

72-290

ANNON, Jack Stafford, 1929-  
THE EXTENSION OF LEARNING PRINCIPLES TO THE  
ANALYSIS AND TREATMENT OF SEXUAL PROBLEMS.

University of Hawaii, Ph.D., 1971  
Psychology, clinical

University Microfilms, A XEROX Company, Ann Arbor, Michigan

THE EXTENSION OF LEARNING PRINCIPLES TO THE  
ANALYSIS AND TREATMENT OF SEXUAL PROBLEMS

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

MAY 1971

By

Jack S. Annon

Dissertation Committee:

Roland G. Tharp, Chairman  
Donald F. B. Char  
James M. Denny  
Ronald C. Gallimore  
John Michel  
Arthur W. Staats

THE EXTENSION OF LEARNING PRINCIPLES TO THE  
ANALYSIS AND TREATMENT OF SEXUAL PROBLEMS

By Jack S. Annon

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 develop, test, and refine a conceptual scheme for the ordering of sexual problems and their treatment from within a learning theory framework. A single-within-subject design using a small number of cases was used to develop a systematic approach to such problems. Inasmuch as this was treatment oriented research, reversals and other experimental laboratory procedures were not used and changes over time were the primary sources of data collection.

Various questionnaires and inventories were specifically developed for use in the assessment and evaluation of subjects treated in this study. Seventy-eight students served as subjects for the collection of normative data for part of the assessment materials (the Sexual Fear Inventory and the Composite Fear Inventory). Fifteen clients, referred from a number of mental health agencies in the community, voluntarily served as subjects for the treatment

research program. Of the 15 subjects, four requested help with homosexual problems, 10 with problems of sexual incompatibility (frigidity, impotence, premature ejaculation), and one with a pedophilic problem.

After an initial assessment period, which ranged from four to twelve hours, a tentative program of treatment procedures was formulated and put into effect for each subject. If it became apparent from the ongoing evaluation that a particular procedure, or the entire program, did not appear to have a functional relationship with the subject's behavior, then modifications were made. Treatment ended when: the presenting sexual problem had been resolved to the subject's satisfaction; or changed to the point where it was no longer of major concern to him; or when the subject decided to stop treatment for any reason.

The treatment research program extended over an eleven month period. Of the 15 subjects: five completed assessment and the suggested treatment procedures (total number of sessions ranged from 21 to 38); five more completed assessment and started treatment but elected to discontinue at various points (sessions ranged from 27 to 42); two were referred for psychiatric treatment after an initial joint interview; and one, who entered late into the program, completed assessment and was still involved in treatment at the end of the formal program period. A detailed description of each of these cases was presented.

As the research progressed a number of inadequacies



with the initial behavioral diagnostic scheme being used became apparent. The stress in the analysis on overt behavior offered no way of dealing with associated emotional and cognitive aspects of the problem. Furthermore, the system offered little direction as to what aspect might best be treated first. Various changes in the conceptual system were made and by the end of the research program it was found that the Staats' A-R-D framework offered the most promising method for attitudinal analysis and for suggesting appropriate treatment sequences.

Implications of the present research for technique were discussed, particularly in regard to: therapeutic use of masturbation; the use of client self-recording measures; and the use of questionnaires and inventories for client assessment and evaluation.

Theoretical implications of the research were discussed in terms of the A-R-D system. It was concluded that an initial analysis of the client's sexual problem from within the A-R-D framework, followed by a behavioral diagnosis of relevant behavioral repertoires, offers the most promising conceptual scheme for the ordering of sexual problems and the development of appropriate treatment procedures. A final case, dealing with a pedophilic problem, was presented illustrating the development and application of learning treatment procedures based upon an initial theoretical analysis in terms of the A-R-D system.

## TABLE OF CONTENTS

ABSTRACT .....	iii
LIST OF TABLES .....	ix
LIST OF FIGURES .....	xi
INTRODUCTION .....	1
Behavior Therapy .....	3
Sexual Behavior .....	17
Sexual Problems .....	19
Treatment of Sexual Problems .....	23
Behavioral Excesses .....	25
Fetish Problems .....	25
Transvestic Problems .....	27
Pedophilic Problems .....	31
Exhibitionistic Problems .....	32
Masochistic, Sadistic, and Voyeuristic Problems .....	33
Homosexual Problems .....	35
Behavioral Deficits .....	42
Problems of Impotence and Premature Ejaculation .....	42
Problems of Frigidity and Dyspareunia ....	47
Difficulties in the Behavioral Treatment of Sexual Problems .....	50
Assessment Difficulties .....	51
Treatment Procedure Difficulties .....	60
Design of the Present Study .....	63
METHOD .....	65
Subjects .....	65
For Normative Data .....	65
For Treatment Program .....	65
Materials .....	66
Life History Questionnaire .....	66
Behavior Assessment Form .....	67
Composite Fear Inventory .....	67
Reinforcement Survey Schedule .....	69
Sexual Fear Inventory .....	69
Heterosexual Behavior Inventory .....	70
Sexual History Form .....	71
Sex Knowledge Inventories .....	71
Procedure .....	72
For Normative Data Collection .....	72
For the Treatment Program .....	74
RESULTS .....	80
Normative Data .....	80

The Composite Fear Inventory .....	80
The Sexual Fear Inventory .....	87
Case Studies .....	99
Homosexual Problems .....	99
Case of Mr. Adam .....	100
Case of Mr. Brown .....	151
Case of Mr. Chan .....	165
Case of Mr. Doi .....	171
Problems of Sexual Incompatibility .....	177
Case of Mr. and Mrs. Frost .....	179
Case of Mr. and Mrs. Goo .....	213
Case of Miss Han and Mr. Ho .....	240
Case of Mr. Inn and Miss Ivy .....	278
A Pedophilic Problem .....	319
DISCUSSION AND CONCLUSIONS .....	320
Implications for Technique .....	320
The Therapeutic Use of Masturbation .....	320
Use of Client Self-Recording Measures .....	334
Use of Questionnaires and Inventories .....	340
Additional Implications for Technique .....	345
Major Theoretical Implications .....	349
The A-R-D System .....	351
The Attitude Function .....	357
The Reinforcing Function .....	360
The Discriminative or Controlling Function .....	363
The Case of Mr. Jones .....	369
Baseline Period .....	382
Phase I: Systematic Desensitization .....	394
Phase II: Masturbatory Conditioning .....	400
Phase III: Social Behavior Training .....	406
Phase IV: Aversive Conditioning .....	423
Phase V: Treatment Withdrawal .....	435
Conclusions .....	449
APPENDIX A: The Life History Questionnaire .....	451
APPENDIX B: The Behavior Assessment Form .....	458
APPENDIX C: The Composite Fear Inventory .....	466
APPENDIX D: The Fear Inventory Data Sheet .....	472
APPENDIX E: The Reinforcement Survey Schedule .....	477
APPENDIX F: The Sexual Fear Inventory--Male .....	483
APPENDIX G: The Sexual Fear Inventory--Female .....	491
APPENDIX H: The Heterosexual Behavior Inventory--Male ..	499

APPENDIX I: The Heterosexual Behavior Inventory-- Female .....	502
APPENDIX J: The Sexual History Form.....	505
APPENDIX K: Means, Standard Deviations, and $t$ Tests for the Composite Fear Inventory Data .....	516
APPENDIX L: Means, Standard Deviations, and $t$ Tests for the Sexual Fear Inventory Data .....	520
REFERENCES .....	525

## LIST OF TABLES

Table		Page
1	Subject Characteristics .....	65
2	Mean Scores on the Composite Fear Inventory .....	82
3	Items and Mean Scores on the Composite Fear Inventory .....	83
4	Mean Scores on the Sexual Fear Inventory .....	90
5	Items and Mean Item Scores on the Sexual Fear Inventory .....	91
6	Sexual Fear Inventory Scores for Mr. Adam .....	137
7	Mr. Adam's Pre and Post Inventory Scores .....	151
8	Mr. Brown's Inventory Scores .....	162
9	Mr. Chan's Inventory Scores .....	169
10	Mrs. Frost's Sexual Fear Inventory Scores .....	188
11	Mr. Frost's Sexual Fear Inventory Scores .....	190
12	Mr. and Mrs. Frost's Personal Goals .....	207
13	Mr. and Mrs. Frost's Pre and Post Inventory Scores .....	212
14	Mrs. Goo's Initial Inventory Scores .....	217
15	Mr. Goo's Initial Inventory Scores .....	218
16	Mrs. Goo's Pre and Post Inventory Scores .....	237
17	Mr. Goo's Pre and Post Inventory Scores .....	239
18	Miss Han's Inventory Scores .....	245
19	Mr. Ho's Inventory Scores .....	258
20	Mr. Inn's Sexual Fear Inventory Scores .....	290
21	Miss Ivy's Sexual Fear Inventory Scores .....	291
22	Mr. Inn's and Miss Ivy's Composite Fear Inventory Scores .....	292

## LIST OF TABLES (Continued)

Table		Page
23	Mr. Inn's Pre and Post Composite Fear Inventory Scores .....	316
24	Mr. Inn's Pre and Post Sexual Fear Inventory Scores .....	317
25	Miss Ivy's Pre and Post Composite Fear Inventory Scores .....	317
26	Miss Ivy's Pre and Post Sexual Fear Inventory Scores .....	318
27	Mr. Jones' Initial Inventory Scores .....	372
28	Mr. Jones' Pre and Post Inventory Scores .....	445

## LIST OF FIGURES

Figure		Page
1	Mr. Adam's Progress in Sleeping Routine .....	120
2	Mr. Adam's Arousal Record .....	130
3	Theoretical Treatment Plan for Mr. Jones .....	380
4	Mr. Jones' Arousal Record .....	448

## INTRODUCTION

The psychological treatment of sexual problems has been known to be costly and time consuming, and the prognosis for change not too encouraging. However, in recent years a new behavioral approach has reported an increased rate of successful therapy for sexual problems that have been resistant to treatment in the past. This approach derives its constructs from psychological learning theory and its methodology from experimental psychology; it views sexual problems as the result of learned behaviors which follow the general principles of learning. Although this model has produced some promising results, its application to sexual disorders has been relatively recent and, at present, there is no systematic learning oriented approach to the analysis and treatment of sexual problems available to the clinician. As a step in this direction, and due to the prevalence of sexual problems and the difficulties associated with their treatment, it was considered of practical as well as theoretical value to design and carry out a study to investigate methods of assessment and treatment in this area. The purpose of the present research was to develop, test, and refine a conceptual scheme for the ordering of sexual problems and their treatment from within a learning theory framework.

The following section outlines the development of the behavioral approach to treatment and provides the general framework for understanding how sexual problems are viewed



within this model. The theoretical background, along with related research, is then given; followed by a description of various systems currently used for classifying such behaviors. A review of the literature concerned with the behavioral treatment of sexual problems is given next. A final discussion of the assessment and treatment procedure difficulties associated with the learning approach to sexual disorders completes the setting of the problem for the present research.

### Behavior Therapy

To help a person change some aspect of his behavior that has become a problem to him or to others has long been the aim of the applied professional. Psychologists, psychiatrists, social workers, psychiatric nurses, and others whose training and experiences are directed toward the amelioration of human conditions have all recognized this as a common goal. However, there is no commonly agreed upon method for achieving this goal, either between disciplines or within a discipline itself. One possible reason for this lack of agreement is the variety of psychological theories and models which exist. Harper (1959), for example, described 36 separate systems of psychotherapy that were considered the main types of treatment up to that time. Since then numerous other models have been advanced (e.g., Implosive Psychotherapy, Reality Therapy, Morita Therapy, Transactional Analysis, etc.). No one system seems to have the support of the majority of practitioners. In relatively recent years a new model has emerged which bases its therapeutic methods on experimentally established principles of learning. This approach has not achieved primacy, but acceptance of it and interest in it is rapidly growing across disciplines and within psychology itself. Evidence for this growth is found in the publication of increasing numbers of books, articles, research papers, and monographs and the appearance of a number of journals entirely devoted to research and practice in the area.

A confusing variety of names have been applied to this model, such as: behavior therapy, behavior modification, conditioning therapy, behavior control, behavioral counseling, learning theory treatment, aversion therapy, behavior change, or any combination of these terms. For some practitioners all these terms seem interchangeable, while for others each has a specific meaning. For the sake of clarity and consistency the framework recently provided by Ullmann and Krasner (1969) will be used throughout this presentation.

Ullmann and Krasner (1969) use the term social influence to include situations in which one human being exerts some degree of control over another and where the focus is on the process of change itself rather than on an evaluation of the social desirability of the behavior being changed. Examples of people who engage in this behavior are salesmen, politicians, teachers, and psychologists interested in opinion change.

One type of social influence is called behavior modification. This concept involves the changing of behaviors that have been labeled socially deviant, either by the person himself or by others. The term may be applied to a variety of techniques used by a broad range of professional and nonprofessional people such as parents, teachers, or therapists.

Within the realm of behavior modification, Ullmann and Krasner (1969) include two conceptually different approaches. One is labeled evocative psychotherapy where treatment is

derived from a psychoanalytic (or "dynamic") model that aims to alter a person's behavior indirectly by first altering certain intrapsychic systems. Examples of this dynamic model would be the Freudian and Rogerian schools of psychotherapy. The second approach is called behavior therapy where treatment is derived from a sociopsychological model whose aim is to alter a person's behavior directly through application of general psychological principles. Though this term covers a number of new therapeutic methods and procedures, they are assumed to have a common theoretical basis in general learning theory (Feingold, 1966; Ford & Urban, 1967; Kanfer & Phillips, 1969; Meyer, 1970; Rachman, 1963; Rachman & Teasdale, 1964; Ullmann & Krasner, 1965).

The major assumption underlying this model is that neurotic or other maladaptive behaviors are acquired or learned and therefore subject to the normal laws of learning as are other behaviors. Learning is defined in a broad sense and includes any aspect of behavior which is acquired as a result of experience; and excludes any behavior which results from direct intervention in the functioning of the nervous system or from maturation.

There are numerous techniques but relatively few basic principles in behavior therapy. One group (Salter, 1961; Wolpe, 1958) base their treatment on the classical conditioning model of Pavlov; another group (Ayllon & Azrin, 1968; Schaefer & Martin, 1969; Tharp & Wetzel, 1969) base some of their procedures on the operant conditioning model after

Skinner (1953); and a third (Bandura & Menlove, 1968; Lazarus, 1966; Moreno, 1958; and Wolpe & Lazarus, 1966) derive many of their techniques from modeling and vicarious processes within a framework of social-learning theory (Bandura, 1969). The various therapeutic procedures themselves have been clearly described by a number of prominent practitioners and researchers in the field (e.g., Ayllon & Azrin, 1968; Franks, 1969; Grossberg, 1964; Kanfer & Phillips, 1969; Rachman, 1963; Rubin & Franks, 1969; Staats & Staats, 1963; Tharp & Wetzel, 1969; Ullmann & Krasner, 1965, 1969; Wolpe, 1969c; Wolpe & Lazarus, 1966).

Some of the procedures, such as Wolpe's (1958) systematic desensitization, have considerable empirical evidence to support them (Franks, 1969). Other techniques, such as covert sensitization (Cautela, 1967), covert reinforcement (Cautela, 1970), guided imagining (Wolpin, 1969, self image training (Susskind, 1970), or verbal satiation therapy (DiCaprio, 1970), are of too recent origin to have accumulated much experimental verification. However, the therapeutic procedures are based upon empirical evidence and are subject to modification; this is another distinguishing feature of the behavior therapist's approach. Yates (1970), for example, believes that the essential feature of English behavior therapy is the application of the experimental method to the individual case, rather than the application of "modern learning theory". On the other hand, Meyer (1970) disagrees with Yates' restrictive definition

and feels that behavior therapy is an approach which is derived from empirical data and laws in the field of learning.

The common view that behavior therapy is essentially applied basic research is supported by a brief look at its history. Wolpe (1969b), for example, cites the well known experiment of Watson and Rayner (1920) with little Albert and the white rat as the initial impetus for behavior therapy. It only remained for Jones (1924) to apply the suggested treatment by Watson and Rayner to her celebrated case of Peter and the white rabbit and thus become the first behavior therapist.

Unfortunately, as Wolpe (1969b) has noted, not much interest was shown in this approach for the next 35 years. It was not until the early 1950s that the advantages of learning theory and the experimental method for the treatment of human problems began to be realized. Initially, learning principles were used post hoc to explain various processes used in evocative psychotherapy (e.g., Dollard & Miller, 1950; Mowrer, 1950). This transition stage then gave way to the a priori use of learning concepts in treatment and the systematic application of these concepts to achieve a particular behavioral goal selected at the start of treatment (Ullmann & Krasner, 1965).

Yates (1970) has identified and traced three parallel, but relatively independent, approaches to behavior therapy as developed in England, South Africa, and the United States.

The work of Shapiro and his associates at Maudsley Hospital in England from 1950 to 1955 is cited by Yates as laying the ground work for the English approach of treating the patient as the object of a rigorous experimental investigation. The basic assumption of this approach is that each patient has a unique problem for which standard methods of treatment are not available. Treatment is carried out by controlled experimental studies on the individual patient (e.g., Jones, 1956; Meyer, 1957; Yates, 1958). By 1960 one of the first collection of readings developing and illustrating this approach as well as others was published by Eysenck.

During this same period Wolpe, Lazarus, and Rachman, working in South Africa, were developing the technique of systematic desensitization. In 1952 Wolpe published the results of a series of experiments in which he produced and then eliminated neuroses in cats. Wolpe later applied the same principles to human neuroses in a variety of ways and he then set forth his now classical procedure (Wolpe, 1954, 1958), which has since spread to England and the United States. In general, most of the therapeutic techniques used by Wolpe and his colleagues are based on the classical conditioning model and are used primarily for the treatment of neurotic behaviors. A number of books devoted to the application of this particular approach have appeared (e.g., Franks, 1964; Wolpe & Lazarus, 1966; Wolpe, Salter, & Reyna, 1964; etc.), and the model currently has many advocates, with Wolpe probably remaining its foremost spokesman.

Paralleling these developments in England and South Africa was the growth of the operant conditioning model in the United States. This approach concentrates its efforts on the systematic control of environmental contingencies to alter behavior as first outlined by Skinner (1953). Lindsley (1956) showed how operant principles could be applied to schizophrenic patients, and Staats (1957) demonstrated the first application of operant conditioning principles to abnormal behavior. With the development of the first token-reinforcer system by Staats in 1959 (Staats, 1970) the application of operant techniques received its real impetus (e.g., Ayllon & Michel, 1959) with its main emphasis on the treatment of institutionalized mental patients (e.g., Ayllon & Azrin, 1969; Schaefer & Martin, 1969). However, Tharp and Wetzel (1969), moving from captive populations, have successfully demonstrated that operant techniques can also be applied to behaviorally disordered children in their own natural environments.

This very brief overview of the developmental history of behavior therapy indicated how very recent this approach is in comparison with the evocative therapies. Up through 1965 there were perhaps a dozen books directly concerned with the application of behavior therapy in the applied setting. Each year since then has shown a marked increase in the number of publications in this area, each offering its own unique contribution to the field. At present there are numerous volumes available in a number of different areas,



such as general overviews of the entire field (Bandura, 1969; Meyer & Chesser, 1970; Neuringer & Michel, 1970; Ullmann & Krasner, 1969; Yates, 1970a), applications in a specific area such as behavioral counseling (Krumboltz, 1966; Krumboltz & Thoresen, 1969; Osipow & Walsh, 1970b), the application of specific learning principles such as those used in the operant area (Ayllon & Azrin, 1968; Bradfield, 1970; Homme, 1970; Mehrabian, 1970; Schaefer & Martin, 1969; Tharp & Wetzel, 1969), and the application of a wide number of procedures to a wide range of problems (Freeman, 1968; Gelfand, 1969; Gray & England, 1969; Levis, 1970b; Osipow & Walsh, 1970a; Paul, 1966; Rachman, 1968; Rachman & Teasdale, 1969; Rubin & Franks, 1969; Wolpe, 1969c; Wolpe & Lazarus, 1966).

Most recently there appears to be a tendency for some to move away from what they see as a limitation in working with overt behaviors exclusively and to deal with cognitive and emotional responses as well (Franks, 1970; Kanfer, 1970; Klein, Dittmann, Parloff & Gill, 1969; Lazarus, 1967; and Staats, 1968a, 1970). Currently, there are those who feel that the gap between evocative psychotherapy and behavior therapy is more apparent than real (Kraft, 1969c) and that there are common grounds of similarity as well as differences (Sloane, 1969a, 1969b). Many therapists are trying to bridge this gap in one way or another. Stampfl (1970) uses a learning based treatment procedure, but retains ". . . certain concepts and modes of understanding

emphasized in conventional psychodynamic approaches to treatment (1970, p. 183)." Others report combining the use of evocative psychotherapy with a particular behavior therapy procedure (Birk, 1970; D'Alessio, 1968) or using behavior therapy and a client-centered approach (Naar, 1970), or even alternating between the two (Hersen, 1970). Some attempt to integrate psychoanalytic theory and the data from behavior therapy (Kamil, 1970), and other behavior therapists work with a "humanistically--oriented" therapist with the same client (McCarthy & Messersmith, 1970).

Wolpe (1969b) decries such practices, feeling that they help to foster the misconceptions about behavior therapy that exist among the various professions. Meyer and Chessner (1970) have listed a number of difficulties that arise with the combined treatment approach, particularly during the early stages of treatment where behavior therapy may be used to relieve the very anxiety that may act as an incentive to the patient to "work" during the beginning stages of insight psychotherapy. Others (Levis, 1970a; Rachman, 1970) have advanced numerous reasons why such an integration between behavior therapy and psychodynamics may not only be questionable but theoretically undesirable as well.

At first glance it does seem somewhat unusual for a therapist to combine the dynamic and behavioral approach in his treatment of a patient. This is particularly so when, in the opinion of some writers (Grossberg, 1964; Rachman, 1963), it was partly in reaction to the accumulating evidence

of poor results with psychoanalysis and other "verbal" therapies that behavior therapy developed. However, many of the current practitioners of behavior therapy received their primary training from within the dynamic model. Without an appropriate theoretical background and a thorough grounding in general learning principles and their application to human problems, it is not too difficult to understand why some "behavior therapists" revert to a dynamic approach when confronted with a complex problem for which no ready made behavioral procedure is available. Compared to the numerous treatment procedures there is little in the literature concerned with methods of behavioral assessment that appears helpful to the neophyte behavior therapist who has received most of his training in an evocative approach.

It appears that even those with considerable background and experience in the application of learning principles to the treatment of human problems have contributed to the separate directions that the field seems to be heading into at this point. The most clear cut example is the manner in which the classical and operant conditioning groups have proceeded in relative isolation from one another. Each seems committed to its own methods and terminologies to the exclusion of the other in its approach to the treatment of human problems.

Staats (1968b; Staats and Staats, 1963) has long advocated a comprehensive, integrated learning theory of human behavior which cuts across separate theoretical orientations,

and he has criticized the two main schools for generally failing to realize the various interrelationships between classical and instrumental conditioning. Recently Staats (1968b) has advanced the conception of a human motivational system which he refers to as the "attitude--reinforcer--discriminative" (A-R-D) system. Staats suggests that the same stimulus may have multiple functions in relation to both forms of conditioning. The A-R-D stands for the three functions that a stimulus may serve. An Attitudinal stimulus is defined as a stimulus which has come to elicit an emotional response through the principles of classical conditioning. He then points out that this same stimulus will also function as a Reinforcing stimulus, as well as serve as a Discriminative stimulus that may elicit overt behavior. One of the many important implications for clinicians in this theory is that because the various stimulus functions are related the three functions may be assessed from observations of the discriminative stimulus value only. Thus, the A-R-D analysis, " . . . provides a behavioral rationale for the use of tests, and indicates that verbal test items are just as behaviorally appropriate as a direct operant conditioning procedure (Staats, 1968b, p. 60)."

Staats also points out that while one school has been concerned with the classical conditioning of attitudes and leaves the remaining learning concomitants uncontrolled, the other approach mainly manipulates response contingent reinforcement and neglects investigation of the classical

conditioning of attitudes which result from the effects of operant conditioning. His analysis points out a direction by which both schools might find a common ground that would help dissolve their schism. Whether this current separation will be dissolved is an open question, but certainly Staats' A-R-D system has important ramifications for behavior therapy research and both schools could profit from an extension of his theory to various areas of application.

Criticism of different methods of behavior therapy has not been confined to the field itself. Numerous criticisms centered around two aspects have been advanced by evocative psychotherapists: symptom substitution and temporary cure. The hypothesis of symptom substitution stems from the medical model and claims that the behavior therapist is only treating the symptom, not the underlying cause of the symptom; therefore, it can be expected that another symptom will arise after the presenting one has been treated (Thorpe & Katz, 1948; Coleman, 1956).

The first argument that has been made against this hypothesis is that there is little, if any, evidence for it (Grossberg, 1964; Ullmann & Krasner, 1965). In addition, there has been a number of more parsimonious and reasonable explanations (e.g., new learning, spontaneous recovery, changing hierarchy of responses, etc.) that have been advanced by numerous writers (Ayllon, Haughton, & Hughes, 1965; Brown, 1970; Feingold, 1966; Grossberg, 1964; Rachman, 1967; Ullmann & Krasner, 1965). More recently, Cahoon (1968) has

argued that these terms have rarely been used in ways that do not involve inferences and constructs peculiar to a specific theoretical orientation and the issue is primarily an empirical matter. Over the years both behavior therapists and psychoanalytically trained therapists have been particularly careful to watch for the emergence of alternative symptoms and only rarely have such possibilities been noted (Brown, 1970; Ullmann & Krasner, 1965).

The second criticism has been that unless insight has been attained by the patient first, behavior change will not be lasting. In response, one has to only consult the multitude of follow up reports presently available in the literature (e.g., Wolpe & Lazarus, 1966; Wolpe, 1969c) to see the stability of behaviors that have been altered by behavior therapy. For those few cases where the previous maladaptive behavior seems to have returned, it has been shown to be readily amenable to follow up treatment (Rachman, 1963). In addition, there have been a number of more parsimonious explanations advanced for such cases (similar to those applied to the hypothesis of symptom substitution). An interesting phenomenon has been noted by an increasing number of therapists in this regard. Namely, after a patient has been successfully treated by some behavioral procedure, he may abruptly experience an "insight" into the origin of his former problem (see Cautela, 1965; Frankel, 1970; Huff, 1970; Kraft, 1969a, 1969b, 1970a, 1970b); or experience a startling shift in the nature of his dreams (Bergin, 1970).

One of the earliest criticisms of behavior therapy is that it is only effective with clearly defined problems such as unitary phobias. It is interesting to note that prior to the advent of behavior therapy, phobias were widely known as difficult to treat. However, in recent years this judgement has been less frequent, particularly after the publication of Wolpe and Lazarus' (1966) text on behavior therapy techniques in which they report successful treatment of a wide range of problems. In their words, ". . . behavior therapy is effective in all neuroses and not only in unitary phobias (1966, p. 11)." (Underscoring theirs.) As Klein, Dittman, Parloff, and Gill (1969) have recently noted, "Behavior therapists now treat a wider range of patients and use a greater variety of treatment methods than before (p. 259)." Currently, the range of problems treated by behavior therapy extend from depression (Lazarus, 1968c) and pervasive anxiety (Cautela, 1966) in adults and complex behavior disorders in children (Tharp & Wetzel, 1969) to autistic (Wetzel, Baker, Rooney, & Martin, 1966) and psychotic (Ayllon & Michel, 1959) behaviors in both adults and children. A number of writers (Eysenck, 1970; Carter & Stuart, 1970; Ullmann & Krasner, 1969; Yates, 1970) have thoroughly discussed and answered all of the above criticisms, and others as well, and further discussion will not be done here.

In summary, it can be said that while there are many untouched areas that need to be explored and researched, a

great deal of information now exists showing the successful extension of learning principles to the treatment of a wide range of complex human problems. This is aptly illustrated in the recent textbook: A Psychological Approach to Abnormal Behavior (Ullmann & Krasner, 1969). Unlike most other "abnormal" texts that devotes little space to the actual treatment of abnormal behaviors--other than, "Such patients are referred for intensive psychotherapy"--a good half of this book is devoted to such treatment, with all the procedures derived from general learning theory principles. Such an approach is made possible, because, as the authors put it, "The central idea of this book is that the behaviors traditionally called abnormal are no different, either quantitatively or qualitatively, in their development and maintenance from other learned behaviors (1969, p.1)."

### Sexual Behavior

The assumption that human sexual behaviors are primarily the result of learning or conditioning has been suggested repeatedly over the past twenty years by researchers from a variety of disciplines (e.g., Ford, 1948; Ford & Beach, 1951; Gagnon & Simon, 1967; Kinsey, Pomeroy & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953; Michelmores, 1964; Montagu, 1948; Ullmann & Krasner, 1965). Early general statements, such as, "It is now quite clear that how a person behaves sexually is largely determined not by inborn factors but by learning (Montagu, 1948, p. 60)", and, "Learning and conditioning in connection with human sexual behavior involve



the same sort of processes as learning and conditioning in other types of behavior (Kinsey, et al., 1953, p. 644)", have more recently given way to carefully reasoned theoretical explanations, with accumulating empirical support, of how sexual behaviors may be acquired through general social-psychological learning principles (e.g., Bandura, 1969; Staats, 1968b; Staats & Staats, 1963; Ullmann & Krasner, 1969).

Until recently, clinicians mainly relied upon psychoanalytic explanations for deviant sexual behavior and treatment was given accordingly. Now there are alternate explanations available that suggest different lines of approach. For example, contrast the psychoanalytic approach where deviant sexual behavior is largely seen as a symbolic manifestation of unresolved unconscious conflicts (Masserman, 1969), with that of McGuire, Carlisle, and Young (1965) who suggest that deviant sexual behaviors may be the result of masturbatory conditioning experiences. In regard to specific deviations, compare the psychoanalytic analysis of sadomasochism as arising from instinctual inclinations (Reik, 1941) or as symbolic representation of repression (Gebhard, 1969), with behavioral analyses (Brown, 1965; Sandler, 1964) suggesting how such behaviors may be acquired through learning principles. Contrast the various dynamic viewpoints that see fetishism arising from castration anxiety resulting from oedipal and preoedipal factors, or as a defense against homosexuality (Gebhard, 1969; Snow & Bluestone, 1969), with

the experiments by Rachman (1966) and Rachman and Hodgson (1968) in which they conditioned sexual arousal in their subjects to colored slides of knee-length women's boots, and then extinguished the response through the use of similar conditioning procedures.

Learning theorists and clinicians do not deny man's biological origins and they recognize the influence of genetic, biochemical, or physiological factors on sexual behavior, but the form and direction that these behaviors take is attributed principally to social-psychological influences (Meyer & Chesser, 1970; Ullmann & Krasner, 1969).

#### Sexual Problems

In dealing with sexual problems, the position of the behavior therapist is that there are no separate principles for "deviant" or "abnormal" and "normal" sexual behavior. For example, in discussing sexual behavior, Ullmann and Krasner write, "As with the other behaviors discussed throughout this book, rather than try to define what is normal and what is not one may ask how anybody comes to like or value anything. Rather than ask how perverted or deviant behavior develops, the question is how any behavior is learned (1969, p. 471)."

Thus, if sexual problems are seen as the result of learned behaviors that follow the general principles of learning, it follows that their extinction or modification may also be achieved by appropriate procedures derived from such principles. This is precisely what the behavior

therapists have attempted to do. As several critical reviews of the behavioral treatment of sexual problems have illustrated (Dengrove, 1967; Feldman, 1966; Franks, 1967; Rachman, 1961; Ullmann & Krasner, 1969; Yates, 1970a), behavior therapists have made considerable progress in an area that has been long known for its resistance to treatment by other approaches. However, as Franks (1967) has commented in his review, "Considering the short time that behavioral approaches to the treatment of sexual disorders have been in existence, the progress made is remarkable. Nevertheless, some major shortcomings, if perhaps inevitable in a period of rapid transition and expansion which permits inadequate time for consolidation, replication, and controlled evaluation, are certainly very much in evidence (p. 214)." Some of these major shortcomings will be discussed later following a summary of the literature concerned with the behavioral analysis and treatment of sexual problems.

There currently exists a number of systems for categorizing sexual behaviors, but none has proved completely satisfactory. Ullmann and Krasner (1969) suggest that one possible reason is that the same act may be emitted for different reasons because of different antecedent conditions. Another is that the same person usually emits a variety of acts, thus the difficulty of placing sexual acts in mutually exclusive categories.

Buss (1966) suggests two categories: deviant object and deviant response; the former for appropriate behaviors

but to wrong stimuli (e.g., homosexual, pedophilic behaviors), and the latter for deviant responses regardless of appropriateness of partner (e.g., sadistic, masochistic, or voyeuristic behaviors).

Eysenck and Rachman (1965) use three classifications: a) inability to make an adequate sexual response to appropriate stimulation (e.g., impotence and frigidity; b) sexual responses to inappropriate stimuli (e.g., fetishistic and transvestic behaviors); and c) combinations of both (e.g., homosexual behaviors).

Staats and Staats (1963) have suggested a more extensive system which includes behavioral deficits, inappropriate behavior, inadequate or inappropriate stimulus control, defective discriminative stimulus control of behavior, and inadequate or inappropriate reinforcing systems. More recently, Kanfer and Saslow (1969) have suggested a rationale for behavioral assessment which classifies behaviors into assets, excesses, and deficits.

While it is recognized that human behavior is rich, complex, and overlapping, such systems offer a tentative method of analyzing sexual problems. Because its simplicity lends itself to exposition and because its authors have presented a detailed description of its extension into behavior analysis, that system proposed by Kanfer and Saslow (1969) will be used here.

By behavioral assets, the authors mean nonproblematic behaviors that the patient or client does well. These are

used in later assessment and treatment and will not be discussed further. Behavioral excesses are those behaviors described as problematic by the patient or an informant because of excess in a) frequency, b) intensity, c) duration, or d) occur under conditions when its socially sanctioned frequency approaches zero. Examples would be exhibitionistic, voyeuristic, and transvestic behaviors. Less obvious examples are fetishistic, masochistic, sadistic, or homosexual behaviors. Behavioral deficits are described as those responses seen as problematic by someone because they fail to occur a) with sufficient frequency, b) with adequate intensity, c) in appropriate form, or d) under socially expected conditions. The most obvious examples in the sexual area are impotence and frigidity.

It should be pointed out that whether or not a behavior problem is viewed as an excess or a deficit depends upon the viewer's vantage point. For example, a therapist may see a homosexual problem as a class of excess behaviors such as a high frequency of visiting certain bars which are known to be attended by those seeking homosexual contacts; or a persistent pattern of short, frequent, homosexual contacts; or intense sexual arousal to certain same-sex stimuli. On the other hand, another therapist might see the problem as basically one of behavioral deficit in that the individual may have failed to develop a class of social and physical heterosexual approach responses or heterosexual arousal responses. However, as Kanfer and Saslow (1969) have indicated, "a

decision about the starting point for treatment is necessary, committing the clinician to a set of priorities for treatment which can later be reviewed and changed (p. 430)."

This latter aspect brings up another distinguishing characteristic of behavior therapy--that of ongoing evaluation. Systematic record keeping of clearly defined ongoing behaviors and responses allows the therapist a means of checking on the influence of his procedures and permits him to modify them where necessary.

#### Treatment of Sexual Problems

The primary goal in the treatment of behavioral excess problems, such as fetishistic, exhibitionistic, or certain forms of homosexual behaviors, is the attempt to increase avoidance responses to stimuli associated with the problem behavior (e.g., the fetish itself or a nude male for the male patient with a homosexual problem). One of the main techniques that has been used for this purpose is some form of aversion treatment. This procedure, derived from the classical conditioning model, attempts to pair the stimulus that elicits an approach response, say a fetish, with an aversive stimulus such as shock (Max, 1935) or drugs (James, 1962). Some of the other procedures developed to increase avoidance behavior are: Covert sensitization (Cautela, 1967; 1970b); emotive imagery (Gold and Neufeld, 1965), implosive therapy (Hogan, 1969); self control (Cautela, 1969; Goldiamond, 1965) or self regulation (Bergin, 1969); thought stopping and discrimination learning (Gold & Neufeld, 1965);

shame aversion therapy (Serber, 1970a, 1970b); and verbal satiation therapy (DiCapro, 1970).

Some critics of behavior therapy erroneously believe that this is where behavior therapy ends, and in its early history this was true. However, as Ullmann and Krasner (1965) have noted, "We think that the therapist who 'removes' maladaptive behavior without helping to replace it with a more adjustive behavior is doing only half his professional job (p. 29)." The lack of certain adjustive behaviors can be viewed as a behavioral deficit, the treatment for which we turn to next.

The main aim in the treatment of behavioral deficits is to increase approach responses to stimuli associated with the problem behavior or to help the individual learn new responses. Examples of behavioral deficits in the sexual area are frigidity, impotence, and premature ejaculation. Some of the techniques that have been successfully used in treating these problems are: systematic desensitization (Wolpe & Lazarus, 1966); guided imagining (Wolpin, 1969); assertive training (Salter, 1961; Wolpe & Lazarus, 1966); emotive imagery (Lazarus & Abramovitz, 1962); behavior rehearsal (Lazarus, 1963, 1966); and covert reinforcement (Cautela, 1970a).

There have been a number of techniques that have been variously labeled but which generally fit the description of successive approximation of responses. Examples of such procedures are those described by Wolpe and Lazarus (1966)

for impotence and related disorders; Seemans' (1956) graduated technique used for premature ejaculation; Haslam's (1965) use of graduated rods for dyspareunia and Wolpe's (1969c) use of graduated imaginary rods prior to the use of actual rods; the sensate focus procedures of Masters and Johnson (1970); and a number of similar approaches to the treatment of frigidity which incorporate erotic readings, vibrators, or masturbation (Clark, 1968b, 1970; Hastings, 1963; Wright, 1969).

A brief review of the range of sexual problems treated by behavioral approaches will follow next. Treatments used for homosexual and frigidity problems will be described in more detail to illustrate the problems encountered in treatment in this area and to provide a basis for further discussion of treatment difficulties with sexual disorders.

### Behavioral Excesses

Fetish Problems. Of theoretical interest in this area were the experiments carried out by Rachman (1965) and Rachman and Hodgson (1968) in which they were able to condition subjects to give sexual responses to slides of a pair of knee-length boots by pairing their presentation with slides of nude women. Similarly, McConagy (1970) reported conditioned penile volume changes to the presentation of slides with red circles or green triangles after such presentations were repeatedly followed by pictures of nudes (female nudes for heterosexual subjects and male nudes for homosexual subjects).



These studies, in conjunction with the masturbatory conditioning hypothesis of McGuire, Carlisle, and Young (1965), mentioned earlier, suggest how fetishistic responses may be learned through classical conditioning principles. Most interestingly, further support for this hypothesis may be found in the psychoanalytic literature on fetishism. The long, carefully detailed, history of a patient generally given in a psychoanalytic case study usually offers an excellent illustration of how such conditioning might have taken place (e.g., see Gorman's, 1964, account of fetishism in identical twins).

Dynamic approaches have usually reported difficulty in treating fetish problems (Shenken, 1964), however, successful treatment has been reported by a number of learning oriented therapists (e.g., Marks & Gelder, 1967; McGuire & Vallance, 1964; Raymond & O'Keefe, 1965). Generally treatment procedures involve the use of some form of aversion therapy which pairs the fetish object (or pictures of it) with either drugs (Clark, 1963; Raymond, 1956;) or shock (Marks & Gelder, 1967; Marks, Rachman, & Gelder, 1965; McGuire & Vallance, 1964; Thorpe & Schmidt, 1964). Thorpe, Schmidt, Brown, and Castell (1964) have reported using an aversion-relief procedure in which verbal stimuli relating to the sexual object are presented visually and paired with shock as the patient reads them. When shock-contingent words cease, the "relief" experienced by the patient is paired with sexually desirable words. Bond and Evans (1967)

report successfully using an anticipatory avoidance procedure for two underwear fetishists.

Barker (1964) was one of the first to point out the treatment implication of pairing shock with fantasy rather than the behavior itself, and more recent studies have usually included shock for both fantasizing and performing the rituals associated with the fetish object (e.g., Marks & Gelder, 1967). Moving away from the use of shock or drugs, Kolvin (1967) has reported the successful use of an aversive imagery technique with a fetishistic fantasy. The fetishistic behavior had not reoccurred at an eleven month follow up.

Transvestic Problems. Many theories have been advanced to account for transvestic behaviors. Dynamic theories usually postulate that transvestites suffer from some form of pathological personality disturbance as a result of castration fears or opposite sex role compulsions (Yates, 1970a). Randell (1959), after analyzing fifty cases, suggests that transvestites fall into two main groups: homosexual or obsessive-compulsive. More recently, Bentler and Prince (1969, 1970) have conducted research that indicates no major psychopathological or personality differences between transvestites and normals.

Biological theories usually suggest some sort of genetic determination, but chromosomal analysis has so far not supported such a theory (Yates, 1970a). Epstein (1961) links transvestic and fetishistic behavior with brain dysfunction.

On the other hand, Housden (1965) carefully reviewed the physical findings in 75 cases of transvestism and found no evidence for any biological etiology.

Behavior therapists suggest that the acquisition and maintenance of such behaviors can most parsimoniously be explained by the general principles of learning. That such behaviors may be acquired is a view that has been suggested by those other than learning theorists. For example, in the cross cultural study of Ford and Beach (1951), after mentioning several examples of anatomical intersexuality which lead some individuals to lead roles actually opposite to their reproductive physiology, the authors conclude: "Taken in combination with the evidence from other societies on transvestities, observations of this nature emphasize the tremendous importance of early experience and social conditioning upon human sexuality (p. 134)."

