arousal and/or higher frequency of orgasm would give a favorable prognosis to an individual who had both a positive attitude toward masturbation and a history of sexual experience involving self-stimulation\(^2\). We would not, however, usually expect to find such an individual requesting assistance, especially if she reported a currently high frequency of masturbatory activities\(^3\). A-R-D theory would also suggest that the prognosis for such a program would not be as good for individuals whose attitudinal and emotional responses were initially negative, and not dealt with prior to attempts at teaching new or more relevant instrumental behaviors. A-R-D theory does not exactly clarify how important the current frequency of a specific behavior is; however, it is obvious that the frequency is related to its existence in the individual's repertoire, the emotional or attitudinal response regarding the behavior, and the probability of reinforcement given its occurrence.

Figure 1 represents several predictions which A-R-D theory would appear to make regarding treatment outcome. One treatment condition (A + B) places initial emphasis on producing positive attitudinal and emotional responses to relevant target behaviors, (e.g., masturbation) as well as a wide range of other sexual activities. The second phase attempts to prompt and maintain relevant target behaviors. The other condition (B) only attempts to prompt and maintain relevant target behaviors and is exactly the same as phase two of condition one.
Treatment A + B: Initial emphasis on producing positive attitudinal and emotional responses to relevant target behaviors. Next attempts to prompt and maintain relevant target behaviors.

Treatment B: Attempts to prompt and maintain relevant target behaviors.

KEY:

+A - Attitude Positive       Hi R - Repertoire Large
-A - Attitude Negative      Lo R - Repertoire Small

Fig. 1 - Predicted outcomes over time (treatment sessions) based on initial attitude and extent of behavioral repertoire.
The slopes of each curve are totally arbitrary and for illustrative purposes only. The rationale for slightly accelerating curves under the negative attitudes portions of treatment B is based on the fact that as a person becomes more exposed (many treatment sessions) to a particular approach, his attitude toward the approach, regardless of content, would logically either become more positive (or perhaps remain the same) or the individual would terminate treatment. The rationale for such a slope is also built on the earlier contention that anxiety (negative attitudinal or emotional responses) likely decreases in any treatment situation which repeatedly exposes the client to the anxiety evoking stimuli.

It should be stressed here that the present research is only concerned with A-R-D theory in that it appears to offer a clear conceptual framework for justifying some of the subsequent experimental hypothesis. No direct effort is being made to test or validate these theoretical assumptions. Of subsequent interest, however, is the potential predictive utility of A-R-D theory in connection with the specific type of therapeutic program soon to be described.

Focus of Present Research

Current evidence appears to support the following conclusions:

1) Females are quite commonly voicing concerns over their frequent lack of sexual responsiveness and/or inability to experience orgasm,

2) Orgasmic dysfunction, and sexual difficulties in general, have been considered by many to be very resistant to therapeutic efforts,

3) With some exceptions, the more successful current treatment approaches are typically confined to a highly select patient population consisting of both motivated and economically advantaged individuals and/or are
accompanied by little empirical data regarding the efficacy of the particular approach, 4) observational learning has been shown to be highly effective in producing both behavioral and attitudinal change in a number of problem areas. However, the systematic and explicit use of observational learning, as a therapeutic modality, has been relatively rare, especially in clinical outpatient settings.

The present study was designed to test the following experimental hypotheses (discussed below): In comparison to untreated control subjects, subjects exposed to a series of videotapes (i.e., observational learning) would experience 1) an increase in certain sexual behaviors (e.g., self-stimulation) discussed and/or modeled on the videotapes, 2) more favorable attitudes toward certain sexual activities presented on the videotapes, and 3) the occurrence of, or an increased frequency of, orgasm.

The study further investigated, relative to each other and an untreated control group, two variations of the videotape treatment program: 1) one group first exposed to a series of videotapes designed to produce change in sexual attitudes, and later to a series designed to directly produce specific sexual behavior changes, and 2) the second group only exposed to the series designed to directly produce specific behavioral change. Because of the tremendously conflicting evidence regarding whether or not prior attitude change is a prerequisite for subsequent behavior change (e.g., Burhans, 1971; Dillehay, 1973; Fishbein & Ajzen, 1972; Schwartz & Tessler, 1972), no specific predictions were made concerning the relative efficacy of the two treatment conditions.
While more extensive details and justification for the treatment program developed will be presented in the Method section, a preliminary glimpse at various aspects of the program is provided here to help clarify some of the empirical questions underlying the main hypotheses given above.

Hypothesis 1: Observational learning and modeling procedures have been repeatedly shown to be powerful modification procedures across a variety of problem behaviors. It was therefore decided that such procedures, if presented in an appropriate therapeutic context, might be effective in promoting, or increasing the frequency of, certain sexual behaviors (i.e., masturbation) that were logically related to the experience of orgasm. Further support for the behavior change potential of observational learning was obtained from the pornography literature which quite consistently has demonstrated "minimal" sexual behavior changes, albeit the very temporary nature of such changes, following exposure to sexually explicit visual materials presented in non-clinical settings.

Of primary consideration was which, of the infinite number of possible sexual behaviors, would be considered most appropriate as targets for change. Following the lead of Masters and Johnson's (1966) data indicating that the most direct route to female orgasm appears to be through masturbation, as well as the demonstrated effectiveness of the therapeutic use of masturbation in treating sexual disorders (Annon, 1973; Lobitz & Lo Piccolo, 1972), it was decided to attempt to influence certain self-stimulation activities that might raise the probability of increased orgasmic responsiveness. In other words, primary emphasis was given to employing observational learning
procedures as a potential means of establishing or influencing the frequency of certain "key" sexual behaviors (e.g., manual stroking of clitoris). A secondary research question concerned what effect the treatment program might have on a wide variety of sexual behaviors that were only minimally discussed and illustrated on the videotapes.

Hypothesis 2: While it was assumed that if changes in behavior occurred as a result of exposure to the treatment program, it seemed only reasonable to assume that some changes in sexual attitudes might also occur. Although it was expected that attitude change would be generally in the same direction as behavior change, no predictions were made as to which, if either, would occur first. Primary attention was given to those "key" attitudes that directly paralleled the "key" behaviors in the preceding hypothesis. A secondary question was directed toward whether or not there would be any change in a large number of attitudes regarding sexual behaviors that were only minimally discussed and illustrated on the videotapes.

Hypothesis 3: As alluded to in the discussion of Hypothesis 1, primary consideration was given to promoting either new "key" sexual behaviors or increasing the frequency of certain masturbatory activities that were not occurring or only rarely occurring when subjects entered the program. Thus, while obviously of paramount important to the subjects, the actual occurrence or frequency of orgasm was not considered a primary index of whether or not the overall therapeutic program (i.e., observational learning) was to be judged successful. Instead, more attention was given to whether or not certain "key" behaviors, which would logically precede orgasm, (e.g., manually stroking clitoris) would be changed in frequency. The de-emphasis
on orgasm, per se, as a primary outcome measure was felt justified for
two major reasons. First, the maximum number of videotape sessions
(approximately 50 minutes each) any subjects were exposed to was six.
Also, all subjects were exposed to the tapes according to a prearranged
schedule which was independent of their rate (or lack) of progress in
the program. This relatively brief and structured exposure time,
coupled with the fact that subjects received virtually no direct, in
vivo, therapeutic advice or support during the time period in which
they were viewing the videotapes, was not necessarily expected to be
sufficient, in and of itself, to produce orgasm. Had there been a
therapist available to supplement (via prompts, reassurance, social
reinforcement) the observational learning procedure, the actual
occurrence, or absence, of orgasm would have undoubtedly occupied a
more prominent role in assessing treatment efficacy. However it was
felt that the most valid way of demonstrating any observational
learning effects required that the procedure not be confounded by the
potential facilitating effects that could be provided by ongoing in
vivo therapist contacts. A second consideration effecting the
decision to de-emphasize orgasm as a primary outcome measure involved
the apparent impossibility of defining orgasm, at least to the extent
that it would be valid and reliable for purposes of this study. In
other words, it was not considered prudent to primarily assess outcome
by the occurrence of a response that could not be precisely defined by
the investigator and would likely be defined in as many different ways
as there were subjects participating in the study.
METHOD

Subjects
Forty females were interviewed and given a battery of assessment measures. Seventeen did not meet criteria for inclusion into the program and were either subsequently treated by the author, independent of the program, or referred to another resource. Of the 23 females who participated in the program, only one person, a control subject, failed to complete the post-treatment evaluation. Fifteen subjects were assigned to one of two experimental conditions while the remaining eight (including the subject who later dropped out) were assigned to a six-week waiting-control condition. Aside from meeting certain specific behavioral criteria (see Criteria for Acceptance to Program), there were no restrictions placed on who was admitted, providing the individual was capable of completing a number of simple assessment tasks. One situation involving a blind woman fell in this category. Fifteen subjects participated with their spouses present while the other eight, who were either single, divorced, or had no available partner, went through the program alone.

All subjects who went through the initial screening interview were considered eligible to receive continued assistance whether or not they were subsequently included as research subjects. Thus any subject, who failed to reach her goals (defined by existence and/or frequency of orgasm) after exposure to the videotape series, was in a position of receiving continued therapeutic services better suited to her individual situation. It should also be noted that due to the conflicting opinion regarding the differences in treatment outcome between primary and secondary (situational) orgasmic dysfunctional females
(cf. McGovern, Stewart & Lo Piccolo, 1973; Masters & Johnson, 1970), no attempt was made to match or control for such differences as long as each subject met the specified behavioral criteria for inclusion into the program.

Subjects were obtained from two major sources: 1) referrals from professionals, including psychologists, psychiatrists, gynecologists, social workers, and clergymen, who had received a copy of a letter regarding the program (Appendix A) or had passed on a similar letter (Appendix B) to clients they felt were in need of such assistance; and 2) self-referrals in response to a short newspaper article mentioning a "Brief Course in Sex" for women with sexual problems. Of the approximately 30 phone calls received in response to this announcement, 16 were eventually interviewed and 12 met criteria for acceptance to the program. Various subject characteristics are given in Table 1 (p. 82) which will be more thoroughly discussed later.

Materials

Since few instruments designed to assess sexual behavior and attitudes have been adequately validated and standardized (Howard, Liptzin & Reifler, 1973) several of the following measures were developed specifically for the present research program. Others were adopted or modified from previous research. It should also be noted that while extensive data was also gathered from the males who participated in the study, most of this was either intended to be used in subsequent research or as additional information for therapists who might be continuing with the subjects after termination of the formal treatment/research program. Therefore, with one exception (Daily Sexual Behavior Checklist - Male) which served as a reliability check
on the comparable female form, all of the male assessment forms have been excluded from the present discussion.

**Sexual Attitude Change Scale (SACS)**

This scale was made up of 78 items (Appendix C, left hand column) concerning statements related to material presented throughout the entire videotape series. The items were typed on 3 x 5 file cards and subjects were asked to sort the cards into one of seven categories: 1) Dislike very much, 2) Dislike much, 3) Dislike some, 4) Neither like nor dislike, 5) Like some, 6) Like much, and 7) Like very much. With the exception of item Number 1, "my body," which always appeared as the first item in the deck, the cards were shuffled before each administration. Fisher (1973) has pointed out that one of the few, but powerful, predictors of a number of aspects of sexual response is a woman's evaluation of her own overall degree of sexual responsiveness. Therefore it was assumed that a self-report measure reflecting degrees of "liking" for a sexual activity might yield a reasonably reliable indication of the respondent's present feelings toward the sexual behavior described. Most of the 78 card sort items involved statements about sexual acts (n = 60) rather than objects or things (n = 18). Fishbein and Ajzen (1972) and Schwartz and Tessler (1972) have indicated that attitudes toward a specific act were definitely better predictors of intentions to perform the act than were attitudes toward the general object. The use of a card sort format to administer each scale has previously been reported by Barlow, Leitenberg and Agras (1969). The items were scored on a 1 (Dislike very much) to 7 (Like very much) basis. Thus, a minimum possible score was 78 (1 x 78) and a maximum score was 556 (7 x 78). All sums were then divided by 78,
leaving a mean range of 1 to 7. While the SACS was thought to provide an indication of the overall changes in item ratings throughout treatment, of particular interest were the ratings on those "key" items that were directly related to their behavioral counterparts on the Sexual Behavior Inventory, discussed next.

Sexual Behavior Inventory (SBI)

This scale consisted of 60 items (Appendix C, right hand column) regarding specific sexual activities discussed throughout the videotape series. As with the SACS, the items were presented in the form of a card sort and all cards were thoroughly shuffled before each administration. In contrast with some sexual behavior measures (e.g., Bentler, 1968), this SBI makes no assumptions regarding ordinal scaling. The four categories into which the SBI cards were sorted included: 1) I have never engaged in this activity, 2) I have engaged in this activity on only one or two occasions, 3) I have engaged in this activity on several occasions, and 4) This activity is part of my regular sexual pattern. After several pilot subjects had been given this scale on two or more occasions, it became apparent that the adequacy of the three "yes" categories to validly and reliably differentiate frequency left much to be desired. Therefore, all subsequent data obtained from the SBI ratings was simply treated as a yes/no (1 or 0) response and considered important only as to assessing the subject's sexual behavior repertoire (but not frequency) at a given point in time. Particularly close attention was given to those "key" behaviors initially rated as having never occurred and after the program placed in one of the three "yes" categories. For purposes of clarity the "key" SACS items and "key" SBI items have been listed
separately in Appendix D. It was also assumed that in addition to reducing possible sequence effects by shuffling the cards, the fact that the "key" items were "hidden" among so many related, yet non-key, items afforded some degree of unobtrusiveness to both measures. The instructions given to all subjects before the SACS and SBI were administered are presented in Appendices E and F, respectively.

**Daily Sexual Behavior Checklist (DSBC)**

Daily checklists for recording the occurrence and frequency of a variety of sexual responses and behaviors have been used by several investigators (e.g., Husted, 1972; Howard, Liptzin & Reifler, 1973; Mann, Sidman & Starr, 1973). The reliability between spouse's independent recording of certain sexual activities has also been found to be quite acceptable (e.g., James, 1971; Mann, Sidman & Starr, 1973). The Daily Sexual Behavior Checklist (DSBC) developed for the present study consisted of 17 items for the female form (Appendix G) and 12 items for the male form (Appendix H). The main difference between the two forms was the inclusion of five items (No. 1 to 5) on the female's reflecting various self-stimulation activities. Subjects were required to record daily the occurrence and frequency of each of the sexual behaviors. They were repeatedly instructed to not discuss the forms with their partners and were continuously reminded to put a zero (0) in the space even if the activity didn't occur. This latter instruction was intended to maximize the chance that all subjects would have fairly equal exposure to the form which would not be the case if they were to simply turn in blank sheets on days where no activity occurred. In other words, the effects that such forms may have on behavior is well documented (e.g., Mann, Sidman & Starr, 1971) so every attempt here was
made to maximize the potential reactivity of the instrument such that it was essentially equal both within and between experimental groups. The DSBC was particularly designed to determine the rate of occurrence of specific sexual activities relative to where the subject was in the treatment program. Of primary concern was the scores on the first five items of the female DSBC. The male form was mainly of interest in that it involved a partial reliability check on the female's ratings.

**General Information Form (GIF)**

This form, with only slight modification, was adopted from material used by Lo Piccolo (1972). Items No. 8 and No. 9 regarding frequency of masturbation and orgasm were of particular interest and also provided a consistency measure for similar items in the SSI. The GIF appears in Appendix I.

**Sexual Responsiveness Survey (SRS)**

Developed by Pion, Anderson and Wagner (1970), the SRS (Appendix J) was given to all female subjects to complete at home after the initial interview. Items 27, 28, 69, 71, 72, 73, and 74 were considered of major importance in so much as they further allowed for a consistency check on similar items in the aforementioned assessment measures. The additional demographic data provided by the survey was to be used in subsequent research.

**Expectancy Questionnaire (EQ)**

This questionnaire, which closely models Goldstein's (1971) "Expected Self Questionnaire," was given to all subjects at the end of the initial interview, thus allowing for comparison of initial expectations between the treatment and control groups.
Oregon Sex Inventory (OSI)

The OSI, developed by Lo Piccolo (1972), was given to all couples participating in the program. However with the exception of playing a minor role in providing further checks on data obtained from previous measures, the OSI was given in connection with research interests outside the scope of the present study.

Problem History

This form (Annon, 1972, unpublished instrument) was administered verbally during the initial interview and enabled the interviewer to obtain, in a relatively brief period of time, a good deal of descriptive and evaluative information from the subject. The information obtained, while allowing for the formulation of a functional analysis of the problem, was intended for possible future use and did not affect the group condition to which subjects were assigned. It did, however, provide some assurance to those subjects who felt the need to 'talk to the therapist about their problems' as well as assist the experimenter in selecting an alternative treatment strategy, apart from the research program, if a subject did not meet the formal selection criteria discussed later. The Problem History is given in Appendix L.

Estimate of Sexual Activity (ESA)

The items making up this form are identical (excluding grammatical changes) to those on the DSBC but were administered verbally by the interviewer. This form provided comparisons between subject's estimated frequency of sexual activities occurring two weeks before the initial interview, and the week following the interview (but before any treatment sessions) during which all subjects were completing the DSBC. The female form of the ESA is given in Appendix M.
Taxonomy of Sexual Performance (TSP)

The taxonomy, developed by Burbank, Leidermann, and Taber (1973) was given mainly to test the potential utility of the instrument. Data obtained from the TSP was considered irrelevant to the present research.

Female's Definition of "Orgasm"

The term "orgasm" is perhaps more ambiguous than any other appearing throughout the various self-report measures. It seems reasonable to assume that some subjects who initially reported little or nothing in the way of orgasmic responsiveness might subsequently change their ratings merely because of changing self-definitions resulting from information gained from some aspect of the treatment conditions. In order to determine whether or not a 'category shift' phenomenon seemed to be influencing subjects' data, independent of their actual activities, each subject was asked to give, in writing, her own definition of orgasm before, during, and after the program. The format for responding to the question is based on a modification of that recently used by Proctor, Wagner and Butler (1973) and appears in Appendix N.

Medical History and Contraceptive Questionnaire

All participating subjects were required to have a routine pelvic examination sometime during the course of the treatment program. Those subjects who chose to have the examination done through medical resources directly available to the research program were required to complete this questionnaire (Appendix O). Unless there was any indication of physical problems relating to the subject's sexual concern, data obtained from this form was not used in the present investigation.
Follow-up Questionnaire

The questions on this form (Appendix P) were administered verbally by the experimenter during the latter portion of the follow-up interview held several days after the last videotape session. The questionnaire allowed for a standardized interview format and proved to be a rich source of anecdotal data regarding many aspects of the treatment program. The questions on this form were not asked until all other data had first been collected.

Videotapes

Each of the two segments of the treatment program consisted of three cassette (duplicates were available on both reel and cartridge) black and white videotapes ranging in length from 29 to 54 minutes. The first three tapes comprised the "attitudinal" segment and will be referred to as the "A" - series (i.e., A₁, A₂, and A₃). The latter three tapes constituted the specific suggestions or "behavior" portion and have been designated the "B" - series (i.e., B₁, B₂, and B₃). While each of the six tapes was quite different as to content, there was a general format which remained constant throughout the series.

1. A male therapist, in an office setting, was observed talking to a male and female (role-players) who had allegedly sought help for a sexual problem. The couple (Lani and Jim) had "consented" to have their treatment sessions videotaped for "purposes of research."

2. Lani and Jim always remained seated with their backs to the camera so as to minimize possible difficulties subjects might experience in any attempts to identify with the physical characteristics of the couple being treated.

3. The therapist, in addition to much discussion with the couple, continuously used supportive aids such as slides, films and a blackboard. In other words, anyone viewing a videotape would see films and/or slides that the therapist was showing to Lani and Jim in his office.
4. Each videotape ended with the therapist commenting that "the time is up now" and that the couple should "... see Mr. Robinson in his office across the hall to fill out some forms he has for them."

5. All subjects viewed the videotapes either by themselves or with a partner in the privacy of a small, comfortable office.

The content of the A-series involved a great deal of sexually related information presented to the modeling couple. Since it was expected that the information might conceivably be applicable to a wide range of sexual concerns, the exact reason for Lani and Jim coming in for help was never revealed until the first tape of the B-series (i.e., B₁). No suggestions or recommendations, whatsoever, were given to the couple throughout the A-series of videotapes. The basic content and order of presentation of the material appearing on the videotapes included the following topics or issues:

**A₁: 1. Anatomy and Physiology**

A. Female—information was presented on such topics as breast size, pubic hair distribution, role of vagina, clitoris, etc. Continuous emphasis here and on remaining tapes was directed toward debunking myths such as vaginal versus clitoral orgasm, importance of breast size, etc. Another main theme throughout the entire A-series was on the broad range and variability of sexual characteristics among human beings.

B. Male—information was given about penis size, circumcision, contraception, etc. As with the female material, repeated efforts were directed toward dispelling myths such as importance of penis size, etc.

**A₂: 1. Sexual Response Cycle**

Discussion and slides were used to explain important aspects of the sexual response cycle for both males and females. Much of the information was taken from the findings of Masters and Johnson (1966).
2. Masturbation

The latter portion of this tape consisted of information concerning the role of masturbation (self-stimulation) in human sexuality. Slides were presented showing a wide variety of male and female self-stimulation practices.

A3: Sexual Activities Involving a Partner

Emphasis was given to the wide range of sexual activities that may be engaged in by couples. The therapist made every attempt to stress that many patterns of sexual activity are commonly engaged in and were appropriate providing they were mutually acceptable and did not harm either the participants or others. Further emphasis was given to the fact that no one activity is "better" than another and that any couple's sexual pattern is highly individual. This videotape concluded with a 20 minute film showing one particular couple engaging in a variety of obviously enjoyable sexual activities.

The B-series of films, while still following the same general procedural format, differed considerably in content from the preceding A-series. Virtually all of the information and discussion presented was either accompanied or followed by very specific suggestions given by the therapist to Lani. The basic content and order of material presented in the B-series was as follows:

B1: At the beginning of this tape, the therapist for the first time discussed the reasons Lani and Jim had sought his assistance. Their primary concern was presented as Lani's frequent lack of sexual arousal and failure to experience orgasm. It was not, however, clarified whether she had ever, under any conditions, been orgasmic. The purpose of this ambiguity was mainly to maximize the chances that both "primary" and "secondary" orgasmic dysfunctional subjects would feel that their difficulty was closely akin to that of the female client appearing in the videotape. Shortly after the beginning of this videotape, the therapist "reviewed" with Lani and Jim "what we know about various aspects of human sexuality." This portion of the tape essentially amounted to a 10 to 15 minute condensed version of the entire A-series. Despite the obvious issue of confounding, this was felt necessary to help orient those subjects who had not been previously exposed
to the A-series. Every attempt was made to make this tape a logical progression from videotape A3 while minimizing repetition and yet providing sufficient information such that those subjects starting at this point would not be aware that Lani and Jim had previously been seen by the therapist. The rationale for the overall treatment approach given to Lani and Jim was that by first knowing much more about herself, via self-exploration and other related activities, Lani would be in a better position of subsequently teaching this to Jim.

1. Self-stimulation

Detailed information and discussion revolved around the advantages of self-stimulation as a means of enhancing sexual responsiveness. Lani and Jim were shown a film regarding one female's approach to self-stimulation with particular emphasis on general body exploration. It was not clear from this film whether or not the female reached orgasm as a result of her activities.

2. Specific Suggestions

Lani was asked to learn about her body through self-stimulation. She was told to do this when she was relaxed and had privacy. Her goal was basically to determine what felt good or pleasurable, however the therapist stressed that sexual arousal was not the purpose of this assignment. Lani was also asked to start on a specific program of Kegel exercises which were thoroughly explained and demonstrated, via slides, during the session. The videotape concluded with the therapist showing the couple a booklet (The Yes Book of Sex: Masturbation Techniques for Women Getting in Touch; Ayres, Rubeinstein & Smith, 1972) which he wanted Lani, and Jim if he cared to, to look over before the next session. Lani and Jim were then told to see Mr. Robinson across the hall as he had some forms for them to fill out and would give them a copy of the booklet and a summary of the Kegel exercise assignment (Appendix Q).

It should be noted here that immediately following each videotape session, which was precisely timed, the experimenter (i.e., Mr. Robinson) entered the viewing room, administered the card sort task (SACS), and gave each subject a folder containing the Daily Sexual Behavior Checklists (DSBC) to take
home and return the following session. After this session, the masturbation booklet and Kegel exercise summary were also put in the folder.

B2: 1. Self-stimulation

Initial discussion centered on Lani's feelings and activities following the previous session. Lani indicated that she had some difficulty precisely identifying the Kegel muscle but was doing better now and had some degree of control in stopping urination each time she did a Kegel exercise. Lani also reported that she had taken several occasions to just generally explore her body and that she found it to be quite enjoyable and relaxing.

Following more discussion devoted to various aspects and questions about self-stimulation, a film was shown involving a female who uses several manual techniques of self-stimulation. It was apparent from this film that the female's activities lead to a good deal of pleasure and probably orgasm.

2. Specific Suggestions

The therapist's suggestions included increasing Lani's self-stimulation activities to where there was more emphasis on identifying sexually pleasurable sensations. The use of fantasy to facilitate arousal was encouraged and she was told to role-play an orgasm. The second Kegel exercise assignment (Appendix R) was also given.

B3: 1. Self-stimulation

This session started by Lani's report that she had definitely improved on the Kegel exercises, though did tend to forget to do them occasionally. Some mild feelings of warmth in the genital area occurred on a couple of occasions. She further indicated that she did attempt to role-play an orgasm but felt kind of silly and inhibited, particularly since she was vaguely concerned that someone might hear her making sounds. Lani also stated that she had definitely found certain areas of her body which were very positive to touch and that things in general seemed to be going okay.

Following discussion about the previous assignment, and answering certain questions raised about self-stimulation, Lani and Jim were shown a film involving a female engaging in a wide variety of
self-stimulation activities. These included stimulation from a shower, extended manual stimulation, body friction on a bed, and stimulation from different kinds of vibrators.

2. Specific Suggestions

Lani was given several suggestions on how to remember to do the Kegel exercises, how to become more comfortable when role-playing an orgasm, and how to get further use out of fantasy to facilitate arousal. She was asked to continue the self-stimulation exercises but now with the purpose of experiencing more sexual arousal. Attaining orgasm was never explicitly defined as a goal but she was directed to try to reach higher levels of arousal by using the suggestions mentioned before. She was also instructed to buy a vibrator and to use it regularly, with a lubricant if necessary. She was finally told that her folder would include a list of prices and locations from where vibrators could be purchased, and a summary of the current Kegel exercise assignment (Appendix S).

It should be remembered that the preceding discussion of film content is merely an overview and by no means describes all the material subjects were exposed to. The major point is that the A-series involved a wide body of sexual information (e.g., all items appearing on SACS and SBI were either briefly discussed and/or presented on slides) designed to facilitate attitude change or at least receptiveness to the material later appearing in the B-series. Absolutely no suggestions or recommendations were given to Lani during the A-series. With the exception of the material presented during the first part of videotape B₁, the B-series was almost exclusively devoted to information (e.g., slides, films), discussion, and direct specific suggestions relating to self-stimulation. The overall format of the specific suggestions roughly paralleled those described elsewhere (Lobitz & Lo Piccolo, 1972; Lo Piccolo & Lobitz, 1972).
Procedure

The study involved three groups which were exposed to one of the following conditions:

1. Experimental Group 1 (E₁)

   One week following an initial interview, subjects began viewing the A-series (A₁, A₂, and A₃, respectively) of videotapes. One tape was shown per session and with few exceptions there was not less than four nor more than six days elapsing between sessions. The time spacing was selected on the basis that less than four days between sessions markedly limited the opportunities for carrying out the suggestion. On the other hand, it was assumed that if suggestions were going to be followed, six days would provide enough time to engage in the activity. This latter assumption was also influenced by a number of studies (e.g., Kutschinsky, 1971) which suggest that if increases in sexual activity do occur following exposure to erotic material, they tend to manifest themselves within 24 hours following exposure. Furthermore, Kutschinsky also reported a serious drop in interest in certain sexual practices four days after the pornography session.

   One week following videotape A₃, subjects returned for "further assessment" and immediately following the reassessment session began viewing the B-series (B₁, B₂, and B₃, respectively). These sessions were scheduled similarly to the A-series, and approximately two weeks following B₃, subjects returned for a "follow-up interview." Most of the assessment measures given during the initial interview were re-administered at this time.

2. Experimental Group 2 (E₂)

   For the first three weeks following the initial interview, these subjects served as a waiting control group while E₁ subjects went through the A-series. When E₂ subjects came in for their first videotape session, which had been scheduled during the initial interview to temporally coincide with E₁ subjects' completion of the A-series, they were reassessed similarly to E₁ subjects. Immediately following this assessment period, they began viewing the B-series. Elapsed time between sessions was the same as for the E₁ group. Following B₃, subjects were asked to return in two weeks for a "follow-up interview."
3. Control Group (C)

Six weeks following the initial interview, which temporally approximated both E1 and E2 subjects' completion of the B-series, C subjects came back for their first "videotape session." This session actually involved reassessment and was followed with a decision by the experimenter regarding what treatment strategy would now be most appropriate. Since by the time that some control subjects entered the program there had already been some data accumulated regarding the efficacy of the two experimental conditions (i.e., E1 and E2), the experimenter had the option of having C subjects go through the A- and/or B-series of videotapes, seeing them for individual treatment, or referring them elsewhere. Two C subjects were, on the basis of a coin toss, subsequently assigned to group E2 and were treated virtually identical to subjects just coming into the program. While data from these subjects was not included in the statistical analyses, it will be mentioned in a later section.

Throughout the study the experimenter conducted all initial and follow-up interviews, and with one exception which was handled by an assistant, was present at every videotape session.

**Group Assignment**

Since it was recognized from the onset that the experimenter's continued presence from the initial interview on could possibly influence the effects of the videotape series, every attempt was made to minimize this source of confounding. Of particular importance was the necessity of keeping the experimenter "blind" during the extensive initial assessment interview as to what groups subjects would be assigned. The strategy selected was an attempt to employ a "semi-random" assignment procedure while at the same time reducing the probability of too many subjects falling in one particular group on the basis of chance alone. This possibility was particularly important because of logistical considerations (e.g., expensive videotape equipment not being used because most subjects happened to be assigned to the six-week waiting control condition).
The designation for each of the three groups (E₁, E₂, and C) was written on three slips of paper with the resulting nine slips being shuffled thoroughly. Just prior to each initial interview one of the secretarial staff associated with the experimenter, but not the research project, drew one of the slips of paper from an envelope. The drawing occurred while the experimenter was taking the subject to a nearby office where the interview was to be held. During the last few minutes of the initial interview, while subjects were completing the Expectancy Questionnaire, the experimenter called, in the presence of the subject, "his secretary" for the expressed purpose of finding out what subsequent "dates were available to begin a videotape series."

During this phone call, the secretary actually informed the experimenter what group the subject should go into on the basis of the slip of paper drawn earlier. Following this phone call the next appointments were scheduled in accordance with the conditions of the group to which subjects were assigned.

The specific ad hoc rules regarding whether or not the group assignment slips were replaced in the envelope after a drawing are as follows:

1. All slips were replaced after drawing until one group had three subjects assigned to it. Thus, until after one of the three groups had three subjects, there was a probability of .33 being assigned to any particular group.

2. When one group had three subjects, one of the slips of paper designating that group was removed from the envelope, thus reducing but not eliminating the probability that the group would be subsequently drawn. Each time afterwards that this group was drawn, the slip was not replaced. For example, Group E₁ was designated on three of nine slips of paper. As soon as three subjects were assigned to E₁, one of the slips was removed,
thereby reducing the probability of next drawing $E_1$ to .25 (i.e., 2 out of 8). Another $E_1$ slip was removed when four subjects had received an $E_1$ assignment, thus lowering the probability of the next draw to .143 (i.e., 1 out of 7). If $E_1$ was "temporarily filled" (i.e., had five subjects), no $E_1$ slips would be left in the envelope until either $E_2$ or C group had had also received five subjects. It is perhaps obvious that the probabilities for the above example would be true if and only if $E_1$ slips were drawn from the pool.

3. As soon as two groups had reached five subjects, all nine slips were replaced in the envelope and the entire procedure started again. The procedure thus allowed for a forced distribution of subjects across the three groups and kept the experimenter blind as to what condition a subject was to be assigned. He was, of course, aware of the varying probabilities any subject had of being assigned to a particular group. The procedure was violated on one occasion when unavoidable scheduling problems on the part of the subject required re-assigning the subject from Group $E_2$ to the six-week waiting control condition.

**Pretreatment Agreement**

In order to increase motivation as well as provide some guidelines as to what was expected of subjects in the "treatment/research program," all subjects who met criteria and wanted to continue were required to sign the Pretreatment Agreement appearing in Appendix T. All subjects signed this document quite willingly.

**Procedural Guidelines and Design of Study**

In an attempt to help the experimenter maintain a consistent non-therapist like role, a set of procedural guidelines was developed which were carefully followed during each contact with a subject. Although it was undoubtedly assumed by all subjects (e.g., because of such factors as the clinical office setting in which they were interviewed and the way they were referred to the program) that they were being first considered clients and only secondarily research subjects, the experimenter was able to minimize whatever influence he might have
had by following the procedural guidelines. These guidelines (Appendix U1-10) were used as a checklist and of course varied as a function of where each subject was in the program. The letters and numbers at the top of each guideline indicate for which group and exactly where in the program the particular guideline was applicable. For example, "(E₁ - A₂)" means that the guideline was only appropriate for a subject who was assigned to Group E₁, and was at the point of viewing the second videotape (i.e., A₂) in the A-series.

Figure 2 presents a diagram indicating where each group progressed relative to one another. Also indicated is the main series of events (and order of events) that occurred during any particular phase of the program. Arrows (↔) indicate those points where, a priori, between group comparisons were planned and subsequently carried out.

**Criteria for Acceptance to Program**

This section has been reserved for later inclusion so that the reader might become more familiar with the various assessment measures being employed. It was assumed that most subjects who came to participate in the program would already feel that it was applicable to them based on the information they had read in the notice "To All Prospective Applicants" (Appendix B). It was expected, however, that some subjects might still be misinformed about the nature of the program and/or might reveal during the initial interview, information that would cast doubt as to the applicability of the program for them. It was also expected that the videotape series might be an appropriate treatment strategy for some clients who shouldn't, however, be included as "research" subjects. The following criteria was therefore adopted
Estimate of Sexual Activity - 2 Weeks Prior to Initial Interview
Sexual Attitude Change Scale (SACS)
Sexual Behavior Inventory (SBI)
Expectancy Questionnaire
General Information Form (GIF)
Daily Sexual Behavior Checklists (DSBC)

Fig. 2. Diagram Representing Design of Program
as a means of deciding, from the very first interview, who should be considered as research subjects. This criteria for "formal" acceptance to the program represents an operational definition of the criteria any and all subjects had to meet before their data was included in the final analysis:

1. Attention was first directed toward certain items on the Sexual Behavior Inventory (SBI - Appendix C). If at the time of the initial interview a subject placed all of the following SBI items in the category, "I have never engaged in this activity," and other data did not contradict these ratings, she was accepted:

SBI Item Number:

22  I have stroked my genitals until I experienced an orgasm.

27  My partner has stroked my genitals until I experienced an orgasm.

34  I have engaged in mutual hand stimulation of genitals with my partner until we both experienced orgasms.

39  I have used a vibrator on my genitals until I experienced an orgasm.

44  My partner has used a vibrator on my genitals until I experienced an orgasm.

51  I have engaged in mutual vibrator stimulation of genitals with my partner until we both experienced orgasms.

56  My partner has used his mouth on my genitals until I experienced an orgasm.

63  I have engaged in mutual mouth stimulation of genitals with my partner until we both experienced orgasms.

71  I have engaged in genital intercourse with my partner until I experienced an orgasm.

73  I have engaged in genital intercourse with my partner until we both experienced orgasms.
I have engaged in anal intercourse with my partner until one or the other or both of us experienced orgasms.

2. If any of the SBI items were placed in one of the three "yes" categories, the subject had to meet certain frequency criteria appearing in other assessment measures. Thus, assuming the following SBI items were rated as having occurred sometime during the past, a subject had to respond to other assessment questions in the direction indicated below before she was included as a research subject:

If "yes" to SBI Item Number:

22 then GIF No. 8 ≤ "once per month" and/or SRS No. 73B = "no."

27 & 34 then GIF No. 10 ≤ "seldom, 25 percent of the time" and OSI page 9 ≤ "occasionally."

39 then GIF No. 8 ≤ "once per month" or SRS No. 73B = "no."

44 & 51 then frequency ≤ once per month

56 & 63 then OSI page 13 ≤ "occasionally."

71, 73, & 77 then SRS No. 28 = "yes" and OSI page 17 ≤ occasionally.

Put more concisely, all subjects accepted for the program fell within one or more of the following descriptive categories:

1. Had never experienced orgasm under any conditions.

2. Had previously, but not currently, experienced orgasm under some conditions.

3. Only infrequently (i.e., rate equal to or less than once per month) experienced orgasm by any form of sexual stimulation.

Since there was no way to predict before the beginning of the program as to how many subjects would have an available and/or willing partner to participate with them, and considering again the conflicting
evidence (e.g., Kutschinsky, 1971) regarding the effects one spouse's presence may have on the subsequent sexual activity of the other, no attempt was made to control or match for this variable. If a partner was available, he was urged to participate, however this was not a prerequisite for inclusion into the program.
RESULTS

Pretreatment Subject Characteristics

Of the extremely varied demographic characteristics that subjects presented, several were somewhat arbitrarily selected as being most potentially relevant to the outcome of the program. Table 1 gives certain pretreatment information that was initially thought important and was expected to be more or less equally distributed across the three groups. The number of subjects per group who responded to several key questions on the Sexual Responsiveness Survey (SRS) is listed in each column. The most obvious between group differences are found on SRS questions #27 and #28 which indicate that only one subject in E2 had never experienced orgasm by any manner of stimulation as opposed to three and four such subjects who were assigned to E1 and C, respectively.

Pretreatment Measures

Since group assignment was on a semi-random basis, no differences in pretreatment levels on the main assessment measures were anticipated. Matching was not considered practical considering the nine-month duration of the program as well as the relatively few number of subjects who eventually met criteria for inclusion. It should also be noted that no subjects dropped out of either group E1 or E2, and only one control subject failed to return for the follow-up interview.

A one-way analysis of variance on the Expectancy Questionnaire scores revealed no significant between-group differences in subjects' initial expectations about the program. The very similar group means for this data (\(E_1 = 37.25; \ E_2 = 37.43; \ C = 38.28\)) indicated that the
Table 1
Between and Within Group Characteristics of Subjects
and Number of Subjects Per Group Responding to
Certain Items on the Sexual Responsiveness Survey

<table>
<thead>
<tr>
<th>Responses at Time of Initial Interview</th>
<th>E1 n=8</th>
<th>E2 n=7</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21-25</td>
<td>2</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>26-30</td>
<td>4</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>30-35</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>35-40</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td><strong>Married:</strong></td>
<td>7</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td><strong>Divorced or Single:</strong></td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td><strong>Partner Participated in Program:</strong></td>
<td>6</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td><strong>Partner Unavailable or Unwilling to Participate:</strong></td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td><strong>SRS #27 &quot;Have you ever had orgasm?&quot;</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>3</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Not Sure</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>SRS #28 &quot;Have you ever had orgasm with intercourse?&quot;</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>No</td>
<td>6</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Not Sure</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>SRS #71 &quot;Have you ever masturbated?&quot;</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>4</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Not Sure</td>
<td>2</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td><strong>SRS #72 &quot;Have you ever masturbated to orgasm?&quot;</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>0</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>No</td>
<td>6</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Not Sure</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>SRS #73a &quot;Do you masturbate now?:&quot;</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>No</td>
<td>6</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Not Sure</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>SRS #73b &quot;If yes, do you have orgasm?&quot;</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes (a)</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td><strong>SRS #74 &quot;Do you often have guilt feelings regarding masturbation?&quot;</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Almost Always</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Occasionally</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Almost Never</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Never</td>
<td>0</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Not Sure</td>
<td>4</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

a. Note: Although 2 subjects indicate "yes" to "masturbating to orgasm now," their frequency was less than once per month which qualified them, along with other data, for inclusion as research subjects.
initial interview did not systematically influence any one group's treatment expectancies more than another's.

The groups did not, however, prove to be as equally matched on pretreatment sexual attitudes and sexual behavior repertoire. The pretreatment group means and standard deviations for the Sexual Attitude Change Scales (SACS - Key Items; SACS - Total Items) and the Sexual Behavior Inventories (SBI - Key Items; SBI - Total Items) are given in Table 2. Those pretreatment differences that were found to be statistically significant will be discussed more fully in the following sections in which the overall results from each of the primary dependent measures are presented.

Table 2

Pretreatment Group Means and Standard Deviations on SACS-Key Items, SACS-Total Items, SBI-Key Items, and SBI-Total Items

<table>
<thead>
<tr>
<th>Assessment Measure</th>
<th>Pretreatment</th>
<th>Group E₁ (n=8)</th>
<th>Group E₂ (n=7)</th>
<th>Group C (n=7)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>SACS (Key Items)</td>
<td>M</td>
<td>32.25</td>
<td>12.35</td>
<td>40.00</td>
</tr>
<tr>
<td>SACS (Total Items)</td>
<td>M</td>
<td>304.00</td>
<td>72.12</td>
<td>333.14</td>
</tr>
<tr>
<td>SBI (Key Items)</td>
<td>M</td>
<td>2.62</td>
<td>1.50</td>
<td>3.86</td>
</tr>
<tr>
<td>SBI (Total Items)</td>
<td>M</td>
<td>28.14</td>
<td>3.08</td>
<td>33.00</td>
</tr>
</tbody>
</table>
Between Group Comparisons on Main Dependent Measures

Table 3 presents the means, standard deviations, and analysis of variance results for each group at Initial Interview, Post-A, Pre-B series testing, and Follow-up Assessment. With the exception of the SACS-Total Items measure, all showed highly significant treatment effects \( (p<.001) \). Each of these measures will be discussed in detail in the following sections.

**Sexual Attitude Change Scale (SACS)**

SACS items were scored on a 1 to 7 basis with 7 representing the highest rating. Each rating was multiplied by the number of cards falling within that particular category and the sum of the 7 category totals constituted the score that went into all statistical analyses. A maximum score on the SACS - Key Items was 63 \((9 \times 7)\) and a minimum total was 9 \((9 \times 1\) lowest rating). For the SACS - Total Items, \((n = 78)\) maximum and minimum scores were 546 \((78 \times 7)\) and 78 \((78 \times 1)\), respectively. Following analysis of variance and subsequent tests on these data, all means were divided by the number of items in the scale, thus reducing both scales back to a common 1 to 7 dimension.