Further support for such learning may be found by reading psychoanalytic case studies of transvestic histories such as those reported by Friedmann (1966) and Stoller (1966, 1967). This is well exemplified by the psychoanalytic treatment of transvestism in the case of a six year old boy reported by Charatan and Galef (1965). The boy was seen in therapy twice a week for two years and the mother was seen twice a week for eleven months. The case description clearly indicates how the mother may have been reinforcing the boy's cross dressing behavior. For example, " . . . the mother, with shame, admitted that at the time she had

'gotten a kick' out of Jon's behavior (p. 163)", and later, "Mrs. Y first noticed Jon dressing in her clothes when he was between two and three years of age. Initially, she thought it was cute and actually encouraged him. By the time he was three and a half, when others were commenting on it, and he began walking and making gestures like a woman, she became concerned (pp. 171-172)." The authors emphasized the importance of both the oedipal and preoedipal factors (such as the boy's castration anxiety) in the genesis of the transvestism. A learning point of view would most likely suggest that the principle of successive approximation might offer a more parsimonious explanation.

A somewhat similar case, but analyzed and treated from a social learning point of view, is that of an eight year old boy with transvestic behavior reported by Dupont (1968). However, in this case the boy himself was not seen and the therapist only had one consultation plus a phone call with the father of the boy. The boy had been dressing in his mother's clothes, both outer and undergarments, on the average of two or three times a week for the previous several months. Dupont analyzed the case from a social learning point of view and gave the father a number of suggestions concerning changes in the parents responses to the child's behavior. After one week of following the given suggestions the transvestic behavior ceased. Twelve years later the patient was reported to be a completely normal young adult after having passed through a normal adolescence. It is

obvious that the boy treated in this last case was not exposed to the years of conditioning that the Charatan and Galef (1965) boy had been, otherwise it would be expected that treatment would not have been so brief.

There are a number of cases reported in the literature where learning oriented procedure have been successful in treating adult transvestite behaviors of long duration. Prior to the advent of a learning theory approach, Lukianowicz (1959) made an extensive review of the various theories and treatments available concerning transvestism and concluded that the therapeutic possibilities were still extremely limited and the prognosis for treatment generally poor. Since that time numerous cases of successful treatment of transvestism by behavioral techniques have been reported (e.g., Clark, 1963; Cooper, 1963; Dengrove, 1967; Raymond & O'Keefe, 1965; Thorpe, Schmidt, Brown, and Castell (1964)).

Early treatment centered around aversive therapy with the use of drugs (Barker, Thorpe, Blakemore, Lavin, & Conway, 1961; Glynn & Harper, 1961; Lavin & Conway, 1961) which are still occasionally used (Morgenstern; Pearce, & Rees, 1965; Raymond, 1967; Raymond & O'Keefe, 1965). However, most therapists soon abandoned the use of drugs, and turned to the more efficient use of shock aversion (Blakemore, Thorpe, Barker, Conway, & Lavin, 1963a, 1963b; Gelder & Marks, 1969; Marks & Gelder, 1967). The disadvantages of using drugs and the advantages of using shock for the aversive stimulus have

been enumerated by several prominent workers in the field (e.g., Barker, 1965; Rachman & Teasdale, 1969), and currently shock used in aversion-relief procedures (Thorpe, Schmidt, Brown, & Castell, 1964) or a modification of such procedures (Clark, 1965) is the usual treatment of choice. Recently however, other procedures have been reported, such as the use of desensitization and assertion (Dengrove, 1967); or shame aversion therapy (Serber, 1970a; 1970b); or combinations of procedures such as Gersham's (1970) treatment of a transvestic fantasy by thought stopping, covert sensitization, and avoidance shock.

Pedophilic Problems. Research and treatment in this area is comparatively rare, with the exception of research that attempts to explore penile blood volume changes in response to pictures of males and females of varying ages (Freund, 1965; 1967). The psychoanalytic viewpoint usually sees the pedophilic as psychosexually immature with intense unresolved oedipal problems and patterns of behavior that indicate some displacement of unconscious, infantile, oral needs (Shoor, Speed, & Bartelt, 1966). Psychotherapy has not been too successful in treating these problems (Shoor, Speed, & Bartelt, 1966), though group therapy has shown some promise (Resnik & Peters, 1967).

One of the first reports of a learning oriented approach was that of Stevenson and Wolpe (1960) who reported successfully using assertive training procedures. Bancroft, Jones, and Pullan (1966) reported partial improvement from

pedophilic behavior in a patient by using aversive shock with photographs and fantasies of children. Barlow, Leitenberg, and Agras (1969) have described the use of covert sensitization with a patient who reported a 13 year history of pedophilic experiences. Their results showed a definite decline in the undesirable behavior during treatment, but unfortunately no follow up data were supplied.

Feingold (1966) offers an excellent description of a successful broad-spectrum approach to the treatment of a sexually inhibited man who was caught by his wife while he was fondling his young sister-in-law. Procedures used involved reeducation, systematic desensitization, and assertive training. Serber (1970a) has recently reported successful results in the treatment of pedophilic behavior by using shame aversion therapy in which the patient is asked to perform his behavior in front of a number of observers.

Exhibitionistic Problems. An explanation of how exhibitionism may be developed through learning has been available for almost half a century (Smith & Guthrie, 1922), but the behavioral treatment for this behavior has only been reported in the past ten years. Unlike the previous problems where aversion was the initial procedure tried, the first reported behavioral treatment in this area used systematic desensitization. Wolpe (1958) reported successfully treating a case by using systematic desensitization for social anxiety and assertive training. Bond and Hutchinson (1960) have reported

similar success by using desensitization to various anxiety-eliciting situations that the patient would usually be in prior to his exposing. Wickramasekera (1968) has reported using systematic desensitization in conjunction with the use of successive approximation of sexual situations and responses. His patient had been an exhibitionist for five years, and after 18 treatment sessions the behavior had ceased and had not reoccurred after ten months.

Other forms of treatment have been with drug aversion (Raymond, 1967), and shock aversion to the patient imagining himself in a situation where he felt an urge to expose himself (Kushner & Sandler, 1966). Evans (1968) has reported success with ten cases by using shock aversion in an instrumental escape conditioning procedure in conjunction with emotive imagery techniques. Serber (1970a) has reported success with shame aversion therapy; Evans (1970a) has had positive results with the Feldman and McCulloch (1965) aversion-relief paradigm with shock and slides containing deviant and normal sexual statements to promote imagery; and Abel, Levis, and Clancy (1970) have described promising results in three cases of exhibitionism through the use of shock aversion applied to tape-recorded descriptions of each patient's individual sexual routines.

Masochistic, Sadistic, and Voyeuristic Problems. On the surface it would appear that masochistic behavior is a glaring exception to the reinforcement theory of learning. However, several learning theorists have outlined how such



behaviors may be acquired and maintained according to general learning principles (e.g., Brown, 1965; Sandler, 1964; Ullmann & Krasner, 1969). Again, such views are not limited to learning theorists. Twenty years ago, Ford and Beach (1951), supported by cross cultural research and from studies on lower animal behaviors, suggested that, "Both the tendency to incorporate painful stimulation in the culturally accepted pattern of precoital play and the type of response to such stimulation are strongly influenced by learning (p. 265)."

For some time learning therapists were hesitant in treating masochistic problems with the usual aversion techniques for fear that such treatment might become pleasurable and thus foster the problem (Yates, 1970a); however, Marks, Rachman, and Gelder (1965) presented evidence that such treatment was as aversive to these patients as any other. Masochistic fantasies have been treated by shock aversion therapy (McGuire & Vallance, 1964; Marks, Rachman, & Gelder, 1965); and Abel, Levis, and Clancy (1970) have recently reported good results in treating, masochistic behavior with their shock aversion therapy applied to taped sequences of descriptions of the behavior. Unfortunately, there appears to be only a limited number of cases treated by behavior therapy in this area.

Mees (1966) used shock aversion to reduce sadistic fantasies and behavior, and Davison (1968) reported the use of covert sensitization in the treatment of a sadistic fantasy

and employed positive counter-conditioning (masturbation to female pictures in Playboy and other magazines) to provide an alternate response. In a related problem, Lazarus (1968b) has successfully used a broad spectrum approach in treating a case of pseudonecrophilia. This case not only offers an excellent example of behavioral analysis, but it demonstrates the use of a number of procedures for handling different aspects of the problem (e.g., assertive training, behavior rehearsal, systematic desensitization, etc.).

There is comparatively little to be found in the literature regarding voyeuristic behaviors. Wolpe (1958) reports indirectly treating a case by using systematic desensitization and assertive training for interpersonal anxiety during which the voyeuristic behavior dissappeared. McConaghy (1964) reported failure in trying to use shock while his patient was sexually excited at the sight of women, but Jackson (1969) reported successful treatment of a patient who had been engaging in voyeuristic behaviors for five years. By using masturbation as a counterconditioning procedure, the behavior dropped out after only eight treatment sessions. At a nine month follow up the patient reported that his desire for voyeurism had dissipated and his sexual energies were directed along more socially acceptable lines.

Homosexual Problems. It is highly probable that more has been written in this area by dynamic and behavior therapists than in all the areas discussed previously. Homosexuality is probably the most controversial area as well

in regard to definition, etiology, and appropriate treatment. To begin with it is difficult to find common agreement on what is a "homosexual", or "homosexual behavior." Kinsey and his associates (1948) were among the first to point out the narrowness of considering a homosexual an "either/or" proposition. They described and list relative degrees of homosexual behavior or responses depending upon such factors as age, environmental circumstances, culture, time periods, and varying situations.

The next debatable question is whether those with homosexual problems are to be considered neurotic or psychotic (Ellis, 1968) or not necessarily mentally ill (Hoffman, 1969). A number of studies comparing homosexual and heterosexual populations have been attempted by use of questionnaires (Evans, 1969; Gundlach, 1969; Manosevitz, 1970) or various personality tests such as the MMPI (Dean & Richardson, 1964; Friberg, 1967; Zucker & Manosevitz, 1966), the 16PF (Evans, 1970), the Maudsley Personality Inventory (Kenyon, 1968), the Rorschach (Goldfried, 1966) or a complete battery of tests (Miller & Hannum, 1963). In general it is found that homosexuals do not differ from heterosexuals in the usual categories (Evans, 1970; Marmor, 1965; Pomeroy, 1969), and they are not psychologically disturbed (Evans, 1970) or more mentally ill (Hoffman, 1969) than the general population. Though there have been some reported differences (e.g., Manosevitz, 1970, found that homosexuals were more sexually active at an earlier age than heterosexuals) most

such findings do not hold up under replication. As Rubin has noted, "We do not yet have a sufficient number of studies of adequate samples of homosexuals under properly controlled conditions to provide a definitive answer (1965a, p. 3)." However, from a learning point of view such distinctions are not relevant, because such labels do not determine the treatment procedures.

Probably the most disputed area concerns the etiology of such problems, which of course leads to what treatment is appropriate. Many researchers and therapists (e.g., Basil, 1970; Ellis, 1965; Marmor, 1965; Rubin, 1965; Weltge, 1969; West, 1967; Willis, 1967; Ullmann & Krasner, 1969; Yates, 1970a) have carefully examined the evidence for hormonal, genetic, or constitutional factors and found it lacking; though some feel such factors may provide a predisposition to male or female gender orientation (Diamond, 1965). Numerous authorities in a number of fields have stressed the role of learning in the formation of homosexual behaviors and responses (e.g., Ford & Beach, 1951; Kinsey, et al., 1948; 1951; Michelmores, 1964; Rubin, 1965; West, 1967). As one prominent researcher in the field recently summed it up, "Most workers in this area now lean toward a conditioning theory, although they acknowledge that physical characteristics or other predisposing factors indirectly play a part in the development of a homosexual pattern (Pomeroy, 1969, p. 12)."

One area of research with the homosexual population

that has shown increasing growth is that of identification of sexual preference through a wide number of procedures such as penile volume change while watching slides or pictures of nude males (Freund, 1963, 1967; McConaghy, 1967, 1970); or pupil response to such pictures (Hess, Seltzer, & Shlien, 1965; Scott, Wells, Wood, & Morgan, 1967); or operant techniques such as shutter pulling frequency to see pictures of same sex stimuli (Brown, 1964). This body of research is not directly relevant to the behavior therapist who primarily works with voluntary clients, but it does suggest possible means for measuring ongoing treatment and outcome effects in such cases.

Another major point of disagreement is whether homosexual problems can be "cured." The implication is, of course, that homosexuality (again, a definitional problem) is an illness. As has been pointed out previously, from a learning point of view such a question is not relevant. The current trend, even among those who are not learning oriented, is to talk of "change" rather than "cure" (Marmor, 1965; Rubin, 1965; West, 1967).

There is considerable disagreement on how much change in orientation can be expected. Curran and Paar (1957) reporting on 100 homosexual patients seen in private practice, concluded that they derived no apparent benefit in terms of changed sexual preference or behavior from psychotherapy as compared to matched patients not so treated. On the other hand, Ellis (1965) cites successful results with his own

work as well as from the clinical reports of over fifty other therapists. Marmor (1965), from a dynamic frame of reference, believes that some patients can be changed and the change maintained over a period of at least five years, given that the patient has adequate motivation to seek a heterosexual love relationship. Many have discussed this problem at length (e.g., Ellis, 1965; Marmor, 1965; Ovesey, Gaylin, & Hendin, 1963; Rubin, 1965; West, 1967) and, in relation to a dynamic approach to treatment, Rubin appears to reflect the general feeling when he concludes:

"A certain number of homosexuals have become exclusively heterosexual as a result of long term psychotherapy. The prognosis for change in the adult homosexual with a long-established pattern of exclusive homosexual behavior is not too encouraging at the present time, though some recent studies have reported a greater rate of successful therapy than in the past. Therapeutic success however, usually requires from 200 to 350 or more hours of therapy, at a cost of many thousands of dollars. Some psychotherapists consider therapy 'successful' if an exclusive homosexual becomes able to enjoy both heterosexual and homosexual relations, eventually learning to control or subordinate his homosexual desires (1965, p. 6)."

Until the advent of a learning oriented approach, treatment has been largely psychoanalytically based and aimed at uncovering the assumed preoedipal origins of the problem (Socarides, 1968, 1969); and as a result there exist numerous accounts of psychoanalytically oriented treatment approaches (e.g., Abarbanel--Brandt, 1966; Bieber, 1964; Ovesey, Gaylin, & Hendin, 1963; Socarides, 1968, 1969). Other approaches have involved existential therapy (Serbin, 1968); Rational--emotive therapy (Ellis, 1965); the use of

adjunctive techniques such as LSD (Alpert, 1969), the acting out of fantasies (Robertello, 1969), or the use of group procedures (Hadden, 1966, 1971; Mintz, 1966; Singer & Fischer, 1967; Stone & Levin, 1950; Stone, Schengber, & Seifried, 1966).

Early learning-oriented treatment methods used aversive therapy with shock (Max, 1935) or drugs (James, 1962) as the aversive stimulus. However, the disadvantages of using drugs gradually become apparent, and currently shock has become the most preferred aversive stimulus (Rachman, 1965), though some feel its use should be as a last resort (Rachman & Teasdale, 1969). As theoretical and experimental sophistication increased, simple classical conditioning procedures gave way to conditioned aversion (Feldman & MacCulloch, 1964, 1965) where the patient could avoid shock by switching off slides of nude males, which were then followed by slides of nude females, or aversion relief procedures (Thorpe, Schmidt, Brown, & Castell, 1964; Thorpe, Schmidt, & Castell, 1964; Thorpe & Schmidt, 1964) where symbolic words are used as stimuli for shock contingencies.

Some therapists have found the use of only one procedure alone to be effective, such as systematic desensitization (Dengrove, 1967; Huff, 1970; Kraft, 1967, 1969a), or covert sensitization (Barlow, Agras, & Leitenberg, 1970; Barlow, Leitenberg, & Agras, 1969; Cautela, 1967). However, many therapists have recently begun to use a wide variety of procedures for one case, such as systematic desensitization,

emotive imagery, and discrimination training (Gold & Neufeld, 1965); or systematic desensitization, shock, and homework assignments (Levin, Hirsch, Shugar, & Kapche, 1968); or self-regulation procedures in conjunction with systematic desensitization (Bergin, 1969). Cautela and Wisocki (1969) have reported an extended treatment program which uses a number of procedures such as covert sensitization, thought stopping, systematic desensitization, behavioral rehearsal, and assertive training. However, whether our present state of knowledge about treatment warrants the use of such a "program" for all clients with such problems is questionable.

Currently, many prominent researchers and therapists in the field are discouraging simple treatment approaches that involve only one procedure (such as shock or systematic desensitization) for only one aspect of the problem (such as aversion to same sex stimuli or desensitization to heterosexual stimuli) (e.g., Basil, 1970; Haynes, 1970; Kraft, 1969d, Pomeroy, 1969; Rachman & Teasdale, 1969; Ramsay & VanVelzen, 1968). Rachman and Teasdale sum up much of the current feeling, "It will not be surprising if patients who have never been able to establish satisfactory heterosexual relationships are found to require considerable assistance after treatment. Such assistance may involve social training, counselling and desensitization. In addition, specific sexual guidance may be required . . . (1969, p. 81)."

Haynes (1970) has criticised many of the past treatment programs which have punished a particular homosexual



response without first providing an alternative response to secure sexual reinforcement.

### Behavioral Deficits

Though all of the previously discussed problems may have behavioral deficits associated with them, this grouping is meant to encompass those situations where the primary problem may be seen as a behavioral deficit. Most such problems may be seen as some form of sexual incompatibility between a couple where they are experiencing difficulty in initiating or achieving mutual satisfaction and pleasure in sexual intercourse. Masters and Johnson (1970) estimate that one half of the marriages in the United States are threatened by sexual dysfunction of one form or another. Other estimates and studies suggest the incidence may be higher (see Coulton, 1970). The foregoing discussion will be limited to those forms which are reported to be most prevalent (Hastings, 1963; Hirsch, 1966; Johnson, 1968; Kant, 1969; Masters & Johnson, 1970).

Problems of Impotence and Premature Ejaculation. This area also is plagued with definitional problems. For example, two of the most common definitions are: "The inability to perform the sexual act (Straus, 1950), or "That condition wherein the male cannot obtain or maintain penile erection satisfactory to him for the purposes of heterosexual coitus (Hastings, 1963, p. 23)." In a similar vein, Simpson (1950) writes, "Potency, or implied male sexual potency, may be defined as the ability to initiate, sustain,

and successfully conclude the act of sexual intercourse to the satisfaction of the male." He then goes on to add, "If we include the words 'and the female' some 50% of potent males might be classified as impotent (p. 692)." To further confuse the issue other writers offer a wide classification system. Mirowitz (1966) describes 17 forms of impotence, two of which are: "The man must imagine he is with a woman other than his actual partner as a prerequisite for potency" and "Men allegedly bi-sexual who are at times capable of lustless intercourse with women, reserving their real passion for concomitant homosexual affairs (p. 28)." One prominent authority includes premature ejaculation as a form of impotence (Johnson & Masters, 1961), then excludes it later (Masters & Johnson, 1965). In addition, impotence may be qualified as functional, temporal, or situational, and these latter qualifications can be helpful if operationally defined. From this brief look at only a few of the definitions reported in the literature, it is not inconceivable that one therapist's impotent patient might be described by another as suffering from satyriasis.

Unlike the problems discussed previously, there are numerous known organic causes for impotence and premature ejaculation, as well as "functional" or "psychogenic" causes (Clark, 1968a; Roen, 1965; Simpson, 1950; Wershub, 1950). As an example, Roen (1965) suggests the following three simple clinical classifications of impotence on the basis of etiology: a) Organic disease causing impotence

(anatomic abnormality; neurologic disease; systemic disease; trauma, either accidental or surgical; and hormonal deficiency); b) Chemical or medicinal impotence (drugs of a narcotic or sedative nature, morphine, alcohol, etc.); and c) Psychologic impotence.

However, despite the large number of known organic causes, most authorities seem to agree that from 90% to 95% of the causes of impotence and premature ejaculation stem from psychological reasons (El Senoussi, 1959; Johnson, 1967; Kaufman, 1967; Kelly, 1961; Roen, 1965; Stafford-Clark, 1954; Wershup, 1959). Unfortunately, authorities disagree as to exactly what these psychological reasons are. Suggested causes range from jet lag and infrequent intercourse (Frank, 1968) to masturbation anxiety (Wershup, 1959) or the fear of discovery or an argument with one's mate (Willy, Vander, & Fisher, 1967). One point that most agree upon is that anxiety or fear seems to play an important role (Clark, 1961; Crider, 1963; Ellis, 1963, 1967; Masters & Johnson, 1966, 1970; Wershup, 1959; Wolfmann & Friedman, 1964; Wolpe & Lazarus, 1966). Psychoanalytic interpretations generally see impotence as a defense against castration anxiety and classical analytic treatment usually entails complete analysis of the Oedipal complex and a reworking of the intrapsychic economy (Ullmann & Krasner, 1969). Learning interpretations generally see impotence problems as the result of conditioned anxiety and treatment is largely aimed at reducing the anxiety associated by the approach to sexual

intercourse (Yates, 1970a).

Prognosis for impotency ranges from those who feel such problems are quite resistant to treatment (Money, 1967) to others who feel that these problems can be cured in the overwhelming majority of cases (Frank, 1968). Treatment for impotence ranges from psychoanalytic therapy (Ovesey & Meyers, 1968) and rational-emotive therapy (Ellis, 1963, 1967) to the use of hypnosis (Hussain, 1964; Kaufman, 1967; Kroger, 1969; Mirowitz, 1966) or mechanical means such as splints and artificial phalluses (Kelly, 1961; Rubin, 1965).

Successful behavioral treatment of premature ejaculation has usually followed along successive approximation lines, such as Seemans' (1956) technique of extended stimulation of the penis; or the use of carefully graded sexual responses (Johnson & Masters, 1961, 1964; Masters & Johnson, 1968; Wolpe, 1958; 1969b; Wolpe & Lazarus, 1966). Occasionally, systematic desensitization has been successfully used (Friedman, 1968; Kraft & Al-Issa, 1968). Most recently, Masters and Johnson (1970) have described excellent results with what they call the "squeeze technique", where the female partner applies pressure to the glans of the penis just prior to the male's report of impending ejaculation.

Treatment for erectile impotence has followed similar lines in that graded sexual responses are used if some arousal to the sexual situation is reported by the patient (Wolpe, 1958) or systematic desensitization is used if no arousal is present (Friedman, 1968; Lazarus & Rachman, 1960;

Wolpe, 1958, 1969c). Lazarus has reported successfully using a group desensitization approach (1961, 1968). In his first report (1961), he assigned his patients randomly to different treatment groups. The patients treated by group desensitization for impotence recovered while those treated by psychoanalytically derived interpretive therapy did not. Salter (1961) has reported success in using a combination of assertive training and blended imagining. Wolpin (1969) has reported good results with his technique of guided imagining. Rather than one approach to one aspect of the problem, more recent treatment has been based on a broad spectrum coverage, such as the combined use of thought stopping, systematic desensitization, and sexual assertion (Garfield, McBrearty, & Dichter, 1969); or Salzman's (1969) carefully extended use of systematic desensitization along with actual sexual responses. A particularly good example of systematic analysis with a broad based approach is the case described by Lazarus (1965) of a 33 year old sexually inadequate man who could not remember when he had last had an erection (it was later discovered that he had "learned" to masturbate without an erection while in a boy's school). Lazarus concentrated on correcting the patients misconceptions about sex, gave him assertive training with females, instructed him to masturbate to the point of orgasm only when he had a reasonable erection, and gave him systematic desensitization to sexual scenes with females. Approximately a year after treatment the man was reported

to be the adequate husband of a 23 year old ex-beauty queen and the father of a two month old daughter. Most recently, Masters and Johnson (1970) have reported promising results with their techniques of sensate focus and successive approximation of sexual responses.

Problems of Frigidity and Dyspareunia. Definitions of frigidity range from simple, restrictive ones, such as lack of vaginal orgasm (Knight, 1943) to more general statements such as abnormally adverse to sexual intercourse (Wittles, 1951). Some authorities divide the problem into primary (never having any response) and secondary (response in past, but not currently) forms (Johnson & Masters, 1961; Smith, 1956). Still others have noted relative, temporal, situational, true, and pseudo forms (Brown, 1966; Hastings, 1963; Schaefer, 1969; Willy, Vander, & Fisher, 1967).

As with impotence and premature ejaculation there are similar known organic causes for frigidity and dyspareunia (Clark, 1962; Ellis, 1961; Hastings, 1963; Willy, Vander, & Fisher, 1967), but here too the majority of the causes are seen as psychological in origin (Ellis, 1961; Hastings, 1963; Hirsch, 1966; Sherfey, 1966). There is also wide disagreement over incidence (Brown, 1966; Haire, 1937; Oneil, 1963; Willy, Vander, & Fisher, 1967; Wittles, 1955) and etiology (Brown, 1966; Johnson & Masters, 1961; Trainer, 1965; Willy, 1970). Some feel the problem is primarily the woman's (Menninger, 1938), while others see the man as the main cause (Haire, 1937), and still others see it as a mutual

fault or mistake (Branson, 1966). Johnson and Masters (1961) note three general types of causes relating to attitudes, relationships, and fear of pregnancy, and more recently (Masters & Johnson, 1965a; 1970) they have suggested that fatigue and preoccupation are the two basic deterrants to full sexual response. Many have stressed some sort of emotional conditioning and previous learning experiences as being of primary importance in such problems (Ford & Beach, 1951; Klemer, 1965; Kinsey, et al., 1948, 1956; Willy, 1967). Psychoanalytic interpretations generally see frigidity as the result of incestuous attachments originating in the Oedipal stage (Brown, 1966), and therefore treatment is never aimed at the problem itself but analysis of the entire personality is necessary to reach the underlying causes (Passmore, 1968; Wittles, 1951). Learning interpretations usually see such problems as the result of conditioned emotional responses and treatment is generally directed at reducing the anxiety associated with sexual behavior.

Prior to the advent of the behavioral approaches, frigidity problems have long been considered refractory to treatment (Smith, 1956; Yates, 1970a). Treatment has ranged from psychoanalytic therapy (Knight, 1943; Wittels, 1951) and rational-emotive therapy (Ellis, 1963, 1967) to the use of group therapy (Stone, 1950), hypnosis (August, 1959, Coulton, 1960; Kroger, 1969; Richardson, 1963), or de-reflection techniques (Frankl, 1963).

Successful behavioral treatment of dyspareunia has been reported by Haslam (1965) through the use of a series of graduated dilators; or by Wolpe's (1969c) extension of Haslam's technique by first using systematic desensitization to the imaginary insertion of graduated rods, followed later by actual insertion of real rods; and by the use of systematic desensitization alone (Lazarus, 1963; Eysenck & Rachman, 1965).

The main forms of behavioral treatment for frigidity usually rely on some form of systematic desensitization (Brady, 1966; Kraft-Al Issa, 1967; Lazarus, 1963; Wolpe, 1969c; Wolpe & Lazarus, 1966); or some form of direct successive approximation approach to sexual responses, such as Wright's (1969) use of explanation and masturbation; Clark's (1968b, 1970) use of vibrators and instructions; Hastings' (1963) use of erotic reading and masturbation; Kaiser's (1969) use of a bio-energetic approach; and Masters and Johnson's (1970) sensate focus techniques.

Other successful procedures that have been reported in the literature are group systematic desensitization (Lazarus, 1968a); automated desensitization with instructional aids (Tinling, 1969); guided imagination (Wolpin, 1969); and implosive therapy (Hogan, 1968) and its extensions (Frankel, 1970). D'Alessio (1968) reports good results from using some behavioral approaches in conjunction with psychotherapy. As noted in previous areas, more recent treatment procedures have attempted to stress a broad spectrum approach, such as



the case described by Geisinger (1969) in which he used assertive training, behavior rehearsal, group verbal interaction, thought stopping, flooding techniques, and systematic desensitization to three separate hierarchies.

### Difficulties in the Behavioral Treatment of Sexual Problems

From this brief review it can be seen that a wide number of sexual problems have been treated by behavior therapy methods. Though there have been many reported successes in the treatment of problems that have been known to be very resistant to treatment by previous methods (Curran & Parr, 1957; Ellis, 1965; Kraft, 1970b; Marmor, 1965; Raymond, 1956; Yates, 1970a), there are also a good number of failures reported with the behavioral approach (Dengrove, 1967; Feldman, 1966; Franks, 1967; McConaghy, 1964; Thorpe & Schmidt, 1964). Various reviews of the behavioral treatment of sexual problems have generally commented upon the fruitful and encouraging results obtained so far, but they have all qualified their optimism by cautioning that the field still has a long way to go with many problems yet to be ironed out (Dengrove, 1967; Feldman, 1966; Franks, 1967; Rachman, 1961; Ullmann & Krasner, 1969; Yates, 1970a).

Whether or not behavior therapy is effective is not the question, its effectiveness with some patients with certain problems has been described. A more appropriate set of questions, as suggested by Ford and Urban (1967), are: "Which set of procedures is effective for what set of purposes when applied to what kinds of patients with which

sets of problems and practiced by which sort of therapists (p. 359)." Similar questions have been put forth by many others (e.g., L'Abate, 1969; Paul, 1969), but answers have been slow in coming from research and practice in this area. Many of the difficulties seem to stem from assessment and treatment procedures that are currently being used, or not used, by learning oriented therapists.

#### Assessment Difficulties

As learning oriented therapists have become more widely known, they have been referred a broader range of patients with a broader range of problems (Klein, Dittmann, Parloff, & Gill, 1969). Without careful assessment procedures, the danger exists that many people with superficially similar problems may be treated by inappropriate procedures. For example, Dengrove (1967), in his review of the literature, has noted that too many studies lump "homosexuals" all together without any attempt at separation.

Kraft (1969b) has pointed to the possible danger of "symptom substitution" without careful assessment procedures; and Mowrer (1966) has also suggested dangers in possible misdiagnosis. Most therapists and researchers strongly advocate a thorough behavior analysis prior to any planned intervention (Ford & Urban, 1967; Kraft, 1969b; L'Abate, 1969; Marks & Gelder, 1967; Staats & Staats, 1963; Tharp & Wetzel, 1969; Ullmann & Krasner, 1965, 1969; Wolpe, 1969c; Wolpe & Lazarus, 1966; Yates, 1970a). Unfortunately, as some have pointed out (Dengrove, 1967; Klein, Dittmann,

Parloff, & Gill, 1969), in actual practice there appears to be little support for the concept of a clear and systematic behavior therapy diagnosis on the part of some therapists.

Even with those who agree that there should be careful assessment, there is disagreement as to exactly what form the assessment should take. Some feel that there is little need for a past social-learning history and the behavior therapist works primarily with the immediate problem behavior without necessarily knowing how it might have come about (Phillips & Weiner, 1966). Others feel that such a history is only necessary in certain cases (Rachman, 1963). However, the strongest case is made by those who believe that a past learning history is essential if the therapist is to derive his treatment procedures from the general body of learning theory and apply them appropriately (Birnbrauer, Burchard, & Burchard, 1970; Staats, 1968b; Staats & Staats, 1963; Ullmann & Krasner, 1969).

More recently, there has been a strong push in the direction of more extended analysis within a broader context (Bucher & Lovass, 1970; Dengrove, 1967; Franks, 1967; Kanfer & Saslow, 1969). For example, Franks (1967) comments, "Something more than behavioral diagnosis is required. It is necessary to develop, as Wolpe and his associates are doing, sophisticated procedures for making a behavioral analysis of the total situation prior to embarking upon a planned program of behavioral change (p. 219)."

While many have stressed the need for careful assessment

prior to therapeutic intervention, it is unfortunate that there seems to be comparatively little in the literature spelling out such procedures. The few exceptions are primarily geared to contingency management of operant behaviors (e.g., Bijou, Peterson, Harris, Allen, & Johnson, 1969; Birnbrauer, Burchard, & Burchard, 1970; Tharp & Wetzel), though recently some promising approaches have appeared in the general counseling (Osipow & Walsh, 1970b) and clinical areas (Kanfer & Saslow, 1969).

Another problem directly related to initial assessment in the sexual area is the one mentioned previously of definition. It is obviously difficult to evaluate the appropriateness or effectiveness of a specific procedure, or to compare it with another, if the only description of the problem given is, say, "The patient has been a practicing homosexual for four years", or, ". . . impotent for two years." Though it is difficult, if not impossible, to compare clients in treatment without operational specification, it is even more difficult without common agreement on some of the more basic terms such as "impotence" or "frigidity." There is an obvious need for assessment procedures that provide for clear descriptions and operationally defined terms.

Another area of disagreement is whether or not relationship variables, such as "rapport" and "empathy", are necessary for the learning oriented therapist in his assessment and treatment procedures. Johnson and Masters (1964),

working primarily in the sexual area, feel that the necessity of rapport first is a myth and they stress quick assessment and treatment of sexual problems. Others feel that understanding and warmth are particularly necessary for interviewing and treating in the sexual area (Golden, 1967; Kinsey, et al., 1948; Klemer, 1965c; Kroger, 1969; Thorne, 1966). Hooker (1965), writing on her longitudinal research with a homosexual population, warns that, while questions concerned with preferred methods and kinds of sexual activity are answered without apparent discomfort, questions that deal with "how" such activities are performed may be much more disturbing--even after many years and hours of interviewing with a person. Obviously, it is the "how" questions that are of particular importance to the learning oriented therapist.

Truax (1966) has suggested that, "therapists high in empathy, warmth, and genuineness are more effective in psychotherapy because they themselves are personally more potent positive reinforcers; and also, because they elicit positive affect in the patient (p. 160)." Others (Leventhal, 1968; Osipow & Walsh, 1970b; Ullmann & Krasner, 1965) have also suggested that the therapists ability to be a reinforcing stimulus may well serve as an operational definition of "rapport". Staats (1968) has offered a theoretical explanation of how the A-R-D qualities of a person may help determine his effect on other people in a variety of ways. However, as Lazarus (in Klein, Dittman, Parloff, & Gill,

1969) has pointed out, "Both Wolpe and I have explicitly stated that relationship variables are often extremely important in behavior therapy. Factors such as warmth, empathy, and authenticity are considered necessary but often insufficient (p. 262)." From the foregoing it seems reasonable to suggest that the learning oriented therapist not arbitrarily reject the concept of rapport, and that he might be most effective if he concentrated on methods of establishing himself with positive A-R-D qualities during his initial assessment procedures and during treatment.

In line with the development of better initial assessment procedures, there has been an equal stress on the need for continual ongoing evaluation of a client's progress so that inappropriate treatment procedures may be altered accordingly (Klein, Dittman, Parloff, & Gill, 1969; Levin, Hirsch, Shugar, & Kapche, 1968; Thoresen, 1969; Yates, 1970a).

There is also a definite need for objective pre and post evaluation measures dealing with sexual interests and behaviors (Feldman, 1966; L'Abate, 1969). However, as Barlow, Leitenberg, and Agras (1969) have indicated, there is considerable difficulty in using objective and observable measures in cases of sexual deviation where more than one person is involved. In addition, ethical considerations are also of importance, and, as Bandura comments, "A major obstacle to the understanding of human sexual deviance, is that, for ethical reasons, experimentation designed to

identify the conditions governing sexual phenomena cannot be conducted. Consequently, the search for the relevant controlling variables must rely on naturalistic studies (p. 512)."

Many have pointed out that behavior therapy, at this stage, is primarily based on a research design which examines the behavior of a single individual over time (Bijou, Peterson, Harris, Allen, & Johnson, 1969; Ford & Urban, 1967; Tharp & Wetzel, 1969; Ullmann & Krasner, 1965; Yates, 1970a, 1970b). Though parametric studies have been done on some of the more established techniques (Paul, 1969), the majority of research has been based on such single subject designs as suggested by Bijou, et al. (1969); Bucher and Lovass (1970); Gelfand and Hartmen (1968); Inglis (1966; and Michael (1970). However, as Staats (1969) has noted, applying learning principles dealing with cases of individual human behavior problems, "precludes in many cases the single--organism designs of the animal laboratory, for example, the presentation and withdrawal of the training conditions and other types of experimental controls (Staats, 1969, p. 74)." This latter type of research, or "clinical trials" as Ford and Urban (1967) call them, can be seen as the ultimate practical test of a therapeutic approach (Ford & Urban, 1967) or as a means of discovering procedures and materials that are functional (Staats, 1969; Yates, 1970a, 1970b).

In the actual clinical situation the therapist does

not select his problem or have the opportunity to control the factors which govern its occurrence, "Nor is he free to select treatment procedures independent of the characteristics of the patient, his problem, or the context within which he is working. The focus of the therapist's attention is completely on the behavior of the individual, and the welfare of that individual is the paramount objective (Ford & Urban, 1967, pp. 361-362)." This does not mean abandonment of the experimental procedures of the laboratory, for as Staats (1969) points out, "one also needs replicability and generality and inevitably this means advancement to work which deals with groups of subjects, employing the principles and procedures first developed with single subjects (p. 75)." It appears, from the foregoing, that parametric studies in the behavioral treatment of sexual problems should await discovery and development of more functional procedures and assessment materials.

While many therapists rely primarily upon patient reports concerning their sexual problems (Klein, Dittmann, Parloff, & Gill, 1969), a number of measures have been developed to aid in assessment and to determine changes in behavior, particularly in relation to fear or anxiety. Akutagawa (1956) developed a scale designed to measure fear. From this scale a number of Fear Survey Schedules (FSS) were developed for use in research and therapy assessment.

The purpose of the FSS is to determine both the number and relative strength of fear-eliciting stimuli, both before



and after experimental intervention or therapy. Unfortunately, a number of problems have arisen from their use: little normative data have been supplied for comparison purposes; what normative data are available are primarily limited to the research forms rather than the clinical forms; and there are a number of scales available so there is little reported consistency of use from one case report to another.

To illustrate some of the problems, Lang and Lazovick (1963) developed a 50 item survey (FSS-I) from Akutagawa's (1956) scale to assess change in phobic behavior and generalized anxiety in experimental studies of desensitization. No normative data were supplied. Geer (1965) developed a form (FSS-II) primarily as a research tool. His scale of 51 items, patterned after Akutagawa's scale, also had norms for college males and females, as well as some correlational figures with personality tests. However, his scale was intended primarily for research interests with behavior therapy.

Rubin, Katkin, Weiss, and Efran (1968) made an orthogonal factor analysis of the FSS-II and found four factors, but the headings were very general and subject to overlap. Bernstein and Allen (1969) also factor analyzed the FSS-II and found five factors for each sex, with 33 items. They supplied names for the factors but no normative data on the scale.

Wolpe and Lang (1964), taking some items from the FSS-I

and supplying others from their clinical experience, developed a 76 item scale (FSS-III) for assessment of clinical change and help in tracking down "free-floating" anxiety determinants. However, they did not supply any normative data. Manosevitz & Lanyon (1965) added 22 items of their own to the FSS-III and developed a 98 item scale for which they did supply some normative data from college students.

Wolpe and Lazarus (1966) published another scale which was actually the FSS-III with two additional items. Again, no norms were reported. Suinn (1968, 1969) developed a 100 item scale, using 75 of the 76 items from the FSS-III, plus the two extra from the Wolpe and Lazarus (1966) scale, and 22 items of his own. Suinn did supply normative data on the total scores for both males and females, but he also showed a 10 point drop in total mean scores on the retesting five weeks later.

Most recently, Rubin, Lawlis, Tasto, & Namenek (1969) factor analyzed 122 items from a fear survey of Lang's. They developed a 40 item schedule that supplied five conceptually pure factors. They did not supply normative data, and hope for comparison with other forms is doomed when it is noted that: they used 26 items from Wolpe and Lang (1964); 1 from Wolpe and Lazarus (1966), and two from Geer (1965), plus 11 different items. Finally, Braun and Reynolds (1969) developed the 100 item Temple Fear Survey Inventory which consisted of 55 items from the FSS-III, 37 items from the FSS-II, and seven additional items. Their factor analysis

resulted in 21 factors for each sex (nine relatively large factors for males and 11 for females). They did not supply norms for the scale items or total scores. From this brief review of some of the more widely used assessment measures in behavior therapy, current difficulties associated with assessment become apparent.

### Treatment Procedure Difficulties

As has been described previously a wide number of treatment procedures have been used by behavior therapists; however, a considerable number have not resulted in successful outcomes. For example, Wolpe (1969a) reports a number of failures with the use of negative practice. Davies and Morgenstern (1960) described their failure with the use of drug aversion therapy in the treatment of transvestic behavior. Clark (1963a, 1963b) has reported failure in using drug aversion with a fetishist, as did Thorpe and Schmidt (1964) using shock aversion with a similar problem. McConaghy (1964) reported lack of success in using shock aversion with a voyeur. In the treatment of homosexual problems a number of failures or relapses have been reported with the use of drug aversion therapy (Freund, 1960); classical conditioning of shock to homosexual fantasy (McGuire & Vallance, 1964); and the use of anticipatory avoidance procedures (Feldman & McCulloch, 1965).

There are a number of possible reasons for these failures. Baker (1965) and Rachman (1965) have both pointed out that chemical aversion is usually highly unpleasant for

the patient as well as for the staff, and that drugs do not allow for tight control of time factors which are known to be important in conditioning procedures. Many feel that it is better to use faradic conditioning rather than chemical to control for these and other confounding factors (Feldman, 1966; Rachman, 1965; Rachman & Teasdale, 1969).

On the other hand many patients have been known to stop or refuse treatment because of the pain involved in faradic conditioning (Rachman, 1965; Rachman & Teasdale, 1969). Wolpe (1969a) believes that the use of aversive conditioning or aversive relief procedures in the treatment of homosexual behaviors is not the first treatment of choice. Rachman and Teasdale (1969) suggest that aversion therapy only be used as a last resort. The restrictive use of aversion therapy without proper assessment is one of the most likely causes of failure in a number of cases.

Franks (1967) warns of the dangers of badly planned aversion therapy, and Feldman (1966) argues for the need to derive aversion therapy treatment logically from the general body of learning theory rather than the inappropriate application of a number of procedures.

Another possible reason for early failures in the treatment of homosexual problems was the therapist's limited approach, such as aversion therapy, to only one aspect of the problem. Most therapists now feel that most cases require a combination of conditioning methods which also help the patient to learn alternate responses (Dengrove,

1967; Feldman, 1966; Meyer & Chesser, 1970; Rachman, 1961).

Bandura (1969) illustrates this viewpoint quite clearly;

"It should be emphasized here that conditioning of sexual attraction to appropriate objects constitutes only part of a broader treatment objective. Persons who have engaged in deviant sexual practices for a long time must develop not only heterosexual attraction but also intricate patterns of heterosexual behavior. This may require, among other things, acquisition of new speech patterns, dress styles, courtship behaviors, modes of sexual stimulation that are closely associated with heterosexual coitus, and many other aspects of sex-role behavior (p. 522)."

Criticism of restrictive use of one technique has not been limited to aversion therapy. Lazarus and Serber (1968) note that, "In some circles, 'behavior therapy' and 'systematic desensitization' are synonymous", and then, later, "Usually, when procedures gain popularity, the boundaries for their specific application become hazy. Even some pioneers of systematic desensitization apply the technique like a shotgun without taking specific aim (p. 215)."

Lazarus (1967, 1968c), along with many others (Franks, 1967; L'Abate, 1969; Meyers & Chesser, 1970; Yates, 1970a), has long advocated a broad spectrum approach to behavior therapy in place of the automatic use of a restrictive range of techniques. Franks (1967) reflects this current view clearly when he states:

"The naive assumption that it is sufficient to work behaviorally with the dominant or presenting problem and that all other aspects of the individual's modes of functioning can be either ignored or treated by non-behavioral means may be viewed as an early phase in the development of a sophisticated behavioral therapy model (p. 213)."

In closing this section on difficulties with assessment and treatment of sexual problems, a final statement by Kanfer and Phillips illustrates the ideal relationship between the two:

"Ultimately, a treatment should not be prescribed just because it is available; rather, it should be selected because factors in the patient's life, history, and environment dictate the choice of a target response (symptom), the use of particular control procedures and reinforcers, and the selection of a given social setting in which treatment should occur (1969, p. 449)."

#### Design of the Present Study

From the foregoing it can be seen that presently there is no systematic learning oriented approach to the analysis and treatment of sexual problems available to the clinician. Although there is a clear need for the development of a broad-spectrum approach to treatment design, we lack a system of analysis which will allow for the ordering of goal priorities and the coordination of selected interventions. As a step in this direction, and due to the prevalence of sexual problems and the difficulties associated with their treatment, it was considered of practical as well as theoretical value to design and carry out a study to investigate methods of assessment and treatment in this area. The main purpose of the present research was to develop, test, and refine a conceptual scheme for the ordering of sexual problems and their treatment from within a learning theory framework. Inasmuch as this was treatment oriented research, reversals and other experimental laboratory procedures were not used

and changes over time were the primary sources of data collection.

Various questionnaires and inventories were specifically developed for use in the assessment and evaluation of subjects treated in this study. While the welfare of each subject was of primary importance, each case was seen as a clinical trial of the assessment and evaluation procedures and as a means of discovering functional materials and therapy techniques. Various modifications were made in the conceptual scheme as inadequacies became apparent during the ongoing treatment program. Toward the end of the research a scheme emerged that appeared to offer the most promising conceptual framework for assessing and treating sexual disorders. This framework was then applied to a final case and found to be highly productive in analyzing a sexual problem and suggesting appropriate treatment procedures.

## METHOD

SubjectsFor Normative Data

Seventy-eight students enrolled in three undergraduate psychology and educational psychology courses at the University of Hawaii served as subjects for the collection of normative data. Subjects characteristics as to sex, age, and marital status may be seen in Table 1.

Table 1

## Subject Characteristics

Sex and Marital status	N	Median Age	Age Range	Age not Given
Males				
Single	28	21	19 - 32	1
Married	4	25.5	23 - 27	
Total Males	32	21	19 - 32	1
Females				
Single	35	20	18 - 28	2
Married	11*	26.5	20 - 49	
Total Females	46	21	18 - 49	2
Total Sample	78	21	18 - 49	3

\* One 23 year old married female did not take the CPI.

For Treatment Program

Fifteen subjects volunteered to enter into the research treatment program. Of the 15 subjects, four requested help with homosexual problems, 10 with problems of sexual incompatibility, and one with a pedophilic problem. These subjects were members of the community who were referred, or voluntarily came for help, with a presenting problem of a sexual nature. Further descriptions of the subjects will be given



during the detailed case presentations given in the results section.

### Materials

A variety of measures and materials were used in the initial assessment, as well as during and following treatment. Some measures were developed specifically for the present research program, while others were used from previous research. The materials used for initial assessment and evaluation were:

#### Life History Questionnaire (LHQ)

The particular LHQ used in the present research program (see Appendix A) was based upon a number of similar questionnaires reported in the literature (Kinsey, et al., 1948; Wolberg, 1954; and Wolpe & Lazarus, 1966). The LHQ was used to obtain an overview of the subject's background in a variety of areas. In order to take full advantage of actual consulting time each subject was asked to fill out the form on his own. The information obtained was first examined by the experimenter (E) alone, followed by further discussion in consultation with the subject. This allowed the subject opportunity to bring up points that he felt were important but inadequately covered by the form. At that time additions or deletions were made to the information and E was able to clarify any questions that the subject may have had about the material. These discussions were also seen as providing a means for establishing E as a positive reinforcer for the subject by E's interest in his personal background. As a

consequence it was hoped that the discussions might help to reduce any initial anxiety the subject may have had over entering into the treatment program.

#### Behavior Assessment Form (BAF)

This form (see Appendix B) was developed for use in the present research program as a primary assessment tool. It was designed to cover those areas suggested by Kanfer and Saslow (1969) to be important for making a behavioral diagnosis upon which to base decisions about specific therapeutic interventions. The form also incorporates certain additional proposals for behavior assessment made by Bijou, Peterson, Harris, Allen, and Johnston (1969) and Wolpe and Lazarus (1966). The BAF was used as a means for assessing behavioral assets, deficits, and excesses; motivational analysis; developmental analysis; sociological changes; behavioral changes; and analyses of social relationships and self control. The information obtained through use of the form was meant to provide the main base for devising an individual treatment program for each subject. This form was filled out by E in consultation with the subject. It was also seen as an additional means for establishing E as a positive reinforcer for the subject.

#### Composite Fear Inventory (CFI)

This inventory (see Appendix C) was compiled from previously published fear surveys, minus duplications. This allowed the comparison of subject's responses with previously reported normative data.

The CFI comprises 175 items which are arranged as follows: Items 1 through 100 are those used by Suinn (1969); items 24 through 101 are those used by Wolpe and Lazarus (1966); items 26 through 101 are those described by Wolpe and Lang (1964) in the FSS-III; items 95 through 146, minus 101, are those used by Geer (1965) in the FSS-II; 40 items located between items 25 and 174 are those reported in the Rubin, Lawlis, Tasto, and Namenek (1969) inventory; items 96 through 130, minus items 97 and 101, are those used in the Bernstein and Allen (1969) scale; 100 items located between items 25 and 162 are those in the Braun and Reynolds (1969) Temple Fear Survey Inventory; and item 175 (seeing a psychologist or psychiatrist) was added in the hope of obtaining a rough indication of the degree of initial anxiety experienced by the subject in relation to E.

Three studies (Bernstein & Allen, 1969; Geer, 1965; and Manosevitz & Lanyon, 1965) have provided data which indicates where average college students may be expected to respond with a "3 plus" (or its equivalent) response to a specific item. These items are identified in the CFI Form itself for immediate comparison with the subject's responses. Item numbers in the CFI followed by a colon (:) indicate an expected response of 3 or more ("A fair amount") by females; and item numbers followed by two periods (..) indicate an expected response of 3 or more by males and females (there appears to be no data available indicating such expected responses from males considered separately).

A Fear Inventory Data (FID) sheet (see Appendix D) was also developed to allow rapid comparison of specific scores obtained by a subject with whatever normative data are available from the literature for that scale score.

The information obtained from the CFI was used in a number of different ways, such as clarification of generalized anxiety sources, indexing relative emotional responses to stimuli for possible hierarchy construction for systematic desensitization, and assessing changes in attitudinal responses to specific stimuli. This is one of the two inventories for which local normative data were collected.

#### Reinforcement Survey Schedule (RSS)

This schedule (see Appendix E) was developed by Cautela and Kastenbaum (1967) to be used in a number of ways such as: to establish rapport; for use in emotive imagery; for helping to shape behaviors during interviews; for shaping behaviors outside of the interviews; for self control behavior; for use in behavioral rehearsal; and as a possible pre and post treatment measurement of outcome.

#### Sexual Fear Inventory (SFI)

This inventory, developed specifically for the present research program, consists of 130 sexually-related items taken from a variety of sources (e.g., sexual hierarchies created for use with systematic desensitization and reported in the literature, sexual attitude scales, and similar sources).

There are two forms of the Inventory, one for use by

males (see Appendix F) and a comparable one for use by females (see Appendix G).

The 130 items comprise four conceptually different areas as follows: Items 1 through 30 were seen as being general in nature (e.g., "nude art" or "exotic dancers"); items 31 through 60 are those that involve the subject personally (e.g., "talking to others about sex" or "being seen nude"); items 61 through 80 are items concerned with social relationships (e.g., "calling a female on the phone" or "a male smiles at you"); and items 81 through 130 consist of physical contact items of a progressively more intimate nature (e.g., "kissing a female goodnight" or "manipulating the genitals of a male with your hand underneath his clothes"). In addition, items 100 through 120 are an appropriate rewording of the items used by Bentler (1968a, 1968b) for his Heterosexual Behavior Inventory. This allowed for a comparison of the subject's attitude toward his reported behavior on the Bentler scale.

The SFI was used in a manner similar to the CFI, only directly concerned with the sexual area. By changing instructions it might also be used as an "arousal" inventory. It was basically used to assess the A-R-D value of sexually related stimuli so that appropriate interventions could be planned. It is the second of the two inventories for which local normative data were collected.

#### Heterosexual Behavior Inventory (HBI)

These inventories were developed by Bentler (1968a,

1968b) and were obtained from him and reproduced for use with subjects in the present research program. The inventories consist of a male (see Appendix H) and a female (see Appendix I) form, each of 21 items. The items describe heterosexual behavior which form a cumulative ordinal scale. They provided valuable information on the subjects' degree of sexual experience relative to the norms supplied by Bentler for a normal college population. They were also used for assessment of behavior change after treatment and as an aid in hierarchy construction for use in systematic desensitization.

#### Sexual History Form (SHF)

This form (see Appendix J) was directly patterned after that used by Kinsey and his associates (1948). It provided a guide for obtaining information covering the following eight areas: physical and physiological data; sex education; nocturnal sex dreams; masturbation; heterosexual history; animal contacts; homosexual history; and erotic responsiveness. This was the primary tool used in obtaining a fairly comprehensive sexual history of the subject, as well as a description of his current sexual behaviors. It was filled out by E in consultation with the subject.

#### Sex Knowledge Inventories (SKIS)

These inventories were developed by McHugh and come in two forms: Form Y (1955) consists of diagrams and questions concerned with vocabulary and anatomy; and Form X (1967) consists of 80 general questions concerned with facts

covering the physiology of sex and important features of sexual relationships. The inventories were used in a variety of ways: Comparison of the subject's performance with norm groups provided; establishing a common vocabulary agreement between the subject and E, as well as between couples where appropriate; to bring to light misconceptions or deficits in the subject's knowledge; as a first step in approximating eventual open communication patterns on sexual matters between couples; and, hopefully, to help change some of the subject's attitudinal responses to certain words or terms through numerous discussions of the material.

In addition to the above described inventories and forms a variety of other materials were used where appropriate, such as: sexual diagrams, charts, and pictures; anatomical models; manikins; appropriate articles, magazines, and books; and a variety of films.

#### Procedure

##### For Normative Data Collection

Three undergraduate psychology and educational psychology classes were visited by E during their normally scheduled class time. The subjects were asked if they wished to participate in a research program which was designed eventually to help other students who might be experiencing sexual problems. They were assured of the complete confidentiality of their responses. They were told that participation was entirely voluntary, that names would not be required, and that those who desired for whatever

reason could turn in blanks papers. However, due to the possible importance of certain subject characteristics, the subjects were asked if they were willing to write on their inventories their age and an "S" if they were single, and "M" if married, or a "D" if divorced or widowed. They were also told that this was only a request and if they preferred they could leave the information off of the paper.

The Sexual Fear Inventory was then passed out, the appropriate form to each sex. The instructions for making the ratings were read aloud from the form by E. A large box was then placed in the center of the room and the subjects told that they could drop their inventories into it when they had finished. When the last subject had dropped in his form, all subjects were asked once more to participate by filling out the Composite Fear Inventory. Directions and procedures were the same as with the SFI, except subjects were asked to write a "G" for girl or a "B" for boy on the forms.

When all the inventories had been completed and turned in, E discussed the purposes of the inventories and how they would be used. He also answered any questions and agreed to meet anyone individually after class if they had further questions or any concerns about their participation.

No subjects refused to cooperate. One subject had to leave for an appointment after completing the SFI and was therefore unable to complete the CFI. All subject characteristics requested were given with the exception of one



single male and two single females who neglected to note down their ages.

For The Treatment Program

Several mental health centers in the community cooperated by referring clients to E for possible inclusion as subjects in the research program. Criteria for inclusion were: that their major, or one of their major, presenting problems be of a sexual nature; that they were not currently receiving treatment for their problem; the absence of severe pathology; and the absence of severe health problems.

Each referral was then seen by E at the referring agency for an initial one hour interview to determine their appropriateness for the research program. If deemed appropriate (and all were initially), then a brief description of the rationale and basic approach of the research program was given, along with the answers to any questions that might arise. Other alternatives were also given such as referral to different staff members of the agency. They were then asked to take sometime to consider whether or not they wished to enter into the research program and to let E know their decision at a later time. All referrals made during one calendar year were given the opportunity of entering into the research program. All who were referred during that time elected to enter into the program. Treatment was carried out in an office provided by the referring agency. The procedure for each subject went generally as

follows.

The subject was asked to fill out a three by five card that asked for his home address and phone number. Each card was assigned a number, which was then the subject's specific code number. The cards were kept in a locked box, which was located in a locked drawer of E's desk. The assessment forms were then shown to the subject and instructions given for filling out each. Any questions were answered as to the eventual use of the information and further clarification of what was expected was given when requested. The subject was instructed to use only his code number on the forms and not to place his name or any other information on the form that might possibly identify him. This precaution was taken to insure confidentiality in case the subject happened to lose any of the forms while completing them away from the center. When he had completed the forms he was to put them in an envelope and deliver them to E prior to his next appointment, in order to allow E time to go over them. The subject was then shown the file cabinet in which the forms would be kept locked. These procedures were designed to ensure the subject of complete confidentiality, a factor that has been suggested as being of extreme importance by numerous researchers in the sexual area (e.g., Kinsey, et al., 1948; Kroger, 1969; Masters & Johnson, 1966; Thorne, 1966). The sequence the subject was asked to follow in completing the forms was: LHQ: CFI: SFI: HBI: SKI-Y: and SKI-X.

During subsequent meetings with the subject the forms and inventories were gone over in detail for clarification, additions and deletions. During this time E attempted to gain as complete a picture of the subject and his relationship to his past and current environment as possible. Osipow and Walsh (1970b) have described this period as one in which the counselor has hopefully acquired the reinforcing value that they feel is necessary for him to have to become an effective agent of change. Similarly, Levin, Hirsch, Shugar and Kapche (1968) report using at least 10 hours for the establishment of rapport and the completion of assessment procedures. The first half of assessment, described above, usually averaged four or five hours.

During this initial assessment period the subject, where appropriate, was referred to his or her own physician for a medical evaluation. This examination was to help determine if there were any genetic, constitutional, hormonal, or disease factors contributing to the subject's problem. If the subject did not have a private physician available, the cooperation of appropriate physicians had been obtained to examine the subject without charge.

After the follow up inquiry on the initial assessment battery E, in consultation with the subject, then completed the Behavior Assessment Form, followed by the Sexual History Form. Obtaining this information usually took an additional four or five hours.

Throughout the assessment E usually took various

opportunities to orient the subject to general learning principles, and to suggest how such principles might account for some aspect of his problem. That such a procedure appears to be an important consideration in effective therapeutic change has been reported by a number of learning oriented therapists (e.g., Davison, 1968; Klein, Dittmann, Parloff, and Gill, 1969). In addition, along the lines suggested by Tinling (1970), a new vocabulary of behavioral description was generally suggested to the subject. For example, the subject would learn the different implications of saying "I had a homosexual experience" rather than "I am a homosexual." The learning principles and rationale behind any suggested treatment procedures were also explained and discussed with the subject (Meyers and Chessser, 1970, have noted that such procedures as described above have become almost customary clinical practice for learning oriented therapists).

Upon completion of the initial assessment E then attempted to organize a tentative rational treatment program based upon a learning oriented conceptual analysis of the obtained information (as Meyers and Chessser, 1970, have pointed out, there is almost unanimous agreement among experienced behavior therapists that this is the most difficult task that the therapist faces). Analysis of the subject's past and current emotional, cognitive, and overt behaviors was begun by seeking answers to such questions as: Are there any medical factors contributing to the subject's

problem? If so, is treatment available and how can it best be incorporated into the present treatment program? What are the subject's positive and negative attitudinal responses to different sexual stimuli? Are they appropriate in relation to his stated goal? Are there cognitive deficits in the subject's knowledge of sexual anatomy and function that may be contributing to his problem? What contingencies seem to be maintaining specific behaviors and how would they be affected by attempts at modification? Are his behavioral repertoires adequate in relation to his stated goal? If not, how can he be helped in acquiring such repertoires?

From this initial analysis a tentative treatment program was formulated and put into effect. The progress of the subject was then closely followed. If it became apparent from the ongoing evaluation that a particular aspect of the program, or the entire program, did not appear to have a functional relationship with the subject's behavior, then modifications were instituted. At such times analysis was also made in an attempt to determine the possible reasons for failure.

Treatment ended when: the presenting sexual problem had been resolved to the subject's satisfaction; or changed to the point where it was no longer of major concern to him; or, when the subject decided to stop treatment for any reason. In the latter case the reasons for discontinuing were discussed and appropriate suggestions or referrals were made.

Upon termination of treatment, whenever possible, the subject was asked to retake the CFI, RSS, SFI, and HBI inventories in order to help assess change in specific areas and to explore their possible future use as pre and post treatment outcome measures. Follow up information on the subject's progress was obtained wherever possible.

## RESULTS

### Normative Data

The Composite Fear Inventory and the Sexual Fear Inventory were specifically designed for individual clinical use with the subjects of the present research program (i.e., clarification of generalized anxiety sources, relative index of emotional responses to stimuli for possible hierarchy construction, etc.). However, it was also felt that it might be of help to have some frame of reference against which to compare the responses of the subjects. There were some norms available for certain subsections of the CFI, but none obviously for the composite form nor for the SFI. Therefore, a limited amount of data were collected from a small sample of undergraduate students attending three introductory classes in psychology and educational psychology at the University of Hawaii. These data were for limited comparative purposes only and were not intended to provide definitive norms against which to assess the progress of the subjects (which would naturally require larger samples for the collection of reliability and validity data).

### The Composite Fear Inventory

A total "fear score" was arrived at for each of the 77 subjects in the following manner: Each of the 175 responses was given a score ranging from 1 (for "Not at all") to 5 (for "Very much"). A subject's total score could range from 175 to 875. Three scores were computed for each subject: his total CFI score; his score on the Geer (1965) FSS-II

items; and his score on the Suinn (1969) items. These latter two were selected for comparative purposes with normative data already available for the scales. For each of these scores means and standard deviations were computed for each of the three classes. Differences between the class means on each of the three scores were found to be nonsignificant (see Appendix K).

Means and standard deviations were then computed for the total CFI scores obtained by single males, married males, and all males in each of the three classes. Differences between each of the class means for each of the three categories were found to be nonsignificant (see Appendix K).

Means and standard deviations were then computed for the total CFI scores obtained by single females, married females, and all females in each of the three classes. Differences between each of the class means for each of the three categories were found to be nonsignificant (see Appendix K).

The data from each of the three classes were then combined and means and standard deviations were computed on each of the three scores for the following categories: total sample; single sample, married sample, males, females, single males, single females, married males, and married females. Differences between the male and female, single and married, single and married male, and single and married female means were all found to be nonsignificant (see Appendix K).



The means and standard deviations for each of the three scores for the total sample may be seen in Table 2.

Table 2

Mean Scores on the Composite Fear Inventory

Scale	$\bar{X}$	SD
Total CFI Score	387.377	87.072
Geer Scale Score	122.987	27.729
Suinn Scale Score	206.597	50.031

Table 3 contains a list of the items on the Composite Fear Inventory along with the mean item score obtained by the total sample.

TABLE 3

Item and Mean Item Scores on the Composite Fear Inventory

Item	$\bar{X}$
1. Beetles	1.377
2. Getting Lost	2.455
3. Gnats	1.844
4. Taking tests	2.455
5. Roaches	2.468
6. The unknown	2.948
7. Horses	1.273
8. Cows	1.182
9. Being put under pressure	2.857
10. Policemen	1.753
11. Frogs	1.623
12. Being disfigured	3.571
13. Storms	1.701
14. Fish	1.078
15. Being punished	2.494
16. Members of the opposite sex	1.442
17. Turtles	1.091
18. Old people	1.597
19. Lizards	2.078
20. Foreigners	1.494
21. Monkeys	1.312
22. Physical illness	2.558
23. Non-poisonous spiders	2.532
24. Looking down from high buildings	2.662
25. Losing control	2.831
26. Loud voices	2.026
27. Feeling angry	2.195
28. Sick people	2.201
29. Angry people	2.675
30. Feeling disapproved of	3.065
31. One person bullying another	3.312
32. Noise of vacuum cleaners	1.403
33. Speaking in public	2.429
34. Crossing streets	1.312
35. Open wounds	2.506
36. Receiving injections	2.104
37. Animal blood	2.013
38. Witnessing surgical operations	2.857
39. Dead animals	2.766
40. Dead people	3.494
41. Seeing other people injected	1.792
42. Human blood	2.156
43. Medical odors	2.026
44. Falling	2.987
45. Being in a strange place	2.260

TABLE 3. (Continued) Item and Mean Item Scores on the Composite Fear Inventory

46.	Entering a room where other people are already seated	2.065
47.	Darkness	2.156
48.	Automobiles	1.312
49.	Being teased	2.052
50.	Failure	3.078
51.	Dentists	2.130
52.	Thunder	1.455
53.	Sirens	1.753
54.	Mice	1.844
55.	People who seem insane	2.753
56.	Imaginary creatures	1.727
57.	Strangers	1.844
58.	Journeys by train	1.273
59.	Journeys by bus	1.247
60.	Parting from friends	2.623
61.	Journeys by car	1.221
62.	People in authority	1.922
63.	Sudden noises	2.545
64.	Dull weather	1.740
65.	Crowds	1.857
66.	Large open spaces	1.143
67.	Cats	1.156
68.	Tough looking people	2.351
69.	Birds	1.065
70.	Prospect of surgical operation	3.078
71.	Sight of deep water	1.909
72.	Being watched working	2.299
73.	Weapons	2.442
74.	Dirt	1.273
75.	Ugly people	1.805
76.	Fire	2.169
77.	Dogs	1.325
78.	Strange shapes	1.468
79.	High places on land	1.662
80.	Nude men	1.909
81.	Nude women	1.610
82.	Enclosed places	1.948
83.	Being in an elevator	1.299
84.	Airplanes	1.364
85.	Being ignored	2.558
86.	Premature heart beats (missing a beat)	2.429
87.	Lightning	1.714
88.	Doctors	1.662
89.	People with deformities	2.260
90.	Sight of fighting	2.857
91.	Flying insects	1.701
92.	Bats	2.351
93.	Harmless snakes	2.714
94.	Crawling insects	2.156

TABLE 3. (Continued) Item and Mean Item Scores on the Composite Fear Inventory

95.	Cemetaries	1.844
96.	Worms	1.844
97.	Being alone	1.987
98.	Being criticized	2.636
99.	Making mistakes	2.532
100.	Looking foolish	3.013
101.	Feeling rejected by others	3.377
102.	Crowded places	1.935
103.	Seeing a fight	2.688
104.	Being with a drunk	2.584
105.	Deep water	2.169
106.	Swimming alone	2.273
107.	Boating	1.558
108.	Stinging insects	2.792
109.	Rats and mice	2.299
110.	Snakes	2.857
111.	Spiders	2.623
112.	Being a leader	1.844
113.	Meeting authority	1.935
114.	Meeting someone for the first time	1.675
115.	Being with a member of the opposite sex	1.351
116.	Being self-conscious	2.338
117.	Speaking before a group	2.403
118.	Death	3.039
119.	Death of a loved one	4.182
120.	Auto accidents	3.532
121.	Losing a job	2.909
122.	Suffocating	3.571
123.	Untimely or early death	3.416
124.	Mental illness	3.195
125.	Illness or injury to loved ones	3.779
126.	Being in a fight	3.364
127.	Illness	2.662
128.	Being misunderstood	2.805
129.	Failing a test	3.052
130.	Not being a success	3.091
131.	Being a passenger in a car	1.416
132.	Thunderstorms	1.558
133.	Heights	2.325
134.	Hypodermic needles	2.234
135.	Driving a car	1.506
136.	Strange dogs	1.831
137.	Blood	2.052
138.	Closed places	1.948
139.	Being a passenger in a plane	1.325
140.	Dead bodies	3.325
141.	Dark places	2.182
142.	Sharp objects	1.909
143.	God	1.403
144.	Arguing with parents	2.623

TABLE 3. (Continued) Item and Mean Item Scores on the Composite Fear Inventory

145.	Life after death	1.688
146.	Roller coasters	2.312
147.	Unclean silverwear in restaurants	2.494
148.	Odors	2.156
149.	Being bullied by someone	3.247
150.	Dirty restrooms	2.883
151.	Loud noises	2.273
152.	Becoming mentally ill	3.364
153.	Falling down	2.610
154.	Loud sirens	1.792
155.	High places	2.468
156.	Guns	2.571
157.	Being in closed places	2.052
158.	Being cut	2.364
159.	Being physically assaulted	3.455
160.	Cuts	2.182
161.	Sharp objects (knives, razor blades, scissors)	1.818
162.	Riding a roller coaster	2.156
163.	Going into a theatre alone	1.714
164.	Harmless spiders	2.299
165.	Thought of having a defective child	3.338
166.	Thoughts of suicide	2.857
167.	Leaving home	2.091
168.	Thoughts of being mentally ill	3.169
169.	Leaving the gas on	2.519
170.	Giving off an offensive odor	2.610
171.	Being punished by God	2.078
172.	Homosexual thoughts	2.649
173.	Sexual inadequacy (impotence or frigidity)	2.519
174.	Masturbation	2.130
175.	Seeing a psychologist or psychiatrist	1.922

---

### The Sexual Fear Inventory

A total "sexual fear score" was arrived at for each of the 78 subjects in a manner identical to that described for the CFI; however, with the SFI a subject's total score could only range from 130 (1 x 130) to 650 (5 x 130). Five scores were computed for each subject; total score on all items (T-Score); Score on the 30 general items (G-Score); score on the 30 personal items (P-Score); score on the 20 social items (S-Score); and, score on the 50 physical contact items (C-Score). For each of these scores means and standard deviations were computed for each of the three classes. Differences between the class means on each of the five scores were found to be nonsignificant (see Appendix L).

Means and standard deviations were then computed for the total SFI scores obtained by single males, married males, and all males in each of the three classes. Differences between each of the class means for each of the three categories were found to be nonsignificant (see Appendix L).

Means and standard deviations were then computed for the total SFI scores obtained by single females, married females, and all females in each of the three classes. Differences between each of the class means for each of the three categories were found to be nonsignificant (see Appendix L).

The data from each of the three classes were then combined and means and standard deviations were computed on each of the five scores for the following categories: total

sample, single sample, married sample, males, females, single males, single females, married males, and married females.

The mean G-Score for males was 51.406 (SD = 13.713), while for females the mean was 61.087 (SD = 18.734). The difference between the male and female mean G-Scores was found to be significant ( $t = 2.465$ ,  $df = 76$ ,  $p < .05$ , two tailed test).

The mean C-Score for males was 97.688 (SD = 40.048), while for females the mean was 121.891 (SD = 50.812). The difference between the male and female mean C-Scores was found to be significant ( $t = 2.224$ ,  $df = 76$ ,  $p < .05$ , two tailed test). Differences between the remaining male and female mean scores were found to be nonsignificant (see Appendix L).

Not only were there significant differences between males and females on these two scores, but there were similar differences between married and single females, with the married females obtaining scores quite similar to the males.

The mean total score for married females was 225.091 (SD = 54.642), while for single females the mean was 290.00 (SD = 87.123). The difference between the married and single female means was found to be significant ( $t = 2.676$ ,  $df = 44$ ,  $p < .05$ , two tailed test).

The mean G-Score for married females was 51.00 (SD = 11.465), while for single females the mean was 64.257

(SD = 19.440). The difference between the married and single female G-Score means was found to be significant ( $t = 2.101$ ,  $df = 44$ ,  $p < .05$ , two tailed test).

The mean C-Score for married females was 88.00 (SD = 29.613), while for single females the mean was 132.543 (SD = 51.412). The difference between the married and single female C-Score means was found to be significant ( $t = 2.676$ ,  $df = 44$ ,  $p < .05$ , two tailed test). Differences between the remaining married and single female mean scores were found to be nonsignificant (see Appendix L).

Apparently the differences between married and single females also had influence on the combined married and single sample as a whole. Differences on all the mean scores between married and single males were found to be nonsignificant (see Appendix L). However, the mean G-Score for the total married sample was 48.667 (SD = 12.048), while for the total single sample the mean was 59.127 (SD = 18.007). The difference between the married and single mean G-Scores was found to be significant ( $t = 2.113$ ,  $df = 76$ ,  $p < .05$ , two tailed test). In addition, the mean C-Score for the total married sample was 90.067 (SD = 37.579), while for the total single sample the mean was 117.175 (SD = 48.967). The difference between the married and single mean C-Scores was found to be significant ( $t = 1.98$ ,  $df = 76$ ,  $p < .05$ , two tailed test). Differences on all the remaining mean scores between the married and single samples were found to be nonsignificant (see



Appendix L).

The means and standard deviations for each of the five scores on the SFI for males, single females, and married females may be seen in Table 4.

Table 4

Mean Scores on the Sexual Fear Inventory						
Scale	Males		Females			
			Married		Single	
	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD
T-Score	239.594	67.711	225.091	54.642	290.00	87.123
G-Score	51.406	13.713	51.00	11.465	64.257	19.440
P-Score	58.094	13.396	53.00	14.820	62.057	19.590
S-Score	32.406	8.547	33.091	9.643	31.143	10.551
C-Score	97.688	40.048	88.00	29.613	132.543	51.412

Table 5 contains a list of the items on the Sexual Fear Inventory along with the mean item scores obtained by males, married females, and single females.

TABLE 5

Item and Mean Item Scores on the Sexual Fear Inventory

Item	$\bar{X}$		
	Male	Married Female	Single Female
1. Nude art	1.125	1.273	1.257
2. Contraceptives	1.344	1.00	1.657
3. Prostitutes	1.844	1.818	2.60
4. Nudity in a motion picture	1.375	1.727	1.543
5. Breasts	1.219	1.364	1.571
6. Sex jokes	1.281	1.545	1.486
7. Erotic photographs and drawings	1.563	1.818	2.229
8. A penis	1.438	1.273	2.314
9. Premarital sexual intercourse	1.906	1.727	2.429
10. Extramarital sexual intercourse	2.531	2.636	3.343
11. A vagina	1.438	1.364	1.543
12. Wife swapping (Husband . . .)*	3.281	3.273	3.914
13. Burlesque shows	1.406	1.455	2.086
14. Exotic dancers	1.406	1.182	1.914
15. Testicles	1.375	1.273	2.20
16. A sex orgy	2.719	3.091	3.543
17. Sanitary napkins	1.25	1.455	1.343
18. Homosexual males	2.50	1.455	2.543
19. Homosexual females	1.969	1.818	2.914
20. Buttocks	1.188	1.091	1.229
21. Nudist camps	1.813	1.455	2.257
22. Vulgar words on public walls	1.375	1.545	1.429
23. Animals having sexual relations	1.344	1.091	1.571
24. Venereal disease	3.50	3.091	3.257
25. Nude men	1.594	2.00	2.429
26. Nude women	1.531	1.818	1.886
27. Nude children	1.063	1.455	1.143
28. Pubic hair	1.281	1.273	1.857
29. Sex play with animals	2.438	2.182	3.114
30. Sexual words	1.375	1.364	1.629
31. Having erotic dreams	1.469	1.727	1.829
32. Seeing your own genitals	1.094	1.364	1.20
33. Touching your own genitals	1.188	1.545	1.629
34. Listening to a discussion of sex	1.313	1.091	1.40
35. Talking to others about sex	1.469	1.364	1.543
36. Failure or difficulty in achieving an erection (. . . an orgasm)*	2.625	2.727	2.571
37. Reading erotic stories or books	1.531	1.727	1.714
38. Seeing erotic movies	1.625	1.909	2.171

TABLE 5. (Continued) Item and Mean Item Scores on the Sexual Fear Inventory

39.	Masturbation	1.875	1.636	2.171
40.	Daydreams about sex	1.563	1.273	1.657
41.	The size of your penis (. . . breasts)*	1.719	1.091	1.514
42.	Having sexual thoughts about women (. . . men)*	1.563	1.636	1.771
43.	Having sexual thoughts about men (. . . women)*	3.188	2.455	2.771
44.	Being seen nude	2.531	2.00	3.171
45.	Nocturnal emissions (wet dreams) (Dreaming to orgasm)*	1.813	1.909	2.371
46.	Seeing a woman undress (. . . man undress)*	1.781	1.455	2.343
47.	Getting a female pregnant (Getting pregnant)*	3.719	2.455	3.914
48.	Reaching an orgasm too quickly or too slowly during masturba- tion or sexual intercourse	2.844	2.364	2.057
49.	Undressing in front of a female (. . . male)*	2.125	1.545	2.657
50.	Seeing the genitals of a female (. . . male)*	1.594	1.818	2.429
51.	Seeing the genitals of a male (. . . female)*	1.313	1.727	1.629
52.	Seeing a nude female statue (. . . male statue)*	1.031	1.636	1.20
53.	Wearing the clothes of the opposite sex	3.75	1.727	1.743
54.	Using a public toilet	1.406	1.818	1.543
55.	Forgetting to pull up the zipper on your pants (. . . dress)*	2.656	1.818	2.40
56.	Visiting a nudist camp	2.344	2.091	2.686
57.	Seeing a female use the toilet (Seeing a male . . .)*	1.906	1.818	2.486
58.	Using sexual words	1.375	1.818	1.886
59.	Seeing a female's panties exposed (. . . male's underwear . . .)*	1.563	1.091	1.343
60.	Experiencing unusual sexual fantasies	2.094	2.182	2.40
61.	Calling a female on the phone (Being called by a male . . .)*	1.469	1.364	1.429
62.	Asking a female for a date (Being asked by a male . . .)*	1.531	2.00	1.257
63.	A female asks you into her house (A male . . . his house)*	1.313	2.182	1.657

TABLE 5. (Continued) Item and Mean Item Scores on the Sexual Fear Inventory

64.	A male asks you into his house (A female . . . her house)*	1.656	1.727	1.20
65.	Sitting in a movie with a female during a hot love scene (. . . a male . . .)*	1.656	1.909	1.743
66.	Sitting in a movie with a female during a hot love scene and taking her hand (. . . a male . . . he takes your hand)*	1.75	1.818	2.114
67.	A female smiles at you (A male . . .)*	1.313	1.364	1.257
68.	A male smiles at you (A female . . .)*	1.625	1.364	1.143
69.	Lying on the beach next to a female (. . . a male)*	1.188	3.364	1.20
70.	Lying on the beach next to a male (. . . a female)*	1.313	1.182	1.143
71.	Starting a conversation with a female (. . . a male)*	1.688	1.364	1.371
72.	A female says she finds you attractive (A male says he . . .)*	1.563	1.545	1.429
73.	A male says he finds you attractive (A female says she . . .)*	3.156	2.182	1.743
74.	Getting a drink for a female (Receiving a drink from a male)*	1.063	1.182	1.229
75.	Lying on a couch beside a female (. . . a male)*	1.594	1.364	2.029
76.	Lying on a couch beside a male (. . . a female)*	2.531	2.636	1.943
77.	Talking alone with a female (. . . a male)*	1.375	1.273	1.286
78.	Having a female flirt with you (Having a male . . .)*	1.656	1.818	1.686
79.	A female asks you for a date (Asking a male . . .)*	1.656	2.364	2.943
80.	Taking a female home after a date (Being taken home by a male . . .)*	1.313	1.364	1.371
81.	Kissing a female goodnight (Kissing a male . . .)*	1.531	1.273	1.457
82.	Accidentally bumping into a female (. . . a male)*	1.375	1.182	1.314

TABLE 5. (Continued) Item and Mean Item Scores on the Sexual Fear Inventory

83.	Sitting in a car in front of a female's house with your arm around her	1.531		
	(. . . your house with a male's arm around you)*		1.273	1.743
84.	Sitting in a car in a remote location with your arm around a female	1.594		
	(. . . a male's arm around you)*		1.364	2.286
85.	Putting your hand on a female's shoulder	1.313		
	(A male puts his hand on your shoulder)*		1.182	1.429
86.	Putting your hand on a male's shoulder	1.844		
	(A female puts her hand on your shoulder)*		1.545	1.943
87.	Dancing with a female	1.344		
	(. . . a male)*		1.091	1.20
88.	Experiencing an erection while dancing with a female	2.313		
	(. . . a male's erection while he dances with you)*		1.727	2.771
89.	Putting your arm around a female	1.344		
	(A male puts his arm around you)*		1.364	1.486
90.	Taking off a female's clothes	1.969		
	(A male taking your clothes off)*		1.909	3.171
91.	Biting a female	1.969		
	(. . . a male)*		1.727	2.343
92.	Being bitten by a female	1.906		
	(. . . a male)*		2.091	2.629
93.	Pressing your body against a female	1.625		
	(A male presses his body against you)*		1.636	2.086
94.	Contact of tongues while kissing a female	1.719		
	(. . . a male)*		1.727	1.971
95.	Caressing the buttocks and thighs of a female	1.875		
	(Having your buttocks and thighs caressed by a male)*		1.818	2.514
96.	Kissing a female's neck and ears	1.625		
	(Having your neck and ears kissed by a male)		1.909	1.771
97.	Caressing a female's shoulders			

TABLE 5. (Continued) Item and Mean Item Scores on the Sexual Fear Inventory

	and back	1.50		
	(Having your shoulders and back caressed by a male)*		1.909	1.80
98.	Caressing a female's hair and face	1.50		
	(Having your hair and face caressed by a male)*		1.636	1.657
99.	Having a female take your hand	1.281		
	(Taking a male's hand)*		1.091	1.371
100.	Kissing the lips of a female for one minute continuously	1.594		
	(. . . a male . . . )*		1.545	1.886
101.	Engaging in sexual intercourse with a female	1.875		
	(. . . a male)*		1.455	2.743
102.	Manipulating the genitals of a female with your tongue	2.156		
	(A male manipulating your genitals with his tongue)*		1.909	3.486
103.	Manipulating the breasts of a female with your hands underneath her clothes	1.781		
	(A male manipulating your breasts with his hands underneath your clothes)*		1.545	2.60
104.	Manipulating the genitals of a female with your hand over her clothes	1.781		
	(A male manipulating your genitals with his hands over your clothes)*		2.091	2.657
105.	A female manipulating your genitals with her tongue	2.281		
	(Manipulating the genitals of a male with your tongue)*		1.727	3.60
106.	Engaging in mutual hand-manipulation of genitals with a female	1.906		
	(. . . a male)*		1.545	2.971
107.	Kissing the nipples of the breasts of a female	1.75		
	(A male . . . your breasts)*		1.636	2.60
108.	Engaging in mutual mouth-genital manipulation with a female to the point of her orgasm and your ejaculation	2.375		
	(. . . a male to the point of his ejaculation and your orgasm)*		2.182	3.486
109.	Manipulating the genitals of a female with your hand			

TABLE 5. (Continued) Item and Mean Item Scores on the Sexual Fear Inventory

	underneath her clothes	1.75		
	(A male manipulating your genitals with his hands underneath your clothes)*		1.727	2.886
110.	A female manipulating your genitals with her mouth to the point of your ejaculation	2.313		
	(Manipulating the genitals of a male with your mouth to the point of his ejaculation)*		2.091	3.743
111.	A female manipulating your genitals with her hand over your clothes	1.875		
	(Manipulating the genitals of a male with your hand over his clothes)*		1.455	2.80
112.	Engaging in heterosexual intercourse using rear entry to the vagina	1.969		
	(. . . with the male using a rear entry to your vagina)*		1.636	3.343
113.	Touching the genitals of a female with your lips	2.00		
	(A male touching your genitals with his lips)*		1.727	3.343
114.	A female touching your genitals with her lips	2.063		
	(Touching the genitals of a male with your lips)*		1.727	3.486
115.	Engaging in mutual mouth-genital manipulation with a female	2.125		
	(. . . a male)*		2.273	3.571
116.	Manipulating the genitals of a female with your hand to the point of massive secretions from her genitals	1.781		
	(A male manipulating your genitals with his hands to the point of your orgasm, or of massive secretions from your genitals)		1.909	2.857
117.	A female manipulating your genitals with her hand to the point of ejaculation	1.906		
	(Manipulating the genitals of a male with your hand to the point of his ejaculation)*		1.636	3.114
118.	A female manipulating your genitals with her hand underneath			

TABLE 5. (Continued) Item and Mean Item Scores on the Sexual Fear Inventory

	your clothes	1.906		
	(Manipulating the genitals of a male with your hand underneath his clothes)*		1.727	2.971
119.	Engaging in mutual hand-manipulation of genitals with a female to the point of her orgasm and your ejaculation (. . . a male to the point of his ejaculation and your orgasm)*	2.031		
			1.636	3.143
120.	Manipulating the breasts of a female with your hands over her clothes	1.688		
	(A male manipulating your breasts with his hands over your clothes)*		1.545	2.429
121.	Having anal intercourse with a female	2.781		
	(. . . with a male)*		2.727	3.857
122.	Mutual masturbation with the same sex	3.781	3.545	4.314
123.	Having sexual intercourse with the female sitting on your lap (. . . while sitting on a male's lap)*	1.813		
			1.636	3.057
124.	Having sexual intercourse with a female in the dining room or living room	2.156		
	(. . . with a male . . . )*		1.636	3.171
125.	Changing positions during sexual intercourse with a female	1.75		
	(Changing positions during sexual intercourse)*		1.455	2.257
126.	Engaging in mouth-genital contact with the same sex	4.031	3.636	4.229
127.	Genital-genital contact with a female without entry	2.031		
	(. . . with a male . . . )*		1.545	2.60
128.	Rubbing the tip of your penis against the female clitoris (A male rubbing the tip of his penis against your clitoris)*	1.75		
			1.636	2.629
129.	In bed with a female who is aroused and eager and you have an erection	1.844		
	(. . . a male who is aroused and eager and has an erection)*		1.545	2.571
130.	In bed with a female who is			



TABLE 5. (Continued) Item and Mean Item Scores on the  
Sexual Fear Inventory

aroused and eager and you can't get an erection	3.688		
(In bed with a male . . . and he can't get an erection		2.545	3.20

---

\* Denotes comparable item on female form.