SACS - Key Items -- Since a major goal of the present study was assessing the relative effectiveness of both the A + B-series of videotapes to an untreated control condition, a number of treatment levels--by--subjects within levels analyses of variance were performed on the SACS - Key Items and other data. Analysis of variance of SACS - Key Items (Table 4) revealed no significant overall between-group effect, however highly significant within-group and interaction effects occurred. Although most of the subsequent between- and within-group comparisons had been planned, the more conservative Newman-Keuls test
Table 3

Means, Standard Deviations, and Analysis of Variance Results for Initial Interview, Post A/Pre B Series, Testing, and Follow-up Assessment

<table>
<thead>
<tr>
<th>Assessment Measure</th>
<th>Initial Interview</th>
<th>Post-A, Pre-B Series Testing</th>
<th>Follow-up Assessment</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>E₁ (n=8)</td>
<td>E₂ (n=7)</td>
<td>C (n=7)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(n=8)</td>
<td>(n=7)</td>
<td>(n=7)</td>
<td></td>
</tr>
<tr>
<td>SACS</td>
<td>M</td>
<td>32.25</td>
<td>40.00</td>
<td>36.86</td>
</tr>
<tr>
<td>(Key Items)</td>
<td>SD</td>
<td>12.35</td>
<td>8.41</td>
<td>10.14</td>
</tr>
<tr>
<td>SACS</td>
<td>M</td>
<td>304</td>
<td>333</td>
<td>342</td>
</tr>
<tr>
<td>(Total Items)</td>
<td>SD</td>
<td>72</td>
<td>33</td>
<td>91</td>
</tr>
<tr>
<td>SBI</td>
<td>M</td>
<td>2.62</td>
<td>3.86</td>
<td>3.71</td>
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<tr>
<td>(Key Items)</td>
<td>SD</td>
<td>1.50</td>
<td>1.86</td>
<td>1.38</td>
</tr>
<tr>
<td>SBI</td>
<td>M</td>
<td>28.14</td>
<td>33.00</td>
<td>31.28</td>
</tr>
<tr>
<td>(Total Items)</td>
<td>SD</td>
<td>3.08</td>
<td>8.16</td>
<td>7.70</td>
</tr>
<tr>
<td>GIF (Item #8)</td>
<td>M</td>
<td>.56</td>
<td>.28</td>
<td>.36</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>1.40</td>
<td>.39</td>
<td>.75</td>
</tr>
</tbody>
</table>

---

* p < .001

a. Group E₁ had n=7 for SACS and SBI Total Items
Table 4

Analysis of Variance of SACS (Key Items)

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>2</td>
<td>182.96</td>
<td>.52</td>
</tr>
<tr>
<td>(A)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S (A)</td>
<td>19</td>
<td>349.13</td>
<td></td>
</tr>
<tr>
<td>Within Groups</td>
<td>2</td>
<td>271.27</td>
<td>12.48 *</td>
</tr>
<tr>
<td>(B)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A x B</td>
<td>4</td>
<td>142.40</td>
<td>6.55 *</td>
</tr>
<tr>
<td>A (A) B</td>
<td>38</td>
<td>21.74</td>
<td></td>
</tr>
</tbody>
</table>

*p<.001

Table 5

Analysis of Variance of SACS (Total Items)

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>2</td>
<td>704.84</td>
<td>.05</td>
</tr>
<tr>
<td>(A)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S (A)</td>
<td>18</td>
<td>14839.58</td>
<td></td>
</tr>
<tr>
<td>Within Groups</td>
<td>2</td>
<td>1919.08</td>
<td>1.29</td>
</tr>
<tr>
<td>(B)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A x B</td>
<td>4</td>
<td>4275.03</td>
<td>2.88 *</td>
</tr>
<tr>
<td>S (A) B</td>
<td>36</td>
<td>1484.45</td>
<td></td>
</tr>
</tbody>
</table>

*p≤.03
(Kirk, 1968) was used in each situation involving comparisons among three means. Otherwise, general multiple-t procedures were employed. Table 6 indicates between-group differences at the initial interview which exceeded the critical t value (p < .05). Quite unexpectedly, Group E2 was found to score significantly higher on the SACS - Key Items than Group E1. Neither E2 and C nor E1 and C differed as to starting level. A smaller, but still significant, difference in favor of Group E2 over Group E1 was also found at the Pre-B phase of treatment. Table 7 reveals that both Groups E1 and E2 scored substantially higher than the Control Groups at follow-up testing and by this point in treatment, significant differences between Groups E1 and E2 had disappeared.

Tables 8 and 9 indicate those changes that occurred for both Groups E1 and E2 over three particular points in treatment where data was gathered. Here again we note the unexpected finding that although Group E1 key item attitude scores changed from initial interview to the end of the A series treatment stage (i.e., Pre B1) this change was statistically nonsignificant. Both experimental groups significantly increased their attitudinal ratings as a function of the B-series treatment phase. Control Group scores showed slight decreases over the six-week waiting period.

SACS - Total Items -- Analysis of variance of this scale (Table 5) indicated no main between or within group effects although a significant interaction effect was obtained. The only significant t test occurred at the follow-up interview where Group E1 scored higher than the Group C. Group E1 was also the only group to show significant change from initial interview to follow-up.
**Table 6**
Newman Keuls Test of SACS - Key Items:
Between Group Means at Initial Interview

<table>
<thead>
<tr>
<th>Differences Among Ordered Means</th>
<th>E₁</th>
<th>C</th>
<th>E₂</th>
</tr>
</thead>
<tbody>
<tr>
<td>E₁</td>
<td>----</td>
<td>4.61</td>
<td>7.75*</td>
</tr>
<tr>
<td>C</td>
<td>----</td>
<td></td>
<td>3.14</td>
</tr>
<tr>
<td>E₂</td>
<td></td>
<td></td>
<td>----</td>
</tr>
</tbody>
</table>

p < .05

**Table 7**
Newman-Keuls Test of SACS - Key Items:
Between Group Means at Follow-up Testing

<table>
<thead>
<tr>
<th>Differences Among Ordered Means</th>
<th>C</th>
<th>E₁</th>
<th>E₂</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>----</td>
<td>11.69*</td>
<td>12.14*</td>
</tr>
<tr>
<td>E₁</td>
<td>----</td>
<td></td>
<td>.45</td>
</tr>
<tr>
<td>E₂</td>
<td></td>
<td></td>
<td>----</td>
</tr>
</tbody>
</table>

p < .05
Table 8

Newman-Keuls Test of SACS - Key Items:

Within-Group Means for E₁ (A + B-series)

<table>
<thead>
<tr>
<th>Differences Among Ordered Means:</th>
<th>II</th>
<th>Pre-B₁</th>
<th>FU</th>
</tr>
</thead>
<tbody>
<tr>
<td>II</td>
<td>----</td>
<td>3.13</td>
<td>13.87*</td>
</tr>
<tr>
<td>Pre-B₁</td>
<td>----</td>
<td></td>
<td>10.74*</td>
</tr>
<tr>
<td>FU</td>
<td>----</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

p < .05

Table 9

Newman-Keuls Test of SACS - Key Items:

Within-Group Means for E₂ (B-series)

<table>
<thead>
<tr>
<th>Differences Among Ordered Means</th>
<th>Pre-B₁</th>
<th>II</th>
<th>FU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-B₁</td>
<td>----</td>
<td>2.43</td>
<td>9.00*</td>
</tr>
<tr>
<td>II</td>
<td>----</td>
<td></td>
<td>6.57*</td>
</tr>
<tr>
<td>FU</td>
<td></td>
<td></td>
<td>----</td>
</tr>
</tbody>
</table>

p < .05
Figures 3 and 4 provide a graphical representation of the various cell means for both SACS key and total items plotted over the three treatment stages. The 1 to 7 attitude scale placed on the ordinate was derived by dividing each mean by the number of items that made up the scale (i.e., SACS Key Items, n = 9; SACS Total Items, n = 78). The exact cell means resulting from reducing both the SACS Key Items and Total Items scores to a common scale are given in Tables 10 and 11, respectively. From figures 3 and 4, it is quickly apparent that Groups C and E₂ (which essentially served as a control group while Group E₁ was going through the A-series) show slight declines on both the SACS scales. Group C continues to decrease from treatment phase B₁ to follow up while Groups E₁ and E₂ show markedly accelerating and parallel increases on the SACS Key Items.

Sexual Behavior Inventory (SBI)

The SBI Key and Total Items were scored simply on the basis of whether or not the behavior had ever occurred. Thus any score on the SBI - Key Items (range 0 to 9) reflected the actual number of behaviors the subject had ever engaged in. For example, if we refer back to Table 3 (p. 87), the 2.62 mean for Group E₁ on SBI Key Items at Initial Interview can be interpreted as the absolute number (i.e., mean for Group E₁) of nine key behaviors that these subjects had ever engaged in. SBI - Total Items scores had a range of 0 to 60. It should be remembered that SBI items were assumed to reflect a subject's sexual behavior repertoire (but not frequency) at any particular point in time and scores could not logically decrease. Thus, 3.0 on SBI - Key Items at Initial Interview meant that on any future retesting, only scores
Fig. 3. SACS - Key Items. Group mean scores on SACS - Key Items as a function of three treatment stages.

Fig. 4. SACS - Total Items. Group mean scores on SACS - Total Items as a function of three treatment stages.
Table 10

a. Group Mean Scores on SACS - Key Items at Initial Interview, Pre-B₁ and Follow-up Testing

<table>
<thead>
<tr>
<th>Groups</th>
<th>Initial Interview</th>
<th>Pre-B₁</th>
<th>Follow-up Testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>E₁</td>
<td>3.58</td>
<td>3.93</td>
<td>5.12</td>
</tr>
<tr>
<td>E₂</td>
<td>4.44</td>
<td>4.17</td>
<td>5.17</td>
</tr>
<tr>
<td>C</td>
<td>4.10</td>
<td>---</td>
<td>3.82</td>
</tr>
</tbody>
</table>

a. Means were derived by dividing the SACS - Key Items group means presented in Table 3 by 9, the number of items in the scale.

Table 11

a. Group Mean Scores on SACS - Total Items at Initial Interview, Pre-B₁ and Follow-up Testing

<table>
<thead>
<tr>
<th>Groups</th>
<th>Initial Interview</th>
<th>Pre-B₁</th>
<th>Follow-up Testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>E₁</td>
<td>3.90</td>
<td>4.28</td>
<td>4.78</td>
</tr>
<tr>
<td>E₂</td>
<td>4.27</td>
<td>4.28</td>
<td>4.47</td>
</tr>
<tr>
<td>C</td>
<td>4.38</td>
<td>---</td>
<td>4.01</td>
</tr>
</tbody>
</table>

a. Means were derived by dividing the SACS - Total Items group means presented in Table 3 by 78, the number of items in the scale.
of 3.0 to 9.0 could be attained. In other words, a subject or group could not "lose" a behavior from its repertoire.

SBI - Key Items -- Analysis of variance of SBI - Key Items (Table 12) revealed highly significant \( p < .001 \) within-group and interaction effects. Comparisons of between-group means at initial interview (Table 14) and follow-up (Table 15) were quite similar with the SACS Key Items results. This time both Groups E2 and C were found to be significantly higher in initial behavioral repertoire than Group E1. However by Pre-B1, these differences had disappeared so that Group E1 appears to have entered the B-series with roughly the same behavioral repertoire as E2 subjects but with a significantly lower attitude score on the parallel key items of the SACS. By follow-up testing, all groups differed significantly from one another with Group E2 showing the highest number of new behaviors.

Tables 16 and 17 present the results of the changes that occurred within Groups E1 and E2 over the three points in treatment where SBI assessment occurred. While both Groups E1 and E2 showed significant changes in the predicted direction, it is particularly interesting to note that Group E1 also changed significantly from the initial interview to the Pre-B1 assessment phase of treatment.

SBI - Total Items -- As indicated earlier, it was logically impossible for "true" scores on the SBI scales to decrease. However this did not preclude the possibility that when sorting the cards on occasions after the initial interview that subjects might not place a card in a "no" category when it had previously been rated in one of the "yes" positions. On the SBI - Key Items, there were a number of reliability checks (e.g., Daily Sexual Behavior Checklist) for this
### Table 12

Analysis of Variance of SBI (Key Items)

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups (A)</td>
<td>2</td>
<td>5.996</td>
<td>.64</td>
</tr>
<tr>
<td>S (A)</td>
<td>19</td>
<td>9.295</td>
<td></td>
</tr>
<tr>
<td>Within Groups (B)</td>
<td>2</td>
<td>21.398</td>
<td>29.05 *</td>
</tr>
<tr>
<td>A x B</td>
<td>4</td>
<td>4.296</td>
<td>5.83 *</td>
</tr>
<tr>
<td>S (A) B</td>
<td>38</td>
<td>0.736</td>
<td></td>
</tr>
</tbody>
</table>

* p < .001

### Table 13

Analysis of Variance of SBI (Total Items)

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups (A)</td>
<td>2</td>
<td>138.21</td>
<td>0.97</td>
</tr>
<tr>
<td>S (A)</td>
<td>18</td>
<td>141.71</td>
<td></td>
</tr>
<tr>
<td>Within Groups (B)</td>
<td>2</td>
<td>379.82</td>
<td>49.23 *</td>
</tr>
<tr>
<td>A x B</td>
<td>4</td>
<td>57.40</td>
<td>7.44 *</td>
</tr>
<tr>
<td>S (A) B</td>
<td>36</td>
<td>7.72</td>
<td></td>
</tr>
</tbody>
</table>

* p < .001
Table 14

Newman-Keuls Test of SBI - Key Items:
Between-Group Means at Initial Interview

<table>
<thead>
<tr>
<th>Differences Among Ordered Means</th>
<th>E₁</th>
<th>C</th>
<th>E₂</th>
</tr>
</thead>
<tbody>
<tr>
<td>E₁</td>
<td></td>
<td>1.09*</td>
<td>1.23*</td>
</tr>
<tr>
<td>C</td>
<td></td>
<td></td>
<td>.14</td>
</tr>
<tr>
<td>E₂</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

p < .05

Table 15

Newman-Keuls Test of SBI - Key Items:
Between-Group Means at Follow-up Testing

<table>
<thead>
<tr>
<th>Differences Among Ordered Means</th>
<th>C</th>
<th>E₁</th>
<th>E₂</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td></td>
<td>1.50*</td>
<td>2.43*</td>
</tr>
<tr>
<td>E₁</td>
<td></td>
<td></td>
<td>.93*</td>
</tr>
<tr>
<td>E₂</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

p < .05
Table 16

Newman-Keuls Test of SBI - Key Items:
Within-Group Means for E1 (A + B series)

<table>
<thead>
<tr>
<th>Differences Among Ordered Means</th>
<th>II</th>
<th>Pre-B1</th>
<th>FU</th>
</tr>
</thead>
<tbody>
<tr>
<td>II</td>
<td>----</td>
<td>1.13*</td>
<td>2.87*</td>
</tr>
<tr>
<td>B1</td>
<td>-----</td>
<td>1.75*</td>
<td></td>
</tr>
<tr>
<td>FU</td>
<td>-----</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

p < .05

Table 17

Newman-Keuls Test of SBI - Key Items:
Within-Group Means for E2 (B series)

<table>
<thead>
<tr>
<th>Differences Among Ordered Means</th>
<th>II</th>
<th>Pre-B1</th>
<th>FU</th>
</tr>
</thead>
<tbody>
<tr>
<td>II</td>
<td>----</td>
<td>.29</td>
<td>2.57*</td>
</tr>
<tr>
<td>Pre-B1</td>
<td>-----</td>
<td></td>
<td>2.29*</td>
</tr>
<tr>
<td>FU</td>
<td>-----</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

p < .05
possibility which did occur on three occasions. However, for the SBI Total Items, no such systematic checks were available and it was indeed observed on numerous occasions that subjects would decide a particular behavior had never occurred after first saying that it had. While such discrepancies were eventually resolved by careful questioning during the follow-up interview, the potential influence of this questioning could seriously confound any attribution of change solely due to exposure to one of the treatment conditions. Thus, although analyses of variance on SBI - Total Items (Table 13) indicated highly significant within-group and interaction effects, no subsequent comparisons between cell means was made on this data.

Figures 5 and 6 show the group mean scores on both the SBI Key Items and Total Items plotted over the three points of assessment during the treatment program. Despite the potential problems with the SBI - Total Items scale, it is interesting to note how closely this scale parallels the results from the SBI - Key Items.

**Daily Sexual Behavior Checklist (DSBC)**

Daily behavior checklists have been employed by a number of investigators (e.g., Husted, 1972; Mann, et al., 1973) to assess possible daily changes in various sexual activities. The present study used a 17-item female DSBC and a 12-item male form. As indicated earlier, the difference in forms was in the omission of the five key self-stimulation items from the male DSBC. Otherwise, the directions and item content were essentially the same. Although there was no way of determining inter-spouse reliability on the DSBC key items, it was felt that ratings on the occurrence of self-stimulation activities could be accepted with greater confidence if there was sufficiently
Fig. 5. SBI - Key Items. Group mean scores on SBI - Key Items as a function of three treatment stages.

Fig. 6. SBI - Total Items. Group mean scores on SBI - Total Items as a function of three treatment stages.
high reliability on some of the mutual items. Over 500 DSBC's were turned in over the course of the study. It is also interesting to note that, while occasionally a subject would forget to bring in her folder to the session, all forms that were given out were eventually returned. Reliability data was based on the DSBC's completed by all subjects who participated in the program with a partner. Only DSBC's which were returned prior to the start of a videotape session were used in this analysis. Thus, the two-week estimates of sexual behavior frequency were excluded from the reliability evaluation. In order to minimize the possible spurious correlations that might occur with the inclusion of a large number of mutual claims of no activity (Mann, 1971), while still preserving the importance of such agreements, a modification of procedures described by Bijou, Peterson, Harris, Allen and Johnston (1969) was adopted. After preliminary inspection of the overall DSBC items, excluding the female DSBC key items, three activities were selected which appeared to be quite specifically defined and occurred with considerably different frequencies. Activities that seldom occurred (e.g., I stimulated my partner's genitals by vibrator) were not considered. The three activities selected, listed in order of decreasing frequency, with the female DSBC item on the top, were:

1. DSBC-F #13 "I stimulated my partner's genitals by hand."  
   DSBC-M # 8 "Partner stimulated my genitals by hand."

2. DSBC-F #12 "Stimulation through sexual (genital) intercourse"  
   DSBC-M # 7 "Stimulation through sexual (genital) intercourse"

3. DSBC-F #14 "I stimulated my partner's genitals by mouth."  
   DSBC-M # 9 "Partner stimulated my genitals by mouth."

Two of the three items involved the female being the "giver" of stimulation because these most closely matched the sentence structure of the
DSBC-key self-stimulation items. The reliabilities of the 246 pairs of DSBC's for each of the above item pairs were next calculated merely by dividing the total number of agreements by the total number of agreements plus disagreements. Agreements of no activity were included. As expected, the resulting percent agreement scores paralleled the relative frequency of each of the activities (i.e., DSBC 13 & 8 = 86%; DSBC 12 & 7 = 96%; DSBC 14 & 9 = 98%). It should also be noted here that only the occurrence and not frequency of the sexual activity was considered in the reliability check. However, since the frequency of any of the three pairs of activities only rarely was indicated as occurring more than once a day (i.e., 1 day = 1 DSBC), inclusion of agreements as to frequency would have only minimally, if at all, affected the percentage agreement scores.

The DSBC scores proved to be the most informative, and possibly reliable, dependent measure throughout the study. Unfortunately, the distribution of scores did not appear to meet the assumptions of standard statistical theory and were thus not ammenable to evaluation by some of the more common parametric, or nonparametric, evaluation procedures. The major problem involved how to calculate a score that would lend itself to any meaningful interpretation. Considering just the first 5 self-stimulation (key items) on the DSBC, it was theoretically possible for any one individual on a given day to engage in an unlimited number of the masturbatory activities. Because of the small number of subjects per group, it was quite possible that if one individual reported many events, and the remaining subjects reported none, the resulting mean score would still suggest that the group had been more "active" than actually was the case. Conversely, one subject
who consistently reported no activity over a long period of time could seriously attenuate scores of all other subjects who were fairly active. Some investigators have reported means on DSBC type measures (e.g., Husted, 1972; Mann, et al., 1973) however fail to report exactly how such means were derived. Another problem concerned the variable number of days that elapsed between videotape sessions. For example, a subject in Group E1 might have three days (and three DSBC's to fill out) between sessions A1 and A2, whereas another subject in the same group would have five days pass between the same two treatment sessions. It was finally decided that each DSBC turned in would represent one opportunity to engage in each of the five key DSBC activities. However, it was also allowed that any number of activities (i.e., frequency < 1) could be reported per opportunity.

The final method of calculating the scores consisted of first treating the number of DSBC's turned in for a certain period (e.g., tape A1 to A2) as the denominator of a fraction in which the numerator included the absolute frequency of the occurrence of any key DSBC activity. These "fractions" were next converted to decimals for each subject in the group. The resulting sum divided by the number of scores in the group constituted "mean daily frequency of any one (or all) key DSBC behaviors engaged in by a particular group at any given time during the treatment program." An alternative method of calculating DSBC scores would be to add up the number of times a particular behavior occurred and divide this number by the total number of DSBC's (i.e., opportunities) turned in. However, this method tends to more seriously inflate the results when only one subject per group may have
accounted for most of the activities reported. On the other hand, the scoring method adopted has the opposite biasing problem of possibly over-attenuating the effects when one subject consistently reports no activity during longer periods of time.