### Case Studies

During a one year period 15 prospective subjects were referred for an initial interview with E. All 15 volunteered to enter into the research program. Four of the subjects requested help with homosexual problems; 10 with problems of sexual incompatibility; and one requested help concerning pedophilic behavior.

Of the 15 subjects, five completed assessment and the suggested treatment program with the total number of sessions ranging from 21 to 38. Another five subjects completed assessment and started treatment but elected to discontinue at various points. Completed number of sessions for this group ranged from 27 to 42. Two subjects elected to discontinue after 17 assessment sessions. Two more subjects (a couple) were referred for psychiatric care after an initial joint interview. The remaining subject completed assessment and was currently undergoing treatment when the formal research period ended (treatment, of course, was continued). A detailed description of these cases follows. All names, descriptions, and other identifying information have been altered to protect the confidentiality of the subjects. No changes have been made which would alter the theoretical analyses or the treatment procedures described.

### Homosexual Problems

Of the four subjects requesting help with homosexual problems, two elected to discontinue after completing the assessment phase, one had to withdraw during treatment to

return to his home state for employment, and one completed assessment and the suggested treatment program. To illustrate the initial analysis of these types of problems, how treatment procedures were devised and implemented, and the outcome, the completed case will be presented in some detail. Following this, a brief presentation of the remaining cases will be given with emphasis on those features which distinguishes each case from the other.

Case of Mr. Adam. Mr. Adam, a Caucasian male in his middle twenties, was a junior executive in one of the larger private corporations doing business in the state. He had consulted a psychologist in private practice who suggested that he contact his district community mental health center. During his intake interview at the center he complained of intense anxiety, inability to concentrate, inability to sleep, and small muscle spasms. For the past month he had been taking tranquilizers prescribed by his physician, but he reported that they "didn't seem to help much." He felt his symptoms were due to his inner conflict over his "homosexual orientation." He was referred to the experimenter for possible inclusion in his research program.

Mr. Adam showed signs of extreme nervousness during his initial interview with E. He constantly shifted his weight in his chair, crossed and uncrossed his legs, kept shifting his eyes away from E, and every few minutes would wipe his palms on his shirt or trousers. When questioned about his feelings Mr. Adam reported that he was anxious, but not

more than he was "all the time." He reported that his anxiety reactions had been steadily increasing during the past few months, particularly after a brief homosexual experience with a fellow worker two months previous. The relationship had not continued but he felt his constant anxiety was the direct result of this experience. He reported being equally aroused and experienced with females as he was with males.

Currently he was sharing an apartment with another junior executive whom he did not like. He had one close female friend that he felt he could talk with and another that he had occasional sexual relations with. The first relationship he described as "Platonic" and the second as merely a way of reacting against his homosexual "nature." He wanted help in two main areas: somehow resolving his homosexual problem, and more confidence in himself in general. E explained the rationale of the approach that would be taken if he decided to enter into the research program. When, after some discussion E suggested that he take some time to think it over Mr. Adam abruptly asked if he could start filling out the forms right away. He felt he must do something and he might as well try this approach as any other. E agreed and gave him the initial assessment battery to take home with him.

The initial assessment period took five one-hour sessions. Because of Mr. Adam's heavy work load and conflicting schedule he was seen on a once a week basis during this

stage. During the fourth session, Mr. Adam appeared even more nervous than usual. Questioning revealed that he had run out of his tranquilizers the previous week. However, he reported no difference in his nervousness and pervasive anxiety whether on the tranquilizers or off of them. He did not want further medication, as he felt it made no difference in his reactions. Considerable time was spent at this point in trying to determine what specific stimuli or situations were associated with his anxiety reactions. Mr. Adam felt that it was a general condition, and not due to anything specific other than his homosexual experience of two months ago and his continuing arousal responses to males during the day. However, he reported the latter as being only about four or five times a day. Other assessment materials indicted more than a usual amount of fear associated with general interpersonal relationships. When questioned about this, Mr. Adam reported that his anxiety might be a little higher when he had to telephone people, or meet new people but that was the extent of his awareness. He was asked to keep a notebook during the following week and to write down when his anxiety seemed suddenly higher than usual. He was to note where he had just come from, where he was at the moment, and where he was going next. He was also to record his activities for each situation. At the following session his notebook revealed that most of his anxious situations seemed centered around areas where he was fearful of being evaluated by others or was called upon to assert

his own feelings with others.

The sexual history was finished at this time and the initial assessment stage was completed. When asked about his own thoughts on the cause of his present problem, Mr. Adam responded with the statement that it was most likely due to his "unresolved Oedipal." When asked to expand on this statement he could only say that he saw his mother as active and aggressive, but he could talk to her, whereas his father was kind, quiet, pious and difficult to talk with. Somehow he believed that this made him want to reach out to men as well as women. He then said that he really was not certain, but it must be something "Freudian like that." He was asked to continue recording anxious responses in his notebook while E went over the assessment materials to devise a first step in the treatment plan.

Examination of the assessment information showed a definite sexual arousal to both male and female stimuli along with overt sexual behavior with both sexes. However, there appeared to be only a minor association between his experiencing an arousal to male stimuli and his anxiety reactions. He saw his arousal responses to males as "proof of his homosexuality" but such responses did not seem to elicit a strong anxiety response. His sexual history did indicate a high degree of anxiety following any overt sexual behavior with males, but inasmuch as he had had only one overt contact with a male in the past two months it was assumed that this was not the major cause of his present

general anxiety.

The assessment information indicated that his anxiety appeared to be associated with three major areas: a) any interpersonal situation which called for an expression of opinion or feeling on his part (particularly anger); b) his work in training employees in technical report writing; and c) working in his office. Evidence for this was found not only in his notebook but by his responding with "a fair amount of fear," or more, to such CFI items as: loud voices, feeling angry, angry people, feeling disapproved of, speaking in public, being criticized, and looking foolish.

A decision had to be made as to whether to first attack the possible anxiety causing situations or the sexual problem itself. Due to Mr. Adam's extreme anxiousness and apparent discomfort it was decided to start working with the former. Because of the wide range of situations and activities associated with the interpersonal area, assertive training was selected to counteract his anxiety responses in this region. Systematic desensitization was chosen as the treatment of choice for his more circumscribed anxiety reactions in his work and office situations. On the assumption that assertive training might also increase his feelings of self confidence (one of his primary stated goals) it was decided to start with this area.

At the following session the above suggestions were made and discussed with him. Using items from his own past and his current behavior as examples, he was shown how he

might have learned to behave in a passive manner in his interpersonal relationships because of unpleasant results in the past when he had attempted to express his feelings to others. It was also suggested that his behavior of avoiding these situations was being maintained by its own success in that it kept him from learning how to handle such situations. To give him some background and a frame of reference for looking at his present sexual circumstance he was given a copy of Ullmann and Krasner's (1969) chapter on "Sexual Behavior" and a copy of the first two pages of the Kinsey, et al (1953) chapter on "Homosexual Responses and Contacts." He was also supplied with appropriate sexual information suggested by his SKI responses. He was asked to take these materials home, read them, and jot down any questions or comments he might care to make for future discussion.

When assertion was explained to him as an alternative response to anxiety in interpersonal relationships he appeared very irritated and dissatisfied with the suggested approach. He felt that he had tried all this before and it had "never worked." Discussion took place of this procedure, particularly the possible differences between his past attempts and the current suggested one (e.g., starting with the least anxiety provoking situation and slowly working up to more anxious ones, applying it in a systematic fashion rather than a nonsystematic one, etc.). He agreed to try the procedure, though with some reluctance. He was assigned three assertive responses before his next session, and his



initial attempts were to be on a small scale. Possible examples were taken from his notebook of the previous week and alternative behaviors rehearsed and tried out in the office until he grasped the idea. He had also reduced his work load and future sessions were set on a two-a-week basis. He was to continue his notebook for future items and discussion.

The following session he reported having "finally" corrected an employee's report the way he felt it should be, and he had prepared himself to face the employee's attack if it came. The difference between this type of assertive response and responses concerned with him asserting feelings directly with a person was discussed with him. His next "assertive response" was telling his roommate that his stereo might cause their neighbors to complain and perhaps he ought to turn it down. Again, this scene was gone over with him and he rehearsed saying his own feelings which turned out to be: "I get upset and can't concentrate on my work when the stereo is loud like that. Would you please turn it down." Other means were also suggested of learning to get along with his roommate, such as mutually agreed upon schedules for stereo playing. His third assertive response had been to tell some of his friends that he did not want to go to a certain movie with them. They had tried to coax him to go but he had held out, asserting that he did not feel like going. They had finally left without him, but to his amazement he found that they held no hard feelings toward

him. This was the first occasion he could recall that he had remained steadfast in such a circumstance, for previously he reported always doing what others wanted for fear of being thought rude or of hurting their feelings.

Mr. Adam responded favorably to his assigned readings, reported that he now felt he had a better understanding of how different sexual responses might have been learned by him. He also felt that he now understood the power of "labeling" behaviors rather than the person.

The next two treatment sessions proceeded in a similar manner: discussing his past assertive responses, examining anxiety causing situations and rehearsing alternative responses, and increasing the number and strength of his assertive responses. He reported that his day seemed a little smoother for him but that he still felt anxious most of the day. To help him further discriminate nonanxious situations and activities, he was asked to start recording positive situations as he had recorded negative ones. To collect baseline data for future sexual treatment he was also asked to record any sexual arousal responses to males or females (defined by him as a "feeling in his genitals").

At the following session Mr. Adam reported an equal number of positive and negative situations. He felt that his recording had made him realize that there were many positive situations in his life as well as negative. He also reported the first day in months that he did not have a nervous reaction most of the day. This day had been spent at

the beach with friends and away from his work situation.

His assertive training appeared to be proceeding well, and treatment was now focused on the work situation. The principles of systematic desensitization were explained and Mr. Adam was asked to begin hierarchy construction of anxiety arousing situations pertaining to his work. He was started in relaxation training and told to attempt to practice at least once each night. The next two sessions were devoted to relaxation training, hierarchy construction, discussing his assertive responses in further detail, and behavioral rehearsal of assertive responses.

Mr. Adam was due to take his first annual vacation in six weeks and he was planning on returning to his home state to visit with his parents. He had just completed training a group of employees and it was considered an ideal time to start systematic desensitization; however, Mr. Adam was asked to start training two new groups of employees and to complete their training before he left on his vacation. This request had caused considerable anxiety in him, but he did not feel that he could justifiably refuse the assignment. It was decided to attempt to complete desensitization to his work situation before he left on his vacation. He appeared to grasp the basic relaxation principles fairly fast, and his imagery seemed good (spontaneously reported color and sounds). His final hierarchy for the training situation, with items arranged according to increasing anxiety provoking situations, was as follows:

1. You are in the training room and you ask a question, and an employee you have underestimated gives a generally good answer.
2. You are in the training room and you ask a question which brings an enthusiastic response.
3. You are in the training room and one of the employees is giving a short presentation.
4. You are in the training room and you ask a question which starts an argument going.
5. You are in the training room and you tell an anecdote and you are waiting for a response.
6. You are in the training room and you notice several employees who are considerably older than you.
7. You are in the training room and waiting for the employees to finish writing sample reports.
8. You are talking in the training room and you find that you have forgotten an important part of your presentation.
9. You are in the training room and you notice one of your smart employees looking bored and disgusted.
10. You are in your training room and you notice some of the employees talking among themselves.
11. You are in the training room and you are reading aloud from a technical manual.
12. You are in the training room and you ask a question, then realize it is too general.
13. You are in the training room and some of the employees ask you to talk about an area you are unfamiliar with.
14. You are in the training room and the employees don't seem to be responding, then you find out that they have not prepared their materials.
15. You are leaving the training room and you are going to talk to another executive.
16. You are leaving the training room and you are going to talk to one of the vice-presidents of the corporation.

The final hierarchy for his office situation went as follows:

1. You are in your office and reading a newspaper.
2. You are in your office working on training materials and you take time off to phone a friend.
3. You are in your office and chatting with another executive.
4. You are in your office and preparing some materials to be mimeographed.
5. You are in your office and you stop working, go out and get a coke, then find it difficult to start working again.

6. You are in your office and all people leave and interruptions cease and you start working on training materials.
7. You are in your office and an employee comes in to see you.
8. You are in your office reading reports and you read one that makes you wonder how to help the employee be more clear.
9. You are in your office and you come across a personal request from an employee for help.
10. You are in your office and preparing your training materials for the next day and you wonder if they will be interesting.
11. You are in your office reading employee reports and you come across one that is poorly written.
12. You are in your office preparing your training materials and you stop and wonder if there will be sufficient material.
13. You are in your office and preparing an examination covering your training materials.
14. You are in your office and preparing special materials for presentation the next day.
15. You are in your office and preparing training materials and you stop and wonder if you will be able to remember it all.

Systematic desensitization to all items on both hierarchies took a total of ten sessions. Desensitization to training room items took a total of 93 presentations; and office items, 70 presentations. Except for the first two sessions, which were to training room items only, items were presented from both hierarchies during each session (i.e., five items from the training situation followed by five items from the office situation). During the tenth session all items were presented randomly from both hierarchies with no anxiety being reported.

His reported pattern of overt anxiety responses in the training room and his office generally paralleled desensitization. For example, during his third session he reported several tense situations in the training room that were

directly from his hierarchy but which had not been presented yet. He reported no responses to those situations that had been presented. During his fourth session he reported discouragement and was almost ready to quit the whole treatment program. He reported considerable anxiety at work that did not seem to be decreasing. Examination of his notebook indicated an accumulation of tense situations in the training room and his office to which he had not yet been desensitized. He also reported an apparent experience of sleep walking which alarmed him (finding things moved about his room when he awoke that he could not recall moving the previous night). He further disclosed that he usually drank quite a bit before going to sleep and he wondered if something could possibly be done about this (a problem that will be discussed later).

He did report that he was feeling much more comfortable in his interpersonal relationships than in the past, but he was now noticing an increase in his arousal responses to males and this had begun to worry him. Examination of his notebook revealed that he had not reported an arousal to males or females for nine days. When questioned, he responded that he had not bothered to mark them down because they were to similar situations that he had carefully described in the past. The importance of his frequency of response was explained to him and he was offered a small golf counter which could be easily attached to his key chain. He readily accepted the counter feeling that it would make such

recording easier.

The following session he reported that things were somewhat better. He had found the counter easy to use and the training room and office situations were becoming a "little" less tense. During the seventh session he spontaneously announced that he had just realized that day that he was no longer anxious about reading employee reports, only bored. He had also had two good days of preparing materials and reading aloud in the training room (those items had been presented two sessions previously). During his eighth session he reported a good training session where most of the employees had not prepared their work, but he was able to extemporize for the whole session, feeling very relaxed and good about it. This was the first time he had ever done such a feat and he had no anxious feeling about it.

At his ninth session he reported just a small amount of tension at certain times in the training room. He further reported feeling very relaxed in his office in preparing training materials (he had completed the office hierarchy the session previous). He said that that morning for some reason only a third of the employees had reported to his first training session of the day but he had felt no anxiety as he might have in the past and he had calmly dismissed them without a further thought. His second training group was also "no problem" to him. It was during this session that his training room hierarchy was completed.

At this point his two main areas of tension were his

inability to sleep without drinking and his increased arousal to males. It is interesting to note that he had not previously reported much anxiety over his arousal to males until his anxiety responses to the other three areas had been reduced. However, he now saw his drinking himself to sleep as his most urgent problem. He was reluctant to return home and have his parents discover that he had to drink in order to sleep. He had mentioned this problem briefly during his fourth desensitization session and then again at the end of his fifth without going into much detail. During the sixth session E took time out from desensitization procedures to inquire further into the problem. After some hesitancy, Mr. Adam revealed that he had started wetting the bed at night. This was extremely embarrassing for him to relate and he attributed it to his heavy drinking. It seems that he had a pattern of drinking about a pint of vodka every night before passing out in bed. He reported that he had been doing this for approximately three years. He had tried in the past to stop but was never able to do so. He was due to leave for home in three weeks and he now desperately wanted help in alleviating the situation.

Due to the long term nature of his behavior and the short time available, the situation did not look very promising and E informed him of this but agreed to see what might be done. A careful description of his usual pattern before retiring was then obtained. The typical pattern of response was as follows: He entered the house--went to the



bathroom--returned to the living room and turned on the TV set--went to the kitchen where he poured himself a half a glass of vodka (or scotch, bourbon, or rum when he could afford it) with a half of glass of water (sometimes orange juice)--he returned to the living room and sat in a chair--he watched TV--drank--during a commercial he would go to kitchen and pour another drink--return to the chair and watch TV. He would continue this sequence until he was quite drunk then, turn off the TV--go to bathroom--strip to undershirt and underpants--pass out on the bed. The next morning his alarm would awaken him--he would sleep about 15 minutes extra (usually making him late for work)--shower quickly--shave--brush his teeth--wash his hair--dress--leave for work.

A number of treatment alternatives were available: the use of aversive conditioning to alcohol or the use of sleeping pills to replace liquor. However, he enjoyed drinking socially and there was not time to start such treatment even if appropriate. Sleeping pills were a possible alternative but it was felt that it would be best to keep them as a last resort. It was decided to first attempt to break up the stimulus-response sequence that he had been following for such a long time by incorporating alternative behaviors. The theory of S-R sequences was explained to him and the following sequence was arranged: He would return home--go to the bathroom--take his clothes off down to his underclothes (to break up the drinking-in-clothes

pattern)--turn on the TV--go to the kitchen and get a soft drink (he liked cokes and orange drinks, but it was hoped that kitchen-glass-alcohol sequence could be changed by coke)--lay on the bed and watch TV (to break up sitting-in-chair-and-drinking sequence and to take advantage of any conditioned cues of sleepiness in bed that may have been acquired). He was to watch TV until ready for bed (he did not want to stop TV watching as he enjoyed this, so it was set up under different circumstances). When he was ready for bed he was then to take a hot shower (showers were indicated as highly reinforcing on the RSS, also it was hoped that it would generally be relaxing)--then to the kitchen for a cup of hot liquid (he liked Ovaltine, also, during relaxation he had reported sensations of warmth in the stomach area, it was hoped this would be a discriminative stimulus for muscle relaxation)--then to bed where he would use his relaxation procedures with instructions for a deep restful sleep. He was told to stay in bed, even if he remained awake all night. It was expected that this would make it easier to sleep the following night. He was to take no further naps during the day, and he was to remove all liquor from his house and confine his drinking to outside the house. He was also shifted to a three-time-a-week schedule so that E could closely follow his progress and continue with desensitization prior to his leaving.

Two days later he reported failure. He had followed the routine well, but he had kept thinking in bed, "it

probably won't work." After lying there feeling drowsy and relaxed, but awake, he decided that he should wait until the weekend before starting this program because he wanted to be alert for his work. He then went down to his car where he had put his liquor and had two full glasses and eventually passed out. It appeared that his new routine was too difficult to start abruptly so the problem was explained to a center psychiatrist, who then personally interviewed Mr. Adam. He was given a prescription for a small number of sleeping pills and also a small number of tranquilizers that were known to have a sleep inducing effect. He was instructed to take two of either one before retiring. E suggested that he pair his pill taking with the previously suggested routine and remove all alcohol from his house and car.

He was seen five days later and reported that he had not had a drink since the previous time described before. The first night he had slept several hours on routine alone, but then he had awakened and took a tranquilizer. The following night he reported the same pattern but with a sleeping pill (took one instead of two). The third night he was "too tired" to use the routine and he took one sleeping pill and another about an hour later. E encouraged him in not drinking, but suggested that he continue the routine and try to drop out using pills in small stages particularly when he felt very tired.

At his next session he reported similar progress, but

he was still relying on the pills as a backup to his routine. At his next session he reported that for the first time he had used the routine alone and had had a deep sleep throughout the night.

At this time a drop in his arousal responses to males and females was also noted. It was possible that the drugs were having this effect, but it was difficult to determine. He was just completing desensitization procedures and he was reporting feeling very comfortable in his training program, his office, and with people. He had also continued to progress well with his assertive training, reporting a number of assertions that were becoming "automatic" without having to plan or think about them.

By the time he completed his training assignment, he had stopped drinking completely, but he still felt somewhat fearful to attempt sleep very often without the pill backup. At this point he was feeling so confident in his general improvement that he asked his employer if he could leave on his vacation early. His request was granted and he made plans to travel across the mainland and see various friends before going to visit his parents. It was felt important to make certain that his sleeping pattern was firmly established and to help him to stop his reliance on the pills, so a card system was set up with him whereby he would send back postcards letting E know of his progress in his sleeping routine. He was also asked to include his arousal responses, as this was the next phase to be worked with upon his return. He

was very cooperative and the system was designed to indicate the date, the number of arousals experienced to males, how many tranquilizers or sleeping pills he took on a given night, whether he used relaxation, a hot drink, or a hot shower, and his degree of sleep ranging from very light, to light, to medium, to deep, to very deep.

He was aware that he did not have enough pills for his entire trip and that he would have to start spacing them out or run the risk of no reserve in case he ran into a difficult situation. He was to attempt to decrease the two pills to one pill, and then to an occasional pill. He was also to attempt to phase out his routine, by dropping out one item occasionally, such as the hot drink or the hot shower. It was also suggested that he take advantage of his traveling to continue his assertive training. When the time came for him to leave he seemed in good spirits and looking forward to his trip. He reported little anxiety at work or with people except for that associated with his arousal to male stimuli. However, he also appeared more relaxed in this area as well. He was even able to enjoy what might have previously been an embarrassing situation. At a company party he had run into the fellow worker with whom he had had his last sexual encounter. He reported no arousal, only amusement at the other man's apparent discomfort as he engaged him in conversation. In fact this person, as well as others, had remarked about the great change in Mr. Adam over the past couple of months. They said they saw him as so much

more relaxed and easy going than in the past. This, of course, was very positive feedback to Mr. Adam and he felt very good about his current situation.

Mr. Adam was not seen again until 6 weeks later. During that time he faithfully sent back his coded reports, except for the time he was traveling by bus or plane. His progress in his sleeping routine may be seen in Figure 1. When he returned Mr. Adam reported that he had slept in a wide variety of places and under varying conditions, but that once he had stopped the pills it was relatively easy going. He reported no difficulty in sleeping and did not now drink in the evening except for an occasional beer with a friend.

At this point, Mr. Adam's progress in different areas of therapeutic concern were examined and he reported the following:

Interpersonal relations. In general, he felt relaxed and doing well with his assertive training. He found himself able to assert himself without premeditation and in a number of situations that he would have found highly anxious in the past (e.g., in an argument with his mother, with a conductor on a train, with his landlord who yelled and screamed at him, etc.). He was receiving a number of party and dinner invitations which he usually accepted, and he was able to enjoy himself at these occasions. He was in the process of moving into another apartment by himself where he wanted to return the social invitations. He was meeting new

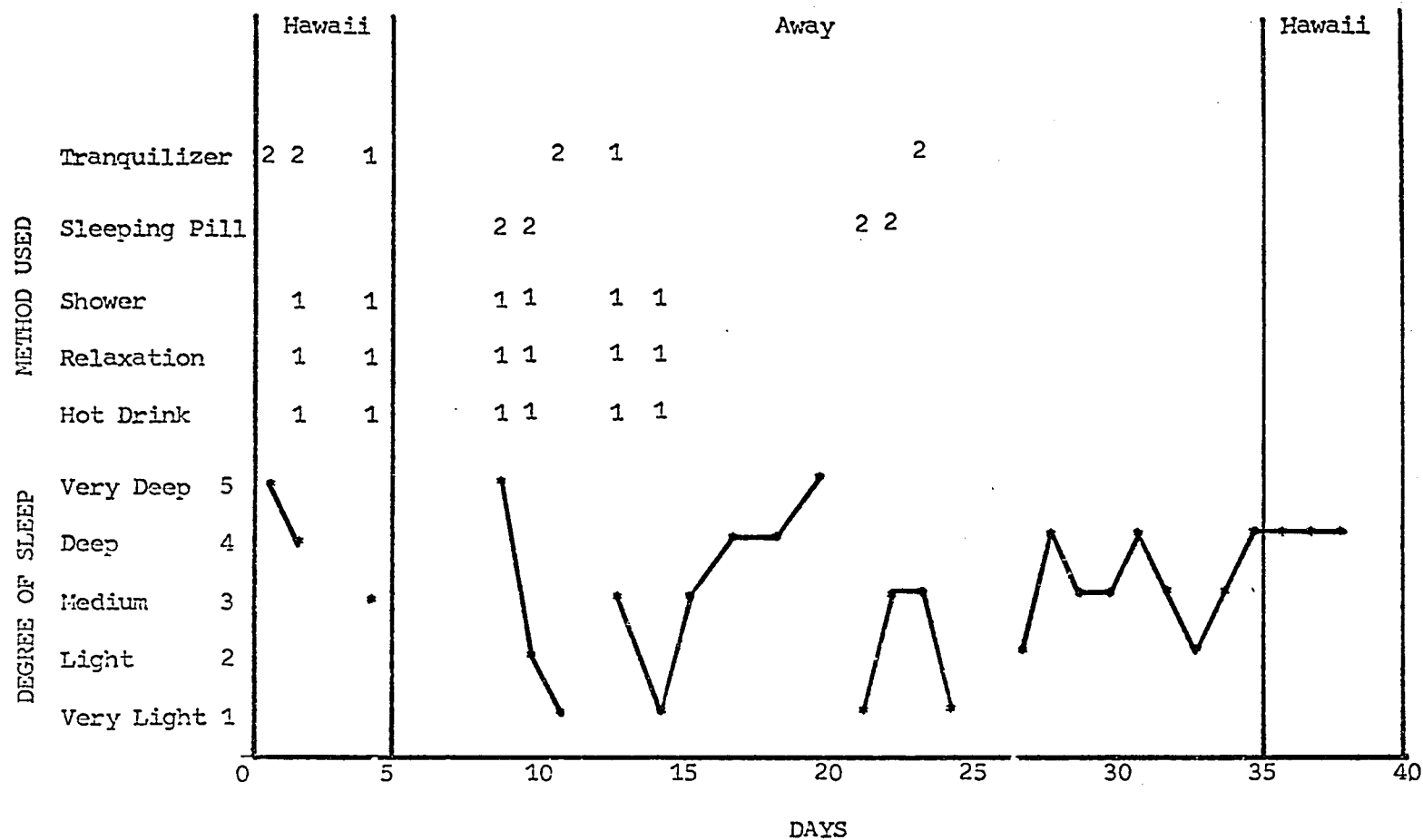


Figure 1. Mr. A's progress in sleeping routine.

fellow workers and had started dating a new secretary to whom he was attracted. He had kissed her on their last date and was looking forward to future contact. Overall, he reported feeling confident and able in interpersonal situations.

Training situations. He was initially anxious about starting his new training group, but found it surprisingly easy. He felt comfortable and found it easy to talk with the employees and respond to their questions and problems with much less anxiety than the previous year. (He could not quite understand the reason for this, and felt it must be that the new employees were quite different and more interested this year than in the past.)

Office situation. Here too, Mr. Adam found himself much more relaxed and comfortable. In fact, he found that he was so comfortable the previous week that he had taken it easy and had not prepared for his training session this week. He now felt some feelings of anxiety about being behind in his preparation, but he was quick to say that he did not want to change this feeling because without it he would "never get anything done!"

Sexual area. Except for the one kiss with his new woman friend, Mr. Adam reported that he had had no physical contact with males or females since starting treatment. He had again come into social contact with the male with whom he had had previous sexual relations on two different occasions since returning from his trip and he reported no



arousal or anxiety during the situations. In fact he had been amused at the other's obvious embarrassment and anxiety over being seen with a third male friend. However, he still reported anxiety over his continuing arousal responses to males in general. He felt that this was the only remaining problem that was of strong concern to him.

Initial assessment had indicated that Mr. Adam experienced definite sexual arousal to certain male as well as female stimuli. A brief description of Mr. Adam's sexual history suggests how he may have acquired such responses. His sexual information came largely from his male peer group while he was between the ages of eight and thirteen. (His father once tried to talk to him about the subject but became embarrassed and gave up.) He read one marriage manual at the age of 19. His initial homosexual contact was at the age of eight or nine and was limited to mutual exploration with boys in the neighborhood. At 11 he entered into a sexual relationship with a male friend which lasted until he was about 13. Contacts were limited to mutual manual and oral techniques, and took place on the average of four or five times a week. He also learned of masturbation from this same friend and experienced his first orgasm at age 11. Frequency of masturbation was about once a day until about a year ago, at which time it tapered off to about four or five times a month. During his adolescent years his main fantasy was the only sexual outlet that he had experienced, namely, manual and oral techniques with males. At 13 he and his

friend had separated and his primary sexual outlet was masturbation until age 19 when he formed a relationship with another teenager. This lasted for only three weeks with frequency of contact of about two times a week. At 21 he had another relationship while traveling abroad. His last relationship took place two months prior to entering therapy.

His heterosexual contact began at 10 when he would attend school dances and "hug" a girl afterward. During high school he would occasionally date and he received his first kiss. It was not until he was 19 that he had his first experience in heterosexual intercourse and this was with a prostitute. He found the experience generally pleasurable in the sense that he had accomplished the act, but he said that it had left him with a "sleezy" feeling. During college he met and became sexually involved with a few girls, one or two times each. The most frequent was one girl three or four times a month for two months. His last heterosexual relationship was with a woman whom he had met at work but this was considered by him as merely an "outlet" and he had had no contact with her since entering treatment.

His first dream to orgasm was at about the age of 12 or 13. Since that time he reports having approximately a dozen such dreams, mostly involving males, but occasionally a female from his past. His current masturbation fantasies were reported as being about evenly divided between males and females.

Currently, it appeared that there were no deficits in heterosexual arousal or behavior, and he had not engaged in homosexual behavior for several months. Continued arousal to same sex stimuli appeared to be his main source of anxiety. He also interpreted these responses as evidence for his "homosexual nature".

It was assumed by E that if his arousal responses to male stimuli were eliminated Mr. Adam would have nothing to support his self-labeled "homosexual nature." A heterosexual response repertoire was present. Treatment was selected from these assumptions. Covert sensitization procedures were initiated.

First Mr. Adam's sexual history was reviewed with him suggesting how his current arousal pattern could be explained by "normal learning" principles rather than by some unexplainable "homosexual nature" that resided within him. He appeared to want to believe this possibility, but was uncertain as to whether he could really accept this view. For the time being he was asked to withhold his final judgment, until he had had a chance to see if a treatment procedure based on normal learning principles might change his arousal pattern. He agreed to try. The rationale of covert sensitization, where aversive imagery would be paired with imagined arousing scenes, was explained to him. He appeared reluctant to accept that such a procedure would be of any help, but he was willing to attempt the procedure. He was then told to start keeping a record of his arousal

responses to females, as well as continuing recording those to males. He was also asked to recall disturbing and uncomfortable situations from his past for possible use as the imagined aversive stimulus. In addition he was asked to pay particular attention to arousal responses to males and to note down the situation as well as the description of the male involved for each response for the following week.

The next session was spent in going over his record of the preceding week as well as looking at previously reported times from prior sessions. Because the effects of covert sensitization have been reported to be highly specific (Cautela, 1970b), a careful attempt was made to identify the relevant characteristics associated with arousal to male stimuli. The distinguishing features that emerged were related to: situation, physical appearances of the male, clothing of the male, and action of the male. The general physical appearance of the male was usually young (under 30), good looking, with an "athletic type" build. Situations that appeared to offer the highest probability of Mr. Adam's arousal, in descending order of frequency were:

1. Walking through the park to or from work.
2. Standing in a line (in a cafeteria or supermarket).
3. Sitting in the cafeteria at work.
4. At the beach.
5. At a restaurant.
6. Sitting in his car at a stoplight.

Additional situations were added to this basic list as

they occurred during the course of treatment (e.g., at the theatre; at a rock concert; looking out the window of his apartment; at a party, etc.). Clothing that was particularly arousing, in descending frequency, was as follows:

1. In "mod" clothes.
2. In tight clothes.
3. Without a shirt.
4. In a bathing suit.
5. Wearing shorts.

Actions performed by the males, in ascending order of arousal, were:

1. Standing still.
2. Sitting.
3. Walking.
4. Scratching self on chest or other parts of the body.

Scenes repulsive to Mr. Adam were seeing a bad automobile accident; seeing students being clubbed by police on television; and seeing blood smeared over things. His reaction to all of the above scenes was mainly one of nausea and upset stomach. It appeared that the nausea was strongly associated with vomiting and therefore it was decided to use imagined vomiting as the aversive stimulus. In order to increase the generalization of his responses it was decided to randomly vary combinations of situation, clothing, and action instead of presenting the same scene repeatedly. Thus, one scene might be: Walking through the park to work, seeing a young, good looking, athletic type male wearing tight

clothing walking toward him. Another might be: Walking through the park and seeing two young, good looking, athletic types sitting under a tree, one without a shirt and the other in tight clothing, scratching themselves. Scenes such as these were varied according to the probability of his encountering them in the immediate future, or having experienced them in the immediate past (e.g., if a weekend were coming up and he was planning on going to a movie, that scene was used; or if he had experienced arousal while standing in a supermarket line the day preceding, that scene was used.)

Mr. Adam was first given relaxation instructions and then presented with a scene followed by the aversive scene. He was then relaxed again and presented an escape scene to the same situation (Cautela, 1967, 1970b). A typical pair of presentations would run as follows:

"Now I would like you to see yourself standing in line at the company cafeteria. You are holding your tray with some papers on it and looking forward to your lunch. Then you notice standing in front of you a young, good looking, athletic type, wearing tight clothing. You get that 'oh, boy' feeling and immediately you begin to feel that nauseated feeling in the pit of your stomach. As you look at him you feel more and more sick. You feel that bitter taste on the back of your tongue. Small food particles start inching up your throat. You desperately swallow trying to keep it down. Suddenly your mouth is filled with vomit and you try to hold your lips closed, but it is no use. You blurt the vomit out, all over your tray and papers, all over his clothes. People yell and jump back from around you. People stare and point at you. All you can see is your vomit on him and your tray and clothes. The putrid smell makes you vomit even more. You drop your tray and continue retching until nothing but water is coming out. Snot is running out of your nose and your eyes are tearing as you see the globs of food and smell the stench. You turn away. Immediately you begin to feel better. You get out of there, go home

and clean yourself and have a good shower and you feel so much better."

A typical escape scene would be:

"I would like you to imagine that you are standing in line at the company cafeteria. You are holding your tray with some papers on it and looking forward to your lunch. Then you notice, standing in front of you, a young, good looking, athletic type, wearing tight clothing. You get that 'oh, boy' feeling but you also start to get that nauseated feeling in the pit of your stomach. You calmly look away and immediately you feel better. You notice an attractive girl in another line and you enjoy yourself as you look at her and try to figure out if she is wearing a bra or not. You eventually get your food and sit down and enjoy eating it, feeling calm and comfortable."

Where possible, an attractive female was used in the escape scene. It was hoped that this might serve as a reinforcement for increasing his looking away from attractive males. However, it was also considered possible that through classical conditioning principles, attractive males might become discriminative stimuli for looking at females and thus strengthen his approach responses to attractive females. Therefore, escape scenes without females were randomly used as well, to engage the principle of intermittent reinforcement.

Covert sensitization was carried out during the next nine sessions, usually on a two-times-a-week basis. A total of 45 pair presentations were made. Combinations of characteristics were made so that those that had a higher probability of being encountered were presented more often than those of less probability (e.g., 12 "walking through the park" presentations as compared to 2 "in the car at stop light" presentations; 16 "mod clothes" presentations as

compared to 5 "wearing shorts" presentations). Figure 2. shows the number of reported arousals to males and females preceding, during, and after covert sensitization.

Three pair presentations were made during the first session, six during the next two, and five for each of the remaining sessions. At the first session he showed good imagery and reported experiencing actual nausea to the presentation of the aversive stimulus. This was supported by the grimaces, shuddering and other body movements he displayed during the aversive image presentation. He was instructed to practice 10 pairs a day on his own. He was also instructed to imagine the aversive scene whenever he encountered an actual situation during the day. He was to continue his record keeping as usual.

During the second COS session he mentioned that he was planning on attending a rock concert that weekend. This scene was then presented with four other general scenes. During the next session E checked over his notebook for the recorded responses between sessions and noticed a high point of 9 male arousal responses (included in point A of Figure 2.) on the day he attended the rock concert. Mr. Adam was then casually asked how things had gone that day. He reported that he had had a good time with his girl (female arousal was 4), then, as an afterthought, recalled that a strange thing had happened at the rock concert. He was sitting there enjoying himself when he suddenly realized he had not experienced one arousal response to males. Out of



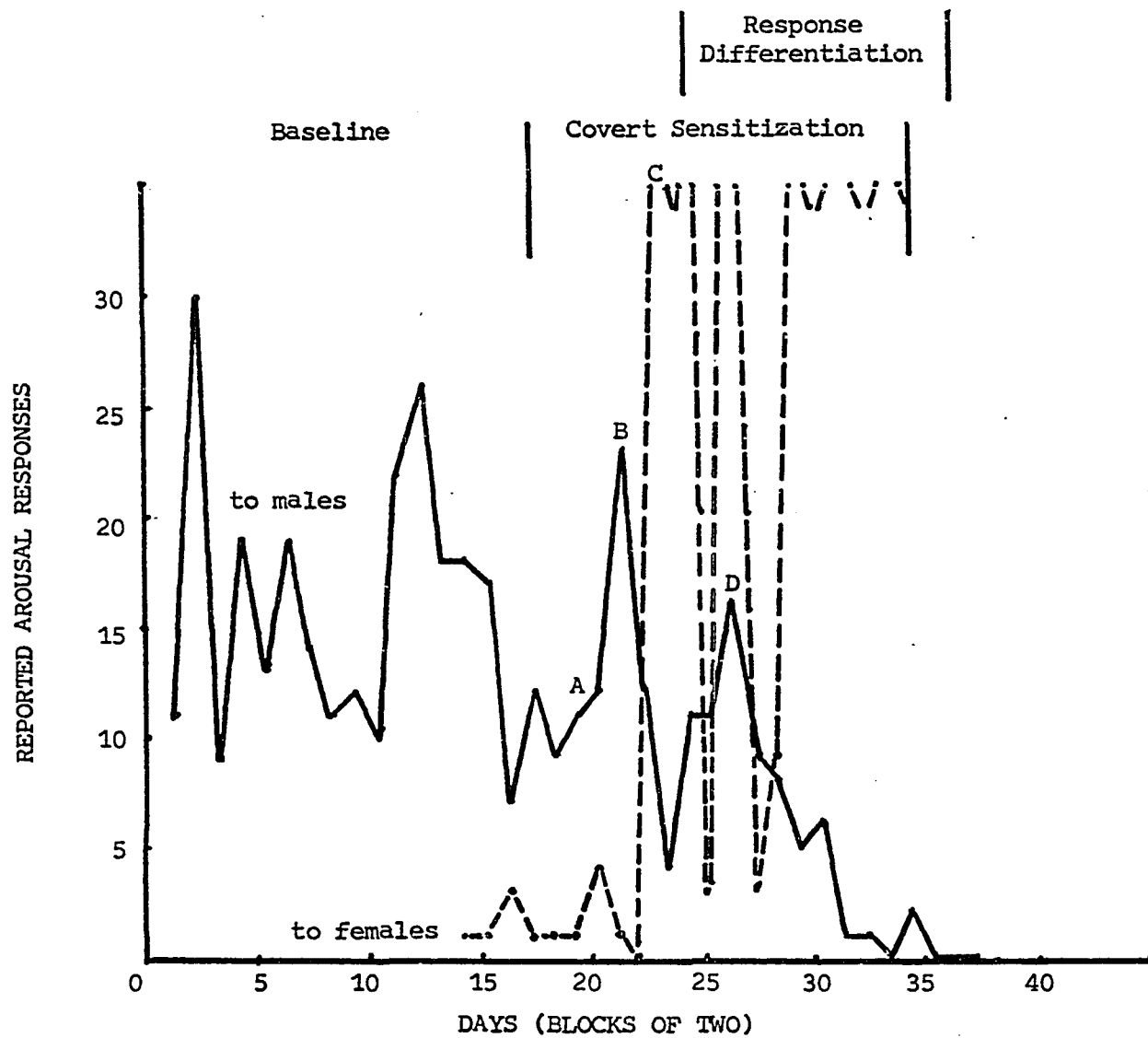


Figure 2. Mr. A's arousal record.

curiosity he started looking around at the males searching for some arousal in himself. When he felt one beginning he would then use the time to practice his "vomiting" imagery. He finally gave this up as too time consuming and returned his attention to the concert performance, which he continued to enjoy without arousal. He also reported that he had not had time to practice relaxing himself and visualizing the aversive stimulus to arousal as instructed until that morning before coming to the center. He was presented with 6 pairs of scenes, and again instructed to practice these at least once daily, along with any scene that came up during the day.