Of first concern was the total number of DSBC-Key Items (i.e., #1-5) that individuals were engaging in during particular points of time. Thus, if all five DSBC items were summed and group means derived by the method described above, we should have an index of the general mean self-stimulation activity level for each group. Table 18 represents the actual number of subjects per group and across treatment phases who actually engaged in one or more of the five DSBC-Key activities. From this data, one can quickly see how many individuals contributed scores greater than zero to the group means. It should be remembered that the data obtained during the initial interview (II) was based on the subjects' estimate of sexual activity occurring during the preceding two weeks. All subjects completed DSBC's for seven days (BL) following the initial interview. Any entry (X) that occurs beneath the symbol for one of the six videotape treatment sessions (A1 - B3) can be interpreted as a subject who engaged in one or more of the DSBC-Key activities following that particular videotape session. For example, subject #1 in Group E1 did not engage in any of the DSBC-Key activities two weeks prior to the initial interview nor during the seven day baseline period afterward. Furthermore, she did not engage in any activity until after videotape session B1. The same, or perhaps other, DSBC-Key activities also occurred following sessions B2 and B3. We can additionally see that following session B3, six subjects in Group E1
Table 18

Actual Number of Subjects Per Group Who Engaged in Some or All of the Key DSBC* Activities

<table>
<thead>
<tr>
<th>DSBC SUMS</th>
<th>Ss</th>
<th>II</th>
<th>BL</th>
<th>A₁</th>
<th>A₂</th>
<th>A₃</th>
<th>B₁</th>
<th>B₂</th>
<th>B₃</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>x</td>
<td>x</td>
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<td></td>
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<td>x</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
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<td>6</td>
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<td>x</td>
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<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>x</td>
<td>x</td>
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<td>x</td>
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<tr>
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<td>8</td>
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<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>≤</td>
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<td>3</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>6</td>
<td></td>
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<tr>
<td>E₂</td>
<td>4</td>
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<td>7</td>
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<td>x</td>
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<td>≤</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>5</td>
<td>5</td>
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<tr>
<td>C</td>
<td>1</td>
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<tr>
<td>≤</td>
<td>3</td>
<td>1</td>
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</tr>
</tbody>
</table>

*Daily Sexual Behavior Checklist
participated in one or more of the five relevant behaviors. Of course, the scores (.00) of the two subjects who reported no such activity were included in calculating the group means.

Figure 7 indicates the mean daily frequency of the sum of the DSBC-Key activities that each group engaged in as a function of each treatment stage. Scores may be interpreted as the average frequency of five self-stimulation activities that different groups engaged over the eight points in treatment where DSBC-Key items scores were tabulated. For example, Group E₁ subjects following session B₁ reported an average frequency of approximately .5 self-stimulation activities per day. This could be re-interpreted to mean that subjects in Group E₁ engaged in one or more of the five key DSBC self-stimulation activities about once every two days following exposure to session B₁ and preceding session B₂.

Although no tests of significance were performed on this data, it is readily apparent that both treatment groups E₁ and E₂ markedly increased the frequency of self-stimulation activities in comparison to the untreated control group. The higher activity level of Group E₂ over E₁ is somewhat puzzling considering that Group E₂ was at a lower level at baseline than Group E₁ was following treatment session A₃.

The DSBC-Key items were further evaluated as to the occurrence and frequency of each item that contributed to the sums given in Figure 7. Because DSBC-Key item number 5 (i.e., "Stimulated my genitals by a method not listed above") was so seldom reported, it was dropped from the list of relevant behaviors. Table 19 indicates which subjects, both between and within groups, reported the actual occurrence (irrespective of frequency) of each of the four DSBC-Key behaviors.
Fig. 7. Mean daily frequency of all Key DSBC activities engaged in as a function of each treatment stage.
Table 19

Actual Number of Subjects Per Group Who Engaged in Each of the Key DSBC (a) Activities

<table>
<thead>
<tr>
<th></th>
<th>DSBC #1</th>
<th></th>
<th>DSBC #3</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>II BL</td>
<td>A₁ A₂ A₃</td>
<td>II BL</td>
<td>A₂ A₃ B₁ B₂ B₃</td>
</tr>
<tr>
<td>S₁</td>
<td>x x x</td>
<td>x x</td>
<td>x x x x x</td>
<td>x x x x x x x x x</td>
</tr>
<tr>
<td>S₂</td>
<td>x</td>
<td>x</td>
<td>x x x x</td>
<td>x x x x x x x x x</td>
</tr>
<tr>
<td>S₃</td>
<td>x x</td>
<td>x x</td>
<td>x x</td>
<td>x x x x x x x x x</td>
</tr>
<tr>
<td>E₁</td>
<td>x</td>
<td>x</td>
<td>x x</td>
<td>x x x x</td>
</tr>
<tr>
<td>E₂</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x x x x</td>
</tr>
<tr>
<td>C</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x x x x</td>
</tr>
</tbody>
</table>

(a): Daily Sexual Behavior Checklist Key Items:
- #1 "Stimulated my breasts by hand"
- #3 "Stimulated my genitals by hand"
Table 19 (cont.)

Actual Number of Subjects Per Group Who Engaged in Each of the Key DSBC (b) Activities

<table>
<thead>
<tr>
<th></th>
<th>DSBC #2</th>
<th></th>
<th>DSBC #4</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ss</td>
<td>II</td>
<td>BL</td>
<td>A1</td>
<td>A2</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
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<tr>
<td>2</td>
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<tr>
<td>3</td>
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<td></td>
<td></td>
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<tr>
<td>E1</td>
<td>4</td>
<td></td>
<td></td>
<td>x</td>
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<tr>
<td>5</td>
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<td></td>
</tr>
<tr>
<td>6</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>x</td>
<td>x</td>
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<td></td>
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<tr>
<td>SUM</td>
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<td>0</td>
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<tr>
<td>1</td>
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<td>x</td>
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<td>2</td>
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<td>3</td>
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<tr>
<td>E2</td>
<td>4</td>
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<td></td>
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<tr>
<td>5</td>
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<tr>
<td>6</td>
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<td>x</td>
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<tr>
<td>7</td>
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<td></td>
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<tr>
<td>SUM</td>
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<td>0</td>
<td>0</td>
<td>1</td>
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<td>C</td>
<td>4</td>
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<tr>
<td>7</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>SUM</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

(b): Daily Sexual Behavior Checklist Key Items:

#2 "Stimulated my breasts by vibrator"

#4 "Stimulated my genitals by vibrator"
This table may be read exactly the same as Table 18 except that now the behaviors are presented individually as opposed to their sums. Figure 8 shows the mean daily frequency of each of the DSBC-Key activities that the three treatment groups engaged in over the eight points in treatment where DSBC scores were calculated. This figure may also be interpreted similarly as Figure 7. For example, we can see that Group E₂, following videotape session B₂, reported "stimulating genitals by hand" (DSBC #3) on an average frequency of .56 times per day or roughly a little over once every two days after this session.

Again it is obvious that both treatment groups exceeded the frequency of self-stimulation activities than that of the control subjects. However it should be cautioned here that the data from Group C subjects was based only on two-week estimates obtained at initial interview, follow-up testing, and a seven-day baseline period where DSBC's were filled out. Closer inspection of Figure 8 reveals a couple of interesting points. On DSBC items involving manual stimulation of breasts and genitals (#1 & #3), Group E₂ exceeded the frequency of Group E₁ following videotape session B₁, despite the fact that subjects in the E₁ condition came into session B₁ having engaged more in these activities. Also on DSBC items #2 and #4, involving vibrator stimulation of breasts and genitals, Group E₁ showed a lesser degree of involvement in these activities than did E₂ subjects during the B series of videotapes. This is somewhat puzzling when considering that E₁ subjects had received some information regarding the use of vibrators during the A series (to which E₂ subjects were not exposed) and two E₁ subjects had actually engaged in self-stimulation with a vibrator prior to the B series of tapes.
Note: #1: Stimulation of breasts by hand

#2: Stimulation of breasts by vibrator

#3: Stimulation of genitals by hand

#4: Stimulation of genitals by vibrator

Fig. 8. Mean frequency of each key DSBC activity engaged in per day as a function of treatment stage.
General Information Form (GIF)

Of particular importance on this questionnaire was item #8 regarding the current frequency of masturbation (see Appendix I). All subjects filled out this form during the initial and follow-up interviews. Scores were calculated by assigning each of the nine response categories a number representing the approximate equivalent days per month. The numerical values given to each response category are presented below in parenthesis:

1. (45) More than once a day
2. (31) Once a day
3. (14) 3 or 4 times a week
4. ( 8) Twice a week
5. ( 4) Once a week
6. ( 2) Once every two weeks
7. ( 1) Once a month
8. (.5) Less than once a month
9. ( 0) Not at all

Thus, if a subject indicated "not at all" during initial interview, and at follow-up indicated "once a week," her pre- and post-GIF scores would be 0 and 4, respectively. The means presented earlier in Table 5 (p. 88) can simply be interpreted as the average number of times out of a 31 day month that the subjects in each of the three groups indicated they masturbated. A 3 x 2 analysis of variance performed on pre- and post-GIF, Question #8 scores (Table 20) revealed both significant main and interaction effects. Comparison of group means at initial interview indicated no significant pre-treatment differences. However, both
Groups E₁ and E₂ showed significantly higher frequencies of masturbation per month than did control subjects when compared at follow-up testing. The difference between Group E₂ and E₁ (E₂ = 15.14; E₁ = 10.88) means at follow-up testing proved to be statistically non-significant.

Table 20

Analysis of Variance of GIF, Question #8

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups (A)</td>
<td>2</td>
<td>207.08</td>
<td>3.58 *</td>
</tr>
<tr>
<td>S (A)</td>
<td>19</td>
<td>57.82</td>
<td></td>
</tr>
<tr>
<td>Within Groups (B)</td>
<td>1</td>
<td>780.01</td>
<td>15.97**</td>
</tr>
<tr>
<td>A x B</td>
<td>2</td>
<td>207.31</td>
<td>4.24 *</td>
</tr>
<tr>
<td>S (A) B</td>
<td>19</td>
<td>48.85</td>
<td></td>
</tr>
</tbody>
</table>

* p < .05
** p < .001

Follow-up Questionnaire and Supplementary Information

As previously indicated, after all the preceding data had been collected, all subjects were asked a number of questions regarding their involvement in the treatment program. While recognizing the potential problems involved in obtaining information through open-ended interviewing techniques, it was decided that this manner of obtaining information would hopefully provide a clearer perspective in which to later discuss the more objective data given earlier.
Table 21 indicates the number of subjects within each of the treatment groups who responded to some of the specific suggestions given during the videotape series. While at first glance the group totals look quite impressive, there was considerable variability as to the frequency in which activities occurred. For example, although 14 of 15 subjects stated they followed "any of the self-stimulation suggestions given . . . ", one subject did little more than take a warm bath and briefly touch her genitals on a couple of occasions in contrast to others who followed religiously every suggestion given.

Table 21

Number of Subjects Per Group (E1 and E2) Responding to Certain Items on Follow-up Questionnaire

<table>
<thead>
<tr>
<th>Responses to Follow-up Questionnaire - Question #8: &quot;I would like to ask you some specific questions regarding certain things that may or may not have occurred during the period that you have been involved in this program&quot;</th>
<th>E1 n=8</th>
<th>E2 n=7</th>
<th>Total n=15</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Did you do any Kegel exercises?</td>
<td>8</td>
<td>7</td>
<td>15</td>
</tr>
<tr>
<td>b. Did you follow any of the self-stimulation suggestions given by Dr. Annon?</td>
<td>8</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>c. Did you attempt to role-play an orgasm?</td>
<td>5</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>d. Did you read the masturbation booklet that was in your folder?</td>
<td>8</td>
<td>7</td>
<td>15</td>
</tr>
<tr>
<td>e. Did you use a vibrator on any occasion?</td>
<td>7</td>
<td>6</td>
<td>13</td>
</tr>
</tbody>
</table>
Table 22 presents some additional information regarding the occurrence and frequency of several sexual activities and orgasm.

Table 22
Number of Subjects Per Group (E₁ and E₂) Reporting Various Sexual Activities and Responses

<table>
<thead>
<tr>
<th>Information obtained from Self-Report Measures and/or Follow-up Interview (All questions asked in the context of: &quot;As a result of the program...&quot;)</th>
<th>E₁ n=8</th>
<th>E₂ n=7</th>
<th>Total n=15</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Engaged in self-stimulation for first time.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>No</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Not Sure</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>2. Increased frequency of self-stimulation.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>8</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>3. Experienced orgasm for first time through self-stimulation.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Not Sure</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>4. Increased frequency of orgasm through self-stimulation.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>No</td>
<td>6</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>5. Experienced orgasm for first time in sexual activities with a partner.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>No</td>
<td>6</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>6. Increased frequency of orgasm in sexual activities with a partner.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>3</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
</tbody>
</table>

The treatment program appeared to be highly effective in promoting an increased frequency of orgasm, but was not sufficient, in and of itself, to help the primary orgasmic dysfunctional female achieve orgasm. A rather unexpected finding involved the number of subjects (8 out of 15) who reported an increased frequency of orgasm in sexual
activities with their partner. Two subjects from Group $E_1$ also reported experiencing orgasm for the first time during mutual sexual contact. Both of these subjects, however, had at some previous point in their lives, experienced orgasm through self-stimulation. Group $E_2$ had 5 out of 7 subjects who increased their frequency of orgasm through self-stimulation while two $E_1$ subjects reported such an increase.

**Females' Definition of "Orgasm"

Subjects' written definitions of orgasm appeared to remain quite consistent over time and were therefore not considered for more detailed analysis. One subject who entered the program at the beginning of the study initially reported that she had never experienced orgasm under any conditions. After the program, however, she decided that she had actually experienced orgasm on several occasions but hadn't realized it until she saw the videotapes. It was because of this subject's apparent "category shift" that the written definition was immediately incorporated into the assessment battery. Although two other subjects at follow-up assessment verbally indicated they were now undecided whether or not they had experienced orgasm, their written definitions of orgasm obtained on three separate occasions were virtually identical.
DISCUSSION

Summary of Major Findings

The results strongly indicate that a variety of sexual behaviors of orgasmically dysfunctional women can be acquired and/or increased in frequency by observational learning (modeling) procedures. Of particular importance was the finding that both videotape treatment conditions were highly effective in getting subjects to use various methods of self-stimulation for the purpose of enhancing sexual arousal. Of the six subjects who at the beginning of the study stated either that they had never or were not sure whether they had ever masturbated, five began using self-stimulation after exposure to the videotapes. Of the ten subjects who at the outset stated they did not currently use self-stimulation for sexual arousal, nine subsequently began engaging in masturbatory activities. Fourteen subjects, including those who had never masturbated, of fifteen subjects increased their frequency of masturbation after going through one of the two treatment conditions.

Results further suggested that the videotapes were highly effective in promoting more positive attitudes, at least as reflected by the SACS, toward self-stimulation activities. However because of the differences between treatment groups as to initial attitudes and sexual repertoire, it was not possible to accurately assess what effects, if any, attitude change had on subsequent sexual behaviors. An unexpected finding involved the highly positive effects the B-videotape series had on both treatment groups' sexual attitudes toward certain "key" self-stimulation activities. This was especially surprising considering that Group E2 had received little preparatory
information, in contrast to the exposure Group E had, before being given (vicariously through a model) specific behavioral suggestions.

Main Dependent Measures

Sexual Behavior Inventory (SBI) - Key Items

This inventory did appear to be a fairly accurate and reliable index of a subject's sexual behavior repertoire at any given point in time. The highly significant increases in the acquisition of novel sexual behaviors (i.e., various self-stimulation activities) does suggest that sexually explicit visual material presented in an appropriate therapeutic context can be used as a powerful supplementary clinical procedure. This does not appear to be the case when individuals are exposed to such materials under more typical conditions (e.g., Mann, et al., 1971). These investigators do, however, state that perhaps:

... if (their) present sample had been composed of individuals manifesting sexual problems such as extreme timidity and inhibition, the additional reassurance provided by the "therapeutic" instructions might have facilitated changes in their behavior following exposure to the films (p. 237).

The SBI was admittedly very limited in the range of self-stimulation activities considered as key behaviors. However, it was also somewhat biased against positive results in that two of the nine key items involved experiencing orgasm, which for reasons previously discussed, was not considered a primary index of successful outcome. The SBI - Total Items scale, supplemented by information obtained at the follow-up interview, indicated that with one exception, every subject in the two treatment groups actually engaged in some previously untried sexual activity(ies) in addition to those indicated on the key
items. Most commonly mentioned were new coital positions, vibrator stimulation involving a partner, and different times and locations where sexual contact occurred. Three subjects also reported attempts, albeit "unsuccessful," at anal intercourse. It is also interesting to note that the one subject, of all those who were exposed to the videotapes, who "indignantly" refused to engage in any self-stimulation activities, did experience orgasm(s) on each occasion she and her partner had intercourse during the period that they were involved in the program.

The degree to which subjects expanded their sexual behavior repertoire, however, does not in and of itself appear particularly relevant without next paying close attention to the context and frequency in which the behaviors occurred.

**Daily Sexual Behavior Checklists (DSBC)**

Although the DSBC data weighed heavily in assessing the occurrence and frequency of certain key sexual behaviors, potential problems of reliability and reactivity should be carefully considered. Lipinski and Nelson (1974) have recently discussed the unreliability of self-recording procedures, particularly when the self-recorder is unaware that reliability is being checked. In the present study, all those subjects who participated with a partner (n = 11) were very much aware that reliability is being monitored. While the instructions indicated that subjects should not discuss or compare their daily forms with their partner, they were told that discrepancies which often occur were very important in accurately assessing their particular situation. Thus, subjects were hopefully motivated to record as accurately (but independently) from their partner as possible
while at the same time being fully aware that their recordings were
continuously checked for reliability. It was also noted, that of the
subsequent discrepancies in ratings that did occur, most were when
one partner rated a behavior as occurring on one day whereas the
partner rated it as having occurred on the immediately preceding or
following day. One might therefore conclude that a large number
(still relatively small when considering the overall percent agreement
scores) of the daily report discrepancies were mainly due to recording
an event on the incorrect day as opposed to actually forgetting or
truly disagreeing that an event occurred. This is also consistent
with conclusions put forth by Mann, et al. (1971). The potential
argument still remains, however, that the reliability of the inter­
spouse recordings does not necessarily insure that female subjects
reported accurately on the self-stimulation items that were unique to
their DSBC. Considering that all subjects were quite motivated for
treatment (e.g., the control subject who failed to return for follow­
up was the only "no-show" out of 112 appointments) and appeared to be
able to quite candidly discuss many aspects of their sex life during
the initial interview, it seems unlikely that much, if any, deliberate
distortion occurred on the DSBC-Key Items. It should also be
remembered that each of the DSBC-Key activities could eventually be
cross-checked by the more unobtrusive SBI scale, which demonstrated a
sizeable increase in most subjects' sexual repertoire. On no occasion
was a subject observed to indicate the acquisition of a self-
stimulation behavior without the occurrence of the behavior previously
appearing on the DSBC. It would therefore appear that whatever disor-
tion in self-recordings there may have been, they would likely have
been in the direction of admitting to a self-stimulation activity which in reality did not occur. Yet this possibility seems to go against common sense when one considers the prevalent social norms about discussing one's own masturbatory activities. In light of many findings which indicate that subjects from both "deviant" and normal populations appear to discuss their sexual activities honestly (Kutschinsky, 1971; Mann, et al., 1971; Masters & Johnson, 1966, 1970) the DSBC data was considered to be highly valid and reliable.

Next we must face the issue of the reactivity associated with the DSBC method of obtaining data. The reactivity of self-recording has been well documented by several investigators (e.g., Kanfer, 1970; Maletzky, 1974; McFall, 1970). Amoroso and Brown (1973) have noted the obtrusive features of such recording measures when assessing sexual behavior raises the distinct possibility that "... having a subject record his past behavior would affect his future sex behavior, or at least his report of that behavior (p. 192)." The DSBC used in the present study was undoubtedly not immune to such influence. Indeed some subjects spontaneously remarked on occasion that they had never really "thought" about a particular activity until they noticed the description appearing on the checklists. (This type of comment more commonly occurred regarding the SACS - Total Items scale.) Mann, et al. (1971) have reported similar observations. Their particular study, designed to test the effects of erotic films on sexual behavior of married couples, also mentioned the puzzling finding that 40% of the females in a control group who only completed daily questionnaires reported positive change for both self and spouse regarding increased openness in sexual discussion. A later report of the same study (Mann,
Sidman & Starr, 1973) also concluded that the effects of erotic films were relatively weak when compared to the effects a daily questionnaire had on the subjects' sexual behavior.

The design of the present study did not allow for determination of the relative contributory effects the DSBC's might have had on subjects' sexual activities. The only comparable point in time where all subjects were filling out the DSBC was the seven-day baseline period following the initial interview. Referring back to Table 19 and Figure 3, one can see that little, if any, increase in the key self-stimulation activities occurred during the baseline period. The only possible hint of the questionnaire, per se, influencing subjects' post-initial interview behavior is for Group E1 on DSBC-Key item #3. Here three individuals reported an occasion of stimulating genitals by hand during the baseline period as opposed to one subject who said this activity occurred two weeks prior to the initial interview. While Group E2 appears to have had a slight increase on this activity, only one subject contributed to the positive data that was obtained. The effects of DSBC reactivity is also clouded by the fact that each group had different amounts of time in which to experience possible habituation effects regarding repeated completion of the questionnaire. Assessment of DSBC reactivity is further confounded by the possible influence of subjects' expectations when they were finally told at the end of the initial interview when their first videotape session was to be scheduled. The only source of data which suggests that the DSBC had relatively little direct influence on subjects' sexual behavior came from the open-ended interview at follow-up testing. At one point all treatment subjects were asked to describe which of the materials
presented throughout the program, if any, they found to be most helpful. Although this question elicited a wide range of responses, no subject even alluded to the positive (or negative) effects of the DSBC. While the DSBC undoubtedly increased some subjects' awareness of their sexual activities, or inactivity, Kutschinsky's (1971) concluding remarks about the reactivity issue seem most appropriate here:

... whether such a "Bewusstmachung" would tend to increase or decrease the subsequent effects (theoretical considerations may lead to both!), or whether it did not have any consequences at all, is unknown. This factor too will be among the many which will have to be varied systematically in a future study (p. 156).

Sexual Attitude Change Scale (SACS)

The SACS scale was not constructed until after the videotapes had been made. Every SACS item reflected a sexually related theme or activity that was both discussed and visually illustrated during the "attitude" (A)-series of videotapes. Of course the exposure time subjects had to each topic varied considerably. The primary research goal here was to assess whether or not subjects' attitudes toward various sexual activities, particularly the key self-stimulation behaviors, would change after exposure to the A-series of videotapes. Of more importance, however, was the later determination of whether or not such attitude change seemed to be related to subjects' willingness to engage in specific sexual activities vicariously suggested in the B-series of videotapes.

The card-sort format for administering the scale allowed for the cards to be thoroughly shuffled before each assessment period. The large number of cards (n = 78) appeared to have both advantages and disadvantages. Faced with such a number of items (which actually only took about 4 to 7 minutes to complete) most subjects made fairly quick
decisions about each item and few subjects were ever observed to "double check" the categories in which they had placed the cards. The length of the scale also appeared to provide some degree of unobtrusiveness to the SACS - Key Items which were essentially "hidden" within the total scale. The different slopes of the curves (Figure 4) between SACS - Key and Total Item means, particularly for Group E2, lends some support to this contention.

The greatest problem with this measure was its obvious vulnerability to situational factors apart from the program. It was often observed that the mood subjects seemed to be in when they arrived for a session was closely related, in one way or another, with their total scores on the SACS scale following exposure to the videotapes. A rather dramatic example of this was provided by a married female who participated in the program during a period where her husband was on a business trip in another country. The husband arrived home just before she was to come in for the follow-up assessment session. Upon arriving for the appointment, she said that she had just told her husband about her involvement in the program. His unexpected anger, and subsequent quarrel, led to him telling his wife that if she were to go to the session, she was not to return home\(^4\). This subject's mean scores on the SACS - Total Items, which had steadily increased to a high of 5.65, dropped to 2.76 following this session. It is particularly interesting to note, however, that the SACS - Key Items mean was only minimally affected by the events that had taken place. The SACS - Key Items mean score following session B3 (and before the family fight) was 6.56 with a subsequent drop to 6.11.
The reactivity issues associated with the SACS closely parallel those previously described regarding the DSBC. However, one additional issue seems worthy of mention. Most subjects completed the cards in shorter periods of time over each successive administration. Yet, there was considerable consistency for many of the SACS items, particularly those which involved sexual activities only briefly discussed throughout the videotape series (e.g., engaging in anal intercourse). That such items tended to remain relatively stable, while others seems to vary as a function of the amount of videotape time spent on the topic, does suggest that subjects were at least reading the cards and sorting them on the basis of their differential affective reactions rather than simply on the basis of some general emotional response set. It is also quite possible that this type of task might have some desensitizing effects that could be of therapeutic value. We might further speculate that sorting such cards that directly relate to activities suggested by the therapist during the B-series may enhance subjects' intentions to engage in a particular activity. For example, in a sense the subject is put in a double bind. If she rates a suggested activity toward the dislike very much dimension, she is potentially faced with "disappointing" the investigator (or therapist) as well as "disagreeing" with the emotional reactions displayed by the model. On the other hand, if she favorably endorses the suggested activity, she may be more disposed to try a given suggestion merely to maintain consistency with her ratings. After all, if she indicated a positive feeling toward sexual activities suggested by the therapist, she might be in the uncomfortable situation of later trying to explain why she "liked" something but failed to
follow through, especially when it involved a direct suggestion given by the therapist. Regardless of the plausibility of the above speculation, it is quite possible that the SACS could be a potential measure of several things other than (or in addition to) a subject's current emotional response toward specific sexual activities.

**Sexual Behavior and Attitudes**

While attempting to avoid the longstanding debate regarding the effects of attitudes on behavior (e.g., Burhans, 1971; Dillehay, 1973; Fishbein & Ajzen, 1972) some attention must be given to the attitude/behavior relationships observed in the present study. Many sex educators have for years accepted the assumption that increased knowledge and improved attitude would affect more positive sexual behaviors across a variety of situations. Increased knowledge about human reproduction and more appropriate attitudes toward sexuality would undoubtedly result in a more competent sexual partner. In attempting to verify some of these assumptions, Johnson (1972) investigated the relationships between knowledge and attitudes toward sexuality and degrees of satisfactory and dissatisfactory marital relationships. It was hypothesized that couples reporting marital satisfaction would tend to have greater knowledge of and more positive attitude toward sexuality than dissatisfied married couples. Of several major findings, Johnson found no significant relationship between sex knowledge and sex attitude and marital satisfaction. In general, sex knowledge and attitude appeared to have both positive and negative affects on marital satisfaction which led to the conclusion that it was not possible to treat these multidimensional concepts as single entities.
The present study attempted to create two treatment conditions which might later reveal whether or not initial attempts to promote positive attitude change was a necessary or helpful pre-condition for influencing change in specific sexual behaviors (e.g., self-stimulation). Unfortunately, the groups unexpectedly turned out to significantly differ regarding initial sexual attitudes and sexual behavior repertoire. Thus, only very tentative conclusions may be drawn. It is first important to note that despite initial differences in pretreatment measures, both groups significantly changed their attitudes and behaviors regarding key sexual activities. However, the lack of significant differences between the treatment groups at follow-up testing is seriously confounded by the fact that it was Group $E_1$ ($A + B$ videotape series) subjects who started at the lower level. Since group data can mask important sources of within-group variation, we might consider some of the individual subjects who went into each treatment condition. Looking at the three lowest SACS - Key Items mean for $E_1$ subjects (i.e., $\bar{X}_1 = 1.33$; $\bar{X}_2 = 2.11$; $\bar{X}_3 = 2.56$) at initial interview, none of these subjects showed any significant increases (in fact one decreased) following exposure to the $A$-series of tapes. However, all three showed marked changes following completion of the $B$-series (i.e., $\bar{X}_1 = 3.33$; $\bar{X}_2 = 4.22$; $\bar{X}_3 = 4.67$). The same three subjects also had the fewest number of key SBI behaviors in their sexual repertoire (i.e., $n = 1$ each) at the start of treatment yet did acquire new behaviors (although not as many as some other subjects) after exposure to the $B$-series. The only comparable $E_2$ subject regarding initial SACS - Key Items level ($\bar{X} = 2.44$) showed a slight
decrease in attitude ($\bar{x} = 2.33$) following exposure to the B-series although did still engage in one new sexual activity. One can thus conclude, that for at least the three extreme SACS scoring subjects in Group E₁, exposure to a wide range of sexual information designed to promote positive attitude change was certainly not demonstrated to be a necessary treatment condition. This does not preclude the possibility, however, that the desensitizing effects of the A-series treatment segment facilitated E₁ subjects' progress through the subsequent B-series.

A different conclusion may be considered if we look at three of the highest initial SACS and SBI Key Item scores for Group E₁ subjects (i.e., $\bar{x}_1 = 4.89$; $\bar{x}_2 = 4.78$; $\bar{x}_3 = 4.44$). Following the A-series, one subject decreased in attitude score, one stayed approximately the same, and one drastically increased (i.e., $\bar{x}_1 = 3.56$; $\bar{x}_2 = 4.89$; $\bar{x}_3 = 6.78$). Only the subject who increased her SACS Key Item attitude score showed any increase in behaviors (from 3 to 6). It should also be noted that this subject's attitude rating of each of the three behaviors she engaged in during the course of the A-series increased after she reported via the DSBC the occurrence of the activity. These three E₁ subjects all engaged in additional new behaviors during the B-series with two of the three subjects further increasing their attitude scores (i.e., $\bar{x}_1 = 4.56$; $\bar{x}_2 = 6.33$; $\bar{x}_3 = 6.56$). If we compare these three higher scoring E₁ subjects to their most comparable Group E₂ counterparts, there are striking similarities. The three E₂ subjects with the highest initial starting SACS and SBI Key Items scores showed the most dramatic changes in both attitude and behavior at follow-up testing.
The data obtained from closer inspection of the extreme dependent measure scores of subjects within each treatment condition very tentatively suggests that 1) there is a high correlation between subjects' initial SACS Key Item scores and sexual behavior repertoire (SBI - Key Items), 2) subjects with initial SACS Key Item scores greater than 4.44 show much faster progress when only exposed to the B-series, and 3) subjects with initial SACS scores less than 2.56 may under some conditions (not yet specified) show as much or more relative attitude and behavior change by only being exposed to the B-series.

Methodological Considerations

Videotapes

The A-series of videotapes was originally developed following the assumption that at least some subjects might first need to have more positive sexual attitudes before they would be willing to follow specific self-stimulation suggestions later presented in the B-series. However the A-series focused on a broad range of sexual phenomenon, many of which were never mentioned during the B-series, rather than just masturbatory activities. For the A-series to have demonstrated a main effect, it would at least have had to demonstrate significant change in SACS - Total Item scores between the initial interview and following tape A3. Such a change did not occur. The effects of the material presented in the A-series only appeared to manifest themselves when combined with the B-series of videotapes. Thus, only Group E1 demonstrated a significant within-and-between-group change in the SACS - Total Items at follow-up testing. This "global" sexual attitude change, however, apparently had no relationship to whether or not
subjects more frequently engaged in sexual activities suggested in the B-series. One might argue that had the A-series spent more time presenting materials regarding self-stimulation, Group E₁'s ratings on the SACS - Key Items would also have been significantly increased. If this were the case, though, it is still difficult to see what practical difference it would make. Group E₂ significantly increased the occurrence and frequency of certain sexual behaviors without any exposure to the A-series and both Groups E₁ and E₂ significantly increased their SACS - Key Item scores only after they entered the B-series.

While there was never any expectation that the two videotape series would clearly delineate the effects of sexual attitudes on novel or infrequent sexual behavior, it was anticipated, although not formally hypothesized, that subjects exposed to the A + B series would tend to do better than those only exposed to the B-series. The only source of data that provides any evidence for the supposed superiority of the A + B series was obtained from the lowest starting level E₂ subject who consistently manifested negative attitudes on the SACS - Key Items throughout the B-series. This subject also never attempted any of the self-stimulation suggestions given. This subject had never experienced orgasm under any conditions and was the only primary dysfunctional female to be assigned to Group E₂. Since the total absence of orgasm was the only variable which clearly differentiated this subject from others in Group E₂, one might speculate that this could be an important characteristic since the three primary (not including two other E₁ subjects who were "not sure") orgasmic
dysfunctional females in Group E₁ all increased their SACS and SBI - Key Item scores. However, some data obtained from two Control subjects contraindicates this notion. After going through only pre- and post-assessment periods as did all Group C subjects, these two subjects were then assigned to Group E₂ and treated as if they were formal research subjects. Although their data was not included in the final analysis, it seems particularly relevant to mention at this point. The two subjects had never experienced orgasm and one had never attempted any form of sexual self-stimulation. Both of these individuals were virtually identical on all relevant pretreatment measures. Following exposure to only the B-series, the first individual showed a sharp increase on the SACS - Key Item ratings and increased her frequency of self-stimulation from less than once per month to two or three times per week. No new behaviors, as reflected by the SBI - Key Items, were attempted. The second subject markedly increased both her attitude ratings and sexual behavior repertoire, and was the only primary orgasmically dysfunctional female of all such subjects who clearly experienced orgasm for the first time in her life following exposure to only the B-series of videotapes.

Perhaps the most important source of confounding when it comes to evaluating the relative effectiveness of the two treatment conditions stems from the approximately 15 minute portion of sexual information given at the start of videotape B₁. This information was provided simply out of the practical consideration that subjects only exposed to this condition could hardly be expected to view the patient models as real if they saw them receiving specific suggestions five minutes
after walking into the therapist's office. The data suggests that if any direct attempt at first promoting attitude change is indeed necessary, it could undoubtedly be accomplished, and probably more effectively, in a much shorter time period than was the case with the A-series.

Experimental Design

As clinical research, the present study included many of the inherent problems associated with such an investigation. The individuals who participated were, at least from their point of view and most of the professionals who referred them, first to be considered patients and only secondarily as research subjects. Both ethical considerations, and the fact that there was not a large subject pool from which to obtain clients, necessitated certain sacrifices regarding tight experimental design. The more obvious problems are presented below in what the present investigator considers to be the most to least important methodological concerns.

1. Group E₂, by first serving as a three-week control group, quite likely had a different level of expectation and motivation than did Group E₁ subjects who started seven days after the initial interview. This would be particularly important if E₁ subjects were experiencing any feelings of disillusionment during the A-series. Some evidence of this came from follow-up interviewing in which a few E₁ subjects reported that while the first three videotapes were very educational and informative, they seemed irrelevant to their individual situation. This problem might be solved by either starting Group E₂ one week after the initial interview or by simply telling all E₁ subjects prior to tape A₁ the purpose for having them see these tapes.

2. All three research groups had quite different exposure times to two of the primary dependent measures (i.e., SACS and DSBC). Other investigators have noted the difficulty in getting waiting control subjects to return daily checklists (e.g., Husted, 1972). It was therefore
decided to just give a total of seven DSBC's (i.e., Baseline period) to both E and C subjects so as to maintain a high probability that all forms would be returned. However doing this restricted subsequent between-group comparisons on DSBC reactivity to the seven-day Baseline period or to only E1 and E2 during the B-series.

3. The potential advantages of random group assignment appear to have been outweighed by the fact that the relatively small sample size for each group resulted in unexpected initial group differences. While this could have been solved by matching subjects on certain characteristics, such matching would have necessitated formal hypotheses regarding the efficacy of one treatment condition over the other.

4. Some subjects participated by themselves while others went through the program with a partner. The relatively small sample size precluded any meaningful assessment of the effects the presence of a partner might have had. Controlling for this factor was not considered practical in that several females would definitely have refused to participate without their spouses being present. On the other hand 8 of the 22 research subjects had no available partner with which to participate.

Experimental Hypotheses

Hypothesis 1

This data quite convincingly demonstrated that subjects exposed to observational learning (modeling) through videotapes both acquired novel sexual behaviors and/or significantly increased sexual activities that were occurring only rarely, if at all, at the time they entered the treatment program. Most significant increases involved certain self-stimulation activities. Many subjects also reported trying new behaviors with their partners, despite the fact that no such activities were explicitly suggested during the videotape series.

Hypothesis 2

Both treatment procedures were effective in promoting more favorable attitudes toward specific sexual activities presented on the
videotapes. The most significant changes in sexual attitudes came on items designed to measure feelings toward certain sexual activities involving self-stimulation. More positive attitudes regarding self-stimulation closely paralleled the occurrence and/or increased frequency of actually engaging in various masturbation activities.

**Hypothesis 3**

Data only partially confirmed the effectiveness of the treatment program in promoting the occurrence of orgasm. Out of six research subjects who clearly fell in the primary orgasmic dysfunctional category, only one individual (a former control group subject whose data was not included in the final statistical analysis) experienced orgasm for the first time as a result of the program. Seven females who at the initial interview said they were nowadays only rarely or never experiencing orgasm markedly increased their rates of orgasm following exposure to the videotapes. While increased rates of orgasm were primarily associated with increased frequency of self-stimulation, a few subjects reported an unexpected increase in orgasm during activities involving a partner.

Because of differences between treatment groups in initial sexual attitudes and behavioral repertoire, no clear support in favor of either of the two treatment conditions was obtained. The data from the total scale attitude inventory did suggest, however, that positive changes in a broad range of sexual attitudes does not appear to be necessarily related to whether or not subjects would engage in various self-stimulation suggestions given vicariously by the therapist model.
Increasing Treatment Program Effectiveness

Observational Learning and Modeling

It was initially felt that a first step in empirically demonstrating the potential utility of modeling procedures to effect sexual behaviors and attitudes was to devise as "pure" a situation as possible in which to present the "therapeutic package." To minimize possible later criticisms regarding confounding by the potential influence of the investigator, considerable effort was expended toward making the investigator as non-therapeutic as possible (e.g., highly structured procedural guidelines). It was also felt that if positive changes in sexual attitudes and behavior could be affected under these conditions, the program definitely could be made much more effective by some later modification. The more recent literature on observational learning and modeling procedures fortunately provides some firm guidelines for the following discussion on increasing the therapeutic value of the treatment program.

There appears to be numerous possibilities for enhancing the therapeutic effectiveness of modeling that were only minimally, if at all, incorporated into the present treatment "package." Options include clear pre-therapy instructions, incremental procedures, the use of models who resemble the observer, observing positive affective consequences accruing to the model, and observing models who provide verbalized guidance and/or reinforcement. Unfortunately, because of ethical and social considerations, most of the supplementary participant modeling procedures which have been repeatedly shown to enhance modeling effectiveness, would not be applicable to treating many sexual concerns.
Perhaps one of the most obvious ways to facilitate clients' movement through a videotape treatment program would be to give clear, pre-therapy instructions. By simply telling a client at the outset that she should try to follow all suggestions given would undoubtedly clear up any ambiguity regarding expectations. Clients might also be given brief written narratives concerning those portions of the videotapes which most frequently elicit questions, most of which in the current study remained unanswered until the follow-up interview.

In the present program careful attention was given to employing incremental steps which quite characteristically produce superior results (Bandura, 1971b). Presentation of all sexual stimuli, particularly slides, was in a manner of what was considered to be gradually increasing intensity. Specific suggestions also followed this format. The problem, however, was that the rate or time between sessions in which subjects were exposed to the material was totally independent of how the individual was doing (or feeling) in the program. The most frequent example arose regarding the Kegel exercises. The videotape model ("Lani") was given a new Kegel exercise assignment involving progressive increases in frequency during each B-videotape session. Several subjects during the follow-up interview remarked that they had at times been kind of discouraged about the Kegel exercises since Lani appeared to be doing so much better than them. In other words, the program was in some parts going "too fast" for a few subjects. Other interfering situational factors included menstrual periods, work commitments, unexpected house guests, etc.
Wincze (1971) has noted the potential difficulty that may arise when a subject is not in control of the stimulus presentation. While in the present program format subjects could not be practically given control over material presented within a particular session, they could be given total responsibility of setting their own pace in proceeding through the videotape series. Put somewhat differently, videotape sessions might be scheduled contingently upon having completed minimal instructional objectives specified in the preceding session. Of course, subjects should have access to in vivo professional advice should unexpected difficulties arise.

While many have indicated that the degree of similarity between the observer and model can facilitate observational learning effects, the research findings indicate that the effects of model similarity are relatively weak (Bandura, 1971b). Akamatsu and Thelen (1974) have suggested that observer characteristics may have the greatest effects in situations where little information is provided to the observer about appropriate or expected behavior. The videotape series, however, provided a great deal of information about appropriate sexual behavior. Nevertheless, it was assumed that because of the very "personal" nature of the present investigation, that degree of perceived similarity between subjects and Lani might indeed have facilitating or impeding effects. Since financial and practical considerations precluded the use of multiple "patient" models, the issue was mainly handled by having the models' back to the camera. This was thought realistic considering the context of the presentation. It may also have been helpful in that subjects were probably reassured of the confidentiality
of the program by seeing Lani's involvement so protected. The models that appeared on the film portions of the videotapes were quite dissimilar from subjects on the response (e.g., masturbation and orgasm) dimension. However none of these film models were especially attractive as to facial features or body build, and several subjects spontaneously remarked that they 'felt better about themselves after seeing them'. Also the subjects were exposed to multiple models (i.e., several films) which is thought to be beneficial.

Some evidence suggests that models are more effective when their actions are seen to elicit social praise and reinforcement (e.g., Bandura, 1971b). Other data also indicates that a behavior coping model, who self-verbalizes throughout, facilitates greater behavioral change and self-report affective change (Meichenbaum, 1973). Modification of the present program would likely include more frequent comments by Lani regarding her progress through various activities as well as many positive responses concerning her affective reactions to the activities.

Walters, Bowen and Parke (1964) have provided some evidence that subjects who observed a model looking at sexual stimuli tended to reproduce the model's looking behavior when later given the chance to view comparable stimuli. Extending this data to the videotape series, we might consider periodically having Lani draw attention to some of the more potentially threatening sexual stimuli. Making comments or asking questions (e.g., female lubrication during arousal) might reduce the frequency of possible avoidant responses that some observers might have to looking at anxiety provoking sexual stimuli. Where appropriate, the
use of various response induction aids (e.g., Bandura, Jeffery & Wright, 1974) might also be incorporated.

The literature on pornography also has many implications for increasing the effectiveness of the present treatment approach. Numerous studies (e.g., Mann, 1971) have shown that exposure to visual erotic stimuli frequently produces short-term sexual arousal, increased marital activity on film-viewing nights, and in some cases increased masturbation and petting. Davis and Braucht (1971) have also indicated that when masturbation, petting, or coitus occurs following exposure to pornography, these behaviors are strongly associated with increases in the number of orgasms. Therefore it seems only reasonable that if such materials were presented within a well-defined therapeutic context, the effects could be both enhanced and channeled in a direction consistent with a client's goals. Bryan and Schwartz (1973) have called attention to the utility of using films to bring comfort to vast numbers of emotionally disturbed individuals. Mann, et al. (1971) have more specifically called for further exploration of the use of erotic films for married couples manifesting sexual problems. The current research has hopefully been a step in this direction. The practicality of modifying and extending the treatment program to many other areas of sexual dysfunction appears only too obvious.