Mr. Adam was not seen for a week. He was in the process of moving and preparing new training materials. When he was seen for his fourth COS session, his record revealed two interesting features in relation to male arousal. There was a high point of 16 responses (included in point B of Figure 2.) and the first 0 response. The high point was the result of attending a party, where, as he put it, "All the gay people in town must have been there and almost everyone was wearing tight, mod clothes." The 0 response was a Sunday spent working and talking with his new female friend. For "some reason" he had just never noticed any males on that day. Another feature of his record was the notation "many" after female responses for a certain day (included in point C of Figure 2.). When questioned about this he said, in a somewhat embarrassed manner, that his relationship with his female friend had progressed to the point where he had spent

the night with her at her apartment. They had spent about 12 hours in bed together during which time he had engaged in sexual intercourse to climax three times. He reported that he was aroused so often that he just could not keep track and he could not see himself taking his counter to bed with him. E agreed that "many" was an appropriate notation for the occasion. (Further open ended lines indicate similar occasions on Figure 2.)

Mr. Adam also reported that he had practiced using aversive imagery when confronted with an actual situation of male arousal, but that he had not done his private COS homework. This was discussed with him and the importance of this procedure stressed, but it was recognized that it was difficult. He agreed that he would try to practice but with everything going so well for him he said it was hard to remember to practice. In general, he felt that many of his life patterns were changing for the better.

At his fifth COS session, he reported that he had practiced once a day for the past two days. He did not like the practice but was willing to continue. He also reported being able to do only three pairs each session. He did not find them as vivid as in the office with E. He also found it becoming "strangely" difficult to practice with real situations. He said the incidents were so brief that he had little time to bring in the aversive imagery. He would notice someone for an instant and then go on his way, though he tried to imagine following the usual routine. He then

spontaneously reported that he noticed something strange happening. He felt his responses to males were not really "arousal" like he felt when he saw a woman. He could not quite describe it other than to say it was "sort of like attention devices." He did not really feel anything specific in his genital area as he had remembered in the past. It appeared that he was going through a process of response differentiation. E informed him that perhaps it might be somewhat different and to pay particular attention to what he was experiencing during the weekend and report back again at the following session. He was going to attend the theatre on the weekend, so this scene was presented along with four others for COS.

At the following session, during general discussion, he reported a good evening at the theatre without one arousal--something that had not happened before. (His explanation was that the movie was particularly absorbing and he had just forgot to notice.) In addition to two more peak responses with female arousal, he had 11 responses for males on one occasion (included in point D of Figure 2.). This turned out to be a Saturday at the beach with his female friend. He had not been to the beach for sometime and seeing all the males in bathing suits had apparently caused the increase. Beach scenes had not been used for COS up to that point (an oversight on E's part.) E then started to incorporate such scenes in the COS. In discussing his reactions after COS, he reported that some of the scenes were becoming

somewhat vague. He had a hard time getting up any interest in the scene and could not work up any "arousal" feeling. At this point he related his difficulties during the past week. He reported that his responses were "all mixed up". He felt that a few were definite arousal responses of the genital kind, but others were just "interest". As an example he recalled starting to mark an arousal down when he realized that it was mainly just interest in looking at the tatoos that were covering the arms of a workman and he noticed several others were looking at the tatoos also. He felt it was definitely not arousal. Most of the items he said he recorded for the past week were those that he could identify with some type of physical feeling--like a difference in his breathing or a slight tightness in his chest--but not necessarily arousal in the genitals. He now felt the whole area was confused. In looking at females, he reported that he did not put down where he just casually admired a good looking woman, unless there was a definite genital arousal. He was not sure what was happening and the whole area was becoming much less interesting to him lately. Somehow everything (the sexual responses associated with males) seemed less important than in the past. He reported similar observations at the following COS sessions.

It appeared that he was experiencing a definite change in his responses to certain male stimuli and that his recordings were not based on the definitions that had been established initially, namely, genital arousal. (This

period is noted as "response differentiation" on Figure 2.) To assess this shift, he was once more asked to fill out the Reinforcement Survey Schedule and the Sexual Fear Inventory. Six months had passed since he had taken the forms during the initial assessment period. He was asked to respond to the items as he viewed them currently.

At the following session he returned the forms and said that he was continuing to have difficulty in keeping his record. When walking in the park or in town he found it difficult to notice anything going on except general interest and looking. He felt it was more like a "habit" than real arousal. He could not seem to work up real arousal responses anymore to the situations, except for a slight "tightness" in his chest. He definitely knew that the intensity of his feelings were less than before. He reported similar difficulty in his practice with scenes. he found it hard to work up real interest in the scene. His explanation for the reason for the change was that he just had too many other things of interest to occupy his mind. His work was going well, he was attending many parties and going out on intimate dates with his female friend.

At this point, instead of using his arousal response as the cue for the aversive imagery presentation, E switched the contingency to his "feeling interested". After presenting 5 pairs of scenes for COS, he reported that the scenes were very clear. The vomiting was very vivid and upsetting, but he said he now had a difficult time in even working up

"interest" in the scenes presented. It was noted that he did report a definite genital arousal during the past few days and this was to a movie scene of a nude male in a bathtub. However, the male was joined by a female and then he was mixed up in sorting out what he was responding to. It appeared that genital arousal responses to males were perhaps limited to actual sexual scenes rather than the general scenes that initially had signalled arousal. Until E had a chance to examine the RSS and SFI, it was felt wise to not change any conditions of procedure. Mr. Adam was asked to continue his practice as usual and to continue his recording.

Examination of the two schedules gave supportive evidence to the shift in relative values of male and female stimuli that Mr. Adam had been reporting. For example, on the FSS, "nude men" had dropped from Much to A fair amount; and "nude women" had advanced from A little to A fair amount. "Being close to an attractive man" had dropped from A fair amount to A little. Also of interest were the items that indicated what he did or thought about more than a certain number of times a day. At initial assessment Mr. Adam had noted that "mental illness" and "travel" were things he thought of 20 times a day; work, career, and home, 15 times a day; and friends and sex 10 times a day. Six months later, he reported sex, sleep, travel, friends, and planning, were thought about only about 5 times a day; and the only things he thought about more than 10 times a day were his work and differences between the "way I feel now and how I felt three

months ago." His total score on the FSS showed little change from initial assessment and 6 months later (i.e., 392 and 400, respectively).

Table 6 shows Mr. Adam's scores on the Sexual Fear Inventory during initial assessment and again 6 months later. For comparison the normative scores for males are also shown.

TABLE 6

## SEXUAL FEAR INVENTORY SCORES FOR MR. ADAM

Mr. Adam's

Initial Assessment	6 Months Later	Norm Group	
		$\bar{X}$	$\sigma$
Total Score: 239	231	239	67
General: 54	56	51	13
Personal: 53	56	58	13
Social: 38	39	32	8
Contact: 94	80	97	40

Comparison of Mr. Adam's initial scores with those he obtained 6 months later show little change except for physical contact items. Both sets of scores fall well within the norm group scores. On the surface there appears to be little change as the result of treatment procedures, however, examination of individual items show expected shifts. For example: fear response to "mutual masturbation with the same sex" and "engaging in mouth-genital contact with the same sex" dropped from Very much to Much; "A male asks you into his house" dropped from Much to Not at all; "nude women," "a male smiles at you", and "lying on the beach next to a



male" dropped from A fair amount to A little. Of interest also, is the comparison of Mr. Adam's responses to the 14 homosexual male stimulus items on his second SFI with those of the male norm group. Six of his responses were one point less than, 6 were equal to, and only two were one point more than the mean male norm group scores for these items. By contrast, Mr. Adam's initial response to the 14 male items showed that only two were one point less, 4 were equal to, and 8 were one or more points higher than the mean male norm group scores.

The information supplied by the inventories, his record keeping, and his verbal responses, all supported the observation that a shift had taken place in the relative values of male and female stimuli in Mr. Adam's A-R-D system. It was also apparent that Mr. Adam's recorded responses to males could no longer be exclusively categorized as "genital arousal" as they had been at the beginning of treatment. It appeared that the category had expanded to include other responses such as interest, attention, habit patterns, and "chest sensations." However, in spite of this expansion the responses in general showed a gradual decline in frequency since starting COS.

At the following session Mr. Adam reported continual difficulty in recording his responses, but this appeared to be a minor difficulty to him compared to what he saw as a real problem. He was beginning to form a relationship with a second woman and wanted to follow up on it, but he did not

know how to start trying to reduce the great deal of time he was now spending with the first woman. He appreciated the humor of the situation when the nature of this problem was contrasted with that of his original one. He laughed and commented that he certainly enjoyed these "new kinds of problems" and he looked forward to tackling it with his own resources. At this point he was given five more COS pair presentations. The response that was paired with aversive imagery was the "sensation in his chest" he had spoken of previously. He reported good imagery and some slight feeling in his chest, but he still felt he had to "work" at it. The issue of his changing responses to males was then discussed with him. Some of the survey material was also mentioned as supporting his current statements. He was asked to try and return to his original criterion of "genital arousal" to male stimuli. He appeared relieved at the request for he thought that he was going to be asked to try and start recording the different shadings of responses that he had been experiencing. He said that he would try but that it was still "all confused." At present the only way he felt could get a real genital response to a male was to go back in his past history to find a specific sexual scene.

At the following session Mr. Adam's record showed no arousal to males for three days in a row and a final two responses on the day prior to his interview. He reported these responses as doubtful ones. In both cases he had just happened to glance at a male who was exercising in the park

in his shorts, and another "typical" scene which he could not recall. He had noticed a brief "kind of physical sensation somewhere in his chest" but not a real genital arousal. Looking back at it he felt that he ought to erase them because they really were so brief and not "genital."

In order to determine what further treatment was appropriate or necessary, it was felt that a review of Mr. Adam's progress since coming in for treatment and an evaluation of his current situation was called for. Two hours were spent in this discussion in regard to his current situation Mr. Adam felt highly confident and positive. He had many outside activities and friends that he looked forward to being with, and he reported only occasional anxiety to what appeared to appropriate situations (e.g., having lunch with the president of the corporation). Mr. Adam's reaction to his progress since coming in for treatment was highly interesting. When each of his previous concerns was brought up for discussion (e.g., his "lack of confidence" feeling, his anxiety over his homosexual orientation, or his training program, or his office work, or his drinking, etc.) Mr. Adam would launch into a number of possible reasons for their resolution without once referring to a treatment procedure that was used. For example, he wasn't really "that anxious" over his so called "homosexual orientation" (he did not recall using those words). It was now seen as more of a "general build up" of other tensions. His training program had improved and he was relaxed because the employees had

changed and he was now a more experienced trainer. His office anxiety had decreased because his fellow workers had become more friendly and he had learned how to handle his work. His drinking problem had faded away because of his trip to the mainland which had offered him a change of environment (overlooking the fact that his behavior had started to change prior to his departure, not to mention that it had been with him for some years prior to moving to this state). E did not attempt to push him into other possible alternate explanations, such as the treatment procedures. However, his apparent feeling that none of the treatment techniques seemed directly associated with his improvement was casually reflected back to him and Mr. Adam apologetically agreed. While he appreciated all the help that E had given him and "certainly talking it over with someone always helps" he admitted that he just could not see how they had anything to do with his improvement. They were too simple to be effective. E did not press the subject any further other than to point out that, whatever the reasons, the important point was that Mr. Adam had certainly made good progress in resolving his problems. To reinforce his feeling of change he was then shown his two RSS forms so that he could compare his responses over the six month time period. His attention was also drawn to the relative shift in male and female responses. He found them interesting, but felt that they were only minor shifts and that if he took it over again today there would be even more shifts. E agreed with him, only

adding this was just more support for his own statement of perceived change.

His responses on the SFI were then shown and discussed with him in a similar manner. In addition to comparing his responses over time, he was also shown how his responses to male stimuli on the SFI compared with the male norm group. He was somewhat surprised to see how similar his responses were to the norm group and appeared pleased with the fact. At this point E turned the discussion to various ways that arousal responses to different types of stimuli might be learned and reinforced, particularly with masturbation. For the first time since the initial assessment Mr. Adam was asked about his recent masturbatory fantasies. Mr. Adam thought a moment, then said that they mainly centered around his recent female friend. However, he also recalled that male fantasies had dropped out entirely during the last two months, even prior to his relationship with his female friend. He seemed quite surprised at this thought. E then discussed the possible conditioning factor involved with masturbation, which Mr. Adam seemed to readily accept. It was also suggested to him that in the future he refrain from using any male fantasies to prevent further conditioning, and that he use female fantasies as often as possible. This seemed to "hit home" with Mr. Adam and he readily agreed. He then admitted that prior to his recent experience with the secretary he had had little imagery to use in the past. His female relationships in college had been mixed with

anxiety and the memories were unclear, so he had continued to use his previous male fantasies.

His arousal responses to general male stimuli were next discussed. It was pointed out to him that the RSS only attempted to measure general pleasurable responses to some stimuli and the SFI was designed for fear and anxiety responses to similar stimuli. Only his record keeping had been designed to measure actual genital arousal to specific sexual stimuli. He was then shown the graph that E had been keeping on his recorded responses (i.e., Figure 2.). Unexpectedly, Mr. Adam seemed quite impressed with the record. When his graph was tied in with his reported responses of visiting the beach, the rock concert, and his relationship with his female friend, as well as the changes since the beginning of COS, he was highly interested. He said that he had not realized it all seemed to fit together after all.

Mr. Adam was then asked where he wanted to go at this point. During the extended discussion that followed Mr. Adam said that he now felt much more confident in handling a variety of situations that would have been anxiety provoking in the past. In addition, he admitted that he seemed to no longer feel aroused by general male stimuli but he wondered what his reaction might be if he encountered outright male sexual stimuli. Such stimuli he described as nude scenes of males in a motion picture, or seeing nude men in a locker room, or touching a male penis, or engaging in any other

overt sexual behavior with a male. At first E thought that Mr. Adam was worried about being able to control his behavior if he encountered such situations, but Mr. Adam denied that this was true. He felt confident in being able to refuse any advances that a male might make toward him, though he thought that he might feel a "little anxious." He just wondered if anything could be done to rid him of possible arousal reactions to such situations. Inasmuch as such circumstances had not occurred for over a half a year there appeared to be no accurate way of determining what Mr. Adam's reactions would be at the present time. It was suggested that he would either have to wait until such a situation occurred or that his current responses to sexual situations that he had found arousing in the past might be examined. He did not relish the idea of going over his past experiences but agreed to try rather than wait for an occasion that might not occur for "years." E agreed to think about the situation and see what might be done. In the meantime he was asked to take the following week to write down any sexual scenes with males that had been highly arousing to him in the past and that he felt might possibly happen to him again in the future. It was suggested that he could start by recalling major scenes he had formerly used during masturbation. He was advised to write down the scene as soon as he thought of it and then immediately proceed to something else so as to not dwell on the subject. In addition to his masturbatory images he was also asked to include any other

arousing experiences from his past that he could recall. He was asked to return in one week.

A number of procedures were considered that might reduce Mr. Adam's possible arousal to male sexual stimuli. On the assumption that deep muscle relaxation was incompatible with sexual arousal, systematic desensitization to a hierarchy of increasingly arousing male sexual scenes could have been attempted. However, there was the possibility that any arousal by Mr. Adam might be stronger than his relaxation. This might mean that relaxation itself could become a discriminative stimulus for arousal.

Covert sensitization to male sexual scenes was another alternative. However, this procedure also had some apparent disadvantages. COS is dependent upon presenting the aversive image to an arousal response rather than directly to the stimuli that elicits such a response. Thus, for example, the intent of using COS previously was to reduce Mr. Adam's arousal responses to males in bathing suits and not to increase his avoidance of males in bathing suits so that he could not go to the beach which he enjoyed. This meant that if COS were used to male sexual scenes, it would be necessary for Mr. Adam to go through a period of experiencing arousal to such scenes which once more might shift the relative reinforcing value of male and female sexual stimuli. It was also considered possible that, because of its extensive use in the past, Mr. Adam might soon become habituated to continued use of vomiting imagery and the scene could prove



insufficiently aversive to override his sexual arousal response.

What seemed to be indicated was the need for some procedure that would reduce as much as possible the opportunity for sexual arousal to be experienced when confronted with potentially arousing stimuli. This could be accomplished by closely pairing the presentation of potential arousing stimuli with a highly aversive stimulus such as shock. In view of Mr. Adam's apparent motivation for treatment, and taking into consideration the availability of his established heterosexual relationship, shock aversion treatment seemed appropriate to consider. Whether Mr. Adam would be willing to enter into such a treatment procedure and, if so, what particular method to follow remained to be determined. It was also considered important to more closely explore Mr. Adam's reasons for wanting something done about his "possible" arousal responses in certain situations before going ahead with any form of treatment.

At the following session Mr. Adam reported that he had accomplished a number of small goals related to his work, car, and budget. He had also reduced his nights with his woman friend so that he now had more time to keep abreast of his work. He had recently had only a few "all night" sessions with her and found them satisfying and sufficient. He also reported that he had not experienced any arousal to males at all during the past week.

He turned in a list of 14 scenes that would have been

highly arousing to him in the past. The majority of the scenes were directly related to overt sexual behavior (e.g., mutual masturbation, oral-genital contact, lying in the nude with another male with interlocking thighs, etc.). He was asked if he had experienced any arousal while recalling the scenes and he replied that he did not think so but his feeling was mainly one of slight anxiety about digging them up again. He definitely did not like thinking about them and was confused about his own reactions. It was pointed out that many of his reactions were similar to those reported by other males to the same situations. It was also noted that the scenes he reported were ones that he would most likely not happen on to by chance, but that they would be the result of a series of voluntary behaviors on his part (i.e., meeting a male, advances being made and reciprocated, etc.). He recognized this and again said that he was confident that he could stop such a sequence from happening. He said that he had been thinking about the whole situation all week and was really uncertain about what he expected at this point. He revealed that for the past month he had seriously considered talking about termination of therapy. Things were going well just like they "used to." He was busy enjoying his work and his friends but he still felt reluctant about stopping. It seemed that his reluctance to quit stemmed from his fear of once more encountering such a panic reaction as he had experienced prior to coming in for therapy. He had sat down and tried to think of all

the things that had happened prior to that panic reaction and he wanted to make sure that they could not bring it on again. In fact, he was now thinking that perhaps it was not his homosexual experience that had brought it on (for he had had those before and though they were anxious for him they had never brought on such pervasive anxiety before), as much as it might be his moving to Hawaii. He now wondered what might happen if he moved to someplace else. Would he react with anxiety again? It was pointed out to him that he had moved several times in the past and it had not brought on anxiety, in fact, traveling to new places was presumably one of the activities he enjoyed the most. He agreed with this observation and then went on to ask if it might have been the result of his new training program or his lack of assertion in his interpersonal relationships.

It was recalled for him that the initial assessment period was primarily focused on an attempt to analyze the different situations that brought on his anxiety. Once these areas were tentatively identified and separated from each other possible ways of dealing with them were suggested. He was told that it was impossible to completely eliminate all anxiety to every possible situation, and that there was no guarantee that he would never experience such an acute situation again as he had had in the past. However, the probability of such a situation occurring again was much less now than it had been previously. First of all, he now could recognize when such anxiety was beginning to build. He

readily agreed with this, stating that his awareness of his own reactions was much more clear for him. When he noticed that he was beginning to feel some anxiety he would carefully examine the current situation as well as what had preceded it and he usually came up with a plausible reason, such as a failure on his part to share his true feelings or a failure to assert his legitimate rights. E also suggested that he now had available a number of methods of handling situations in the future such as assertion, and relaxation before, during, or after a particular anxiety evoking event. He asked if it were possible to use systematic desensitization by himself for particular situations that might become anxiety provoking in the future. E agreed that it was possible and some discussion ensued as to what sort of situations would appropriate and how to deal with them.

It was at this point that Mr. Adam verbalized the thought that he could be his own therapist in the future. He excitedly asked if it were possible for him to continue to use the covert sensitization technique on his own if he ever encountered an actual sexual arousal response to male stimuli in the future. He was assured that it was entirely possible and again considerable time was used to discuss the various ways he might use the technique (e.g., using the aversive imagery in the actual situation where he found himself aroused, practicing the scene at least five times at home while relaxed, practicing in advance of a situation that he felt might bring on arousal, etc.).

At this time E mentioned the possibility of shock aversion treatment. Mr. Adam seemed somewhat intrigued by the idea, though he admitted he would not look forward to it. However, his main feeling seemed to be one of wanting to "go on his own". He felt that things had been going well for him for some time and after the previous discussion he felt much more confident in handling his own future. He now thought that things had finally come together for him during the session and he felt a great sense of relief. He asked what E thought about trying on his own. E supported his decision and agreed to be available should Mr. Adam decide he would like to check back for any reason. Several other points were discussed such as Mr. Adam continuing to avoid using male imagery in his masturbatory fantasies and continuing his assertion responses in appropriate situations. Finally Mr. Adam was given the CFI and HBI, to fill out and drop off at his convenience. Mr. Adam appeared in good spirits as he shook E's hand warmly and said goodbye.

Table 7 shows Mr. Adam's scores on the Composite Fear Inventory and the Heterosexual Behavior Inventory during initial assessment and after treatment. For comparison the appropriate normative scores are also shown. Mr. Adam's scores show a slight increase.

TABLE 7

## MR. ADAM'S PRE AND POST INVENTORY SCORES

Scale	Mr. Adam's Scores		Norm Group	
	Assessment	Post Treatment	$\bar{X}$	SD
CFI Total Score:	342	358	387.38	87.07
Geer Scales:	106	112	122.99	27.73
Suinn Scales:	186	199	206.60	50.03
HBI Scores:	14	17	14.48	6.15

in reported fear and sexual behavior over time; however, all scores fall within one standard deviation of the mean reported score for the norm group.

Contact sessions, from initial interview through assessment and treatment, totaled 38. Time elapsed from initial interview to final session was approximately seven months.

Case of Mr. Brown. Mr. Brown, a Caucasian male in his early twenties, was referred to his community mental health center by a counselor at the community college which Mr. Brown was attending. He had originally gone to his college counselor asking for help with his "educational" problem. He was uncertain as to requirements for graduation and wanted help in vocational planning. After appropriate vocational testing and interpretation, he revealed his "real" problem. He said he was sexually afraid of girls since his first and only contact at age 16 when he found himself impotent. He had since had several homosexual contacts with males and was now very fearful of his "homosexual nature breaking through." He was afraid that his friends would

find out about his true nature and that he would therefore loose them. He felt that he would commit suicide if he ever became a "full blown" homosexual. He reported no arousal to females whatsoever. He was referred to a mental health center for treatment.

At the mental health center he was seen by a psychologist for a total of 23 sessions spread over a period of nine months. Initially therapy was insight oriented toward a goal of self acceptance. However, as treatment progressed he became more anxious and systematic desensitization to female contact was begun. Mr. Brown resisted this procedure, claiming that nothing was happening to him. He could not see how such a procedure could prevent him from reversion to homosexuality and therefore he did not think that the amount of tension and anxiety invested in the technique were worth it. The procedure was abandoned and an attempt was made to work through his apparant resistance.

Four months prior to Mr. Brown's expected graduation from his community college the present research program was initiated and Mr. Brown was asked by his psychologist if he would be willing to consider transferring into the program. He agreed to an initial interview with E.

After the research program was explained to him, Mr. Brown agreed to take part even though he was cautioned as to what he might realistically expect to accomplish in the short four month period prior to his graduation. Assessment was begun and Mr. Brown was seen two, and sometimes three,

times a week, depending upon his availability. Assessment took 18 sessions, during which a number of planned interventions were made in regard to academic problems such as study habits and paper writing.

Mr. Brown's sexual history showed limited contact with females both in dreams and in actuality. He could only recall once having had any arousal to a female and this was when he was 16 and highly intoxicated. He had succeeded in removing the girl's blouse and fondling her breasts, but he had become highly anxious when he found that he was unable to obtain an erection. By contrast, he had had several opportunities for mutual exploration with boys during pre-adolescence and had had about six or seven sexual encounters with males since puberty. For the past year he had not had any further contact in a desperate attempt to control his "homosexuality."

His masturbatory fantasies had been limited to males except for one time about a year previous at which he attempted to visualize intercourse with a female, but the picture had been too "fuzzy" and unsatisfactory. He currently had a masturbatory frequency of about four times a month which he described as mechanical and without imagery.

As part of the "proof" for his homosexuality he related that he had cross dressed as a child for about four years. Detailed questioning indicated that this behavior on his part had been highly reinforced by attention and actual aid on the part of his mother, aunt, and neighborhood women.



(always commenting on what a "cute little girl" he would have been) even to the point of buying him little dresses). He reported stopping this practice when he witnessed the death of his brother in an automobile accident. Mr. Brown, wearing girls clothes, had been standing in the doorway of their home when he saw his younger brother run over. Everyone but he had run out to his brother but he felt too ashamed to be seen in his clothes. It was only after considerable probing that he could recall this last incident of his cross dressing. Later it was suggested to him how he might have learned to cross dress due to the reinforcing behavior of his relatives and their friends, and also of how the one time pairing of his dressing with a highly traumatic incident might have been strong enough to prevent him from engaging in the behavior again. This suggested explanation seemed to offer him a great feeling of relief for he had never considered the matter in this way and had assumed it was only evidence of his true "homosexual nature."

His stated goals at the conclusion of the assessment period were "somehow to prevent his homosexual nature from coming out" and to "have normal relationships with women." When asked for evidence of his homosexual nature (other than the cross dressing mentioned above) he replied that it was his feminine behavior with his friends. Further clarification indicated that he saw his submissive role with males as being his feminine behavior. He felt the way he acted with them, speaking in a high pitched voice, giggling, and always

acceding to their demands were examples of such "feminine" behavior. With women, he reported no hope of success for he never felt anything toward them. He also had some thoughts that his problem may have its roots in his biological background.

Medical evaluation indicated no physical or organic complications and he was assured he was a normal healthy male. As in the case of Mr. Adam he was asked to keep a notebook of pleasant and anxious situations. The data indicated high anxiety associated with situations which required any form of assertion with his friends on his part. His usual response in such situations was one of submissiveness which he ascribed to his "feminine" half. To provide an alternative response in such situations he was trained in assertive behaviors in a similar manner as described in the case of Mr. Adam. He also engaged in behavioral rehearsal with E of such situations, with special emphasis on lowering his voice and controlling his giggling.

Unlike the case of Mr. Adam, Mr. Brown had no apparent arousal to females and no social skills in this area. In an attempt to change the discriminative value of females in general and sexual relations in particular, he was given an intensive course in female sexual anatomy, physiology, and function (his knowledge was very limited; for example, he thought that the "clitoris" was just the medical term for the female "belly button"). This was accomplished with the use of life sized female models, charts, diagrams, and

pictures. This was followed by an intensive course in suggested techniques of female arousal and sexual intercourse. Discussions and demonstrations with models in his sessions were supplemented with outside reading materials, such as Ellis and Conway's (1967) The Art of Erotic Seduction and McCary's (1967) chapter on techniques of sexual arousal, as well as books containing photographs demonstrating such techniques. In addition, he was supplied with an 8mm hand viewer and several films demonstrating a number of approaches to female arousal and intercourse.

Apparently, these procedures were helpful in changing the discriminative stimulus value of sexual situations with females, for after completing them he reported with enthusiasm that for the first time in his life he really felt confident about knowing what to do in such situations. In fact, from conversations with his male friends, he discovered that he now knew much more than any of them in this area and he was looking forward to his first opportunity. However, he still had a deficit in social skills with females that would lead to such opportunities and he still reported no arousal to females. A classical conditioning procedure was then implemented in an effort to change his attitudinal response toward females, and successive approximation was instigated in an attempt to help him acquire social skills.

At the same time that he was being instructed in seduction techniques he was also asked to use female fantasies while masturbating. Initially he had difficulty with such

imagery and to help him he was supplied with numerous colored photographs of female genitalia, then a variety of pictures showing the entire nude female body, and finally pictures and films of men and women engaging in a variety of sexual relations.

On his first masturbatory attempt he reported that it took him about fifteen minutes compared to his usual three to five minutes and that he experienced a "strange feeling" but it was not uncomfortable. As he progressed he began to report a "warm" feeling toward the female pictures as well as similar feelings toward actual females he encountered during the day.

It was at this point that he was started on successive approximation procedures to help him acquire social skills with females. He began by smiling once at a female he knew in class, then smiling at females he did not know, then chatting with a female he knew, then asking a female he knew for coffee, until there were several females with whom he could start a conversation without too high a degree of anxiety. He then attended a party where one female, whom he reported a "warm" feeling toward, spent most of the evening talking and laughing with him. He was amazed to find himself extremely aroused with a strong erection, but he was uncertain of what to do next. After that occasion he used her in his masturbatory fantasy and found it highly satisfying. He soon reported experiencing similar arousals to other females with whom he came in contact. He

also volunteered that he now realized that he had not been experiencing "arousal" with males but only a strong feeling of companionship or friendship--it "just wasn't the same feeling he felt toward girls."

At this point Mr. Brown graduated and he had two weeks remaining before he was to return to work in his home state. In general his progress had been rapid in a number of areas. He was now able to assert himself with his male friends and spoke in a strong voice without any trace of his "feminine" behavior of the past. He felt "strong" and comfortable with males and no longer viewed himself as submissive. He was now experiencing arousal to females and felt confident about his ability "once he got them into bed." He also had acquired some degree of social skill in initiating contact with women and talking with them on a superficial level. As a rough indication of progress, at the beginning of the successive approximation procedures, Mr. Brown had been asked to rank the female social items (61 through 98) on the Sexual Fear Inventory as to the degree of anxiety he thought he would experience if engaging in such an activity. The items were ranked from 0 for "no anxiety" to 10 for "extremely high anxiety". His mean score for the items was 7.00. Fifteen days later he was again asked to rank the items and he obtained a mean score of 4.92. One week later, at his final session, he was again asked to rank the items and he obtained a mean score of 4.63. (He appeared quite surprised at his apparent reduction in anxiety to these items for he had felt

he had scored them all about the same each time.) However, he still reported feeling very anxious about what to do between the time he initiated contact with a female and perhaps eventually had sexual relations with her. He viewed sexual relations as the final proof to himself that he was indeed not a "homosexual." No amount of discussion on E's part seemed effective in helping him change this criterion. He claimed that he could recognize "intellectually" from all that had happened that he was indeed not a "homosexual" but that he could not really "feel" it was true until he was able to have sexual relations with a female. E attempted to caution him about his expectations and suggested that he continue his progress in small steps. However, less than two weeks before his coming departure Mr. Brown, somewhat sheepishly, reported that he was not sure how it had happened but he had agreed to move into a house with four women during his remaining days. He now felt highly anxious about the prospect. He was advised to set definite limits on his expectations and not to make any direct sexual contact as long as he felt the least bit of anxiety. It was suggested that he could use the time to increase his social skills in relating with women and to not proceed further unless it was first jointly discussed with E. He made the move and when he came in for his session he reported that he had had heavy anxiety attacks throughout the day and night. It seemed that one of the women had been "great", warm and understanding, and he did not know how to respond

to her. Another kept leaning against him while he studied and kept offering to prepare him meals and snacks. The third, he found the most appealing sexually, but her constant giggling and extremely "feminine" behavior caused him anxiety. The fourth was very plain and kept to herself. His problem was now knowing how to behave as a "male." He was uncertain as to whether he should cook or wash dishes or was that "only for the women." He did not know what was expected of him and he wanted very much to be accepted as a male. A long discussion was held concerning the confusion caused by labeling certain activities "male" or "female." He was supported in continuing to express his own feelings about subjects or activities rather than not engaging in behaviors that might be considered "feminine." It was also suggested that if he just learned how to talk with the women in different situations, he would have learned quite a bit more than if he did not have such an opportunity. He seemed somewhat reassured, though E suggested the possibility that he might look for a less anxiety provoking living arrangement before he left.

When he returned for his next appointment he reported that a fifth girl had moved into the house and he had decided to move out and to move in with a married couple who had invited him previously. He was supported in his decision and the remaining sessions were spent in discussing ways he could continue on his own to experiment with different social skills.

At his last session he reported considerable anxiety over the thought of not being able to consult with E in the future. He was supported in his own ability to handle various situations as they occurred, using his past learning as an example. It was suggested that he continue to use female pictures for masturbation and to extend them to Playboy pictures and then to pictures of women in bathing suits. Some time was spent in going over the various self control techniques he had learned such as assertion, successive approximation, impulse control and others. At the end of the session he asked if he could come back and see E in the future if it became necessary for some reason. He was assured that E would be available.

It was considered unfortunate that Mr. Brown had to withdraw from treatment at this point. Mr. Brown had made considerable progress in a relatively short period of time, but whether his new behaviors had acquired sufficient reinforcing value to be maintained without the structure provided by his contacts with E remained an open question.

Mr. Brown's scores on the Reinforcement Survey Schedule, the Composite Fear Inventory, and the Sexual Fear Inventory obtained during initial assessment and again two months later when he withdrew from treatment may be seen in Table 8. The mean scores for the appropriate norm groups are also provided for comparison purposes.



TABLE 8  
MR. BROWN'S INVENTORY SCORES

Scale	Norm Groups			
	Initial Assessment	2 Months Later	$\bar{X}$	SD
Reinforcement Survey Schedule	365	375		
CFI Total Score:	406	348	387.38	87.07
Geer Scales:	131	113	122.99	27.73
Suinn Scale:	224	184	206.60	50.03
Sexual Fear Inventory				
Total Score	391	325	239.59	67.71
General	70+	62	51.41	13.71
Personal	82+	64	58.09	13.40
Social	70+	55+	32.41	8.55
Contact	169+	144+	97.69	40.05

Mr. Brown's scores on the Reinforcement Survey Schedule show a slight increase over the two month period, and conversely there is a marked decrease in reported fear as measured by CFI. While Mr. Brown's scores on the CFI, Geer, and Suinn scales during initial assessment all fell within one standard deviation of the mean score for the norm group, his scores two months later show a definite decrease.

On the Sexual Fear Inventory taken during initial assessment, Mr. Brown's total score fell within one standard deviation of the mean score obtained by the norm group. However, his individual scores on the subscales were all greater than one standard deviation above the mean reported scores

of the norm group. Two months later Mr. Brown's scores showed a reduction in all categories, with his obtained scores on the General and Personal subscales now falling within one standard deviation of the norm groups mean scores. However, despite his reduction in reported fear responses, his obtained scores on the Social and Contact subscales are still more than one standard deviation greater than the mean scores obtained by the norm group.

His score on the Heterosexual Behavior Scale stayed at 7 as compared to a mean score of 11 reported by Bentler (1968a) for a comparable norm group.

Contact sessions, from initial interview through assessment and treatment up to the time of withdrawal, totaled 29. Eleven of the sessions were devoted to treatment. Time elapsed from initial interview to termination was approximately four months.

Follow up note: Two weeks after Mr. Brown had left he wrote informing E of his progress. Part of his letter reads as follows:

Things are really getting heavy. I got home last Wednesday and I called this girl who has always thought I was a good kid and went out with her Saturday night and had a grand time. I should have brought her home when I felt like it but I let her talk me into a ride so I have rather bad vibes, but I have another date with her tonight and Saturday night. And we may be going out with another couple tomorrow which I think I'd better avoid. I said yes because I want to get into this social trip but I'm biting off a lot more than I can chew and I know it. After Saturday, I'm going to have to cool it because I'm starting to feel a tremendous demand and its bringing the anxiety to a critical level. Its especially hard because this place is

just as it was before and its overwhelming me with stimuli that have always evoked homosexual attitudes....

I'm going to read all those articles you gave me. I seem to have reached another one of those depressing plateaus where homosexuality looks more and more comfortable. I know I have to get out of here as soon as I have the money but its going to be hard not to settle in to a rut. For all I can do is try to practice the social graces and keep a positive attitude until I can get back to Hawaii or someplace where I can use these skills while not under the close scrutiny I feel forced to contend with here....

It is apparent that Mr. Brown was continuing in his attempts on his own but finding it difficult to cope with his environment. Two months later a final letter was received, part of which reads as follows:

You either have received or will be receiving a request for information from a psychiatrist I saw last night for the first time.

Things have improved 100% from the way I was before I saw you. My self confidence is greatly increased which has cut down my nervousness, which has cut down my submissiveness behavior, which has improved my relationships with both sexes. This increases my self confidence even more, etc. The homosexual attitudes come and go--mostly go. The responses are not as intense and less frequent, like I can put my arm on somebody's shoulder because I like him and that's about it. I enjoy girl's company much more but I still feel a demand which is a hassle. But I'm not all uptight the way I was. Several people have remarked on a change in me. For the better which is great because I'm still somewhat shackled by public opinion.

. . . . The anxiety attacks persist in crowds and other random situations (a phobia which had been discussed during assessment but one which was not treated due to lack of time) but the good doctor has given me some more valium. He seems like a real nice guy but he's not as good at interpreting my generalities as you were. Hope to come back to Hawaii but my plans are very tentative . . . .

I don't know what else to say now. Wish I could have made it on my own but I feel as though I've reached a point where I need another push or something. The "Christine Jorgenson Story" is a movie now--a very bad one--but it could have been devastating to me a few months ago. Hope this finds you well. Will keep you informed and whatever. Still thanking you....

A letter, requesting information, and accompanied by a signed release statement, was received from a psychiatrist at a mental health clinic a short time later. An outline of Mr. Brown's treatment program was sent to the psychiatrist, along with a tentative plan of successive approximation of social contacts that E was considering had Mr. Brown been able to continue in treatment.

Case of Mr. Chan. Mr. Chan, an oriental male in his early twenties, had 19 contacts with a female psychiatrist at a mental health center ranging over a period of three years. Initially he reported a number of specific fears concerning dogs, crowds, bus stops, drugs, and death. Later he reported a strong homosexual fear as well. However, after a few sessions with his psychiatrist he would find that things seemed to go better for him and he would fail to keep his appointments or cancel them, until he again found himself in some sort of acute anxiety situation. At these times he would make another appointment and express his intention of "really working on his problem this time" only to repeat the same pattern. He saw his main problem as a homosexual one. He had engaged in mutual masturbation with male friends at the age of eight or nine and had had approximately

six homosexual experiences with males until age 15. He had one petting experience with a female at age 16 which turned out very pleasant but he had been too inexperienced to attempt to go any further. His masturbatory fantasies were entirely male.

He finally came to his psychiatrist and requested someone new with the intention of really working on his homosexual problem. He was referred for possible inclusion in the research program. The program's approach appealed to him and he agreed to enter into a "firm commitment".

Assessment extended over 17 sessions. The length was due to a number of continuing problems that required intervention (e.g., helping him acquire work, draft counseling, referrals for various minor medical complaints, etc.). He also had a difficult time in setting specific goals for himself. At one time he would express a desire to "give up his homosexual yearnings" and try females, only to later state that he actually preferred a homosexual relationship. When asked to keep a notebook he would either forget the notebook at home or forget to make entries. When asked to keep a record of his arousal to males and females he complained that there were too many to record. He was given a small hand counter and promptly lost the counter. He was given another and forgot to carry it with him. He usually arrived 10 to 20 minutes late for his appointments at which time he would be very apologetic and always have a "rationale" reason for his tardiness.

Toward the end of assessment when a number of minor problems had been resolved he started expressing the thought that perhaps he really did not need to work on his problem at this time but "it would work out by itself." It was suggested that he consider taking a few more sessions to complete the assessment period and then take a close look at what he wanted to attempt to achieve. He agreed but began to cancel scheduled appointments, always for a "good" reason. Assessment was completed at the beginning of summer. At this time he was again asked what he hoped to achieve, pointing out that his original goals were somewhat unclear and kept fluctuating. He said that he had a difficult time deciding what he wanted and at the moment he was looking forward to just taking a summer course at the university and having a good time, particularly after working so hard at his new job during the past few months. E suggested that they stop at that point and that Mr. Chan spend some time re-evaluating his goals and to make an appointment when he came to some decision. Mr. Chan quickly agreed.

Three months later Mr. Chan came in with a list of goals: a) friends; b) self confidence; c) wanting to do and experience; and d) possible arousal toward women, but not for the sake of their being women, but to meet the demands of the culture. E attempted to operationalize these goals but found it very difficult. Mr. Chan stated that he really was not sure he wanted to change but thought maybe he

"should". Once more he was going to reconsider and let E know at a later time. E pressed him into making a definite appointment one week later.

At his appointment Mr. Chan was quite excited about a new job that had taken with a musical group. He said that he had finally found another person who was "bi-sexual" and for the first time he felt he could talk to someone about it who was not a "professional." He had not had an overt homosexual experience since he was 15 and he thought he ought to really give it a try before he considered giving it up. In addition, he also reported a female in the group who really "turned him on" and he was looking forward to experimenting with her. He said that he was sorry for all the time that had been spent on him but he felt that he really ought to experiment himself and see what happened while he had the chance. E accepted his decision only pointing out that if Mr. Chan did really want to make a "choice" between male and female partners he might consider starting with the female first, seeing as how he had already had experience with males previously. Mr. Chan agreed that that would probably be the "fair" thing to do and promised to consider females first. It had been six months since Mr. Chan had taken the initial assessment battery of inventories and E decided to take advantage of this opportunity and ask Mr. Chan if he would agree to once more take the battery. It was considered of interest to see what sort of changes might occur over time when a specific treatment program was not

given. Mr. Chan readily agreed and took another set. One month later, and after a brief reminder note from E, Mr. Chan returned his completed forms.

Table 9 shows the scores obtained by Mr. Chan on the various inventories during initial assessment and again six months later. For comparison purposes, the mean scores of appropriate norm groups are also given.