It should be remembered that the present program was never considered to be necessarily sufficient in and of itself to enable all subjects to reach their individual goals. The treatment approach did, however, prove to be a major first step for most subjects in establishing a foundation and later momentum for attaining their various goals concerning increased sexual responsiveness. The
investigator (i.e., therapist) personally continued treatment with several individuals following their participation in the program. (Others were referred to professionals affiliated with the research.) In all but one case treatment involved relatively few sessions and usually consisted of giving more specific suggestions logically following those that had appeared in the videotapes. Furthermore, in each case except one every female either eventually reported the occurrence of orgasm or markedly increased the frequency and conditions in which orgasm was experienced. The obvious financial and therapeutic benefits most subjects received by being first exposed to this supplementary therapeutic approach certainly warrants further research attention.

Theoretical and Research Implications

A previous section devoted considerable attention to the potential applicability of A-R-D theory, particularly as interpreted and applied by Annon (1971), as a guide for the appropriate assessment and treatment of sexual problems. Of primary importance was the theoretical issue concerning immediate attempts to promote operant behavior without first considering the individual's attitudinal and emotional responses to stimuli associated with the desired behavior. Theoretically, A-R-D theory would appear to suggest that attempts to directly influence sexual behavior (i.e., masturbation) when a person has a highly negative attitudinal reaction to such activity would be largely unsuccessful. Unfortunately, because of pretreatment group differences in initial sexual attitudes, conclusions regarding the applicability of the A-R-D theory position to the present patient population must remain highly tentative. The results do suggest that sexual attitudes cannot
be considered a global entity or easily generalized to varied sexual phenomena. Significant overall increases of \( E_1 \) subjects' total sexual attitudes had no observable effect on the acquisition or increased frequency of certain self-stimulation behaviors. While one may quite legitimately argue that the A-series of films was not specifically addressed to topics involving masturbation, the fact still remains that Group \( E_2 \) significantly increased both their masturbatory attitudes and behavior without any exposure to the A-series. Also, the minimal effects of the A-series at increasing \( E_1 \) subjects' attitudes toward masturbation somewhat highlights the apparent effects of the B-series to influence both specific sexual attitudes and behaviors. In other words, while \( E_1 \) subjects entered the B-series with still significantly lower attitudes toward certain masturbatory activities than did \( E_2 \) subjects, both groups at follow-up showed significant positive changes in key sexual attitudes and they did not significantly differ from one another. Thus, it is hard to see what practical difference improvements in the A-series would make. In fact, one might speculate that a B-series format could appropriately be used for all subjects, and that special alternatives could be devised to assist those hopefully few individuals that failed to respond. It would also appear that any direct attempts to influence sexual attitudes should place more emphasis on changing the subject's perceptions of the consequences of performing particular behavioral acts; this would be in contrast to the common practice of trying to devise persuasive messages whose purpose is to change attitudes toward the attitude object (Burhans, 1971).

The clinical nature of the present study precluded (and was not primarily concerned with) specific findings that would generate support
for one or the other of many theoretical positions. That must be left
for more highly controlled experimentation. In their concluding
comments Amoroso and Brown (1973) quite realistically state:

Although we cannot condone sloppy research in any area, we
nevertheless believe that, particularly in sex research,
the emphasis at present must be on what is investigated
rather than how it is investigated. . . . For the present
we may well have to sacrifice tight controls and elaborate
instrumentation in favor of more unconfined, more realistic,
more natural situations. If not, we may get carried away
with overcontrol and inappropriate instrumentation, and so
destroy what we are trying to measure (p. 194).
Dear Colleague:

For the past year the Sexual Counseling Services of the Family Planning Program at Kapiolani Hospital has been engaged in ongoing research into various therapeutic approaches to the treatment of a wide range of sexual problems.

One result of this research is the development of a therapeutic program designed to help women who report difficulty in experiencing orgasm and/or a satisfactory level of sexual arousal. The program involves a time commitment of anywhere from three to six sessions of an hour-and-a-half each. The number of sessions will vary depending upon individual medical and behavioral evaluation. While it would be desirable for the woman to participate jointly in the program with her spouse or partner, this is not a necessary condition for acceptance. A small basic fee of $10.00 will be charged for each hour-and-a-half session. Part of the fees may be covered by various insurance plans, depending upon the individual plan.

The program formally started July 15, 1973 but because of staff and time limitations we earlier indicated that the number of referrals would be limited. We are now, however, in a position to accept additional individuals into the program, and we welcome any referrals you might want to make. If you would like further information or would like to make a referral, please call 941-5881 and ask for our Clinical Research Associate, Craig Robinson. We will be glad to answer your questions or set up an appointment for your referral.

Enclosed are several copies of a letter which may either be posted or given directly to any interested individuals.

Sincerely,

Jack S. Annon, Ph.D.
Director, Clinical Training and Research
Sexual Counseling Services

Ronald J. Pion, M.D.
Director, Family Planning Program

Ralph W. Hale, M.D.
Chairman, Department of Obstetrics & Gynecology
University of Hawaii School of Medicine
APPENDIX B

To All Prospective Applicants:

During the past year, the Sexual Counseling Services of the Family Planning Program at Kapiolani Hospital has been engaged in ongoing research into various therapeutic approaches to the treatment of a wide range of sexual problems.

One result of this research is the development of a therapeutic program designed to help women who report difficulty in experiencing orgasm and/or a satisfactory level of sexual arousal. The program involves a time commitment of anywhere from three to six sessions of an hour-and-a-half each. The number of sessions will vary depending upon individual medical and behavioral evaluation. A small basic fee of $10.00 will be charged for each hour-and-a-half session. Part of the fee may be covered by various insurance plans, depending upon the individual plan.

If you are interested in participating in this program, please call 941-5881 and tell the secretary that you would like more information regarding the sexual treatment program. The secretary will take your name and phone number and you will be later contacted by our Clinical Research Associate, Craig Robinson, who will provide you with more details regarding what the program involves.

Those persons wishing to participate will be asked to come in for an initial interview, at which time assessment will be made regarding the suitability of the program for each prospective participant. (There will be no charge for this particular session.) While it would be desirable for the woman to participate jointly in the program with her spouse or partner, this is not a necessary condition for acceptance. Persons accepted will be asked to fill out various evaluation forms and will be given appointment times for future sessions.

Depending on the number of people participating and possible scheduling difficulties, the date of the first session following the initial interview may vary anywhere from one to five weeks. Every attempt will be made to schedule appointments at the participant's convenience.

Jack S. Annon, Ph.D.
Director, Clinical Training and Research
Sexual Counseling Services

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### APPENDIX C

<table>
<thead>
<tr>
<th>SEXUAL ATTITUDE CHANGE SCALE (SACS)</th>
<th>SEXUAL BEHAVIOR INVENTORY (SBI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FEMALE ITEMS</strong></td>
<td></td>
</tr>
<tr>
<td>1. My body</td>
<td>1.</td>
</tr>
<tr>
<td>5. My pubic hair</td>
<td>5.</td>
</tr>
<tr>
<td>8. The small lips of my genitals</td>
<td>8.</td>
</tr>
<tr>
<td>11. My vaginal lubrication</td>
<td>11.</td>
</tr>
<tr>
<td>12. My partner's body</td>
<td>12.</td>
</tr>
<tr>
<td>15. My partner's penis</td>
<td>15.</td>
</tr>
<tr>
<td>17. My partner's anus</td>
<td>17.</td>
</tr>
<tr>
<td>18. Stroking my breasts</td>
<td>18. I have stroked my breasts.</td>
</tr>
<tr>
<td>20. Stroking my anus</td>
<td>20. I have stroked my anus.</td>
</tr>
<tr>
<td>21. Inserting one or more fingers</td>
<td>21. I have inserted one or more</td>
</tr>
<tr>
<td>inside my vagina</td>
<td>fingers inside my vagina.</td>
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<td></td>
<td>(SACS)</td>
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</tr>
<tr>
<td>22.</td>
<td>Stroking my genitals until I experience an orgasm</td>
</tr>
<tr>
<td>23.</td>
<td>My partner stroking my breasts</td>
</tr>
<tr>
<td>24.</td>
<td>My partner stroking my clitoris</td>
</tr>
<tr>
<td>25.</td>
<td>My partner stroking my anus</td>
</tr>
<tr>
<td>26.</td>
<td>My partner inserting one or more fingers inside my vagina</td>
</tr>
<tr>
<td>27.</td>
<td>My partner stroking my genitals until I experience orgasm</td>
</tr>
<tr>
<td>28.</td>
<td>Stroking my partner's breasts</td>
</tr>
<tr>
<td>29.</td>
<td>Stroking my partner's penis.</td>
</tr>
<tr>
<td>30.</td>
<td>Stroking my partner's testicles.</td>
</tr>
<tr>
<td>31.</td>
<td>Stroking my partner's anus</td>
</tr>
<tr>
<td>32.</td>
<td>Stroking my partner's genitals until he experiences orgasm</td>
</tr>
<tr>
<td>33.</td>
<td>Engaging in mutual hand stimulation of genitals with my partner.</td>
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<tr>
<td>34.</td>
<td>Engaging in mutual hand stimulation of genitals with my partner until we both experience orgasms.</td>
</tr>
<tr>
<td>35.</td>
<td>Using a vibrator on my breasts</td>
</tr>
<tr>
<td>36.</td>
<td>Using a vibrator on my clitoris</td>
</tr>
<tr>
<td>SACS</td>
<td>FEMALE (Cont.)</td>
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<tr>
<td>------</td>
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</tr>
<tr>
<td>37. Using a vibrator on my anus</td>
<td>37. I have used a vibrator on my anus.</td>
</tr>
<tr>
<td>38. Inserting a vibrator inside my vagina</td>
<td>38. I have inserted a vibrator inside my vagina.</td>
</tr>
<tr>
<td>39. Using a vibrator on my genitals until I experience an orgasm</td>
<td>39. I have used a vibrator on my genitals until I experienced an orgasm.</td>
</tr>
<tr>
<td>40. My partner using a vibrator on my breasts</td>
<td>40. My partner has used a vibrator on my breasts.</td>
</tr>
<tr>
<td>41. My partner using a vibrator on my clitoris</td>
<td>41. My partner has used a vibrator on my clitoris.</td>
</tr>
<tr>
<td>42. My partner using a vibrator on my anus</td>
<td>42. My partner has used a vibrator on my anus.</td>
</tr>
<tr>
<td>43. My partner inserting a vibrator inside my vagina</td>
<td>43. My partner has used a vibrator inside my vagina.</td>
</tr>
<tr>
<td>44. My partner using a vibrator on my genitals until I experience an orgasm</td>
<td>44. My partner has used a vibrator on my genitals until I experienced an orgasm.</td>
</tr>
<tr>
<td>45. Using a vibrator on my partner's breasts</td>
<td>45. I have used a vibrator on my partner's breasts.</td>
</tr>
<tr>
<td>46. Using a vibrator on my partner's penis</td>
<td>46. I have used a vibrator on my partner's penis.</td>
</tr>
<tr>
<td>47. Using a vibrator on my partner's testicles</td>
<td>47. I have used a vibrator on my partner's testicles.</td>
</tr>
<tr>
<td>48. Using a vibrator on my partner's anus</td>
<td>48. I have used a vibrator on my partner's anus.</td>
</tr>
<tr>
<td>49. Using a vibrator on my partner's genitals until he experiences an orgasm</td>
<td>49. I have used a vibrator on my partner's genitals until he experienced an orgasm.</td>
</tr>
<tr>
<td>50. Engaging in mutual vibrator stimulation of genitals with my partner</td>
<td>50. I have engaged in mutual vibrator stimulation of genitals with my partner.</td>
</tr>
<tr>
<td>51. Engaging in mutual vibrator stimulation of genitals with my partner until we both experience orgasms</td>
<td>51. I have engaged in mutual vibrator stimulation of genitals with my partner until we both experienced orgasms.</td>
</tr>
<tr>
<td></td>
<td>(SACS)</td>
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<tr>
<td>---</td>
<td>--------</td>
</tr>
<tr>
<td>52.</td>
<td>My partner using his mouth on my breasts</td>
</tr>
<tr>
<td>53.</td>
<td>My partner using his mouth on my clitoris</td>
</tr>
<tr>
<td>54.</td>
<td>My partner using his mouth on my anus</td>
</tr>
<tr>
<td>55.</td>
<td>My partner inserting his tongue in my vagina</td>
</tr>
<tr>
<td>56.</td>
<td>My partner using his mouth on my genitals until I experience an orgasm</td>
</tr>
<tr>
<td>57.</td>
<td>Using my mouth on my partner's breasts</td>
</tr>
<tr>
<td>58.</td>
<td>Using my mouth on my partner's penis</td>
</tr>
<tr>
<td>59.</td>
<td>Using my mouth on my partner's testicles</td>
</tr>
<tr>
<td>60.</td>
<td>Using my mouth on my partner's anus</td>
</tr>
<tr>
<td>61.</td>
<td>Using my mouth on my partner's genitals until he experiences an orgasm</td>
</tr>
<tr>
<td>62.</td>
<td>Engaging in mutual mouth stimulation of genitals with my partner</td>
</tr>
<tr>
<td>63.</td>
<td>Engaging in mutual mouth stimulation of genitals with my partner until we both experience orgasms</td>
</tr>
<tr>
<td>64.</td>
<td>Kissing my partner</td>
</tr>
<tr>
<td>65.</td>
<td>Engaging in tongue kissing with my partner</td>
</tr>
<tr>
<td>66.</td>
<td>My partner rubbing his penis over various parts of my body</td>
</tr>
</tbody>
</table>
67. Rubbing my breasts over various parts of my partner's body

68. Engaging in genital intercourse with my partner on top

69. Engaging in genital intercourse with me on top of my partner

70. Engaging in genital intercourse with my partner using rear entry to my vagina

71. Engaging in genital intercourse with my partner until I experience an orgasm

72. Engaging in genital intercourse until my partner experiences orgasm

73. Engaging in genital intercourse with my partner until we both experienced orgasms

74. My partner's semen

75. My partner coming on my body

76. Engaging in anal intercourse with my partner

77. Engaging in anal intercourse with my partner until one or the other or both of us experience an orgasm

78. Exercising the muscles of my vagina by repeated tightening and relaxing
<table>
<thead>
<tr>
<th>SACS (Key Items)</th>
<th>SBI (Key Items)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. Stroking my breasts</td>
<td>18. I have stroked my breasts.</td>
</tr>
<tr>
<td>21. Inserting one or more fingers inside my vagina</td>
<td>21. I have inserted one or more fingers inside my vagina.</td>
</tr>
<tr>
<td>22. Stroking my genitals until I experience an orgasm</td>
<td>22. I have stroked my genitals until I experienced an orgasm.</td>
</tr>
<tr>
<td>35. Using a vibrator on my breasts</td>
<td>35. I have used a vibrator on my breasts.</td>
</tr>
<tr>
<td>36. Using a vibrator on my clitoris</td>
<td>36. I have used a vibrator on my clitoris.</td>
</tr>
<tr>
<td>38. Inserting a vibrator inside my vagina</td>
<td>38. I have inserted a vibrator inside my vagina.</td>
</tr>
<tr>
<td>39. Using a vibrator on my genitals until I experience an orgasm</td>
<td>39. I have used a vibrator on my genitals until I experienced an orgasm.</td>
</tr>
<tr>
<td>78. Exercising the muscles of my vagina by repeated tightening and relaxing</td>
<td>78. I have exercised the muscles of my vagina by repeated tightening and relaxing.</td>
</tr>
</tbody>
</table>
APPENDIX E

SEXUAL ATTITUDE CHANGE SCALE (SACS)

Instructions

In order to select the best procedures to assist people who are having sexual concerns or difficulties, it is necessary for us to know your present attitudes about sexually related activities and your feelings about your own and your partner's body.

The cards you have been given are to be sorted on the basis of how much you presently like or dislike the statement appearing on the card. There are great differences between people regarding their sexual preferences and there are no right or wrong answers to the cards.

Read the statement on each card and place the card in one of the seven categories that best describes your present feeling about the item. You may find sexual behaviors described that you have not engaged in. However, it is not necessary to have actually experienced the activity in order to put it in one of the categories. The question is: "If today you were confronted by such a situation, would you expect to like or dislike the activity described?"
APPENDIX F
SEXUAL BEHAVIOR INVENTORY - FEMALE

Instructions

On each of the cards you will find a description of a sexual behavior or activity which a female may have engaged in. Read each statement and put the card in the category that most nearly describes your behavior.

The cards should be sorted on the basis of whether or not the activity occurred after you were 12 years old. Activities that may have occurred before the age of 12 years are not considered in this inventory.

This inventory has been developed for both sexually experienced and sexually inexperienced persons. There are great differences between people in their sexual activities. Please note that you are asked to only indicate the extent to which each of the activities may have occurred. You are not asked for your attitude or feelings.
APPENDIX G
DAILY SEXUAL BEHAVIOR CHECKLISTS - FEMALE (DSBC)

Daily Record

<table>
<thead>
<tr>
<th>Date</th>
<th>Code</th>
</tr>
</thead>
</table>

1. Please keep a daily record of how many times you engaged in the following behaviors. Indicate the number of times you engaged in any of the activities by putting the number on the line in front of the statement. Mark "0" if you did not engage in the activity.

<table>
<thead>
<tr>
<th>Number of times</th>
<th>Orgasm</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Stimulated my breasts by hand.</td>
<td>( )</td>
</tr>
<tr>
<td>2. Stimulated my breasts by vibrator.</td>
<td>( )</td>
</tr>
<tr>
<td>3. Stimulated my genitals by hand.</td>
<td>( )</td>
</tr>
<tr>
<td>4. Stimulated my genitals by vibrator.</td>
<td>( )</td>
</tr>
<tr>
<td>5. Stimulated my genitals by a method not listed above.</td>
<td>( )</td>
</tr>
<tr>
<td>6. Partner stimulated my breasts by hand.</td>
<td>( )</td>
</tr>
<tr>
<td>7. Partner stimulated my breasts by mouth.</td>
<td>( )</td>
</tr>
<tr>
<td>8. Partner stimulated my breasts by vibrator.</td>
<td>( )</td>
</tr>
<tr>
<td>9. Partner stimulated my genitals by hand.</td>
<td>( )</td>
</tr>
<tr>
<td>10. Partner stimulated my genitals by mouth.</td>
<td>( )</td>
</tr>
<tr>
<td>11. Partner stimulated my genitals by vibrator.</td>
<td>( )</td>
</tr>
<tr>
<td>12. Stimulation through sexual (genital) intercourse.</td>
<td>( )</td>
</tr>
<tr>
<td>13. I stimulated my partner's genitals by hand.</td>
<td>( )</td>
</tr>
<tr>
<td>14. I stimulated my partner's genitals by mouth.</td>
<td>( )</td>
</tr>
<tr>
<td>15. I stimulated my partner's genitals by vibrator.</td>
<td>( )</td>
</tr>
<tr>
<td>16. Engaged in mutual hand stimulation of genitals with my partner.</td>
<td>( )</td>
</tr>
<tr>
<td>17. Engaged in some form of sexual stimulation either by myself or with my partner, not listed above.</td>
<td>( )</td>
</tr>
</tbody>
</table>

2. Did you experience an orgasm today? Yes ____ No ____

3. If yes, how many? ____

4. If you experienced an orgasm, place a check mark inside the parenthesis following the statement that most closely describes the behavior you were engaging in at the time of orgasm. Put one check mark for each time you experienced orgasm. The number of check marks will be the same as the number you wrote in Question 3.
APPENDIX H

DAILY SEXUAL BEHAVIOR CHECKLISTS - MALE (DSBC)

Daily Record

<table>
<thead>
<tr>
<th>Date</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Please keep a daily record of how many times you engaged in the following behaviors. Indicate the number of times you engaged in any of the activities by putting the number on the line in front of the statement. Mark "0" if you did not engage in the activity.

<table>
<thead>
<tr>
<th>Number of times</th>
<th>Orgasm</th>
</tr>
</thead>
<tbody>
<tr>
<td>____________</td>
<td></td>
</tr>
<tr>
<td>1. I stimulated my partner's breasts by hand.</td>
<td>( )</td>
</tr>
<tr>
<td>2. I stimulated my partner's breasts by mouth.</td>
<td>( )</td>
</tr>
<tr>
<td>3. I stimulated my partner's breasts by vibrator.</td>
<td>( )</td>
</tr>
<tr>
<td>4. I stimulated my partner's genitals by hand.</td>
<td>( )</td>
</tr>
<tr>
<td>5. I stimulated my partner's genitals by mouth.</td>
<td>( )</td>
</tr>
<tr>
<td>6. I stimulated my partner's genitals by vibrator.</td>
<td>( )</td>
</tr>
<tr>
<td>7. Stimulation through sexual (genital) intercourse.</td>
<td>( )</td>
</tr>
<tr>
<td>8. Partner stimulated my genitals by hand.</td>
<td>( )</td>
</tr>
<tr>
<td>9. Partner stimulated my genitals by mouth.</td>
<td>( )</td>
</tr>
<tr>
<td>10. Partner stimulated my genitals by vibrator.</td>
<td>( )</td>
</tr>
<tr>
<td>11. Engaged in mutual hand stimulation of genitals with my partner.</td>
<td>( )</td>
</tr>
<tr>
<td>12. Engaged in some form of sexual stimulation with my partner not listed above.</td>
<td>( )</td>
</tr>
</tbody>
</table>

2. If you engaged in any sexual activities today, did your partner experience an orgasm? Yes ____ No ____

3. If yes, how many? _____

4. If your partner experienced an orgasm, place a check mark inside the parenthesis following the statement that most closely describes the behavior you were engaging in at the time of her orgasm. Put one check mark for each time she experienced orgasm. The number of check marks will be the same as the number you wrote in Question 3.
APPENDIX I

GENERAL INFORMATION

Please complete the following by placing an X in the space that most closely describes your present response to the sexual activity described.