Scores obtained on the Reinforcement Survey Schedule and the Heterosexual Behavior Inventory show practically no change. There appears to be a slight increase in the fear scale scores; however,

TABLE 9

## MR. CHAN'S INVENTORY SCORES

Inventory	Mr. Chan's Scores		Norm Group	
	At Assessment	6 Months Later	$\bar{X}$	SD
Reinforcement Survey Schedule	378	377		
Heterosexual Behavior Inventory	1	1	11.14	6.86
Composite Fear Inventory				
Total Score	411	459	387.38	87.07
Geer Scale	135	143	122.99	27.73
Suinn Scale	216	245	206.60	50.03
Sexual Fear Inventory				
Total Score	150	215	239.59	67.71
General	36	37	51.41	13.71
Personal	37	38	58.09	13.40



Social	24	28	32.41	8.55
Contact	53	112	97.69	40.05

his initial scores and those obtained six months later fall within one standard deviation of the mean scores obtained by the norm group. Two interesting features are noted in examination of the scores obtained on the Sexual Fear Inventory. The scores shown for the initial assessment scales are at least one standard deviation less than the mean score obtained by the comparable male norm group. Six months later his scores show little change except for that obtained on the contact subscale which showed an increase. Whether this was due to his expectations of actual contact or not it is difficult to determine.

Mr. Chan was seen for a total of 17 sessions, which extended over a period of eight months.

Follow up note: Four months later Mr. Chan came to the center where he had been seen asking if he could see E immediately. E was not available, and after some hesitation he asked if he could see his previous (female) psychiatrist. She described him as apparently flustered and excited, and very hesitant about stating the reason for his visit. Finally he disclosed that he wanted to see some books or pictures showing sexual intercourse. It seemed that he had become quite close to a married woman whose husband was temporarily away. He had finally revealed his "bisexuality" to her which she apparently accepted calmly. The previous night he had been talking with her and found that he had become quite

highly aroused and he eventually expressed his feelings. He was stunned to find that the woman had similar feelings toward him. He interpreted this as a possible invitation and that night he was planning on taking her to a concert. He now felt highly anxious about his "virginity" and uncertain as to the best way to proceed. He wanted to come across as experienced to her, yet knew that this would be impossible. He felt a high degree of "tightness and nausea" in his stomach when he thought about having relations with her. He reported having experienced similar feelings when he and another male had talked about the possibility of entering into a sexual relationship. He now wanted to be able to be completely relaxed.

The psychiatrist assured Mr. Chan that it was natural to experience "butterflies in his stomach" over the possibility of such a situation and Mr. Chan seemed greatly relieved. She then borrowed some of E's pictorial materials and went over them with Mr. Chan to give him a general notion of what to expect. She also suggested that Mr. Chan be as honest as possible, under the circumstances, with the woman and attempt to express his thoughts and feelings openly with her. It was further suggested that in all probability the woman would be more than willing to help him along in the situation. Mr. Chan then left, apparently feeling much more comfortable and looking forward to his date that evening.

Case of Mr. Doi. In many respects, Mr. Doi's case was similar to Mr. Chan's. He was an oriental male in his early

twenties taking part time work where he could find it. He had a previous history of 14 contacts with a psychiatrist at the center with a similar record of not attending appointments. He entered into the research program and attended the assessment period, but ceased attending shortly after treatment had begun. In contrast to Mr. Chan, however, he had an extensive history of homosexual contacts, reporting having previous relations with over 200 males. During assessment he averaged three to four different homosexual contacts a week. He reported no arousal to women whatsoever and only brief heterosexual petting experiences in his early teens. His hierarchy of sexual preference were males, masturbation (exclusively to male imagery), and low on the list --as a last possible resort--females. His reported attitudinal responses were all positive to males and highly negative to females. However, he appeared to sincerely want to stop his activity with males and to attempt to have relations with females and live a "normal" life.

The distinguishing feature of this case was the apparent effect of initial treatment. Careful analysis of the assessment information suggested that his masturbatory fantasies might offer the best opportunity in attempting to change his attitudinal responses to females (frequency was approximately 20 times per month). While he was also supplied with general sexual information in an attempt to change the discriminative stimulus value of females, he was asked to masturbate to female imagery only. It was suggested that he

use only images of engaging in anal intercourse and fellatio with a female. This was an attempt at approximation, as this was his preferred form of contact with males.

At his second treatment session he reported masturbating twice to such imagery. The first time lasted 15 minutes (compared to his average of three minutes) and was difficult, but he eventually experienced orgasm. He described the images as faceless and fuzzy as he could not quite remember what females looked like. When he finished he reported feeling somewhat strange and "alienated" as though it was not really he who was doing the act. Yet he also reported feeling strangely pleased and proud of himself that he had done it. The next occasion, remembering how long it had taken him previously, he alternated with imagery of males but was careful to use a female at the point of orgasm. This time it took him only about nine minutes. He also reported that he did not feel quite so strange. Later that day, while sitting on a bus he reported that he suddenly became aware that he was staring at a female sitting next to him. He then realized that he had "looked over" at least five females that day, trying to really see what they looked like. This was extremely unusual for him, having barely noticed females in the past. Somewhat later when he saw a male that "turned him on" he was also surprised to find himself looking at the two females that were with the male. He was told to continue his imagery and to use males as little as possible (he was not proscribed from having relations

with males). He was instructed to attempt to use his senses as much as possible and to imagine specific female qualities such as smooth buttocks, firm breasts, long soft hair, etc. He reported having a difficult time remembering what females really looked like and it was suggested to him that he use his new awareness of females to notice their perfumes or other feminine characteristics.

He failed to keep his next appointment. When he was seen at the following appointment he explained that he had received a call from the airport and a very close male friend had returned unexpectedly from the mainland. During the initial assessment sessions Mr. Doi had had a very brief but intensive relationship with this friend. His departure to live on the mainland had left Mr. Doi very depressed and he felt this had greatly helped him to enter into treatment. His friend had missed Mr. Doi also, and had impulsively decided to return here to live with him. Mr. Doi felt in a quandry. He liked this person very much but he felt it would not last and would end up like all the other experiences in his past. However, he also wanted very much to stay with him for he had been very lonely for the past few months. However, he felt that for the first time in his life he was really making progress on his "homosexuality." He eagerly reported that he had gone to a welcome home party for his friend and he had found himself talking with a female for most of the evening. He had attended another party the following day and was highly pleased to find several

females waving to him and inviting him to talk with them. He still felt tense about the situation but had stayed with them and enjoyed himself. He also reported that as he was walking across the street that morning he had seen a girl and he was amazed to discover that he was aroused by her to the point of erection--something he did not think possible. He very much wanted to continue in treatment at this point but was extremely undecided about what to do with his friend. Since his return he had not masturbated once, due to their high frequency of sexual contact. Mr. Doi also reported that he did not find his sexual relations with his friend as satisfying as they had been in the past, and that that morning he had actually refused him contact--something he had never done before. However, he did not want to hurt his friend's feelings and he did enjoy his company in all other areas.

It was suggested that Mr. Doi might try to continue using his female fantasy, only instead of during masturbation--which had ceased--he could consider using it during his relations with his friend. Mr. Doi thought this might be one answer for the immediate situation but he was still undecided about what to do about the future.

Mr. Doi again failed to keep his next appointment. At the following appointment he reported that he had been moving to a new home and had been working day and night and had fallen asleep prior to his appointment "forgetting to set the alarm clock."

He reported that he had failed in his assignment with

his friend. He could not remember to use the imagery until after they were through having relations or when he was not with him. He felt he may have been avoiding the whole situation. He thought he just could not do anything while his friend was living with him and he had to make a decision of whether to continue or withdraw from treatment. Actually, he had thought about it for some time and had finally decided to withdraw from treatment. However, when he told this decision to another friend, a former homosexual contact, this friend surprised him by saying that he should continue in treatment or face what he would be like 40 years from now. This advice had again thrown Mr. Doi into confusion. Considerable discussion of different alternatives ensued. It was finally suggested that he might not be in a good position to make an immediate decision and that both he and E should talk about it at greater length before making any concrete plans. Mr. Doi seemed relieved and agreed to come in one week from then, during which time he would try and resolve some of his own ambivalent feelings.

Mr. Doi failed to keep his appointment. Two weeks later he called the secretary, explaining he had been ill at his new house, which had no phone, but he would come in later to reschedule a new appointment. Two days later he came to the center and asked to see E briefly so that he could apologize and explain what had happened. He reported still feeling confused and undecided and another appointment was scheduled. Unfortunately, Mr. Doi failed to keep that

appointment nor has he called since. Apparently he made the decision to stay with his friend and withdraw from treatment.

Mr. Doi was seen for a total of 17 sessions, the last three of which were devoted to treatment. Time elapsed from initial interview to the last contact was approximately three months.

#### Problems of Sexual Incompatibility.

Of the ten subjects (five couples) requesting help with problems of sexual incompatibility, two were referred to another agency before assessment was completed, four elected to discontinue during treatment, and four completed assessment and the suggested treatment program.

In the case of the couple referred to another agency, the husband, a Caucasian male in his middle twenties, was referred by a physician in a medical center. The husband complained of chronic impotence and lack of communication with his wife, and he was also concerned about his vocational future. His wife was currently on the mainland settling some of their affairs and was due to return shortly. E agreed to see the husband concerning his vocational problem and tentatively accepted him into the research program pending acceptance by his wife whom he also declared had a "sexual problem." Vocational counseling and initial assessment was undertaken with the husband. When the wife arrived and attended a joint interview with her husband, she appeared to be experiencing an acute anxiety reaction to her



return and reported experiencing severe disorientation. It was disclosed that she had been hospitalized for psychiatric care about a year previous, and just prior to her return here she had visited her former social worker. He had strongly recommended that she report to a clinic for intensive psychiatric treatment as soon as possible. This matter was discussed with her at length and, with her agreement, E made arrangements to refer them to a psychiatrist at the mental health clinic where he had been seeing the husband. E agreed to complete vocational counseling with the husband and to see them at a later date for specific work on the sexual problems if they still felt it appropriate after receiving psychiatric treatment. Both felt this to be the best course of action. Inasmuch as neither has made contact with E since the initial interview, the case will not be discussed further.

Of the four remaining cases, the two that completed treatment will be presented at length, while only distinguishing features will be presented for the remaining two.

The first case to be presented in detail is one in which the husband came in complaining about the lack of sexual response on the part of his wife. However, his wife did not see this as a problem. By contrast, the second case concerns a wife whose presenting problem was her concern over her failure to achieve a climax with her husband. However, her husband did not see this as a problem.

The third presentation concerns a single female

complaining of her inability to achieve a climax from sexual relations with males. Only certain aspects of this case will be presented to illustrate the application of certain procedures not used previously.

The final case will be presented in considerable detail to illustrate how treatment is presented, and modified, in a situation where the male is experiencing premature ejaculation and impotence and the female is not experiencing orgasm.

Case of Mr. and Mrs. Frost. Mr. Frost, a Caucasian male in his late twenties, was employed by the Federal Government in a research capacity. During intake interview at a mental health clinic he complained of a sexual problem with his wife, in which his wife was described as completely lacking in responsiveness. He felt the remainder of his marriage was good and he wanted help in resolving the sexual aspects. He was referred for possible inclusion in the research program.

Mr. Frost appeared for his initial interview with E by himself, explaining that his wife did not know that he was seeking outside help. He described his wife as a quiet, reserved woman who seldom showed emotions of any kind. Though he was aware of her apparent lack of emotional responsiveness during their six month courtship, he felt that she would change after they were married. They had now been married for two years, and though he thought she was showing progress in "opening up" a little to friends, he felt she had not changed at all in their sexual relationship. He described

her as completely passive in their sexual relations, never initiating contact or touching him. She would generally refuse to kiss him and wouldn't allow him to touch her breasts or genitals except on rare occasions. Total time from initiation of contact, through intromission and ejaculation, averaged about three or four minutes. He said he had tried to be patient with her and to talk about the situation, but she would generally refuse to discuss the matter except to say that she found it satisfactory and no cause for concern. Mr. Frost had repeatedly talked of their seeking professional help but his wife had only responded by telling him to be patient and not expect her to change overnight. He now claimed that he was to the point where he was seriously considering having an extramarital affair. He currently found himself becoming highly responsive to many females with whom he worked, but he did not want to take advantage of the situation without one more attempt to work the matter out with his wife.

It was apparent, that under the present circumstances, nothing could be done without the willingness of his wife to cooperate. It was suggested that Mr. Frost have a frank talk with his wife and share his current concern about their marriage with her. Depending upon her feelings E would then be willing to see her, either alone or together with him, to discuss the availability of appropriate services.

The following week Mr. Frost and his wife came in together. Mrs. Frost, a Caucasian woman in her late twenties,

appeared very angry and upset about the whole situation. She did not see her "performance" as a problem. She saw it as only a problem to her husband. She said she was perfectly satisfied with their sexual relationship. She felt that it was just her "nature" to not show feelings pointing out that her whole family behaved in a similar manner. The only problem she saw in her marriage was her husband's unwillingness to make plans and stick to them. She saw him as continually changing his mind about what they would do or not do on a given occasion. E did not attempt to suggest any specific goals, but explained the services that were available at the clinic, depending upon what they saw as a possible problem that they would like to work on (e.g., individual counseling, general marriage counseling, couples group counseling, individual or joint counseling for a specific problem such as the sexual one, etc.). E's research program and particular approach was also explained. Finally, it was stressed to Mrs. Frost that she consider what she wanted for herself and not to force herself into something that she was not committed to on her own. By the end of the interview Mrs. Frost appeared to be slightly less angry and said that she would think the whole matter over.

One month later, Mrs. Frost came in by herself for an appointment. She said that she had thought things over and decided that she did not want group services or general marriage counseling, however she would like to work on the problem of her "coldness" over sex", as her husband saw it.

She also did not want to work on it alone, but would like him to be involved as well. However, she wanted to begin at some later time. Her parents were coming to stay with them during the forthcoming holidays and then they were expecting friends from Europe to stay with them awhile. She was also starting a new job (she was a professional working in the helping professions) and wanted time to get settled in that area. It was agreed that E would wait to hear from them when they were ready.

Three months later Mr. and Mrs. Frost made an appointment and came in together. The interview was mainly devoted to obtaining a general individual and joint history. It appeared also that their pattern of sexual contact had not changed during the past three months. The husband, very verbal and articulate, dominated most of the session. His wife remained silent unless directly questioned and then would speak with as few words as possible. The general assessment procedures were explained and they were given the initial forms. They were asked to fill them out independently and bring them in when they returned for their individual appointments. They were scheduled to be seen separately on a twice a week basis where possible.

Initial assessment for Mr. Frost took six sessions. During that time he showed a consistent pattern of responding in a general abstract manner to most questions asked of him. For example, when asked about his preferred frequency for sexual relations with his wife, he would respond with a

verbal essay on cross cultural patterns of sexual responses around the world (he had traveled widely in his work and had a fund of experiences from which he would abstract). This type of response was not limited to the sexual area, but appeared to be his typical pattern of response to any question. It took effort on E's part not to get caught up in his overgeneralizations, for he was a very entertaining story teller.

By contrast, initial assessment for Mrs. Frost took only four sessions. During this time E found himself doing most of the talking. Mrs. Frost initially appeared very tense and nervous and E attempted to put her at ease as much as possible. Generally, she would respond in a laconic manner and seldom would spontaneously offer information. Toward the end of the assessment period she appeared to be much more comfortable and at ease, however she continued to respond in a somewhat limited manner. By the last session she mentioned that she felt she was becoming more at ease with her husband in their sexual contacts and she revealed that she had recently initiated contact with him on several occasions. However, he did not respond so she felt angry and thought it was all useless.

When this was casually mentioned to her husband by E, he responded that she had once reached out and touched him that week, but he had been reading and was "not sure" what she wanted. He had returned to his book and she had stormed off. Later at 3 A.M. in the morning he had gone to bed

and had relations with her but she "behaved just as she always had." He seemed surprised when it was suggested to him that his response to her overture might not be the most helpful way to increase her responding in a similar manner in the future. He had a fairly good knowledge of learning principles and when this particular situation was explained in that manner, he quickly grasped the point. It had never occurred to him to look at his own behavior in such a manner and he was quite impressed with its apparent relevancy.

(This type of reaction on his part also became a consistent pattern of response throughout most of the treatment phase. His behavior always made clear sense to him after the fact.)

At the end of the assessment phase Mr. Frost was asked for his specific goals in treatment. His goals were centered on his wife becoming warm and responsive in her relationship with him, her kissing him and initiating sexual relations, and her being able to have a sense of humor over the situation and to laugh and enjoy sexual relations with him. When pressed for a goal for himself, he could not come up with one. When asked what he thought his wife's goal for him might be, he responded with the thought he might be "more planned" and not so carefree; be better dressed than he was; and possibly take more showers.

During the general discussion which followed it was brought up that his expectations of his wife might be somewhat unrealistic and it might be best to keep his expectations open to whatever progress was made. It was also

brought to his attention that it was likely that reaching their individual goals would involve reciprocal give and take on both their parts in a number of areas.

Mrs. Frosts's primary goal was better communication between her husband and herself. She saw her lack of sexual responsiveness as secondary, though she was "willing" to work on the sexual aspect because of pressure from him. She displayed strong adverse reactions to her husband's "unwillingness" to make firm decisions and stick to them. She felt she could never predict what they were going to do each day or what he wanted to do tomorrow, or in the future. She also disliked the way he would come back with multiple possibilities when she made a simple request or suggestion. For example, she would suggest that they go to a movie and he would then come back with "10 other things as well" but not pick any one of them himself. She felt that when they were together and he started talking on a subject she could never get a word into his verbal deluge. She would then get angry and he would immediately want to rationally "talk" about it, but if she attempted to he would never listen to her but do all the talking himself. (The usual pattern at that time was for him to continue to verbally press her in anger or to stalk off by himself until he cooled down. Her pattern was to withdraw and refuse to talk to him at all--sometimes for several days in a row.)

It was apparent that the primary goals for each were not the same. Mr. Frost saw the main problem as a sexual one,



primarily the fault of his wife. Mrs. Frost saw the main problem as one of communication, primarily the fault of her husband. The initial assessment information indicated a strong possibility that if either problem were treated to the exclusion of the other, cooperation by one of the spouses would most likely be limited if given at all. The assessment information was carefully examined to see if there was a possibility of initiating a treatment program that would attempt to deal with both problems simultaneously.

Mrs. Frost's sexual history indicated limited experiences in a number of areas. She received little formal knowledge about sexual matters other than brief warnings from her parents about "what boys were after." She could recall no erotic dreams and reported no sexual experience with other females. Her contact with boys in high school had been limited to hand holding and dancing. She received her first kiss in college and dated several different men but would never allow them to advance further than occasional breast manipulation over her clothes. Her unwillingness to go further was ascribed by her to her strong Catholic upbringing. She had discovered masturbation through self discovery but had stopped the practice several years ago. She had never experienced orgasm through masturbation, did not find it particularly arousing, and had only engaged in it about a dozen times altogether. Her first experience with sexual intercourse had been with her husband about three months prior to their marriage. She enjoyed her relations with him,

but did not particularly care for prolonged foreplay. Though she had not experienced orgasm with him she did not see this as any particular problem. (A medical evaluation by her private physician indicated no anatomical or physiological complications that might have contributed to her lack of response.) She reported not experiencing any arousal to such things as erotic books, movies, pictures, art or seeing or thinking about nude men or sexual situations. It appeared she only experienced arousal to direct physical contact. This form of contact was described as being touched or stroked on her breasts, thighs and genitals by her husband. When asked, in light of this fact, why she did not care for prolonged foreplay by her husband she responded that it never lead anywhere so she usually felt that she may as well just "get it all over with." She also did not find kissing particularly pleasing and she did not like to initiate any direct contact herself. This was strongly supported by her responses on the Heterosexual Behavior Inventory. She had engaged in seven of the twenty one behavior descriptions, compared to a mean of 13 reported by Bentler (1968b) for 135 college females. With the exception of kissing and engaging in sexual intercourse, she responded with a "No" to all items that began with "I have . . .". Similarly, her reported "fear" responses to these items on the Sexual Fear Inventory were all checked in the Much and Very much categories. This is in contrast to her reported Not at all responses to items of a male doing something to her, as well

as her generally low reported fear responses to sexual items. Table 10 shows Mrs. Frost's scores on the Sexual Fear Inventory compared to normative data collected from single and married females.

TABLE 10

## MRS. FROST'S SEXUAL FEAR INVENTORY SCORES

Category	Mrs. Frost	Norm Group			
		Married		Single	
		$\bar{X}$	SD	$\bar{X}$	SD
Total Scores:	218	225.09	54.64	290.00	87.23
General:	42	51.00	11.47	64.26	19.44
Personal:	34	53.00	14.82	62.06	19.59
Social:	23	33.09	9.64	31.14	10.55
Contact:	119	88.00	29.61	132.54	51.41

Mrs. Frost's scores are generally less than other married women, with the exception of physical contact items. However, when discussing her responses she reported that her real feeling was not one of fear as just lack of interest and "not wanting to do such things." Even when questioned further it was difficult to determine whether she felt anxious about these behaviors or not. Her reported fear responses on the Composite Fear Inventory were also significantly low as compared to the norm group. Her total fear score was 219 as compared to the norm group mean of 387.38 (SD = 87.07); her score on the Geer scale was 65 as compared to the norm group mean of 122.99 (SD = 27.73); and her score on the Suinn Scale was 124 as compared to the norm group mean of 206.60

(SD = 50.03). There was no particular cluster of fears except for speaking in public.

Mr. Frost's sexual history indicated that most of his knowledge about sexual matters came from his peer group. His father "never" made any contributions on the subject. He had had several experiences with females and males prior to adolescence involving mutual exhibition and physical exploration. He started masturbation at about age seven and used the females in the neighborhood for his fantasies. His current frequency was about seven times a week using Mrs. Frost and other females he saw during the day for his fantasy images. Mr. Frost also was raised in a Catholic family and he recalled always being admonished to leave the "good little catholic girls alone." His heterosexual contacts had been limited to kissing and breast manipulation until the time he left home at 21. He then had his first experience with sexual intercourse with a prostitute. Since that time he has had relations with about a dozen different women, none of which lasted more than a few months, until he met his wife. He had engaged in 17 of the 21 behaviors listed on the Heterosexual Behavior Inventory, as compared to a mean score of 14 reported by Bentler (1968a) for his sample of 108 comparable males. Table 11 shows Mr. Frost's scores on the Sexual Fear Inventory compared to normative data collected from the male sample.

TABLE 11  
MR. FROST'S SEXUAL FEAR INVENTORY SCORES

Category	Mr. Frost	Male Norm Group	
		$\bar{X}$	SD
Total Score:	139	239.59	67.71
General:	31	51.41	13.71
Personal:	32	58.09	13.40
Social:	24	32.41	8.55
Contact:	52	97.69	40.05

Compared to their relative norm groups Mr. Frost's scores are even lower than his wife's scores. Also similar to his wife, his reported fear responses on the Composite Fear Inventory were low (Total Score: 257; Geer Scale: 65; Suinn Scale: 148).

In sexual relations with his wife, Mr. Frost reported a high degree of frustration and confusion. Kissing was practically "nil" and he could not understand why. Sometimes his wife allowed him to touch her breasts and genitals yet other times she would just stop him and hurry him to intromission and ejaculation. Their positions were limited to male superior, after one brief attempt on his part to have her take a superior position. On that occasion she had appeared and looked so awkward to Mr. Frost that he had laughed outright. She became immediately hurt and never attempted it again. Mr. Frost admitted that he had a difficult time discussing sexual matters with his wife as well as with other people. It was a topic that he felt very reticent

about discussing. He also reported feeling inadequate in his own knowledge of techniques and hesitant to try anything with his wife because she seldom responded with any behavior but rejection. From the results of the Vocabulary and Anatomy Sexual Knowledge Inventory, it was apparent that both Mr. and Mrs. Frost had little formal knowledge to draw upon. Mrs. Frost scored in the 33rd percentile and Mr. Frost in the 27th percentile as compared to High School Seniors.

The frequency of their relations had dwindled from an average of three to five times a week during their first year of marriage to only three or five times a month during the past couple of months.

It was apparent that the thought of sexual relations had started to become a discriminative stimulus for avoidance for both of them. Mr. Frost's frustration and consequent anger over his wife's lack of response had also become aversive to his wife. She reported that she was unable to discuss anything that upset her without Mr. Frost informing her that it was due to their sexual relationship.

One possible treatment approach would have been systematic desensitization for Mrs. Frost to a hierarchy of her initiating and engaging in various sexual behaviors with her husband. However, this approach by itself would not allow for immediate handling of other problems, such as Mrs. Frost's complaint about her husband's lack of decision making. She felt that before their marriage he was highly

optimistic and confident about his plans for the future, but since their marriage he appeared to be undecided about "almost everything." There seemed to also be a definite deficit in sexual knowledge and behaviors on both their parts and systematic desensitization would not add to their acquiring new skills of knowledge. There was also some doubt as to whether Mrs. Frost was experiencing actual anxiety over the performance of certain behaviors. Systematic desensitization would also not allow Mrs. Frost to acquire skills in communicating with her husband. In fact, it was possible that such a procedure might further reinforce her "passively accepting" male instructions without expectation of any assertion on her part.

In an attempt to continue the cooperation of both partners it was decided to use a number of procedures from the very beginning that would not only attempt to deal with the different areas involved but would hopefully reinforce each other.

To change the reinforcing value of sexual relations it was decided to start by having them temporarily stop having relations. This was to be followed by successive approximation of various sexual behaviors along lines used by Masters and Johnson (1970). However, Mrs. Frost would be given control over the degree of progression. This was to allow her to learn new behaviors in a nonthreatening atmosphere and to help her to learn ways of communicating her feelings to her husband. Because responsiveness by Mrs.

Frost was the primary goal of her husband it was hoped that he would find her efforts in this area reinforcing enough to follow her lead. It was also hoped that this behavior on his part would generalize to other non-sexual areas. To help further promote communication between them they would also be supplied with reading materials on sexual matters and be asked to discuss them with each other. To initiate this type of discussion E would start by discussing similar material during their sessions. E also planned to use the joint sessions as a method of observing their ongoing communication and suggesting further ways as to how they might learn new communication skills. It was hoped that once sexual relations became reinforcing for both and after they had had an opportunity for learning communications skills they would then be better able to enter into making concrete plans for the future that would be agreeable to both.

The first joint treatment session provides an example of how this type of approach was implemented. When asked for their joint goals in their sexual relationship Mr. Frost immediately dominated the conversation. His wife attempted to speak on several occasions, but Mr. Frost paid no attention to her and continued with his own list of expectations of his wife. Mrs. Frost's contributions became limited to an occasional nod or shake of her head. Finally, E broke in to Mr. Frost's monologue, by asking Mrs. Frost directly what her views were. She responded angrily by saying that she saw her husband's expectation of her performance in bed as



judgemental and very inhibiting. This brought a quick retort from Mr. Frost and in a moment they were both talking at once, neither listening to the other. At this point E interrupted them and asked them to examine what had been happening up to that point. Their argument was used as an illustration of a learned response pattern. Their previous statements were each carefully examined along with the feelings these statements evoked in each of them. Then they were asked to tell each other how they felt about their current sexual relationship with each other. During this time E attempted to increase the probability of their listening to one another by having one rephrase what they believed the other to be saying --and to the other's satisfaction--before making a statement of their own. Approximately a half hour was devoted to this procedure and both appeared to find it helpful in promoting more understanding of what the other person was trying to communicate. For example, for the first time Mrs. Frost discovered that her husband also felt inhibited and blocked in his sexual relations and she was quite touched. Conversely, Mr. Frost was surprised and pleased to hear his wife report that she really did receive pleasure from their sexual contacts.

At this point it was easy for them to accept the suggestion that their current sexual behavior with one another could also be looked upon as a learned response pattern acquired in much the same way as their patterns of verbal communication. The general approach for helping them to

learn new ways of relating in the sexual area was then discussed. To supplement the discussion and to initiate their verbal communication they were given a number of readings: the chapter on sexual behavior from Ullmann and Krasner (1969); Wright's (1949) article on orgasm in women; and a copy of an article from the lay press concerning Masters and Johnson's work with couples. In addition, their responses to the Sexual Knowledge Inventories were discussed and they were returned their forms and asked to go over their papers together and to discuss them and to make notes on any questions that they may have about any of the information given. They were also asked to refrain from sexual intercourse for the time being and the concept of gradual stages of sensual and sexual intimacy was explained. They were asked to begin by spending a minimum of three sessions with one another prior to their return in three days. They were to pick a time when both were as free from emotional and physical fatigue as possible. They were then to take turns exploring different ways of giving and receiving pleasure to and from one another through touch. They were to avoid the genital areas and the wife's breasts and the session was not to culminate in any specific sexual expression. They were to have no specific goal other than to find out what was pleasurable to them. The sessions were to last as long as they wished, but if at any time Mrs. Frost felt anxious or uncomfortable she was to stop. It was stressed that the main purpose of the sessions was to allow them both the opportunity, without

any expectation, to find and experiment with different ways of giving and receiving pleasure through the sense of touch. Both seemed accepting of the suggestions and they were scheduled on a twice a week basis so that E could keep close contact on their progress.

At the second session three days later the first of a series of unforeseen events that was to interfere with some aspect of the treatment program was reported. A few hours after leaving their first session some close friends from the mainland had unexpectedly dropped in to spend a few days with them. They gave up their bedroom and Mr. Frost slept on the floor while Mrs. Frost slept on the couch. They had no privacy and were unable to start their sensate sessions. They obviously had no choice but to wait until their company left.

The session was spent in going over some of the arguments they had become involved in during the past few days and alternative ways of communicating were explored. In addition some of the reading materials were discussed and their relevancy to them and their situation examined. Mrs. Frost was given a copy of Wright's (1969) book "More About the Sex Factor in Marriage" and asked to follow her suggestions for self discovery and sexual self awareness. It was hoped that if she could discover what was specifically pleasurable to her and was able to bring herself to a climax she could then share this information with her husband in their joint sessions. Both their Reinforcement Survey Schedules were gone over with them and a number of mutually pleasing

situations were selected. The suggestion was then made that they actively engage in one of these activities after they had had an opportunity for a sensate session. It was hoped that this would serve to reinforce their having sessions together as well as increase their positive attitudinal responses to the sessions.

Each subsequent session progressed in a similar manner depending upon what had happened between sessions. For example, the night after their mainland company had left Mr. Frost pressed his wife into having sexual intercourse with him. Mrs. Frost had been angry but had said nothing. (Mr. Frost explained his behavior by saying that he understood this to be separate from their sensate sessions.) The following night Mrs. Frost had waited for a sensate session only to have her husband fall asleep. She felt hurt and angry again, but said nothing until they came in to talk with E.

The importance of Mrs. Frost expressing her feelings to her husband was stressed and various ways of her learning to do this were explained. It was also strongly suggested to Mr. Frost that they were to refrain from sexual intercourse at this time so as to not resensitize Mrs. Frost to the situation. This was made very plain to him when he heard his wife express her feelings during the session. He said that he had had no idea that she felt the way she did. Mrs. Frost was also strongly supported by E in her stated desire to stop a session when she began to feel anxious or upset.

After they reported positive responses to touching, rubbing, kneading and stroking, they were moved to the use of their mouths with particular emphasis on exploring the different ways they could find of giving pleasure with their teeth, tongue and lips. As usual Mrs. Frost was instructed to set the pace for their sessions. In an attempt to promote more verbal statement of their feelings instead of using non verbal cues, a "time out" procedure was instituted. It was suggested that in order to handle situations where they might be tired or upset about something, each could have a "time out" night from sensate sessions whenever they wished, with no questions being asked or explanations necessary. However, they were limited to one each during any one week. However, once in a session if Mrs. Frost felt upset or anxious she could still halt the session. She was instructed to only go as far as she felt the experience to be positive and satisfying to her. Both reacted positively to the idea and felt free to use it. In preparation for their next step (to genital and breast contact) time was also devoted to discussion of sexual anatomy and function in general and to their specific responses. This was done by using their Sexual Knowledge Inventory responses as a starting point and bringing in appropriate models and other visual aids and reading materials when necessary.

As they moved to genital contact they showed much more willingness to discuss their feelings and thoughts with each other. However, their discussions would usually come some

time after they had the feelings or thoughts. For example, Mrs. Frost reported on one occasion having a cold and not feeling too well. She did not directly communicate this to her husband, but he was aware that she did not seem to be responding very much in their sensate session. Because of her lack of usual reaction he was uncertain of what to do and he became clumsy in his attempts to please her. Mrs. Frost thinking he was getting impatient, stopped him from foreplay and insisted on him making entry which he did. After a time he reached a climax but felt rushed into it and unsatisfied. Neither could sleep, and after an hour Mr. Frost went to make something to eat and Mrs. Frost followed him and they both started discussing the situation. They both verbally went over the session and related to each other what they were feeling when each responded the way that they had. Afterwards they both reported feeling very positive about each other and the whole communication. E verbally reinforced their exchange and suggested that they might also attempt to share their feelings closer to the time of experiencing them, rather than at some later time. Their opportunity came a few nights later. Mr. Frost was enjoying himself in foreplay, when his wife suddenly told him to "stop" and Mr. Frost immediately assumed he had done something wrong and he went limp in frustration. His wife became angry and left the bed. He followed immediately, recalling E's suggestion that he was to try to share his feelings as soon as possible. He told his wife that he felt frustrated

and angry. That he was really enjoying himself until she said "stop" and then he fell limp as he waited for her to tell him what he had done wrong. He told her he saw it as an example of when he gets no helpful feedback from her-- where he has to guess what is going on with her. As it turned out Mrs. Frost had felt some slight pain from having her hair pulled when he had made entry and she had just wanted him to stop a moment while she disengaged her hair. Then she felt angry because of the way he had collapsed. They both laughed over the situation and she apologized for not telling him what was wrong at the moment and he in turn apologized for not asking her what was wrong and assuming it must be something he had done. They went back to bed and had a pleasant session. They both thought later how it might have ended had not Mr. Frost attempted to let her know what he was experiencing.

At this point in time they were engaging in intercourse and both reported feeling generally positive about the results. It was decided that they would continue to have some daily contact but how their contact ended was to be left open, from just hand holding or stroking to full relations. As usual Mrs. Frost was to set the limits depending upon her finding the situation pleasant and enjoyable.

Of more immediate concern to them was the increased number of arguments which they were having. There seemed to be many contributing factors to increased feelings of pressure and tension for both of them. Mrs. Frost had changed her

job again and was having difficulty with her supervisor. She was also having difficulty with a summer graduate course she was taking at the nearby University. Mr. Frost's government contract was going to come to an end in several weeks and he was very undecided about what he was going to do next. They found themselves "constantly" arguing about these and other matters.

E had an opportunity to observe a number of these arguments during their joint sessions. It was noted how both would usually bring past history into their dispute instead of dealing with the specific current situation. It was also observed that Mr. Frost seemed to have a habit of trying to outguess what Mrs. Frost was going to say and he would say what he thought she meant before she actually had a chance to express her thought. These patterns were pointed out to them and alternate patterns explored and practiced during their sessions, but progress was slow. It eventually became evident that their sexual relations were being adversely influenced by their general disagreements. That this was not noticed sooner was an error on E's part. For several sessions E had failed to inquire about their sexual progress and had been concentrating on teaching communication skills.

What had been happening outside the sessions was finally brought to E's attention during the tenth joint treatment session. At this time E noticed that both Mr. and Mrs. Frost seemed to be in a somewhat depressed state. Inquiry was made into possible reasons for their feelings and several



facts came to light. For example, it seemed that the previous Sunday Mrs. Frost became angry with her husband for refusing to discuss his job plans and therefore she refused his sexual advances later in the afternoon. That evening Mr. Frost had "gotten even" by refusing her advances. Neither had exchanged their feelings with the other, and both felt angry. They also reported that lately their sexual contacts had become highly patterned. Mrs. Frost again did not seem to want foreplay and preferred direct body contact and intromission until her husband reached a climax. The encounter was described as lasting only about five minutes. Mrs. Frost did not blame the situation on her husband but just felt it was her problem. She felt discouraged that they appeared to have all the alternatives available to them but that they were not really trying to use them, either in their sex life, their general communications, or their future planning. E suggested that it was apparent they were both under a great deal of pressure and perhaps this would be an appropriate time to evaluate what they had accomplished so far and where they wanted to go from here. The remainder of the session was devoted to a review of what had been done and experienced to that point, with E taking special care to point out the specific advances each had made in a number of areas. Finally, when asked where they wanted to proceed they were undecided. Several alternatives were examined. One was possible termination. Mr. Frost would soon be involved in job hunting, and in the mean time they could

continue to apply the principles they had learned on their own. Another alternative, was to continue with the treatment program after some redefinition of goals and possible modification of procedures. E suggested that they take a few days to assess their present situation and to decide what they wished to do. Regardless of their decision, they were asked to make an appointment in a few days to discuss the matter further.

They returned saying that they had carefully thought of the various alternatives and had, first, individually, then jointly, decided to continue in the treatment program together. They had felt positive about the gains that they had made in the sexual area and wanted to concentrate their attention there. Questioning revealed that Mrs. Frost had only pursued Wright's suggested self discovery on a casual basis. She had not attempted to bring herself to a climax manually but had examined herself and had done some exploration for "pleasantness." E suggested the possible use of a vibrator as an aid, but Mrs. Frost flatly refused. She said that she knew that it had been used in treatment with others from the reading materials, but she just did not like the idea for herself. E did not attempt to press the use of a vibrator but he did stress the importance of exploring her own rhythms and responses and her sharing her findings with her husband. She agreed to try.

Further examination of their present pattern of sexual behavior suggested that structure was once more necessary if

they were to continue their positive results achieved earlier and not fall into a repetitive pattern. To move them from their present three minute sessions, they were asked to start extending their sessions by five minutes each day. They were to spend five minutes together, no less, the first session; ten minutes the next; and to continue adding five minutes each day, using a clock if necessary. They were given a copy of McCary's (1967) chapter on techniques of sexual arousal as a guide for further exploration during their sessions. They were asked to read the chapter carefully and discuss it with one another, and to attempt at least one new approach each session. Both felt that the structure would help them to maintain their contacts on a steady basis, something they had been avoiding. They were also intrigued with the techniques which they had looked at initially, but neither had been able to mention their interest to the other. It was stressed that they find what was pleasing for them and not to rely on any specific techniques but feel free to branch out and explore on their own. They were also reminded to engage in some other mutually pleasant activity following their sessions.

At their following appointment, one week later, they both seemed in a good mood and reported good progress. They had extended their sessions to a minimum of thirty minutes. Mrs. Frost had been exploring her own responses and had started teaching what she found pleasing to her husband. It was still difficult for them both to discuss everything they

were thinking about with each other during the sessions but both felt they had made more progress in the past week than in the previous month. Mr. Frost was particularly pleased with his wife and commented on her being much more free in her responses in the past week than at any time since their marriage. They had also returned to spending more time with one another in spite of their increased work loads. They found it particularly pleasant to engage in one of their "reinforcement" activities after their sessions. They had made a special effort to help each other state their feelings. For example, Mr. Frost had wanted to take a time out one night after a particularly exhausting day but he was fearful that Mrs. Frost might interpret it as a rejection. He had done everything to let her know he was tired except tell her, but she appeared to not understand. He finally told her directly he wanted to take a time out. He said he felt angry and defensive about it at the time, but he later realized how helpful it had been. She had accepted his request calmly and matter of factly and he felt relieved. He said he realized it was certainly better than pretending to fall asleep and feeling guilty about the deception. He claimed that he now found it much easier to express what was on his mind to her.

Two weeks later they reported continued progress, though there were occasional ups and downs. Mr. Frost happily reported that he had suddenly become aware that he no longer had any "expectations" about his wife's "performance" and,

more important for him, about his own performance with her. He was finding their sessions very pleasant and enjoyable wherever they might lead. Mrs. Frost reported similar feelings.

At this time they were asked to independently make a written list of goals they would like to achieve or expectations they had of their general relationship as well as their sexual one. They were asked to consider goals for themselves as well as for each other, but to not mutually discuss them for the present.

At the following session they brought in their lists and E said they would be examined and they would go over them together at the next session. They reported continued good progress. They both felt their sessions with each other were much more relaxing and fun. They were trying out new positions suggested in their "technique" paper and enjoying the situations. For example in attempting rear entry, they both found themselves feeling clumsy and awkward. However, Mrs. Frost had burst out laughing and they soon found themselves rolling in uncontrollable laughter together (a marked contrast to the situation reported previously by Mr. Frost during assessment). Mr. Frost still reported a general reluctance to ask specific things of his wife but he felt he was improving. Because of the increased frequency of intercourse they reported (12 times in the past 5 days) E thought it might be wise to have them both take a "time out" together. It was suggested that they had both been doing very well and

perhaps had earned a vacation so as to avoid any build up of expectation of each other. E was surprised when they both immediately rejected the suggestion. They said that they were enjoying their sessions and neither felt pressured. They both reported they had no qualms about requesting a "time out" if they wanted it. E withdrew the suggestion and left it to them to proceed at their own pace.

At the next session both came in beaming. After going over their goals independently and turning them in they had discussed their future plans together and had started to formalize what they were going to do. E had examined the goals that they had turned in previously and he had prepared a list of them on a single page so that they could be compared with one another. A copy was given to both and their similarities and differences discussed (Refer to Table 12).

TABLE 12

## MR. &amp; MRS. FROST'S PERSONAL GOALS

## Mrs. Frost's Expectations

## Mr. Frost's Expectations

General

- |  |  |
|--|--|
|  | (of self)  |
|  | 1. Provide for Mrs. Frost's welfare (job and continuous welfare and security). |
|  | 2. Obtain job working in special area of competence in Foreign Country.        |
|  | 3. Eventually, some say in Country's policy.                                   |
| (for both)                                     | (for both)   |
| 1. A completely relaxed and open relationship. | 1. Comfortable home with Mrs. Frost and 3 children.                            |
| (of Mr. Frost)                                 | (of Mrs. Frost)  |
| 1. Less interpretation of                      | 1. General happiness and easy  |

- what she says.
2. If interpretation is made, then at time when she has made statement instead of at a later time. (Gives her a chance for clarification.)
  3. Some type of overt acknowledgement by Mr. Frost that he hears her when she indicates that a statement of situation was upsetting to her. (So she won't feel that anger is the only way to draw attention to it.)
- going attitude toward what and how they do things. That Mrs. Frost be an understanding and loving mother (which he now believes is true.)