Some of the questions refer to sexual activities involving a partner. If you do not currently have a person whom you would consider a "partner," write NA beside the number and move on to the next question. Only skip those questions that you cannot answer because of the unavailability of a partner.

If you currently have more than one partner, answer the questions in terms of the partner with whom you have the most frequent sexual contact.

1. How frequently would you like to have sexual intercourse?
   
   ___ more than once a day   ___ once every two weeks
   ___ once a day             ___ once a month
   ___ 3 or 4 times a week   ___ less than once a month
   ___ twice a week           ___ not at all
   ___ once a week

2. How frequently do you and your partner have sexual intercourse?

   ___ more than once a day   ___ once every two weeks
   ___ once a day             ___ once a month
   ___ 3 or 4 times a week   ___ less than once a month
   ___ twice a week           ___ not at all
   ___ once a week
3. Who usually initiates sexual intercourse?
   ____ I always do                  ____ my partner usually does
   ____ I usually do                 ____ my partner always does
   ____ my partner and I each initiate about equally often

4. Who would you like to have initiate sexual intercourse?
   ____ myself, always               ____ my partner, usually
   ____ myself, usually              ____ my partner, always
   ____ my partner and I equally often

5. For how long have you and your partner been having sexual intercourse?
   ____ less than 6 months           ____ 4 to 6 years
   ____ less than one year           ____ 7 to 10 years
   ____ 1 to 3 years                ____ more than 10 years

6. For how long do you and your partner usually engage in sexual foreplay (kissing, petting, etc.) before intercourse?
   ____ less than one minute         ____ 11 to 15 minutes
   ____ 1 to 3 minutes               ____ 16 to 30 minutes
   ____ 4 to 6 minutes               ____ 30 minutes to one hour
   ____ 7 to 10 minutes

7. How long does intercourse usually last, from entry of penis until your partner reaches orgasm (climax)?
   ____ less than one minute         ____ 11 to 15 minutes
   ____ 1 to 3 minutes               ____ 16 to 30 minutes
   ____ 4 to 6 minutes               ____ 30 minutes to an hour
   ____ 7 to 10 minutes
8. How often do you masturbate?

___ more than once a day  ___ once every two weeks

___ once a day  ___ once a month

___ 3 or 4 times a week  ___ less than once a month

___ twice a week  ___ not at all

___ once a week

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

___ nearly always, over 90%  ___ seldom, about 25% of the time

___ usually, about 75% of the time  ___ never

___ sometimes, about 50% of the time  ___ have never tried to

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

___ nearly always, over 90%  ___ seldom, about 25% of the time

___ usually, about 75% of the time  ___ never

___ sometimes, about 50% of the time  ___ have never tried to

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

___ nearly always, over 90%  ___ seldom, about 25% of the time

___ usually, about 75% of the time  ___ never

___ sometimes, about 50% of the time  ___ have never tried to
12. When your partner makes sexual advances, how do you usually respond?

____ usually accept with pleasure
____ often refuse

____ accept reluctantly
____ usually refuse

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

____ greatly aroused
____ not aroused
____ somewhat aroused
____ negative—disgusted, repulsed, etc.

14. Does your partner have any trouble in getting an erection, before intercourse begins?

____ never
____ sometimes, 50% of the time
____ rarely, less than 10% of the time
____ usually, 75% of the time
____ seldom, less than 25% of the time
____ nearly always, over 90% of the time

15. Does your partner have any trouble keeping an erection, once intercourse has begun?

____ never
____ sometimes, 50% of the time
____ rarely, less than 10% of the time
____ usually, 75% of the time
____ seldom, less than 25% of the time
____ nearly always, over 90% of the time

16. Overall, how satisfactory to you is your sexual relationship with your partner?

____ extremely unsatisfactory
____ slightly satisfactory
____ moderately unsatisfactory
____ moderately satisfactory
____ slightly unsatisfactory
____ extremely satisfactory
17. Overall, how satisfactory do you think your sexual relationship is to your partner?
   ___ extremely unsatisfactory  ___ slightly satisfactory
   ___ moderately unsatisfactory  ___ moderately satisfactory
   ___ slightly unsatisfactory    ___ extremely satisfactory

18. List three things about your own sexual behavior that you would most like to change.
   1. 
   2. 
   3. 

19. List three things about your partner's sexual behavior that you would most like to change.
   1. 
   2. 
   3. 

20. Check one of the following:
   ___ The questions above were answered in terms of my activities with my present partner or spouse.
   ___ The questions above were answered in terms of my activities with the person with whom I have most frequent sexual contact.
   ___ I do not presently have a person who I would consider a partner and have skipped those questions regarding sexual activities involving a partner.
APPENDIX J
SEXUAL RESPONSIVENESS SURVEY

Name ___________________________ Date __________________
Age ______ Occupation ____________________________
Partner's Age ______ Partner's Occupation ____________________________
Your religious affiliation ____________________________
Active __________________________ Nominal ____________________________
Last school grade ______ Parents' Occupation ____________________________
Marital Status: Single ____ Not married but stable relationship ____
                 Married ____ Divorced ____ Widowed ____ Separated ____

1. Physical Health:
   Before marriage Excellent ____ Good ____ Fair ____ Poor ____
   After marriage Excellent ____ Good ____ Fair ____ Poor ____

2. Number of children: Boys ____ Girls ____ Have children affected
   your health? Yes ____ No ____ Not Sure ____

3. Parents' relationship: Excellent ____ Good ____ Fair ____ Poor____
   Dominant parent: Father ____ Mother ____

4. If parents did not live together, were they: Divorced ____
   Separated ____ Not married ____

5. Father employed only ____ Mother employed only ____
   Both employed ____

6. Communication about sex in parental home: Questions answered
   freely ____ Questions answered with reservation ____
   No discussion of sex ____
7. Parental attitudes: Sex beautiful _____ Beautiful, but not to be talked about _____ Not to be talked about because shameful _____ Did not know parental attitudes _____

8. What do you think about your parents' sexual adjustment?
   Excellent _____ Good _____ Fair _____ Poor _____

9. Parental attitudes about nudity or partial nudity in the home:
   Father: Modesty important _____ Attitude not known _____
           Modesty unimportant _____
   Mother: Modesty important _____ Attitude not known _____
           Modesty unimportant _____

10. Parents' attitude about intercourse before marriage:
    Much concern and fear _____ Parents worried about your getting involved _____ Attitudes not known _____ Parents encouraged _____

11. Where was your knowledge about sex and reproduction acquired?
    (Put an M next to where you received much information, an L next to where you received little information, and an O next to where you received none)
    Parents _____ Siblings _____ Friends _____ School _____ Church _____
    Movies _____ Books _____ Other (Specify) _______________________

12. Menstrual knowledge obtained from your parents:
    Complete information _____ Some information _____ No information_____

13. Religious attitudes and influences regarding sex:
    No sense of religious pressure _____
    My religion effects my attitudes regarding: (check as many as needed)
    Masturbation _____ Premarital petting_____ Premarital intercourse _____ Marital Intercourse _____ Mouth-genital activities_____
    Abortion _____ Contraception _____
14. Dating: Encouraged by parents ____ Parents tightly controlled dating ____ Little control by parents ____ Parents not aware or concerned about dating ____

15. Petting on dates: No guilt ____ Some guilt ____ Much guilt ____

No petting ____

16. Were you satisfied with your dating? Yes ____ Somewhat ____

No ____

17. Intercourse before marriage: None ____ With future spouse only ____ With future spouse and other love relationship ____

With love relationship only ____ Not necessarily in love relationship ____

18. Present feelings regarding (past) non-marital sex relationships:

Satisfied ____ Indifferent ____ Dissatisfied ____ Not sure ____

19. Does your partner often desire intercourse when you do not?

Almost always ____ Occasionally ____ Almost never ____ Never ____

Not sure ____

20. Do you often desire intercourse when your partner does not?

Almost always ____ Occasionally ____ Almost never ____ Never ____

Not sure ____

21. When you do not desire intercourse, do you have intercourse anyway to please your partner? Almost always ____ Occasionally ____

Almost never ____ Never ____ Not sure ____

22. When your partner does not desire intercourse, does he/she have intercourse anyway to please you? Almost always ____

Occasionally ____ Almost never ____ Never ____ Not sure ____

23. Are you satisfied with your sexual relationship? Yes ____

No ____ Not sure ____
24. Do sexual fantasies or daydreams play a role in arousing you before intercourse? Yes ____ No ____ Not sure ____

25. Do you have sexual dreams? Yes ____ No ____ Not sure ____

26. If yes, do you have orgasm (relief of sexual excitation following stimulation and arousal, sometimes called climax) with sexual dreams? 
   Yes ____ No ____ Not sure ____

27. Have you ever had orgasm? Yes ____ No ____ Not sure ____

28. Have you ever had orgasm with intercourse? Yes ____ No ____ Not sure ____

29. Is simultaneous orgasm necessary for you and your partner for complete satisfaction? Yes ____ No ____ Not sure ____

30. Is it acceptable for you or your partner to have orgasm before vaginal penetration? Yes ____ No ____ Not sure ____

31. How does your orgasm occur? During vaginal intercourse ____
   By fantasy and daydreams ____ By manual stimulation (by partner) ____ By manual stimulation by yourself ____
   By several of above means ____ Doesn't occur ____

32. How does your partner's orgasm occur? During vaginal intercourse ____
   By fantasy and daydreams ____ By manual stimulation (by partner) ____ By manual stimulation by self ____ By several of above means ____ Doesn't occur ____

33. Does your partner have orgasm when you are together sexually? 
   Always ____ Most of the time ____ About half the time ____
   Almost never ____ Never ____ Not sure ____

34. Are you satisfied with the frequency of your partner's orgasm? 
   Satisfied ____ Dissatisfied, but not concerned ____
   Dissatisfied and unhappy about it ____ Indifferent ____
35. Are you satisfied with the frequency of your orgasm?
   Satisfied _____ Dissatisfied, but not concerned _____
   Dissatisfied and unhappy about it _____ Indifferent _____
36. If your partner's orgasm does not occur with vaginal penetration,
   are you: Satisfied _____ Dissatisfied _____ Not concerned _____
          Not sure _____ Orgasm does occur with penetration _____
          Orgasm does not occur by any means _____
37. If your orgasm does not occur with vaginal penetration, are you:
   Satisfied _____ Dissatisfied _____ Not concerned _____
          Not sure _____ Orgasm does occur with penetration _____
          Orgasm does not occur by any means _____
38. Do you feel that orgasm is necessary for you to have satisfaction
   in your sexual relationship? Yes _____ No _____ Not sure _____
39. Do you feel that genital size is important to your enjoyment?
   Yes _____ No _____ Not sure _____
40. Do you feel it is acceptable for the male to initiate sex?
   Yes _____ No _____ Not sure _____
41. Do you feel it is acceptable for the female to initiate sex?
   Yes _____ No _____ Not sure _____
42. Do you feel it is acceptable for you to initiate sex?
   Yes _____ No _____ Not sure _____
43. Do you feel comfortable undressing in front of your partner?
   Always _____ Sometimes _____ Seldom or never _____
44. Does your partner feel comfortable undressing in front of you?
   Always _____ Sometimes _____ Seldom or never _____
45. What is your feeling about looking at your partner undressed?
   Comfortable _____ Uncomfortable _____ Repelled _____
46. Do you feel comfortable dressing in front of your partner?
   Always ____ Sometimes ____ Seldom ____ Never ____

47. Does your partner feel comfortable dressing in front of you?
   Always ____ Sometimes ____ Seldom ____ Never ____

48. Do you find that your physical surroundings are a hindrance to having a satisfactory sexual relationship (i.e., lack of privacy, etc.)?
   Often ____ Occasionally ____ Rarely ____ Never ____

49. Do you feel that you must always have intercourse at a particular time of the day (as in the evening before going to sleep)?
   Yes ____ No ____ Not sure ____

50. Check any of the following situations which may now be influencing (increasing or decreasing) your sex activity. (You may check more than one)

   Separation ____ Marital disturbance ____ Pregnancy ____
   Health (yours or partner's) ____ Lack of privacy ____
   Economic situation ____ I have lost interest ____ Partner has lost interest ____ Interest in another person ____
   Other (specify) ____

51. Do you feel your partner provides an adequate sexual outlet for you? Yes ____ No ____ Not sure ____

52. Check any of the following feelings you often have after intercourse:

   Satisfaction ____ Dissatisfaction ____ Guilt ____ Uneasiness or anxiety ____ Other (specify) ____
53. What aspects of your sex life would you change?

Increase frequence of intercourse _____ Decrease frequency of intercourse _____ Have more nearly the same sexual desires as partner _____ Increase ability to achieve orgasm _____ Eliminate fears of pregnancy _____ Increased ability of partner to delay orgasm _____ Variation, time, position, etc. _____ Boredom _____ Other _____

54. I find the following helpful to use in attaining sexual arousal (check appropriate item(s))

Fantasies _____ Books (love stories, etc.) _____ Movies _____

Pictuers (nude, erotic, etc.) _____ Music _____ Perfume (or after shave lotion) _____ Alcohol _____ Drugs (marijuana, etc.) _____

Verbal stimulation _____ Physical contact _____ Other (specify) ____

55. The following is a scale of sexual responsiveness. Point A represents total lack of sexual feeling (excitation or arousal). Point B denotes maximal responsiveness.

Mark an X where you think you fit on such a scale at present

Lack of Interest A ___________ B Maximal Responsiveness

Mark an X where you have been in the past practicing self-stimulation (masturbation)

A ___________ B

Mark an X where you have been in the past with partner

A ___________ B

Mark an X where you would like to be

A ___________ B

56. Do you and your partner communicate with each other your feelings about sexual matters?

Usually _____ Sometimes _____ Seldom _____ Not sure _____
57. Do you and your partner differ in attitudes on the following? (check the appropriate response)

Finances  Yes___ Sometimes___ No___ Not sure___
Raising children (if any)  Yes___ Sometimes___ No___ Not sure___
Religion  Yes___ Sometimes___ No___ Not sure___
Leisure activity  Yes___ Sometimes___ No___ Not sure___
Sexual matters  Yes___ Sometimes___ No___ Not sure___
Infidelity  Yes___ Sometimes___ No___ Not sure___

58. Is there continuous disagreement between you and your partner on any of the above matters?

Yes _____ No _____ If yes, which one(s) ____________________________

59. Have you sought help previously for any of the above?

Yes _____ No _____

60. Are you and your partner using any method of birth control?

Condoms (rubbers) _____ The pill _____ IUD (coil, loop) _____
Foam _____ Diaphragm _____ Rhythm method _____ Withdrawal _____
No method _____

61. How do you feel about your method or lack of method of birth control?

Satisfied _____ Dissatisfied _____ Insecure _____ Not sure _____

62. How many children do you want? _____ How many do you have? _____

63. If you have more (or fewer) children than you want, does this present a problem within your marriage?

Yes _____ No _____ Not sure _____

64. Do you often feel a need to take a shower before or after intercourse?

Yes _____ No _____ Not sure _____

65. Are you familiar with the term douche? Yes _____ No _____
66. What is your attitude concerning vaginal hygiene following intercourse (douche)?
   Favorable____ Reservations____ Unfavorable____ No attitude____
67. Do you have intercourse during menstrual periods?
   Often ____ Sometimes ____ Almost never ____ Never ____
68. How do you feel about intercourse during menstrual periods?
   Indifferent ____ Prefer intercourse at other times ____
   Prefer intercourse during menstrual periods ____
   Believe it harmful ____
69. How do you feel about masturbation? Natural and acceptable ____
   Neutral ____ Unnatural and should not be done ____
70. What were your parents' attitudes about masturbation?
   Encouraging ____ Neutral ____ Discouraging ____
71. Have you ever masturbated? Yes ____ No ____ Not sure ____
72. Have you masturbated to orgasm? Yes ____ No ____ Not sure ____
73. Do you masturbate now? Yes ____ No ____ If yes, do you have orgasms? Yes ____ No ____
74. Do you often have guilt feelings regarding masturbation?
   Almost always ____ Occasionally ____ Almost never ____
   Never ____ Not sure ____
75. Do you feel sexually attracted to a member of the same sex?
   Often ____ Occasionally ____ Seldom ____ Not sure ____
   Never ____
76. Are there any problems not discussed in the survey?
   Yes ____ No ____
APPENDIX K

EXPECTANCY QUESTIONNAIRE

Instructions - Female

Listed below are several common sexual concerns or problems that people frequently experience. Please read each of the problems carefully and decide how much you expect it to be like or unlike you after your treatment here. Then place an X in the parenthesis ( ) over the words which best fit how you realistically expect the problem to describe you after you have completed the treatment program.

Do not answer these problems on the basis of what you hope, wish or would like to be; only answer according to your realistic expectations.

There are no right or wrong answers to these problems.

1. Feeling guilty about certain sexual behaviors:

   ( ) expect ( ) expect ( ) expect ( ) expect
   almost often sometimes seldom never

2. Not enjoying sexual intercourse:

   ( ) expect ( ) expect ( ) expect ( ) expect
   almost often sometimes seldom never

3. Not experiencing orgasm during sexual activity with a partner:

   ( ) expect ( ) expect ( ) expect ( ) expect
   almost often sometimes seldom never

4. Having a negative attitude regarding common sexual activities:

   ( ) expect ( ) expect ( ) expect ( ) expect
   almost often sometimes seldom never
5. Uncomfortable about trying sexual activities other than those now engaging in:

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<tr>
<th></th>
<th>expect</th>
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<tr>
<td>almost always</td>
<td>often</td>
<td>sometimes</td>
<td>seldom</td>
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6. Not experiencing orgasm by any manner or stimulation:

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7. Only experiencing orgasm through self-stimulation:

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<td>seldom</td>
<td>sometimes</td>
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8. Concern over ability to sexually arouse a partner:

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9. Fear of pain or discomfort from sexual activity involving a partner:

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10. Concern about body:

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APPENDIX L

Date ____________  Code Number ____________
                    Age ____________

PROBLEM HISTORY

1. Description of current problem.

2. Duration and course:
   A. Onset (Age; gradual or sudden, precipitating events; contingencies)
   
   B. Changes over time (increase, decrease, or fluctuate in severity; frequency, intensity; functional relationships).

3. Client's concept of cause and maintenance of problem.
4. Treatment and outcome:
   A. Medical Evaluation (name; specialty; date; results)
   B. Professional help: (name; specialty; date; form of treatment; results)
   C. Self-treatment: (type and results)

5. Current goals of treatment (ideal and concrete)
APPENDIX M

ESTIMATE OF SEXUAL ACTIVITY - FEMALE
2-WEEK PERIOD PRECEDING INITIAL INTERVIEW

Date ___________________________ Code ___________________________

1. I am going to read off a list of sexual activities. On each one I would like you to estimate how often it occurred during the past 2 weeks. While I know you may have forgotten some of the events, just try to estimate how often each occurred.

<table>
<thead>
<tr>
<th>Number of times</th>
<th>Orgasm</th>
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2. Did you on any occasion during the past two weeks experience an orgasm?

   Yes _____ No _____

3. If yes, how many?

4. Which of the sexual activities I mentioned earlier most closely describes the behavior you were engaging in at the time of orgasm? I will read them off again for you.
"Orgasm is an experience that may involve many different physical and emotional sensations which often vary greatly from person to person. Please write a brief statement indicating what an orgasm feels like to you. If you have never had an orgasm, please describe how you think it would feel."
APPENDIX 0

MEDICAL HISTORY AND CONTRACEPTIVE QUESTIONNAIRE
(Initial Visit)

The goal of this questionnaire is to help us to improve the quality and efficiency of your medical care. The information that is provided is confidential and will become part of your medical record. Please fill it out as accurately and as completely as you can.