#### Sexual

1. That sexual relationship becomes completely fulfilling to both.
1. Expression by Mrs. Frost of affection (By smiles, ideas, and activities) in sexual relationship.)
2. Of Mrs. Frost using her hands more.
3. Of Mrs. Frost kissing more.
4. Of Mrs. Frost initiating flirtation.

It was interesting to note that these expectations were written over a week and a half previous to their session and when they both read them together for the first time they realized that they had already accomplished many of them. Mrs. Frost was very surprised to see that her husband wanted three children for they had never discussed it before. She also had hoped for about three children. Again E underlined the importance of stating their expectation to one another. Their attention was also directed to the difference in clarity of the stated expectations and the importance of operationalizing their terms. It was suggested that unless they had some concrete specifications they could not determine when their

goals had been accomplished or not. As an example Mrs. Frost's clear, operationalized expectations of her husband in general areas was contrasted with Mr. Frost's more general expectation of his wife ("General happiness and easy-going attitude toward what and how they do things"). Mr. Frost was asked to attempt to concretely specify what his wife could actually "do" that would indicate to him that she had an "easy-going attitude." He was asked to compare his expectation with hers. In her case there was a specific request to him that he could follow and know whether he was doing it or not.

By contrast, they were both asked to examine how they switched their degree of specificity when it came to their expectations in the sexual area. Here, Mrs. Frost's expectations were broad and general and difficult to define. On the other hand, Mr. Frost's expectation of his wife were very specific and told her exactly what he was expecting.

Both said that they found this discussion very helpful and they both planned on sitting down and discussing their expectations further with the sheet as a guide. Mr. Frost mentioned how he had been getting better at not interpreting his wife's statement as much as he used to, and that now he was also learning to discuss his thoughts at the time of their occurrence. Mrs. Frost agreed, saying he had changed quite a bit in the past week. In a similar manner, it was also noted that Mrs. Frost had been initiating flirtations and kissing quite frequently in the past week as compared



to the time when Mr. Frost had written his expectations, and her husband admitted that she had improved a great deal in that area. For himself he reported that he still found it difficult to say these things directly to her. For example, he had wanted to ask her to use her hands more in their love making but he had been reluctant to do so because of a fear of rejection. Mrs. Frost stated that she wished he had brought it up during the situation rather than now. Mr. Frost admitted that he was basing his expectations on her past reactions and not on her recent behaviors. E also suggested that Mr. Frost could do what his wife had been doing, such as taking her hand and guiding her to show her what he wanted. Mr. Frost seemed hesitant and doubted whether she would let him. He seemed taken by complete surprise when Mrs. Frost smiled and said in a provocative manner, "why don't you try it sometime and see?"

The following week they both came in for their session in high spirits. Several job offers had come through and they were waiting now to hear from one other prospective employer. They had gone over their mutual expectations of each other and had done some long range planning. In general, they decided to take one of the offers to work in a Foreign Country for the next three years, then return to the United States where they would invest their savings in a home and start their family of three children. They had started packing and were looking forward to their new venture together. They had continued to enjoy their sexual relations and both

felt much more relaxed and comfortable in discussing their desires with one another, but they still felt that they had to continue working at it.

In reviewing the original goals of each in coming in for treatment, both felt that they had achieved them. Though Mrs. Frost had still yet to reach a climax during their relations she appeared to regard this as a minor problem that would take care of itself. She reported that several sessions had been "very close" for her and she felt it was only a matter of time. E mentioned the possibility of focusing in on this area, but Mrs. Frost appeared more than satisfied with her own progress and was looking forward to just letting it "happen." They readily agreed to again fill out the inventories and they were asked to return for one final session where they could bring up any further questions or thoughts that they might have.

They both returned for the final session in good spirits having further discussed their goals and expectations of one another. They felt that they still had some small unresolved problems but thought that they could handle them themselves, particularly now that they were really able to "listen" to one another and to communicate their understanding. They were asked to occasionally keep E informed of their whereabouts as he would like to see how things were going for them. They readily agreed and expressed their warm appreciation for all that had been done on their behalf.

The pre and posttreatment scores on the different inventories used for Mr. and Mrs. Frost may be seen in Table 13.

TABLE 13

## MR. AND MRS. FROST'S PRE AND POST INVENTORY SCORES

Scale	Mrs. Frost		Mr. Frost	
	Pre	Post	Pre	Post
SEXUAL FEAR INVENTORY:				
Total Score:	218	204	139	144
General:	42	42	31	36
Personal:	34	36	32	31
Social:	23	25	24	25
Contact:	119	101	52	52
COMPOSITE FEAR INVENTORY:	219	306	257	280
GEER SCALE:	65	99	65	83
SUINN SCALE:	124	171	148	157
REINFORCEMENT SURVEY SCHEDULE:	376	349	388	374
SEXUAL BEHAVIOR INVENTORY:	7	11	17	18

Examination of Table 13 yields some interesting findings, some of which are difficult to explain. In regard to the Sexual Fear Inventory, Mr. Frost showed little change over treatment time, whereas Mrs. Frost shows a slight drop in reported fear due to her reporting less fear to physical contact items. This would be expected as well as her increase in the number of reported sexual behaviors engaged in as indicated by the results of the HBI. The unexplained

finding is that both Mr. and Mrs. Frost showed an increase in general fear responses as indicated by their scores on the Composite Fear Inventory. However, their posttreatment fear scores are still well below the mean scores obtained by the norm groups for the Fear inventories (i.e., CFI  $\bar{X}$  = 387.38, SD = 87.02; Geer  $\bar{X}$  = 122.99, SD = 27.73; and Suinn  $\bar{X}$  = 206.60, SD = 50.03).

Also of interest is the slight drop in reported scores on the Reinforcement Survey Schedule for Mr. Frost and the larger decrease for Mrs. Frost. This appears to be contrary to their reported feelings during the last several sessions.

Contact sessions, from initial interview through assessment and treatment, totaled 26 for Mr. Frost and 24 for Mrs. Frost. Nineteen of the sessions were joint contacts. Time elapsed from initial interview to final treatment session was approximately 9 months, however actual assessment and treatment took only four months.

Case of Mr. and Mrs. Goo. Mrs. Goo, an oriental female in her late twenties, had heard about the research program through a social worker friend who was employed by a mental health clinic. She came in to see if something could be done about her lack of sexual response with her husband. They had been engaging in sexual relations for four and a half years, but she had never reached a climax--nor had she experienced an orgasm by any other means. She reported that in the past few months their sexual contacts had "progressively deteriorated" from a frequency of two or three times a week to only

once or twice a month. While this frequency was all right with her she felt that a "normal wife" should experience orgasm and have relations several times a week (she had derived her expectancies from talking with her female friends and reading popular magazines). Her husband did not see their relationship as being a problem and he had never complained. She also reported "mixed up" feelings concerning her sexual relationship with her husband. For example, it was all right if she initiated sexual contact, but not if he did--yet she wanted him to initiate contact. She complained about his "insensitive" foreplay and wanted him to be a good "lover"--yet she would stop him when he tried something new. She was uncertain of what to do and was hoping that E could do something about the situation.

Though there was some question about her motivation and her ability to carry through treatment (e.g., she reported a history of starting new projects and then dropping them, or of getting bored with things quickly). E agreed to talk with her husband and see if something might be suggested. In the meantime she was referred to her physician for a medical evaluation.

Mr. Goo, an Oriental man in his late twenties, was a carpenter who contracted his services. When he came in alone for an initial interview he said that he would be willing to help his wife with "her" problem but it was not a big thing for him. He felt that their sexual and personal relationship was satisfactory, though he did express some irritation

at his wife's "unpredictability"--always jumping around from one thing to another. When asked for a description of how he saw their sexual relationship he did say that he felt it could probably be better, but that his wife always stopped him from experimenting, so that he just concentrated on his own enjoyment whenever they had contact. After further discussion of his wife's complaint, and E's approach to helping them, Mr. Goo decided that it might be worthwhile for him, in addition to his wife, to enter into the program.

The wife's medical evaluation indicated no anatomical or physiological condition that might be contributing to her complaint of unsatisfactory response with her husband. Mrs. Goo was still quite firm in her stated conviction to "do something" about her situation so they were both given the initial forms and assessment was begun.

Assessment for Mr. Goo took six sessions, while Mrs. Goo took 11 sessions. These sessions extended over a two and a half month period due to a number of difficulties. Mr. Goo was just starting a new contract and his work schedule was extremely heavy. Sometimes he overslept and missed his appointments, other times he just "forgot." Twice he became sick with a cold and several times he had to continue at work during his appointment time.

Mrs. Goo's appointments were also irregular. She too would report minor ailments that would prevent her from coming in, or her own work schedule would interfere, or she would just "forget" the time. On one occasion a close

member of her immediate family had to be hospitalized in a mental institution and some time was taken to discuss this situation.

Half way through the assessment period another event took place which necessitated immediate intervention. Though she had been using an interuterine contraceptive device, Mrs. Goo, to her dismay, discovered that she was pregnant. This situation was further complicated by two factors. One year previous, while using oral contraceptive pills, Mrs. Goo had unexpectedly become pregnant. At that time, after much deliberation and contrary to their religious convictions, they had decided to have an abortion performed. Mrs. Goo had flown to a foreign country for the operation and it had been a traumatic experience for her. She also had an extreme fear of operations in general, stemming from an unfortunate incident in her childhood and reinforced by numerous incidents that had happened to friends.

Assessment came to a stand still while this situation was explored with her and her husband. Once more they elected to have an abortion performed and time was spent in preparing Mrs. Goo for the operation and providing support for her following it (now a legal operation in this state).

The assessment period was also marked by constant arguments and disagreements between Mr. and Mrs. Goo. At one point Mrs. Goo had packed her suitcase and was prepared to return to her parents in California. However, she agreed to stay and work on the marriage after Mr. Goo made a special

plea for her to "wait and see." The following day Mr. Goo told E that the next time such a situation came up he would just let her leave without stopping her.

Scores obtained by Mrs. Goo on the initial assessment forms may be seen in Table 14. Where available, appropriate normative data are also supplied for comparative purposes. In all cases Mrs. Goo's scores fall within one standard deviation of the mean scores obtained by the norm groups. Her somewhat low scores on the Sexual Fear Inventory supported her interview statements that she did not feel anxious in

TABLE 14

## MRS. GOO'S INITIAL INVENTORY SCORES

Scale	Mrs. Goo's Scores	Norm Group	
		$\bar{X}$	SD
Reinforcement Survey Schedule:	350		
Composite Fear Inventory:			
Total Score:	380	387.31	87.07
Geer Scale:	123	122.99	27.73
Suinn Scale:	211	206.60	50.03
Sexual Fear Inventory:		(Married Females)	
Total Score:	195	225.09	54.64
General:	59	51.00	11.47
Personal:	42	53.00	14.82
Social:	27	33.09	9.64
Contact:	67	88.00	29.61
Sexual Behavior Inventory:	18	13.27	6.66



sexual situations. Her usual feeling was one of mild arousal and an almost "complete lack of feeling" once entry was made. Her sexual history indicated limited experience. She could only recall one mildly arousing dream around the age of 16, but no details. She had attempted masturbation out of curiosity at about age 14, but "nothing" happened. She found it pleasant to a point, but then the feeling died away. She had not tried again. Her only experience in sexual intercourse was with her husband.

Scores obtained by Mr. Goo on the initial assessment forms may be seen in Table 15. Where available, appropriate normative data are also supplied for comparative purposes. Not only are Mr. Goo's reported fear scores lower than his wife's, but, in all cases they are over one standard deviation lower than the mean scores obtained by the norm groups.

TABLE 15

## MR. GOO'S INITIAL INVENTORY SCORES

Scale	Mr. Goo's Score	Norm Group	
		$\bar{X}$	SD
Reinforcement Survey Schedule:	251		
Composite Fear Inventory:			
Total Score:	216	387.31	87.07
Geer Scale:	63	122.99	27.73
Suinn Scale:	122	206.11	50.03
Sexual Fear Inventory:			
Total Score:	138	239.59	67.71

General:	30	51.41	13.71
Personal:	31	58.09	13.40
Social:	21	32.41	8.55
Contact:	56	97.69	40.05
Sexual Behavior Inventory:	18	14.48	6.15

These scores also appear to lend support to his apparent easy going accepting attitude towards various everyday problems that he displayed during his interviews. His sexual history indicated a wider range of past experience than his wife's.

Up to this point Mrs. Goo had mainly felt a sense of duty to satisfy her husband as quickly as possible. Her goals were mainly centered on having her husband engage in more petting, more kissing, being more gentle, and wanting him to do something new in new surroundings. She also wanted to experience a climax to 'prove' she had feelings like other women.

Mr. Goo's goals were less clear but he finally settled on hoping his wife would use more hip movement; that she would stay in bed with him for awhile after their relations before running off to take a shower; and be more active in general. He also thought it might "be nice" if she could experience a climax.

In general, they both also indicated that they wished there could be some way of reducing their arguments and disagreements that seemed to be on the increase. E informed them that he would go over the assessment materials to see what might be suggested and scheduled their first joint

treatment session the following week. However, as an example of the type of response that lead E to wonder about motivation for treatment, Mrs. Goo requested that their first treatment session be put off one more day because the day selected was the day she usually went to the beach with the "rest of the girls."

The assessment information indicated no anxiety associated with the sexual situation by either partner. Mrs. Goo reported no feelings of any kind other than an initial "slight arousal." However, there appeared to be a definite deficit in sexual behaviors that lead to arousal. Due to Mrs. Goo's recent pregnancy and operation they had not engaged in sexual intercourse for the past month. In the hope of increasing the reinforcing value of the sexual situation E hoped to keep them on this deprivation schedule for awhile longer. Their initial treatment program was quite similar to that described for the previous couple. Assigned readings, instructions and discussions were used to help them acquire a new sexual behavior repertoire. The procedure of successive approximation of sexual response was used to support the acquisition of new skills as well as hopefully change the discriminative value of the sexual situation to one of positive approach. In addition, Mrs. Goo was also encouraged to begin self exploration of her own sexual response in the hope that she would eventually experience arousal and possibly orgasm. Later, further training could be used to help response generalization to her husband.

As with the previous couple, training in communication skills would also be instituted.

This program was begun and they were seen on a three-times-a-week basis. As with the assessment period, appointments during treatment were cancelled or missed due to minor illnesses, interfering work schedules, or oversights. There were also numerous events that interfered with the smooth progression of the program. For example, at their first sensate session, Mrs. Goo had prepared by wearing a negligee, having champagne ready, and soft lighting and music. However, when Mr. Goo came home from work and saw the situation he responded with outright laughter. Mr. Goo felt quite hurt, but "suffered" through their session. During their session with E Mr. Goo revealed that his laughter was actually in response to embarrassment and not knowing how to respond. These things were discussed and used as example of miscommunication.

Many other events happened in a similar fashion. First a friend of Mrs. Goo's stayed with them for a while thus interfering with their privacy. Then a friend of Mr. Goo's stayed with them. There were constant arguments between them concerning Mr. Goo's nagging his wife about her diet or getting a job, or Mrs. Goo nagging her husband about being late for appointments or parties, or not planning for the future. All of these disagreements appeared to bring on negative attitudes by one toward the other and would carry over into their sensate sessions. They would also fail to keep their sessions with one another for numerous reasons. In addition

Mrs. Goo was having no success in finding anything beyond mild pleasure in her own self exploration, though she said that she had attempted to follow the suggestions given her.

After about one month of the treatment program it seemed apparent that re-evaluation was necessary. At a joint session with E Mr. and Mrs. Goo were asked to examine their progress, or lack of it, and to evaluate what they thought was happening. Both felt that the means for achieving their goals were available but, for some reason, they just did not seem able to do what was suggested. A long discussion followed as to whether they wished to continue with an altered program or possibly terminate. Both felt they had achieved some degree of progress and they elected to continue, promising that they would make a serious attempt to follow what was suggested to them.

After further discussion, a number of changes in the program were instituted. To help them set individual and mutual goals and to clarify their expectations of one another they were asked to independently make a goal list (as with the previous couple). To reduce the frequency of their arguments and disagreements, E suggested a number of behavioral contracts. To help Mrs. Goo discover her own arousal responses, it was suggested that she experiment with a vibrator. A structured schedule was put into effect, for their mutual sessions.

During the next two months progress varied, depending upon what area was being worked with. They both turned in

their expectations of each other and their future goals, and, as with the previous couple, they were shown ways of operationalizing their goals. This seemed to reduce quite a bit of tension they had begun to experience with each other and they eventually made tentative plans for the next two years. (these plans involved Mrs. Goo working and she voluntarily sought out employment, much to Mr. Goo's satisfaction.)

Behavioral contracts in several areas further reduced the constant irritation that they were experiencing with one another. For example, there were a number of behaviors by each that would always irritate the other in connection with their going out to a party or keeping an appointment. Mrs. Goo felt her husband would never be ready on time if she did not constantly remind him about the time and urge him to start shaving or taking a bath. Mr. Goo would respond by becoming irritated and move even slower which would further infuriate his wife. After an extended and detailed discussion the contract which was finally set up, and agreed upon by both, went as follows: First, both had to agree on the time they should leave. Each would alternate on occasions by suggesting what they felt the appropriate time should be for them to leave the house. If the other agreed with that time, it was used. If the other disagreed with the time, that person would make a counter proposal. If the first agreed to this, then it was used. If the first did not agree then they would both compromise on a time exactly half way between their two suggested times. Depending upon the

situation, Mr. Goo would have the option of saying at what time he would like one reminder from Mrs. Goo. She was to warn him only once at that time. After that it was Mr. Goo's responsibility to be ready to leave on time. The contingency set up for Mr. Goo if he was not ready in time was that Mrs. Goo, without comment, would leave by herself in the family car. Mr. Goo, when he was ready, would then have to follow in his work truck by himself (he strongly disliked driving his work truck on formal occasions). The contingency set up for Mrs. Goo if she warned Mr. Goo more than once about the time was that for each time she warned him, five minutes more would be added onto their agreed upon departure time (something very aversive to Mrs. Goo).

Similar contracts were set up regarding other areas such as dinner preparation, waking Mr. Goo up in the morning, comments on Mrs. Goo's diet, and so on. Over the next two months both kept to their part of the agreements and a considerable amount of tension between them was apparently reduced. They found themselves enjoying each others company more and attending more functions together. It was not until the setting of the contracts that they were apparently able to take advantage of the communication skills that they had been exposed to earlier in treatment. For the first time they reported that they were really beginning to listen to each other and to understand what the other was saying and feeling.

In the sexual area progress was partial. They had

eventually purchased a vibrator but Mrs. Goo had felt hesitant about using it herself so they used it in a joint session. Mrs. Goo found it highly arousing and eventually found herself going beyond her usual stage of arousal. Finally, it appeared she was about to experience a climax when she stopped her husband. She said that she suddenly felt scared, as if she was "going to fall apart--in pieces." She reported that she had never experienced that feeling before and was afraid to "just let go." She also said that she was going to wait awhile before using the vibrator again because she was "sore" from its use the first time. E did not press her further except to suggest that she now was aware that she could experience arousal and possibly a climax. It was suggested that she proceed at her own pace and continue to explore her own potential.

A week later she experienced her first orgasm with the vibrator and reported some disappointment "that that was all there was to it." She reported that she had run to a mirror to examine her nipples to make certain that she had had an orgasm (looking for responses she had learned from her assigned readings). E stressed her forgetting these clinical aspects and concentrate on using imagery of her husband and of experiencing her own pleasurable feelings in the situation. However, she reported that she now felt good that she knew she was capable of reaching a climax like any other "normal woman." Initially she said it took her an hour of use to reach a climax but over the weeks this time reduced to about



ten or fifteen minutes. She also reported increased awareness of sensual feelings in other situations such as taking a shower or having her body rubbed with a towel.

Unfortunately progress in the sexual situation with her husband did not proceed as smoothly as in these other areas. At the time of reevaluation of the program a structure had been set up whereby each partner was alternately responsible for setting up the room and occasion for their sensate sessions (to avoid the expectancies of Mrs. Goo as in the first session and to allow Mr. Goo to take his share of responsibility for the sessions). This worked fairly successfully for awhile, but there were continual situations that appeared to interfere with their regular progression (e.g., one or the other would get sick, a sudden conflict in work schedules, etc.). Mrs. Goo seemed to find more reasons for not following through than Mr. Goo and E had a difficult time in trying to clarify what was happening. She complained that part of the sessions she found pleasurable, but then things would just "stop" and she would feel nothing.

Finally, about three months after treatment had begun E noticed that Mrs. Goo would make a brief wry face when she would mention her husband touching certain parts of her body. Further exploration of her actual reported feelings at these times led to the disclosure that she was actually experiencing a high degree of anxiety when her husband touched her, particularly in certain areas. It was then revealed that had a habit of sneaking up on her at various times through the

day and suddenly grabbing her either on the arms, breasts, buttocks, or waist. She had learned to respond with tension each time he touched her. It also seemed that her husband made comments about certain parts of her body that upset her. These, unfortunately, would usually be made during their sensate sessions as well. For example while in bed he had made the comment that the top half of her body looked like a "nice young woman", but her bottom half was "way too big". His response was that he was just agreeing with the statements that she always made about herself, such as when she asked, "just look at my stomach, isn't it flabby?" Whereupon, he would promptly agree with her. Under such circumstances the sensate sessions with her husband had become highly negative for her. When asked why she continued to deny this sort of response from the beginning, she replied that all the other procedures had worked so well that she thought this one would also change things for her if she just waited long enough. It seemed that every time in the past when Mrs. Goo reported "no feeling" she was actually experiencing a very strong negative feeling. It was an error on E's part for not following up on this possibility earlier. It was also unfortunate that the assessment materials and initial analysis did not reveal this information.

Because of her obvious anxiety associated with the situation their sensate sessions were stopped and systematic desensitization to a number of hierarchies of sexual and nonsexual contacts by her husband was suggested. Both

agreed to the procedure and hierarchy construction and relaxation training was begun. To continue the involvement of the husband E suggested that he could help in the treatment by presenting the items and attending all sessions. Both appeared to respond very positively to the proposal.

Both were trained in relaxation and then the husband was given a written set of relaxation procedures that he could read to his wife while at home. The first hierarchy to be worked with was concerned with the sexual situation and went as follows (in increasing order of anxiety production):

We are at home, in bed together, and I begin to . . .

1. gently rub your shoulders.
2. gently kiss your neck.
3. gently caress your ribs.
4. gently caress your breasts.
5. gently caress the outside of your thigh.
6. gently caress your waist.
7. gently caress your butt.
8. gently caress your pubic area.
9. gently caress your inner thighs.
10. gently caress your stomach area.

Numerous difficulties were encountered from the very beginning. Mrs. Goo appeared to have a difficult time in learning the relaxation techniques. She would complain of different muscle group tightness, interrupt the procedures to ask irrelevant questions, or release tension without waiting for the signal from E (Mr. Goo, on the other hand,

learned the technique of relaxation in a comparatively short time). By taking careful steps to adapt the procedure to Mrs. Goo's complaints, she was eventually able to report that she was fairly relaxed and found it comfortable. However, she then reported experiencing sudden attacks of "spinning and heaviness." E guided Mr. Goo in giving the instructions as soon as possible for she reported no such sensations when her husband gave them. Initially, she also appeared to resist Mr. Goo's patient attempts. In the middle of the procedure she would suddenly tell him to "hurry up" or "slow down"; she would tighten her calf muscles when he asked her to tense her thighs; or her left hand when asked for her right. By carefully changing the instructions to suit her, she eventually appeared to reach a fair degree of relaxation. However, her reported imagery also appeared very poor and special efforts were then taken to train her in imagery.

Some of this apparent resistance to the procedures may have been a reaction to several events that took place between them while at home. Mr. Goo was initially cautioned about not approaching and grabbing his wife as he had previously. The next session, Mrs. Goo, "jokingly" complained that now her husband was teasing her verbally by saying, "look out, I'm going to grab you!" though he never did. He claimed that he only meant the statements as a joke and did not mean to upset her. A few sessions later, Mrs. Goo reported that he reduced his teasing to only saying

"grab--grab" or "touch--touch". He had stopped making comments about her stomach, but he now began to complain about her "flat feet" that looked like a "truck had gone over them." E spent one session attempting to explore with Mr. Goo the possible reasons for this behavior. From examination of the consequences of past teasing efforts on his part with his wife, it appeared that his teasing techniques were one of his primary approaches to engaging in sexual behavior with her, and in the past they had been intermittently successful. E, unaware of this, had not suggested alternate behaviors and Mr. Goo appeared to be searching through a related class of responses on his own. With some additional prodding from his wife, Mr. Goo also asked when he was going to be able to have regular sexual relations with his wife. E agreed that Mr. Goo was in a somewhat awkward position, but suggested that if he could be a little more patient, in the long run it would be to their mutual benefit. (Mrs. Goo gave an audible sigh of apparent relief.) However, as it had been previously agreed upon, Mrs. Goo was to continue to sensate her husband to climax when he desired and when mutually agreeable. (Mrs. Goo had reported that she did not mind touching her husband, and in fact found it quite enjoyable and arousing for her.) Mr. Goo appeared agreeable to the temporary solution, though E was still somewhat uncertain of his feelings. E also explored some other behaviors that Mr. Goo might be able to substitute for his past "grabbing behavior" with his wife. After further discussion

Mrs. Goo suggested a number of actions that he might do which would not disturb her (e.g., nuzzling and kissing her gently on the neck; rubbing her back and shoulders, etc.). Again, Mr. Goo seemed satisfied.

By seeing the couple three times a week and by having them practice relaxation together each night at home, and Mrs. Goo by herself when she could, E felt that they reached the stage where desensitization could begin.

During the first session Mr. Goo presented the first two items, three times each, to his wife without any signalling on her part. She reported improved imagery as they went along, with no anxiety. They were advised to practice systematic desensitization to these two items at home at least once before returning for the next session. (Mr. Goo had been fully informed about what to expect and had been supplied with a number of written alternative responses in case of any signalling on Mrs. Goo's part.)

At the following session they both appeared in a good mood. They had practiced systematic desensitization twice the night before. That morning when they awoke Mr. Goo, on his own initiative, had engaged in both behaviors with Mrs. Goo and she reported that she had found it very enjoyable and comfortable.

Mrs. Goo was then relaxed and Mr. Goo presented the first four items, three times each, again with no signalling. In the discussion which followed Mrs. Goo reported that the scenes were not too vivid but she felt comfortable with them

(her tone sounded almost bored with the procedure). They were advised to practice at least once and to go no further than they had that day.

At the third session Mr. Goo went as far as the eighth item on the hierarchy with no signalling from his wife. Afterwards, Mrs. Goo reported complete boredom with the whole session and complained about the slowness of the presentations, and the great number of times each was presented. E again explained the rationale of proceeding slow rather than fast, and allowing sufficient time for relaxation between items (E had been surprised by her apparent lack of anxiety response to the higher items and had signalled Mr. Goo to spend more time than usual on relaxation between presentations). Mrs. Goo said that she understood the caution and felt it was just her usual impatience and frustration with her husband when he does things so slowly. E agreed that perhaps the presentations were too slow and that they would try to move faster in the future. She reported that the imagery was "all right" and she felt nothing but relaxed all the time. Mr. Goo also reported that everything was going well with him and he looked forward to continuing. They were advised to continue to proceed no further than the items covered that day, both in desensitization and in behavior.

The day of their next appointment, Mrs. Goo called the secretary to cancel it and said that she would be in by herself to see E at the following session. On that day, she again called and cancelled, "due to a change in work

schedules", and she said that she would see E at the following scheduled appointment.

Mrs. Goo came alone to her appointment, explaining that even though her husband very much wanted to come in with her she would never be able to tell her "real reasons" if he were present. It seems that she had been experiencing a high degree of anxiety during many of the previous item presentations, but she had not signalled because she did not want to hurt her husband's "manhood." She felt that if she showed anxiety to his presentation of a statement that he was touching her, particularly in front of E, her husband's feelings about his manhood would be hurt. When asked if she signalled at home when they were alone, she said she had not for the same reason. Though she said she had asked him about it once and he had said that it did not bother him, she did not believe him. To further support her feelings, she claimed that after she had "jokingly" complained about his continued teasing attempts at touching her, he had brought it up to her at home and was very hurt that she had said it to E. She said that he seemed unwilling to discuss his feelings with E during the sessions, and would wait until they got home and then complain to her. At home she reported that he would keep asking her why she was not aroused by him when other women appeared to find him attractive. She also felt that he was working too hard to continue coming to the center three times a week and that he needed more rest. Though E took the responsibility



for their current situation and offered to reconsider the whole situation, Mrs. Goo appeared to have made up her mind to discontinue treatment. She was thankful for all that E had done but felt that things were just not working out and she was even getting worse in her displeasure at being touched by her husband. E attempted to explain that her not signalling had probably led to the current sensitization and that other measures could be taken to rectify the situation, but Mrs. Goo was firm in her decision to stop. She said that she would just try to work things out by herself and that sex was "never very important to her anyway." She really did not care about her own lack of response, but she had just heard from her girl friends what she was missing and thought she would see what it was all about. She said that she felt she was now a normal woman and knew that a climax was possible for her, and perhaps with time it would work out. She would do her best not to show her displeasure when her husband touched her and perhaps she could get over it. No effort on E's part could dissuade her from discontinuing. Mrs. Goo was highly appreciative of all that had been done, claiming that they now had definite plans for the future, they had many fewer arguments and knew how to handle them when they did occur, and that they got along much better than they ever had in all areas except the sexual one. She felt that the real problem was her husband's feelings about his manhood, and if he would come in and talk with E maybe he could get over "his problem." She felt it would be useless

to continue because she could never be honest with her husband and E together.

Mrs. Goo was informed that E would be more than willing to talk with Mr. Goo if he wanted to come in and talk about the situation. He also said he would be glad to see either of them or both of them again at a later date if they decided that that would be appropriate. It was also agreed that E would leave their appointments open for the following week in case one or both wanted to discuss it further. After that, it would be left to them whether they wanted to continue again. If they decided to continue, E suggested that they would start by re-evaluating their present situation and what had been done to that point, and seeing what changes could be made that would be satisfactory to them both. If they decided to discontinue for the present, Mrs. Goo was asked to please contact E at least by the end of the next month or two to let him know how their situation was. As it seemed apparent that Mrs. Goo had made her mind up on the matter, E then spent sometime discussing the positive gains they had made and suggested various alternatives that they might pursue on their own in the future. Mrs. Goo then left, again thanking E for all that had been done.

The following week Mr. Goo came in alone. He appeared hesitant and somewhat embarrassed and spoke in general terms. When E eventually inquired as to what prompted his visit, Mr. Goo appeared surprised. It seems his wife had told him that E wanted to see him and that he "had" to go in and see him.

He had not known what to expect, thinking that E had some sort of "earth-shaking news" for him. When informed that there had been some apparent miscommunication, Mr. Goo seemed quite relieved. He then subtly attempted to find out what his wife had told E, but E avoided a direct response by inquiring how Mr. Goo saw the situation. He responded by saying that his wife thought things were not working out in the sexual area and that she was hesitant about hurting him. When pressed for his own reactions, he denied any question of being hurt, but felt he ought to go along with his wife's feelings. He felt that they had accomplished a great deal since first coming in for treatment and that their life was much better. He felt that were now working together toward mutual goals, they had fewer arguments, and their general relationship was greatly improved over the situation of a few months earlier. They had made reservations to leave the Islands in five months and start on their traveling before settling down to start a family and enter into their own business. His general positive attitude seemed genuine and he was profuse in his appreciation for what had been done. In relation to the sexual area he felt they had also made good gains and he was optimistic that the gains would continue. However, E's suggestion that they might consider re-evaluating the present situation to increase their gains was politely refused. Mr. Goo seemed satisfied with matters as they were, but said that he would be more than willing to continue at some later time if the situation did not continue

to improve. As with his wife it appeared that Mr. Goo had also made his mind up on the matter. E therefore spent time in discussing various ways of continuing their relationship from where they were at present, but still left the door open for them at some future date. E also requested that Mr. Goo make some contact in the next few months as to how things were going, letting him know he was very much interested in their continued progress. E also asked if Mr. Goo would consider filling out some of the questionnaires again, explaining that this would help in working with future couples. He readily agreed and said he would ask his wife if she would complete them also.

Two weeks later the completed forms were returned. Table 16 shows Mrs. Goo's initial scores on the various inventories at initial assessment and six months later. Appropriate normative data are also supplied.

TABLE 16

## MRS. GOO'S PRE AND POST INVENTORY SCORES

Scale	Mrs. Goo's Score		Norm Group	
	Initial Assessment	6 Months Later	$\bar{X}$	SD
Reinforcement Survey Schedule:	350	315		
Composite Fear Inventory:				
Total Score:	380	245	387.31	87.07
Geer Scale:	123	79	122.99	27.73
Suinn Scale:	211	135	206.60	50.03

Sexual Fear  
Inventory:

Total Score:	195	165	225.09	54.64
General:	59	45	51.00	11.47
Personal:	42	36	53.00	14.82
Social:	27	21	33.09	9.64
Contact:	67	63	88.00	29.61

Inspection of Table 16 shows a decline in all scores for Mrs. Goo. Initial assessment scores on the CFI were strikingly similar to the comparative norm group scores of married females, but six months later her scores were over one standard deviation lower than the norm group, indicating a marked decrease in reported generalized fears. Of interest is her response to item #173, which is Sexual inadequacy (Impotence or frigidity). On initial assessment she had responded with "Very much" fear, while six months later she checked "A little" (she had first checked "Not at all" but had crossed this off and checked the next highest category).

Scores obtained on the SFI also show a decrease with those on the Personal and Social scales apparently accounting for her greatest decrease. Her obtained scores on the contact scale showed only a slight decrease. Of interest are her responses to items #36, #95, and #98. To "failure or difficulty in achieving orgasm" her response changed from "Much" to "Not at all." To "having your buttocks and thighs caressed by a male" her responses increased from "A little" to "A fair amount". To "having your hair and face caressed

by a male" her response decreased from "Very much" to "Not at all".

Table 17 shows the scores obtained during initial assessment and again six months later for Mr. Goo on the various inventories.

TABLE 17

## MR. GOO'S PRE AND POST INVENTORY SCORES

Scale	Mr. Goo's Scores		Norm Group	
	Initial Assessment	6 Month's Later	$\bar{X}$	SD
Reinforcement Survey Schedule:	251	264		
Composite Fear Inventory:				
Total Score:	216	183	387.31	87.07
Geer Scale:	63	58	122.99	27.73
Suinn Scale:	122	118	206.11	50.03
Sexual Fear Inventory:				
Total Score:	138	146	239.59	67.71
General:	30	34	51.41	13.71
Personal:	31	33	58.09	13.40
Social:	21	22	32.41	8.55
Contact:	56	57	97.69	40.05

It is interesting to observe that Mr. Goo's obtained scores showed an increase in reinforcing items, a decrease in generalized fear responses, and an increase in sexual fear responses. However, despite the changes in direction of the fear inventories, his scores are still greater than one

standard deviation lower than those reported for the comparative norm group.

Contact sessions, from initial interview through assessment and partial treatment, totaled 36 for Mrs. Goo and 30 for Mr. Goo. Twenty-three of the sessions were joint contacts. Time elapsed from initial interview to final session was approximately 8 months.

Follow up note: Two months after her last session Mrs. Goo called E and asked if she could make an appointment to see him. When E immediately agreed, she then inquired if there would be enough time to do something inasmuch as they were due to leave the islands in three months. E replied that the amount of time necessary would depend upon the particular problem involved and he offered to see her the following day to discuss the matter in detail. However, Mrs. Goo replied that she would prefer to wait until after the forthcoming holidays and come in some time after the following month. E pointed out that this would leave less time to deal with the particular situation, but Mrs. Goo replied that she was going to be too busy with shopping and working. It was left to Mrs. Goo to make an appointment whenever she felt she had sufficient time to discuss the matter. She had not made an appointment as of two months after her phone call.

Case of Miss Han and Mr. Ho. Miss Han, an oriental female in her early twenties, was referred to E by her clinic psychiatrist, whom she had been seeing for the past eight

months. She had entered into therapy because of depression over marital difficulties which she felt stemmed from her failure to enjoy sexual relations. Over the course of therapy she had divorced her husband and had turned over custody of her children to relatives. She felt much better about her current life situation but her sexual relationships with men continued to be disappointing to her. Her psychiatrist had suggested that she look into the possibility of entering into the present research program.

During her initial interview with E she confessed that she was really not sure "why she was here." She reported difficulty in relating sexually to males, but she did not appear too concerned over her problem. However, she thought that it might be "helpful" to try something new and see what might happen. When E reflected her apparent lack of concern about her situation (in an attempt to gauge her motivation for treatment) Miss Han broke into tears. She eventually reported that she was fearful of rejection. She was afraid she might stop without completing therapy and then E would be angry with her. She said that she could not be 100 percent certain that she would "stick it out", though she wanted to try. Though she could achieve an orgasm through masturbation, she had never experienced orgasm during sexual relations. Her sexual relations with her husband had always been associated with anxiety and pain. During the time she was dissolving her marriage she had tried an affair with a friend, Mr. Ho, to see if her response was only limited to



her husband. Though the experience had been somewhat more pleasurable, she found that she was still unable to experience an orgasm. Since her divorce she had had affairs with approximately seven different men, with the same result. At this point she was looking at herself as a complete failure as a woman. Her primary goal as she described it was to achieve an orgasm with a male and all it signifies. Currently, she had limited her relations to Mr. Ho and she was hopeful that she could achieve a full personal and sexual relationship with him.

E explained the particular approach of the research program and discussed the possibilities of having Mr. Ho cooperate in the treatment program. However, Miss Han was uncertain as to whether she could "trust" Mr. Ho to cooperate. She felt that the relationship was somewhat onesided and that he did not have a full commitment to her. In fact, at that time he was considering moving to the mainland. However, she said that she would think about it and approach him as to the possibility. An appointment was made to begin assessment and Miss Han was referred to a clinic physician for a medical evaluation. She revealed that she was somewhat fearful about this examination because she was currently suffering from "some sort of warts" on her genital area.

The assessment period extended over two months and involved thirteen contacts. This lengthy period was necessitated by numerous complications. Her medical examination revealed that she had condylomata acuminata of the

external genitalia (a form of venereal wart) that might be a contributing factor to her reported lack of response. This was only the beginning of a series of medical complications that extended throughout assessment and treatment. She was referred to a private gynecologist for further examination and treatment which revealed a vaginal infection, tipped uterus, and eroded cervix--apparently stemming from the time of the birth of her children. Miss Han was very reluctant to receive medical treatment and E was as supportive as possible to see that she kept her appointments and fully discussed her situation with her physician. The warts were burned off, but reappeared later and had to be treated again. Medication was given for the infection, and her cervix was treated by freezing.

During this time there was also a delay in her period and for a while it appeared as though she were pregnant, but eventually this proved untrue. E also strongly suggested that she inform Mr. Ho that he should have an examination and possible treatment, but Mr. Ho had limited resources and was reluctant to enter treatment. He reported through Miss Han that he had has some kind of "itching" for three years and had seen numerous physicians who had given him a number of medications, none of which worked.

Because of her medical condition and because of the possibility of continued aversive conditioning, E had strongly suggested that Miss Han temporarily refrain from further sexual contact until such time as she had completed her

medical treatment. She attempted this, but Mr. Ho apparently became very angry with E for interfering with his personal life. Mr. Ho was also being seen by a female social worker at the clinic and he made an appointment for Miss Han and himself with her. He disclosed to her that he felt his own image as a male was being attacked. He had told Miss Han that he would be willing to help her with her problem if he could, but that he wanted his social worker in on the sessions as well. E informed Miss Han that this was agreeable, if it turned out that this approach was appropriate to her situation. When asked for her feelings on the matter Miss Han was still uncertain as to how he felt toward her and their future relationship. Miss Han did report that she liked his social worker very much and that if they did work together she had no reservations about her being present. E then suggested that they finish assessment before attempting to make any decision.

During this period Miss Han was also faced with financial problems and having to move out of her apartment on her own. In addition, she and Mr. Ho had several experiences with LSD and marijuana that ended in their having sexual relations. Her response was as it had been in the past. At one point, Miss Han felt that she could no longer continue her relationship with Mr. Ho and she broke it off. At this same time she was also depressed about not hearing from her children (particularly on Mother's Day) and she became severely depressed. She reported a number of suicidal

impulses and E spent considerable time working through this period with her. By the end of assessment she had elected to start seeing Mr. Ho again, deciding that a "painful relationship of some type was better than no relationship at all."

Miss Han's scores on the various inventories, along with comparative norms, may be seen in Table 18. Her responses on the Composite Fear Inventory generally clustered around interpersonal relationships and fears of criticism and evaluation. However, her total score is still within one standard deviation of the norm group scores. On the Sexual Fear Inventory scores, there is a striking difference between

TABLE 18

## MISS HAN'S INVENTORY SCORES

Scale	Miss Han	Norm Group	
		$\bar{X}$	SD
Reinforcement Survey Schedule:	373		
Composite Fear Inventory:			
Total Score:	450	387.31	87.07
Geer Scale:	143	122.99	27.73
Suinn Scale:	244	206.60	50.03
Sexual Fear Inventory:		Married Females	
Total Score:	373	225.09	54.64
General:	88	51.00	11.47
Personal:	94	53.00	14.82
Social:	44	33.09	9.64

Contact:	147	88.00	29.61
Sexual Behavior Inventory:	18	13.27	6.66

those scores obtained by Miss Han and those obtained by the norm group. Depending upon the scale her sexual fear scores range from one to three standard deviations higher than those reported by married females. Additional assessment information indicated anxiety associated with her own sexual anatomy and behavior, and a general lack of knowledge of norms concerning female sexual behavior and function.