TODAY'S DATE Month Day Year

GENERAL INFORMATION

NAME ____________________________

Last First Middle

ADDRESS ____________________________________________________________

______________________________________________________________________

TELEPHONE NO. ___________ BIRTHDATE ______________ AGE ___

ETHNIC BACKGROUND __________________ SOCIAL SECURITY NO. ______

REFERRED TO CLINIC BY Craig H. Robinson, Clinical Research Associate

Circle highest year of school: Check where appropriate:

High School 1 2 3 4 ____Single

University ____ Undergraduate ____ Married

____ Graduate ____ Divorced or separated

____ Widowed
I. GYNECOLOGICAL HISTORY

1. Date of first day of last normal menstrual period _________.

2. How old were you at the time of your first menstrual period?
   ________ Years Old.

3. During the last couple of years have your menstrual cycles been:
   1) Shorter than 21 days YES NO
   2) longer than 40 days YES NO

4. How would you describe the amount of flow:
   Light, Average, Heavy

5. Do you bleed for longer than 7 days? YES NO

6. Do you bleed or spot between periods? YES NO

7. Do you have much pain with your periods? YES NO

8. Do you bleed or spot during or after intercourse? YES NO

9. Do you have pain during or after intercourse? YES NO

10. Would you like additional information or instruction in the techniques of monthly self-examination of your breast? YES NO

11. Have you had a pelvic exam within the last 6 months? YES NO

12. Have you ever been pregnant? YES NO
    If yes:
    a) How many pregnancies have you had? _____
    b) How many children do you have? _____

13. Have you ever had an abortion? YES NO
    If yes:
    a) How many? _____
II. CONTRACEPTIVE HISTORY AND DESIRES
1. Which methods of contraception have you used?
   ____ Birth control pills  ____ Rhythm
   ____ Intrauterine Device  ____ Withdrawal (pulling out)
     (IUD, loop)  ____ Douche
   ____ Diaphragm  ____ Other (Please identify)
   ____ Condom (rubber)  ____ Foam
   ____ Cream or Jellies  ____ None
   ____ None

2. Do you desire additional information concerning contraceptive methods?  YES NO

3. At this time, which method is your first choice  Second choice

4. Do you plan on having children in the future?  YES NO

5. If you now have as many children as you desire, are you interested in a permanent method of contraception for yourself or your partner (i.e., tubal ligation, vasectomy)?  YES NO

III. GENERAL MEDICAL HISTORY
1. Has a serious medical illness impaired your general health?  YES NO

2. Have you been under a physician's care within the past year?  YES NO

3. Has there been any significant change in your general health during the past year?  YES NO

4. Are your activities limited by health?  YES NO

5. Are you taking prescribed medicines or drugs?  YES NO
   If yes, please specify

6. Are you taking other medicines or drugs (i.e., L.S.D., speed, ups, downers, hash, tranquilizers, diet pills, etc.)?  YES NO
   If yes, please specify
7. Are you allergic to any medications? YES NO
    If yes, please indicate which ______________________

8. Do you now have or have you ever had: (Indicate with check)

   ___ An operation
   ___ Heart disease
   ___ Kidney disease
   ___ Jaundice or hepatitis
   ___ Diabetes
   ___ Pneumonia
   ___ Asthma
   ___ Thyroid disease
   ___ Cancer
   ___ Venereal disease (syphilis, gonorrhea)
   ___ Migraine headaches
   ___ Blood clots (empolism)
   ___ Bleeding disorders (hemophilia)
   ___ Severe depression
   ___ Stroke
   ___ Chronic fatigue (tiredness)
   ___ Other serious illness or medical problems

9. Do any members of your immediate family (i.e., parents, brothers, or sisters) have any of the above conditions? YES NO
    If yes, please specify ______________________
PHYSICAL EVALUATION

HT. _______ WT. _______ B.P. _______ HCT. _______ PAP. _______

Urine Prot. ______________ Sugar ______________ Micro. __________

Other Tests _______________________________________________

Breasts ___________________________________________________

Abdomen __________________________________________________

Extremities _______________________________________________

Pelvic Exam _______________________________________________

Additional Remarks _________________________________________

Contraceptive Rx: __________________________________________

If none, state reason: _______________________________________

Return visit recommended ____________________________________

Names of staff: ______________ Name of Physician ____________
FOLLOW-UP QUESTIONNAIRE - Female
(Verbally Presented)

1. "What were your overall reactions to the videotapes?"

2. "In this kind of program, people typically have a wide variety of feelings regarding what they should, or should not be, doing. What were your feelings regarding what was, or was not, expected of you?"

3. "Of all the materials presented since your involvement in this program, what did you find to be most helpful?"

4. "What did you find to be least helpful?"

5. "Did any part of the program cause you to feel any anxiety or discomfort?" (If yes, "what?"; "did you feel better or worse as you went along?")

6. "Do you feel that the videotapes had any effect on your sexual attitudes?" (If yes, ". . . in what way?")

7. "Do you feel that the videotapes had any effect on your sexual activities or behavior?" (If yes, ". . . in what way?")

8. "I would like to ask you some specific questions regarding certain things that may, or may not, have occurred during the period that you have been involved in this program."
   a. "Did you do any Kegel exercises?" (If yes, DETAILS)
   b. "Did you follow any of the self-stimulation suggestions given by Dr. Annon?" (If yes, DETAILS)
c. "Did you attempt to role-play an orgasm?" (If yes, DETAILS)

d. "Did you read the masturbation booklet that was in your folder?"

e. "Did you use a vibrator on any occasion?"

9. (If necessary, ask about Daily Checklist items 17, Female form and 12, Male form)

10. (If necessary, ask about any discrepancies on the Sexual Behavior Inventory)

11. "Did the program contribute to any change in your feelings or behavior toward your partner?"

12. "What presently concerns you the most about your sexual attitudes and behavior?"
APPENDIX Q

KEGEL EXERCISES (Post B-1)

Purpose

Dr. Arnold Kegel originally developed these exercises to help women who had the problem of urinary stress-incontinance (leakage of urine due to weakness of the muscles around the neck of the bladder and surrounding the vagina). Quite unexpectedly, he discovered that after some time had been spent strengthening, his orgasmic patients seemed to develop a greater capacity for experiencing orgasm, and his non-orgasmic patients began experiencing orgasm.

The main muscle is called the pubococcygeus (P-C) muscle which, after continued exercise, not only strengthens urinary sphincter control but also increases muscle tone of the vagina accompanied by increasing ability to voluntarily constrict the vagina. As a result, there appears to be increased vaginal perception and sensation particularly during sexual (genital) intercourse.

Strengthening the P-C muscle seems to be very important for women who desire increased responsiveness to genital stimulation.

How To Find The Muscle

While sitting on the toilet, spread your legs as far apart as possible and start and stop the flow of urine. The P-C muscle is the only one that can accomplish this while in this position.

Exercise B-1

1. The next time you urinate today, spend a few seconds identifying the P-C muscle.

2. Starting tomorrow, clench or tighten up the muscle for 1 or 2 seconds, then relax. Do this 10 times in a row.

3. The exercises should be done 6 times each day. Do them each time you urinate, and if you urinate less than 6 times, do them also in the morning and at bedtime.

GOAL - 60 Kegel exercises per day; 6 sessions of 10 exercises each session.
APPENDIX R

KEGEL EXERCISES (post B-2)

Exercise B-2

1. Increase Kegel exercises by 10 per session so you will be doing 120 exercises per day; 6 sessions of 20 exercises each session.

2. Start new exercise ("Flick") 10 times per day. The Flick is merely a very brief Kegel exercise (½ to 1 second). Associate the Flicks with either fantasy or whatever you find is positive.

GOAL - 120 Kegel exercises and 10 Flicks each day.
KEGEL EXERCISES (Post B-3)

Exercise B-3

1. Increase Kegel exercises by 5 each day and continue 6 sessions per day. In other words, tomorrow you should do 25 during each of the 6 sessions. The next day you should do 30 during each of the 5 sessions.

Continue increasing until you are doing 50 Kegel exercises during each of the 6 sessions.

Do not associate the exercises with urination anymore. Do them anytime during the day or evening such as when you're shopping, at a movie, etc.

2. Add 1 more Flick each day. Tomorrow you should do 11, the next day 12, etc. Continue to associate this exercise with fantasy or whatever you find is positive.

GOAL - 300 Kegel exercises each day and an increase of 1 Flick each day. The exercises should be continued for several weeks.
APPENDIX T

PRETREATMENT AGREEMENT

This treatment program is being offered as part of a long range research project which therefore necessitates several requirements that must be agreed to by persons accepted for treatment.

1. Ongoing evaluation of the program will be made and will eventually be presented in a public research report. No names will be used in the report and precautions will be taken to insure the confidentiality of material obtained from all individuals.

2. The treatment program requires that each participant agrees to participate in a minimum of three sessions. These sessions will mainly involve a series of closed-circuit TV programs viewed in privacy, preferably with a spouse or partner.

3. Prior to viewing each program, participants will be required to complete a brief assessment task. Between sessions, participants will be required to keep a daily inventory of certain sexual behaviors. Forms will be provided by Mr. Robinson and should be returned at the beginning of each session.

4. A routine medical (gynecological) examination will be required of all females entering the treatment program. The examination will be available from the Kapiolani Family Planning Program physicians at a fee of $10.00. Participants may also have the examination from their regular physician, however in this case it will be the participant's responsibility to insure that the examination is completed and a report is sent to Mr. Robinson before completion of the treatment program.

5. There will be a charge of $10.00 for each session, not including the initial interview. The number of sessions will vary anywhere from three to six, depending upon individual medical and behavioral evaluation. Participants are encouraged to pay the fee each time they come in for a session. Should this become a financial hardship, Mr. Robinson will attempt to assist you in making alternate financial arrangements which will be satisfactory to all concerned.

I accept the above conditions and agree to abide by the requirements outlined above.

__________________________  _________________________
Date                        Signature

__________________________
Signature
APPENDIX U

PROCEDURE

(All Ss - Initial Interview)

I. Overview of Program - Explain briefly about the following:
   A. Show "Letter to Prospective Applicants"
   B. Videotapes
      1. Time, content, number of sessions
      2. "Possible delay" in scheduling
   C. Assessment
      1. Pre, ongoing and post
      2. Necessity for honesty; awareness of their possible apprehension, etc.
      3. Medical evaluation
         a. If Kapiolani . . .
         b. If elsewhere . . .
   D. Pretreatment Agreement
      1. Possibly won't be candidate
      2. Possible 1 to 6 week delay
      3. Sign agreement

II. Sexual Attitude Change Scale (SACS)
   A. Lay out categories
   B. Give both instructions
   C. Both complete

III. Problem History (female)
   A. Male moves to another room
      1. Fills out:
         a. Oregon Sex Inventory (OSI)
         b. If finishes early, wait until called
   B. Female
      1. Verbally responds to:
         a. Taxonomy of Sexual Performance
         b. Sexual Behavior Estimate--Past 2 weeks
         c. Problem History
         d. Female's Definition of "Orgasm"

IV. Problem History (male)
   A. Female moves to another room
      1. Fills out:
         a. General Information Form
         b. To let me know when finished
   B. Male
      1. Verbally responds to:
         a. Taxonomy of Sexual Performance
         b. Sexual Behavior Estimate--Past 2 weeks
         c. Problem History

V. Sexual Behavior Inventory (SBI)
   A. Lay out categories
   B. Give each written instructions
   C. Both complete
PROCEDURE (Cont.)

VI. Expectancy Questionnaire
A. First asked about times they have available
B. Both complete
C. During above, call secretary to determine group assignment

VII. Scheduling
A. If E₁:
   1. Schedule next appointment 1 week later
   2. Give directions to office
   3. Give female folder containing:
      a. Daily Sexual Behavior Checklists
      b. Sexual Responsiveness Survey (SRS)
      c. OSI if female participating with partner
   4. Give male folder containing:
      a. Daily Sexual Behavior Checklists
   5. Review Instructions
      a. Questions
      b. Emphasize not to compare or discuss forms
   6. Return folder next appointment
   7. Give address and phone number where I can be contacted

B. If E₂:
   1. Schedule next appointment 3 weeks later
   2. Give directions to office
   3. Give female folder containing:
      a. Daily Sexual Behavior Checklists for next 7 days, return by mail
      b. OSI if female participating with partner
      c. Sexual Responsiveness Survey (SRS)
   4. Give male folder containing:
      a. Daily Sexual Behavior Checklists for next 7 days, return by mail
   5. Review instructions
   6. Return folder next appointment or mail
   7. Give address and phone number where I can be contacted

C. If C₂:
   1. Schedule next appointment 6 weeks later
   2. Give directions to office
   3. Give female folder containing:
      a. Daily Sexual Behavior Checklists for next 7 days, return by mail
      b. OSI if female participating with partner
      c. Sexual Responsiveness Survey (SRS)
   4. Give male folder containing:
      a. Daily Sexual Behavior Checklists for next 7 days, return by mail
   5. Review instructions
   6. Return folder next appointment or by mail
   7. Give address and phone number where I can be contacted
APPENDIX U₂

PROCEDURE

(E₁ - A₁)

I. Greet Clients
   A. Ask about assessment difficulties
   B. Ask about medical evaluation
   C. Collect Daily Sexual Behavior Checklists
   D. Collect $10.00

II. SACS
   A. Lay out SACS categories
   B. Give each written instructions
   C. Both complete

III. Videotape A₁
   A. Darken room
   B. Show volume control
   C. Start tape and leave room

IV. During Tape
   A. Make out receipt
   B. SACS cards shuffled
   C. Prepare folders including
      1. Receipt
      2. Daily Sexual Behavior Checklists

V. After Tape
   A. Lay out SACS categories
   B. Give each written instructions
   C. Both complete
   D. Give each folder
   E. Confirm next appointment
   F. Answer, but do not elicit questions
APPENDIX U₃

PROCEDURE

(E₁ - A₂)

I. Greet Clients
   A. Ask about assessment difficulties
   B. Ask about medical evaluation
   C. Collect Daily Sexual Behavior Checklists
   D. Collect $10.00

II. Videotape A₂
   A. Darken room
   B. Show volume control
   C. Start tape and leave room

III. During Tape
   A. Make out receipt
   B. SACS cards shuffled
   C. Prepare folders including:
      1. Receipt
      2. Daily Sexual Behavior Checklists

IV. After Tape
   A. Lay out SACS categories
   B. Give each written instructions
   C. Both complete
   D. Give each folder
   E. Confirm next appointment
   F. Answer, but do not elicit questions
APPENDIX U_4

PROCEDURE

(E_1 - A_3)

I. Greet Clients
   A. Ask about assessment difficulties
   B. If necessary, ask about medical evaluation
   C. Collect Daily Sexual Behavior Checklists
   D. Collect $10.00

II. Videotape A_3
   A. Darken room
   B. Start tape and leave room

III. During Tape
   A. Make out receipt
   B. Shuffle SACS cards
   C. Prepare folders including:
      1. Receipt
      2. Daily Sexual Behavior Checklists

IV. After Tape
   A. Lay out SACS categories
   B. Give each written instructions
   C. Both complete
   D. Give each folder
   E. Set up or confirm appointment in 1 week
      1. Make sure 1½ hour time block is scheduled
      2. Mention re-evaluation and alternatives:
         a. May be asked to see "next series of three tapes," or
         b. given "certain treatment alternatives available now
            that they have completed the first series"
   F. Answer, but do not elicit questions
APPENDIX U5

PROCEDURE

(E1 - B1)

I. Greet Clients
   A. Ask about assessment difficulties
   B. Collect Daily Sexual Behavior Checklists
   C. Female's Definition of "Orgasm"

II. SACS
   A. Lay out SACS categories
   B. Give each written instructions
   C. Both complete

III. SBI
   A. Lay out SBI categories
   B. Give each written instructions
   C. Both complete

IV. Elicit Involvement in B1-B3
   A. Questions, concerns, etc.
   B. If necessary, discuss treatment alternatives

V. Videotape B1
   A. Collect $10.00
   B. Darken room
   C. Start tape and leave room

IV. During Tape
   A. Make out receipt
   B. Shuffle SACS cards
   C. Prepare folders including:
      1. Receipt
      2. Daily Sexual Behavior Checklists
      3. Masturbation booklet
      4. Kegel exercises - Summary, Post B1

VII. After Tape
   A. Lay out SACS categories
   B. Give each written instructions
   C. Both complete
   D. Give each folder
   E. Schedule next appointment
   F. Answer, but do not elicit questions
APPENDIX U6

PROCEDURE

(E2 - B1)

I. Greet Clients
   A. Ask about any OSI, SRS and Sexual Behavior Checklist difficulties
   B. Discuss 3 week time lapse and necessity for brief re-assessment
   C. Female Definition of "Orgasm"

II. SACS
   A. Lay out categories
   B. Give each written instructions
   C. Both complete

III. SBI
   A. Lay out SBI categories
   B. Give each written instructions
   C. Both complete

IV. Videotape B1
   A. Collect $10.00
   B. Show volume control
   C. Darken room
   D. Start tape and leave room

V. During Tape
   A. Make out receipt
   B. Shuffle SACS cards
   C. Prepare folders including:
      1. Receipt
      2. Daily Sexual Behavior Checklists
      3. Masturbation booklet
      4. Kegel exercises - Summary, Post B1

VI. After Tape
   A. Lay out SACS categories
   B. Give each written instructions
   C. Both complete
   D. Give each folder
      1. Explain importance of Daily Sexual Behavior Checklists
      2. Answer questions regarding checklist
      3. Emphasize not to compare or discuss forms
   E. Schedule and/or confirm next two appointments
   F. Answer, but do not elicit questions
APPENDIX U7

PROCEDURE

(E₁ & E₂ - B₂)

I. Greet Clients
   A. Ask about assessment difficulties
   B. Collect Daily Sexual Behavior Checklists
   C. Collect $10.00

II. Videotape B₂
   A. Darken room
   B. Start tape and leave room

III. During Tape
   A. Make out receipt
   B. Shuffle SACS cards
   C. Prepare folders including:
      1. Receipt
      2. Daily Sexual Behavior Checklists
      3. Kegel exercises - Summary, Post B₂

IV. After Tape
   A. Lay out SACS categories
   B. Give each written instructions
   C. Both complete
   D. Give each folder
   E. Confirm next appointment
   F. Answer, but do not elicit questions
APPENDIX U8

PROCEDURE

(E1 & E2 - B3)

I. Greet Clients
   A. Ask about assessment difficulties
   B. Collect Daily Sexual Behavior Checklists
   C. Collect $10.00

II. Videotape B3
   A. Darken room
   B. Start tape and leave room

III. During Tape
   A. Make out receipt
   B. Shuffle SACS cards
   C. Prepare folders including:
      1. Receipt
      2. Daily Sexual Behavior Checklists
      3. Kegel exercises - Summary, Post B3
      4. List regarding vibrators

IV. After Tape
   A. Lay out SACS categories
   B. Give each written instructions
   C. Both complete
   D. Give each folder
   E. Set up, confirm, 2 week follow-up appointment
   F. If E1:
      1. Discuss continued need for assessment
      2. Subsequent treatment alternatives contingent upon next session
      3. Mention that this tape was end of videotape series
   G. If E2
      1. Mention re-evaluation and alternatives:
         a. May be asked to see "next series of three tapes," or
         b. Give "certain treatment alternatives available now that they have completed this videotape series"
   H. Remind them to return Masturbation booklet
   I. Answer, but do not elicit questions
APPENDIX U9

PROCEDURE

(E₁ & E₂ - Two Week Follow-up After B₃)

I. Greet Clients
   A. Collect Daily Sexual Behavior Checklists
   B. Collect Masturbation booklets

II. Sexual Attitude Change Scale (SACS)
   A. Lay out categories
   B. Give each written instructions
   C. Both complete

III. Sexual Behavior Inventory (SBI)
   A. Lay out categories
   B. Give each written instructions
   C. Both complete

IV. Follow-up Interview (Female)
   A. Male moves to another room
      1. Fills out:
         a. Oregon Sex Inventory (OSI)
         b. If finishes early, wait until called.
   B. Female
      1. Fills out:
         a. General Information Form
         b. Definition of "Orgasm"
      2. Verbally responds to:
         a. Taxonomy of Sexual Performance
         b. Follow-up Questionnaire
         c. Any comments or questions she'd rather ask in absence of partner

V. Follow-up Interview (Male)
   A. Female moves to another room
      1. Fills out:
         a. Oregon Sex Inventory
   B. Male
      1. Verbally responds to:
         a. Taxonomy of Sexual Performance
         b. Follow-up Questionnaire
         c. Any comments or questions he'd rather ask in absence of partner

VII. Joint Interview
   A. Open discussion regarding goals, satisfaction, treatment alternatives or termination, etc.
   B. De-brief regarding research portion of this phase of treatment
   C. If necessary, make appropriate referrals or continue with them personally
   D. Confirm phone number and address for long term follow-up
APPENDIX U_{10}

PROCEDURE

(C_{2} - Six Week Follow-up After Initial Interview)

I. Greet Clients
   A. Ask about OSI, SRS and Sexual Behavior Checklist difficulties
   B. Discuss 6 week time lapse and necessity for re-assessment

II. SACS
   A. Lay out SACS categories
   B. Give both written instructions
   C. Both complete

III. SBI
   A. Lay out SBI categories
   B. Give both written instructions
   C. Both complete

IV. Interview (Female)
   A. Male moves to another room
      1. Fills out:
         a. Oregon Sex Inventory
         b. Definition of "Orgasm"
      2. Verbally responds to:
         a. Taxonomy of Sexual Performance
         b. Estimate of Sexual Activity - Preceding 2 weeks
         c. Questions, comments, concerns since initial interview

V. Interview (Male)
   A. Female moves to another room
      1. Fills out:
         a. Oregon Sex Inventory
         b. Expectancy Questionnaire
         c. To let me know when finished
      B. Male
         1. Verbally responds to:
            a. Taxonomy of Sexual Performance
            b. Estimate of Sexual Activities - Preceding 2 weeks
            c. Questions, comments, concerns since initial interview

VI. Joint Interview
   A. Assign to:
      1. A_{1}-A_{3}, A_{1}-B_{3}, B_{1}-B_{3}, or individual treatment
   B. Discuss fees, insurance plans, etc.
FOOTNOTES

1. The A-R-D represents three functions a single stimulus may acquire for an individual:
   
   A - the attitudinal or emotional function
   
   R - the reinforcing function
   
   D - the discriminative function

   An individual's particular A-R-D system is mainly established through classical conditioning principles (Staats, 1968) and it is assumed that the A-R-D system is a strong determinant of overt behavior. The system is hierarchical in that there are subsystems within a given system, and any given stimulus may have both a relative and absolute reinforcing intensity when compared to a stimulus in another system or within the same system (Annon, 1971).

2. In this example, and the following ones, any reference to repertoire refers to the individual's past and present experience with activities most directly related to the target sexual behavior, i.e., masturbation. Any behaviors logically related to masturbation (e.g., fondling of own breasts, self-stimulation of genitals) would be considered relevant whereas other sexual activities (e.g., kissing a partner, heterosexual genital intercourse) would be considered as a set of behaviors relevant to "another" sexual behavior repertoire.

3. This assumption would only hold true for a female who was mainly concerned about her lack of responsiveness to self-stimulation. Obviously many females, who are consistently orgasmic to
masturbation, complain of orgasmic difficulties because they are unable to experience arousal and orgasm through heterosexual activities.

4. The formal assessment portion of this session was followed by a lengthy discussion of the events that had transpired and some suggestions as how she might deal with the situation upon returning home. This whole episode vividly pointed to the potential importance of developing a procedure to provide some degree of feedback to husbands who were either unwilling or unable to participate with their wives.
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