Her sexual history revealed that she received her first kiss from a boy at age 14. Petting was limited to kissing and general body contact until age 17 when she experienced breast manipulation, both manually and orally, with her future husband. She found this experience highly pleasant. Because of their religious beliefs, they had agreed they would not have sexual intercourse until after marriage. At age 18 they stated mutual genital manipulation which was described as "pleasant." He also initiated her into performing fellatio with him, but often got angry because she "didn't know how to do it." He made one attempt at cunnilingus with her, but "gagged" and never attempted it again (from this time on, she always felt that there was something "unclean" about her genitals.) He did agree to manually bring her to orgasm, but only after she had performed fellatio. On her 19th birthday, despite their prior agreement, he insisted on having sexual intercourse. She found it extremely

painful and bled quite profusely. Despite her continued pain, he insisted on having intercourse with her every night for the next two weeks. By the end of that time intercourse was highly aversive to her. However, they continued to have relations on the average of four or five times a week until their marriage a few months later. He had initially used a condom to prevent conception but shortly stopped and informed her that she should use the "rhythm" method. She became pregnant. At this same time she was having extreme difficulty in getting along with her mother. In an attempt to solve both problems they were married. He joined the merchant marines and they moved away from the islands. She reports that from the beginning they disagreed on religion, politics, marriage roles and ideas of child rearing. She felt that the only thing he was interested in was the "service and sex." She described her sexual life as "awful." Her husband wanted her to wear black stockings and underclothes prior to all their relations. She would have to sit on a chair and cross and uncross her legs while he watched her. When he became aroused he usually preferred being satisfied orally rather than through intercourse. Initially, he would bring her to a climax through manual stimulation. However, he would perform this service by leaning on his elbow and rubbing her methodically, periodically sighing and asking her how long it was going to take. She finally asked him to stop and he happily agreed. She would avoid relations as much as possible, but actual intercourse took place on the

average of three times a month until two weeks prior to her giving birth to twin boys. He resumed relations within four weeks of her birth and she secretly hoped that her "stitches would be torn" to stop him.

For the following year their relations consisted of her dressing in black stockings and underwear and performing fellatio on him. At this time she entered into an affair with Mr. Ho to see if it was possible for her to have "normal" relations. As reported, it was more pleasurable, but still highly limiting to her. She had then gone into treatment with her clinic psychiatrist.

Another important aspect of her sexual history, with strong theoretical implications, is the area of masturbation. At the age of eight she had learned about masturbation through reading a Marriage Manual she found in her mother's drawer. She experimented and found it highly pleasurable. She then masturbated every night until about the age of 10 at which time she attempted to limit herself to three times a week. Though she had experimented with some vaginal insertion, she did not find this arousing and her technique was limited to direct clitoral stimulation using a side to side motion. She generally experienced an orgasm in from five to ten minutes, and she was usually multiorgasmic. Her accompanying imagery had progressed through a variety of stages. When younger she had fantasized older men making love to her. Around age 12 the "men got younger" and they would masturbate her. Eventually, this fantasy lost its arousal value and

and she began to use "groups" of men having intercourse with her, one after another. During her marriage she reported her fantasies changed to those of a more sadistic nature, where she would be tied and beaten then sexually attacked by a large number of men while others watched. More recently these images had failed to satisfy her and she had begun to turn to the use of dogs and horses in her fantasy, which she found highly arousing. She had been using dogs for the past two months and had just begun using horses. When initially hearing this history E had privately wondered whether this conditioning would generalize to actual dogs and horses. (On the Reinforcement Survey Schedule she had checked dogs "A little" and horses "Much"). A partial answer came during initial assessment. Miss Han revealed, somewhat hesitantly, that when she had made a visit home the previous month she had lured the family dog into her bedroom and exposed herself to him, but that nothing had happened. A few weeks later, she again reported letting her roommate's dog into her bedroom and letting him "smell her" but he also failed to respond. At this point E felt it best to briefly explain the possibility of her masturbatory fantasies conditioning her to arousal associated with dogs and horses. This seemed to make sense to her and she appeared to realize the implications. She also felt greatly relieved that it might have such a "logical" basis rather than be the signs of her "growing insane."

Other assessment information indicated a number of areas of concern outside the sexual area. Her generally depressed



state and suicidal thoughts were still present. She apparently had extreme difficulty in asserting her own feelings or desires with anyone. She listed as an "asset" her ability to not show her emotions. She felt she had no other assets as she was inadequate and a failure in all her relationships. Her obvious attractiveness, sensitivity to feelings of others, apparent intelligence (high grade point average in college, scholastic honors) and other factors were entirely overlooked by her. Through her past experiences with her father, husband, and boyfriends she had apparently learned to inhibit any feelings on her own part, particularly anger and affection. Almost invariably she would do what was expected or demanded of her by others. These patterns obviously extended into her sexual relations as well.

In her present depressed state, sexual relations as well as other daily activities appeared to have little reinforcing value to her. Because of this, and particularly because of her suicidal ruminations, her depression was treated first. Her depression was approached in a number of ways. Initially a modified form of Lazarus' (1968c) time projection was used to help her achieve a distance perspective about her current situation. A careful analysis of her ruminations were made and thought stopping introduced, supplemented by reading materials and behavior rehearsal. Environmental changes were also suggested as to moving out of her apartment where she disliked her roommate, seeking and securing an interesting job, and active involvement with Mr. Ho.

Once into active treatment she appeared to respond positively and eventually the sexual area was approached. For purposes of clarity treatment procedures pertaining to the sexual problem will be presented exclusive of other interventions. However, to give some idea of the complexity of treatment in cases such as this a brief description of some of the other problems encountered during the first phase of treatment will be given.

Miss Han again missed her period and her first pregnancy test came out positive. This necessitated exploration of alternatives available and decision making on her part (later tests proved negative). Her medical treatment throughout this period was also confounded by having her gynecologist leave the islands and she was seen by a series of different physicians each of whom suggested different approaches. She moved into a house with other people, but the house was broken into and robbed. This meant another period of house searching and moving. She obtained a job but had numerous difficulties relating with the other workers and her supervisor. This was handled through continued assertion training and exploring alternate ways of behaving with behavior rehearsal. Her relationship with Mr. Ho was constantly fluctuating from highly positive to highly negative and was a recurring point of discussion. These, and numerous other minor illnesses, called for a range of intervention measures that were not directly associated with the sexual problem.

It was apparent from Miss Han's sexual history that ...

sexual intercourse had become negatively conditioned for her and was a discriminative stimulus for avoidance. Her primary sexual outlet was masturbation but she also felt guilty about this (from her early religious background) and disturbed over her fantasies. Her gynecologist had stressed abstinence from intercourse during her medical treatment and E had supported his statement. It was also hoped that this would change the reinforcing value of intercourse for her. To help change the discriminative value of sexual behavior in general and sexual intercourse and masturbation in particular, Miss Han was given a number of reading and pictorial materials. These were fully discussed with her and explanations of sexual function and physiology were supported by the use of models, diagrams, and charts. Discussion of these materials also apparently helped to make a change in her attitude about herself. (e.g., She was relieved and pleased to find that masturbation was common to many other women and that her "clitoral" as opposed to "vaginal" orgasms did not mean she was "neurotic").

Inasmuch as sexual intercourse was proscribed, and her feelings about Mr. Ho ambivalent, the main area of concentration was on her masturbation. E requested that she temporarily stop masturbation while they were working with her depression. She had agreed, not feeling much "in the mood" anyway. The treatment plan derived was to change her masturbatory practices to those most closely approximating actual sexual intercourse. To prevent further possibility

of conditioning arousal to animals, and to hopefully increase her arousal to males, gradual changes in her imagery would be suggested. The rationale of the program was explained to her and she was eager to begin. In regard to imagery, she was asked to stop using animals and use her previous fantasy of males in general and at the point of orgasm to try and bring her imagery to one male only, preferably Mr. Ho.

Her usual pattern of behavior was to lie on her back, her legs closed and straight, one hand on her stomach and the other directly stimulating her clitoris in a sideways motion. She was asked to attempt to stimulate the area around her clitoris as well and shown on a model what was expected.

Between appointments she had an opportunity to practice on two occasions. On the first occasion she imagined herself in a night club filled with men and she was on a conveyor belt as various men would touch and fondle her. She then switched to thoughts of Mr. Ho at the point of orgasm. She found the experience highly satisfying. On the second occasion she used the same imagery, but felt a reduction in feeling, and it took her much longer almost 15 minutes. Apparently the deprivation schedule had helped initially, but the second occasion had lost some of its appeal. This was explained to her and the importance of continuing as she had was stressed.

Over the next few weeks her fantasy was changed to

fewer and fewer men, as well as starting to use more probable circumstances. She found it much easier to use Mr. Ho in her fantasies although she reported the experience to be lacking in the satisfaction she had known from her previous fantasies. At this point she was only engaging in oral-genital contact with Mr. Ho and avoiding intercourse. By then her warts were gone and she and E were both attempting to have Mr. Ho see a urologist. She also "gave in" and had sexual intercourse with Mr. Ho one night after reading some pornography with him. She felt mixed in her feelings. She wanted to because it had been two months since she had had intercourse, but she felt guilty because of E's prohibition. She also felt disappointed over her lack of assertion in refusing Mr. Ho. She felt that Mr. Ho had left it all up to her as it was "her" problem and he would attempt relations unless she stopped him.

Again it was suggested that they refrain from intercourse at least until Mr. Ho had an opportunity to have a medical examination. She reported that her experience with him had been much more pleasant than in the past, but she had been too mixed up in her guilt feelings to really "let go." At this point she was asked to start approximating actual sexual intercourse with her body during masturbation. She was asked to bend her legs and spread them, as well as attempt some slight insertion of her fingers into her vulva.

This suggestion turned out to be an error on E's part. Miss Han reported that she had not been able to achieve an

orgasm with the previous suggestions, particularly with her legs bent. The next day she had been ready to revert to her old posture and fantasies but managed to refrain. She tried once more and after some time (approximately twenty minutes) managed to achieve a climax, but it was not very satisfactory. At this point she was ready to give up the whole plan. E admitted that he had made an error in suggesting steps which were obviously too big, and that her new learning had not had sufficient time to be established. It was suggested that she leave her legs straight for the present and only concentrate on using more of the vulva. At this point she admitted that she was looking for quicker progress and again wondered if she should approach Mr. Ho about participating in the program. She said she would think about it and feel him out again. (Inasmuch, as most of her daily life centered around Mr. Ho it appeared that he eventually would have to be included in some manner.)

At the following session she reported that she had thought it over and had asked Mr. Ho to participate and he had agreed to help. However, she still was hesitant about him, feeling that he might leave half way through the program. Inasmuch as Miss Han was confining herself to him exclusively it appeared appropriate to attempt to include him. E therefore saw Mr. Ho and began individual assessment with him preparatory to devising a program for both of them.

Miss Han reported progress in using her vulval area more, reverting back to direct clitoral stimulation only

when she began to lose feeling otherwise. After a week she reported that she was also able to have her legs partially open. She also reported having sexual relations with Mr. Ho again, and found them highly arousing but still unable to let herself enjoy the situation completely.

She had continued to cut down on her fantasy until now she was usually using a single male in a probable situation, generally Mr. Ho. She also reported an attempt to use a wastebasket to keep her legs apart while masturbating, but half way through she recalled E's explanation of possible conditioning and she had burst out laughing. As she explained, "I could just see me walking around getting aroused by wastebaskets!" She changed to using a pillow. She was now moved to attempting actual insertion of her fingers in the vaginal rim at point of orgasm.

The following week she reported continued good progress. She was using the full surface and vulval area and finding it arousing, where it had not been before. In fact, she said that she had tried to go back to direct clitoral stimulation alone and was surprised to find that it was not as satisfying. She was complimented on her good progress and encouraged to continue concentrating on vaginal insertion and imagery of actual intercourse with Mr. Ho.

During this time she also reported that she and Mr. Ho had again taken some LSD and that it was a "sexual trip" for her. They had not had intercourse but they had nude body contact which alone resulted in a climax for her.

Unfortunately, afterward she also experienced anxious feelings that she was not going to come out of the trip and it took her sometime to lose her panic while Mr. Ho held her. E strongly suggested that she refrain from taking drugs so as to not possibly resensitize herself to sexual situations, which were apparently becoming more positive for her.

The following week she reported being able to use partial insertion of her fingers during masturbation and she found it very pleasant. It was at this time that initial assessment with Mr. Ho was completed and a revised treatment program instituted. Before going into the program it will be necessary to give a brief amount of background information on Mr. Ho.

Mr. Ho an oriental man in his late twenties, had been in therapy with a number of therapists, on and off, for several years. He had received over one hundred individual and group contact hours at a community mental health clinic. Mr. Ho's social worker characterized him as inwardly anxious and quite depressed in the sense of being pessimistic about life and having a low opinion of himself in relation to others.

Table 19 shows Mr. Ho's obtained scores on the various inventories along with those obtained by a comparable norm group.



TABLE 19  
MR. HO'S INVENTORY SCORES

Scale	Mr. Ho's Score	Norm Group	
		$\bar{X}$	SD
Reinforcement Survey Schedule:	413		
Composite Fear Inventory:			
Total Score:	292	387.38	87.07
Geer Scale:	93	122.99	27.73
Suinn Scale:	165	206.60	50.03
Sexual Fear Inventory:			
Total Score:	183	239.59	67.71
General	35	51.41	13.71
Personal:	42	58.09	13.40
Social:	40	32.41	8.55
Contact:	66	97.69	40.05
Sexual Behavior Inventory:	21	14.48	6.15

Mr. Ho's CFI scores show generally less reported fear than the norm group. His primary area of concern was centered around interpersonal relationships. This is further supported by noting that his sexual fear is reportedly less than the norm group, except for social items where his score is almost one standard deviation greater than the norm group.

Mr. Ho's sexual history indicated that he started masturbation through self discovery at age 12. Frequency to adolescence was approximately twice a day. He could not

recall adolescent frequency except to note that it increased when he was anxious. Currently his frequency was about twice every three days. Usual time to orgasm was about five or ten minutes. His fantasy was usually limited to girls he would meet, or his past girl friends, or former wife, and occasionally Miss Han.

In adolescence he had always thought of sex as being very bad (he claimed this stemmed from his early religious training). At 16 he kissed a girl for the first time and almost blacked out. At 17 he had his first experience with tongue kissing and breast manipulation of a girl, feeling it was all "wrong somehow." At 19 he experienced his first sexual relationship with a girl, but she kept withdrawing every time she thought he was about to reach a climax (he did not know about contraceptives). Finally when he broke down and cried, feeling utterly inadequate, she gave in and held still and he found it very satisfying. From then until his marriage about age 26 he had experience with about 8 partners. At age 24 he met his future wife who would allow entry but no movement on his part. He reports that from that time to the present he never really enjoyed sexual relations as he had in the past. He was married for a year and a half, but had no relations with his wife after the first four months. He occasionally had relations with a prostitute, but he preferred to masturbate. He had one extra marital affair which did not last long. His wife, feeling he ought to have some sex, suggested that he have relations with

Miss Han (when she also was married). She did not expect it to last, but when it appeared that he was going to continue with her she finally accepted his previous statement that he would never learn to love her and she obtained a divorce. Since that time he had relations with two other women other than Miss Han. He found none of them really enjoyable. The only enjoyable sexual experiences he could recall were when he was on drugs, and a few times when he was with Miss Han and not on drugs.

Assessment took six sessions. Initially he was asked if he would like to have his social worker present, but Mr. Ho declined saying that he felt it was no longer necessary. E had outlined his particular approach to Mr. Ho who seemed somewhat skeptical. Mr. Ho had obtained his bachelor's degree in psychology at a mainland college and he had "been turned off by learning theory". However he said he would adopt a "wait and see" attitude. Half way through the assessment period he brought up his most prominent concern which was about his vocational future. After some discussion it was decided to do some vocational testing with him and sometime was spent in test taking and going over the results with him. This seemed to help make the present situation with E more positive. He was also referred for a medical evaluation to a clinic physician. He returned feeling frustrated and angry. He was told that he did not have any infection at present, and that the best prevention of his recurring itching was to keep washing himself and keep dry

underwear (E later learned that Mr. Ho had been treating himself with a variety of home remedies and that he also was taking Miss Han's medication). He was offered the names of several urologists for more detailed examinations but he chose to wait and see what happened.

In relation to Miss Han, there was some question on his part as to his degree of feeling toward her. He said that since she initially had relations with someone else shortly after her divorce he had never felt the same about her. In discussing his continued sexual relations with Miss Han contrary to her physician and E's suggestions, he only responded by saying it was her problem and up to her to stop him if she wanted. He saw his part as letting her know how he feels. E suggested that he could be of help to her by abstaining temporarily himself, but he felt that it would not be right to curtail his own behavior. He did not think that E's approach was going to fare very well, but he agreed to "try" and see what happened. His own past experiences were discussed with him and E attempted to set their mutual satisfaction and experiencing of each other as a goal, rather than his "helping her." Mr. Ho was somewhat reluctant to feel that he could gain from the experience, but he agreed to try and not have sexual relations with Miss Han until their first joint session.

Up to this point Miss Han had received a total of 14 treatment sessions. Her progress in imagery and approximation to sexual intercourse while masturbating had progressed

fairly smoothly. At this time it was E's intention to attempt to set up a mutually open and agreeable relationship between them and allow for the gradual transfer of Miss Han's masturbatory responses to actual genital contact between them. However, Miss Han still had some reservation about being completely open with Mr. Ho and she was reluctant to openly discuss her masturbation with him present. Mr. Ho also had reservations about sharing certain aspects of his past with Miss Han. It appeared that mutual treatment, under these limitations, was going to be exceedingly difficult. However, it was mutually agreed upon that Miss Han would meet with E for a half hour alone, followed by a joint hour meeting, followed by a half hour with Mr. Ho. This was to provide both with an opportunity to impart something they felt pertinent, but were unable to communicate directly to each other. In addition this would allow Miss Han time to discuss her own progress in masturbation. Accordingly, Miss Han was requested to keep a notebook record of her masturbation activity. She was to put down the elapsed length of time, the type of behavior engaged in, and the fantasy used. In this way it was hoped that gradual approximation of behaviors could be achieved and transferred into the actual situation with Mr. Ho.

For the remainder of the treatment program numerous problems arose outside the sexual area that required some sort of intervention. With Miss Han it was problems with her job, the remarriage of her former husband, a threatened suit for

custody of their children, and fainting spells which lead to a number of medical tests that revealed she had a mild form of epilepsy. For Mr. Ho it was problems associated with drugs and his vocational future. His fungus infection returned and a thorough examination by a urologist revealed a prostate infection as well.

A major problem for both of them was their inability to communicate openly with one another resulting in their both reacting to each other on the basis of past behavior rather than on the new behaviors they were attempting to learn. Throughout the remainder of treatment E made a continual effort to teach them communication skills and emotional expression as described with previous cases. However, because of their long history of avoidance of emotional expression progress was extremely slow. Concurrent with these problems and their interventions was the thread of the sexual problem which shall now be presented in more detail.

In the hope of counterconditioning their discomfort in the sexual situation, and to allow Miss Han time to explore her own developing sensual and sexual feelings, successive approximation of sexual responses was initiated. This was explained to them at their first joint session with suggestions as to how to go about their "sensate" explorations. In addition they were given reading materials to supplement the discussion. Mr. Ho seemed somewhat disappointed and responded with, "Is that all?" It seems that he had been expecting a particular sexual technique that would guarantee

Miss Han experiencing an orgasm and he was looking forward to having outright sexual relations with her that night. E attempted to express his understanding of Mr. Ho's disappointment and then spent some time in discussing the reasons for this particular approach. Mr. Ho shrugged and left without comment. Thus the joint sessions were initiated.

At their next session Miss Han reported disappointment that Mr. Ho had almost "fallen asleep" at their sensate session. However, she was surprised to hear him say in the session with E that he had found their sessions extremely pleasant. E stressed the importance of sharing their feelings at the time that they were experienced and spent some time going over their past session until they had shared all that they had been experiencing.

Meantime, Miss Han had been moved to deeper insertion in her vagina during masturbation, with Mr. Ho as her only image. At the next session she reported their sensate sessions were highly satisfactory for her. What previously had been only sensual had become highly arousing to her. At this point they were moved to mutual genital contact.

This phase had some difficulty particularly with Miss Han's former negative conditioning to being manually stimulated by someone else. However, Mr. Ho seemed to respond favorably and Miss Han, with the help of her masturbation fantasy, soon found herself enjoying the situation. To give an illustration of how her own private behavior and fantasy was tied into the joint sexual situation, the following is

taken from her journal record:

"pillow under hips. Began thinking about Mr. Ho looking at my body and masturbating me, while I masturbated area above vagina at random. Up and down, and sideways strokes. Legs apart. Right hand pulling on stomach. Came very fast and switched to thought of intercourse--legs apart.--2nd. orgasm (thought of Mr. Ho coming with me) legs closed, hand using sideways motion--same with third orgasm." The time for the above was three minutes.

Unfortunately, progress seemed to reach a standstill at this point. Miss Han had requested more kissing from Mr. Ho but he said that he just did not feel like it. They also had arguments over other problems.

At this point, when she was angry with Mr. Ho, Miss Han found that she could not use his imagery in masturbation and she would switch to a strange man to "get even." As she reported afterward, she had not realized how much the imagery was affecting her.

Unfortunately, Mr. Ho was privately reporting that he really did not care too much for Miss Ho anymore. He was beginning to feel that the only thing they had in common was sex as there was not much else to their life at present.

In an effort to increase the reinforcing value of their sexual relationship E suggested that they take a holiday from sexual contact for one week. During that week they were to engage in any number of activities that they both wished, both independently and together. Suggestions were made to them from their Reinforcement Survey Schedules (e.g., listening to classical music together; going hiking where they can see mountain scenery; playing tennis; going skin diving;



meeting and talking with mutual friends whom they had recently been avoiding, etc.).

At the next meeting they reported having had a fairly good time together. Miss Han had continued her masturbation and reported her first failure in reaching a climax since beginning treatment. Careful analysis of her notebook indicated she had simultaneously experimented with new physical positions as well as changing her fantasies. She was cautioned about changing too many activities at one time. She also reported having a dream to orgasm the previous night. It seems that in the past few weeks she had had several dreams of this nature, something which she had never experienced previously. She could not quite recall the exact content of the dreams, but when she would awake she reported that she was not making direct physical contact with her body.

They were continued on mutual genital contact, but misunderstandings invariably came up. For example, much to Miss Han's delight, Mr. Ho had initiated a sensate session (however, when relating this Mr. Ho reminded her that she had dropped a hint to him earlier that day--of course, Miss Han immediately felt hurt). Mr. Ho first sensated Miss Han, but she soon found that she had to stop him because she was beginning to feel "too" aroused. She was afraid she would build up a self demand for orgasm. She then started sensating him, (unfortunately Mr. Ho had felt somewhat put out for being stopped and he thought he had done something wrong).

Miss Han felt particularly good when she saw that Mr. Ho had a firm erection, but when she started kissing him he seemed to lose it. She then felt that something was wrong with her. In discussing this with them E inquired of Mr. Ho what had happened. He denied that the kissing had interfered, but said that he had just stopped his fantasies at that moment. Miss Han then felt hurt that Mr. Ho had to use fantasies while being with her. E spent some time attempting to show Miss Han that this was Mr. Ho's particular pattern of response, and like her, he too was attempting to move toward different patterns. She appeared to finally accept the situation, though she still seemed somewhat put out. This was the typical tenor of the joint sessions.

At this point they were moved to intromission with Miss Han in a superior position, with no pelvic movements. This was to allow her time to absorb her own sensations and to remove any demand from her for performance as in the past. Knowing about Mr. Ho's previous experience with his former wife, there was some hesitancy about this step, but Mr. Ho privately said that he felt he could handle it as he knew it would not always be this way.

Unfortunately, E underestimated the situation. They had had several arguments so they did not have a session together until a few days later. Then in the morning Miss Han had masturbated to a fantasy of Mr. Ho and had found it very satisfying. That evening they had a session together where intromission was made and Miss Han remained still. She

found the session extremely satisfying and pleasurable, reporting that for the first time she was able to concentrate on her own sexual feelings rather than on what Mr. Ho might be thinking. Afterward, she asked Mr. Ho what he had been feeling. He replied that he did not want to talk about it, but would discuss it when they saw E. (Mr. Ho found himself reacting as he had previously when his wife would not allow him movement--however his feelings were not as bad as he had thought they would be but he did not want to discuss them with Miss Han at that time.) Miss Han, believing she had done something wrong, felt rejected and angry at his lack of communication. Later when he did go to her and try to discuss it with her, she refused to listen to him and turned him away (she had coincidentally been making good progress in her assertion training at this stage). Mr. Ho had responded angrily that she was always "making a big thing out of small things" and he had stormed away. The rest of the week-end was miserable for both of them. At that point Miss Han was angry with Mr. Ho and with E as well and decided to quit treatment. To illustrate the powerful influence of her masturbatory imagery at this point the following is taken from her notebook at that time:

"Saturday: Not sure of the time. Written Monday night. Did not write it Saturday--was trying to forget therapy, Mr. Ho, and everything else painful."

"Thought of stripping in an exclusive nightclub with mirrors above and behind me. Masturbated in front of the audience of 35 - 40 some odd men. Eventually having intercourse with a rubber phallus at the end of a long conveyor belt which goes out into the audience. Masturbating sideways.

First climax moderate (Oddly enough, and much to my disappointment--fantasy did not turn me on as much as I thought it would. Second climax immediately following--thought of Mr. Ho during climax which was better than the first one--even though I did not want to. Afterwards I felt like the fact that I wasn't turned on so much anymore by the old fantasy, and the fact that I would think about Mr. Ho so tenderly and so impractically was all just a cruel joke played on me (by myself or others--what the hell difference) at my expense."

After that weekend, Mr. Ho had entered her room and talked with her openly about his own past sexual "hangups." At that point it then made some sense to her but she was still angry. He also took that time to tell her of his having had sexual relations with her girl friend. Miss Han did not know how to respond. They ended by having intercourse in a rough mixture of "anger and tenderness."

During their session with E following these events, Miss Han appeared very miserable, feeling that E was taking Mr. Ho's side and not appreciating her efforts. Her most angry complaint was that Mr. Ho did not love her or care about her at all. The session lasted two hours, during which Miss Han and Mr. Ho both ventilated their feelings. Finally when both had heard each other out and had had a chance to respond, to each other, E suggested that they take time to consider carefully where they wanted to go from here. Surprisingly, Mr. Ho stated flatly that he wanted to continue with the treatment program. He felt that they were at a crucial point and should go on or there would be a real setback. Miss Han was somewhat more reluctant, but felt very positive about that day's session. She also reported feeling

anxious about the separation of appointments, and wondered if they could stop the outside appointments and just meet jointly. Mr. Ho was also in full agreement. They both indicated a sincere desire to be open and honest with one another.

The treatment plan from then on was to go through the following sequence: 1) Intromission and Miss Han remain still; 2) slow movement on Miss Han's part; 3) Miss Han still and slow movement on Mr. Ho's part; 4) slow movement on both their parts; 5) proceed to natural movement. All of these to be done in the female superior position which allowed Miss Han and Mr. Ho more freedom of movement. Repeated intromission was also mentioned. Miss Han was to continue as in the past with her masturbation whenever she felt the desire.

Due to a variety of circumstances they were not seen again together until two weeks later. Miss Han was reluctant to come in and Mr. Ho had made the appointment. Miss Han had "forgotten" to keep her record, though she reported it to be much the same. She was also fearful that they would be rejected because they had done so poorly on their treatment program. They had done what was suggested but each had ended in hard thrusting which lead to a climax for Mr. Ho but not for Miss Han. They had also experimented with a variety of positions. Miss Han reported that she had found the sessions much more pleasurable than in the past, even though she failed to reach a climax. She reported feeling conflicted in that she now knew Mr. Ho dreaded contacts

that would not end in release for him, so she felt compelled to thrust for him. Mr. Ho reported no desire for the sessions, but once in them found them satisfying. When pressed where they wanted to go from here, Miss Han seemed surprised. She had expected to have treatment ended by E for their failure to keep to the suggested program. After some discussion, Mr. Ho finally stated that he would like to see Miss Han achieve a satisfactory sexual relationship for herself. He said he would be willing to go through a period where it was not satisfactory for him if it would help. Miss Han felt relieved at this, though she still thought he seemed a little reluctant. When asked if there had been anything else left unsaid in the past week, Miss Han spoke up and said that she wished that Mr. Ho would use masturbation with her as he had done a little in the past. She felt that that phase had been passed over too quickly. She revealed that he did not "do it right" but that she had a hard time trying to show him the way that pleased her. E was unaware that this had been dropped out of their program and he agreed to more closely incorporate this aspect into their treatment program when they next met. Mr. Ho was leaving on a visit to the mainland the following morning and would not be back for a while. In the meantime Miss Han requested help in vocational planning which was carried out until Mr. Ho's return.

At the next joint session, following Mr. Ho's return from the mainland, they revealed that they had had sexual intercourse the night before Mr. Ho had left and the night of

his return. They had not attempted any of the previously suggested approaches, but had followed their own inclinations. Mr. Ho reported the sessions to be very satisfactory for him "experiencing more feeling than he had in a a long time." However, he also said that Miss Han had stopped her own activity at certain points as if she did not want to become aroused. Miss Han responded that she had been trying to changing to a superior position but she had not said anything about it. Mr. Ho had interpreted her movements on past behavior but had failed to check them out with her. Miss Han also reported positive responses to their sessions, claiming that she was beginning to experience sensations that she had never felt before, and quite different from those experienced during masturbation. She also commented that it seems her "head" would be aroused way before her "body" and that her body never seemed to quite catch up.

In order to allow her sufficient time in a non-demanding situation to explore her own feelings, it was again suggested that they not use hard thrusting at this time but to allow Miss Han to experiment and explore different movements and rhythms with no other goal in mind. It was also suggested that Miss Han guide Mr. Ho in exploration of her genitals to experiment and discover what was most pleasing to her. Again, their communicating their thoughts with each other was stressed along with the continued suggestion that they attempt not to judge each other's behavior on the basis of past experience.

The next few weeks saw uneven progress due to a number of factors. Initially, Miss Han made positive gains. Mr. Ho had manually followed her lead on two different occasions and she had achieved orgasm both times (with the help of male group fantasy the first time, and fantasy of Mr. Ho the second). She also found actual insertion and exploration "surprisingly pleasurable." However, she experienced some pain and tenderness within her vagina. Their sessions were interrupted by a visit to her gynecologist, who determined that she had a minor abrasion and slight vaginal infection. During this period E suggested they use the time to continue manual guiding and exploration. Unfortunately, Mr. Ho reported some weariness with the situation and again it was recommended that Miss Han continue to provide manual stimulation for Mr. Ho's release as well. She was positive about this situation, but Mr. Ho primarily wanted complete sexual relations.

At this same time, both were going through other personal difficulties. Mr. Ho had had a physical fight with his supervisor and had lost his job. Miss Han had received word that the adoption of her children had gone through and she was very upset over the situation. She felt she could not discuss it with Mr. Ho present and had turned for a "female" point of view to Mr. Ho's social worker. She had one contact with the social worker during which time she ventilated her feelings about her children and former husband, and her growing sense of disillusionment with Mr. Ho. E suggested that



perhaps she reconsider her goals in the present treatment program, but she responded that she wanted to continue with what she was attempting. She felt she had made very positive gains in the sexual area up to this point even though it was obviously difficult with Mr. Ho having his own problems.

At this point E suggested the next step in bridging from Miss Han's masturbatory behavior and fantasy to the joint sexual situation. Each session was to start with Miss Han guiding Mr. Ho to what was most pleasing to her, particularly in the genital area (cautioning Mr. Ho not to rely on previous responses and be open to exploration). When Miss Han felt pleasantly aroused and ready they were to proceed to intromission, while Mr. Ho continued genital stimulation. During this time Mr. Ho was to remain relatively still and allow Miss Han to use her own pacing of movement, but to continue manual genital stimulation of Miss Han. It was hoped that this would not only take advantage of Miss Han's past experience, but that intromission would help provide positive conditioning for Mr. Ho's manual stimulation of Miss Han. A variety of possible positions were discussed to facilitate the procedure, but particular stress was placed on finding what was pleasant to both without any expectations of reaching a certain "goal." Mr. Ho was also referred to a urologist because of his complaint of finding a sore on his penis and his feeling that his fungus infection had returned.

The day of their next appointment, Miss Han called in asking if they should keep their appointment inasmuch as

they had not had relations since their last meeting. It seems that Mr. Ho's medical examination revealed a minor infection from a cut on his penis, as well as a prostate infection. He was advised to refrain from sexual contact for a week. E suggested they might use the appointment in discussing other areas of their relationship, but Miss Han asked if she could use the time to look for a new job. It was finally agreed that they would come in together the following week, after trying what had been suggested previously.

A brief contact with Miss Han's former clinic psychiatrist revealed that Mr. Ho had approached him and had requested therapy with him. The psychiatrist, knowing Mr. Ho was involved with E's research program, was hesitant and had suggested discussing the matter with E first.

At their following appointment with E, Miss Han arrived early and said that she wanted to talk with E alone for a while. She reported feeling very depressed for the past two weeks since her last contact with E. She had not looked seriously for a job and she experienced continual friction with Mr. Ho. The previous week she had come in to see the social worker she had seen previously but had not been able to schedule an appointment for two weeks. At this point she felt that her "sexual problem" was not of paramount concern to her anymore. She felt that she had made good progress, but she was now more concerned about her future and her "place in life" with others. She also said she had strong

feelings that it was not with Mr. Ho. She reported having a difficult time discussing her feelings about him in their joint sessions, because she did not want to hurt him. She reported that it was getting more and more difficult relating to Mr. Ho. For example, she said that in the past if Mr. Ho was invited somewhere or wanted to go somewhere alone with a mutual friend, he would not ask her along or even suggest the possibility. However, recently when she was invited to a party she had asserted herself and said that she preferred to go alone as it was primarily for women, but Mr. Ho had become quite hurt and resentful. She also reported having one sexual contact in the past week where she attempted to guide him, but he did not seem to "care" to follow her lead. She reported that he would agree during their session with E but not follow through when they were together at home. She felt that she just "couldn't force him to continue anymore."

After further discussion of her feelings, E agreed that it no longer seemed appropriate to continue working in the sexual area until something was done about their basic relationship. When asked what she would like to do Miss Han was undecided as whether to continue with E or to see the social worker. On one hand, she felt that the social worker "being a woman" could understand certain things--about children and other women--that men do not, but, she also felt that without Mr. Ho in the sessions it might be different with E. It was suggested that she consider whomever she

felt might be of most help for her present situation. E said he would certainly be more than willing to continue seeing her but if she felt that a woman's viewpoint at this time would be more beneficial she should not hesitate to make an appointment with the social worker. She appeared relieved to have a choice and at this moment Mr. Ho arrived.

He was appraised of Miss Han's current feelings and asked where he saw himself at this particular point. Mr. Ho, as with Miss Han, felt that he had made considerable progress in the sexual area but felt that other things were more pressing for him at present. He was uncertain of his new job, felt much pressure from people around him, and unsure of his relationship with Miss Han. He then said that he had made contact with Miss Han's former clinic psychiatrist for possible therapy. He felt that he would like to look more closely at his own life situation and felt on a "plateau" at present.

At this point it was apparent that neither felt the sexual problem to be dominant and accordingly E supported their decisions to seek individual treatment. Their past progress was reviewed and possible suggestions on how they might proceed in the future without structure were offered.

After further thought Miss Han decided that she would like to make an appointment with the social worker. They were both informed that E would be available to see them at a future time if they should both desire it. Both thanked E for his understanding and past help and the session was

terminated. It was E's hope that perhaps with the imposed structure on their sexual relationship removed, they both might be able to carry over what they had learned into a more spontaneous and natural relationship.

Contact sessions, from initial interview through assessment and partial treatment, totaled 42 for Miss Han and 21 for Mr. Ho. Thirteen of the sessions were joint contacts. Time elapsed from initial interview through the final session was approximately 8 months.

Follow up note: During the next two months, Miss Han saw her social worker a total of four times. The social worker reported that Miss Han seemed to have made good general progress in her ability to handle her life situation since the first time she had seen her six months previous. Their contacts had been primarily devoted to an attempt at integration of Miss Han's thoughts and feelings regarding Mr. Ho, her children, and her future. They had not discussed the sexual situation other than Miss Han's comments that she had noticed that she used her sexual fantasies of "groups of males and animals" whenever things were not going right between her and Mr. Ho. As of their last contact, Mr. Ho and Miss Han were still seeing one another, and Miss Han somewhat begrudgingly--according to her social worker--reported that Mr. Ho was doing "exceedingly well" in his therapy with the clinic psychiatrist.

Case of Mr. Inn and Miss Ivy. Mr. Inn, an oriental male in his early twenties, had reported to the infirmary of a

local college he had been attending. He complained of uncertainty and anxiety in connection with his sexual behavior. He wanted to know if it was normal for a male to bleed when he had intercourse. He also complained of difficulty in maintaining an erection while having relations with his girlfriend. An examination by a physician showed a slight tear of the frenulum of his penis and he was informed that the injury was not rare and would heal quickly. Inasmuch as he was not then attending the college he was referred to his state mental health clinic for his apparent impotence problem.

Miss Ivy, a Caucasian female in her early twenties came to her district mental clinic three days later. She was concerned with her inability to reach an orgasm during relations with her boyfriend. She also related to the intake social worker that her boyfriend, Mr. Inn, had been referred to the clinic, but he had not yet decided to come in. She wondered if something could be done for her as well as for her boyfriend. Further questioning by the intake worker revealed that neither Miss Ivy nor Mr. Inn had been using any contraceptive methods and Miss Ivy was referred to a Planned Parenthood agency for contraceptive counseling. The social worker also contacted E about possible referral for his research program. E agreed to see them either individually or together for an exploratory interview.

Two weeks later Mr. Inn and Miss Ivy came in for a joint appointment with E. After each having had their

individual contacts they had decided to let things "ride for a while." However, at this time they both thought that they would like to see just what possibilities might be offered.

They had known each other for approximately one year. Their first sexual relations with each other had taken place about two months previously and they both saw the occasion as a "disaster." Somehow she had let him know that she was not expecting to have a climax and he had tried doubly hard to help her achieve one. However, he had ejaculated immediately upon intromission and as a result felt very embarrassed. They had tried three or four more times since that occasion and each time had been more displeasing for both of them. Mr. Inn had experienced gradually declining erections until he had finally been unable to achieve any erection at all. Both felt very upset about the situation, particularly when Mr. Inn experienced bleeding during their last relationship.

Other areas of their relationship were explored and found to generally free of tension and discord. They each lived with their respective parents. His parents liked Miss Ivy and she was always welcomed in their home. However, Miss Ivy's parents had never met Mr. Inn and they said they did not wish to meet him. This was the only problem area that both felt strongly. They had no immediate plans for marriage, but expected to marry after they had completed their education and Mr. Inn was employed. They had many mutual interest and shared similar friends.

Several possibilities were suggested to them, ranging from their starting fresh with no expectations of each other and just see how matters went, to individual or joint counseling, or E's research program, which was briefly outlined to them. After more discussion Mr. Inn wanted to enter into the research program immediately. However, E sensed some hesitancy on Miss Ivy's part, so he insisted that they take more time to consider the matter both individually and jointly. It was stressed that if they decided to come in jointly it should be because of a commitment on both their parts and not one expecting to enter only for the sake of the other. Inasmuch as they had not gone to the Planned Parenthood agency as of yet, they were also advised to make an appointment as soon as possible if they expected to continue their sexual relationship. E then went into a brief discussion of the various contraceptives available and answered questions that they had. They then left and said that they would contact E when they had decided what they wanted to do.

A few days later Mr. Inn called saying that they had decided to enter jointly into the research program. He also asked where he could buy condoms and exactly what to ask for. He was supplied with appropriate information and appointments were schedule for them to begin assessment. Each was seen individually twice a week for a total of eight assessment sessions each. The assessment period itself was complicated by a number of factors which necessitated some form of intervention at various points.



During her first interview, Miss Ivy appeared somewhat reluctant to enter into treatment and seemed to be participating mainly on Mr. Inn's behalf. She asked many questions concerning E's qualifications and attitudes toward his work and how the assessment materials were to be used. However, after considerable discussion she appeared to more accepting of the situation. When asked for a statement of what she hoped to achieve from treatment, she expressed a desire to have a free comfortable sexual relationship with Mr. Inn which would hopefully end in her reaching a satisfying climax.

During the second interview Miss Ivy seemed somewhat agitated and preoccupied so E put aside the assessment materials and explored her current feelings. It seemed that Miss Ivy was one week overdue with her menstrual period, though she was usually "highly regular." She was worried and concerned about the situation. She had discussed it with Mr. Inn and they had decided to seek an abortion if it proved necessary (a legal medical procedure in this State); however, both were upset and uncertain of what to do next. After further discussion, E called a clinic physician and an appointment was made for a pregnancy test the following week. It was also suggested to Miss Ivy that she have a thorough medical evaluation for herself labeled "frigidity" problem (she had revealed fears that she may not be "built correctly" and thus preventing her from experiencing full arousal and orgasm). She readily agreed to the suggestion and appeared

to feel relieved that positive steps were being taken concerning her situation.

As assessment continued other problems would arise and be discussed such as her growing difficulty in relating to her mother or her sisters. Just prior to her medical appointment Miss Ivy was relieved to find that her menstrual period had started. Through an apparent misunderstanding she was not examined during her appointment and she was again referred to the Planned Parenthood agency for contraceptive planning. E suggested she request an examination at that time which she agreed to do.

Assessment with Mr. Inn also had its difficulties. At the beginning of assessment both Mr. Inn and Miss Ivy were asked to temporarily refrain from engaging in sexual relations to avoid further complicating the situations. Both had immediately agreed. However, during the second interview with Mr. Inn when E decided to explore Mr. Inn's apparent nervousness in the session, he revealed that they had once more engaged in intercourse. He explained that his parents had left for a two week trip and with such an opportunity to use the house he could not resist one more attempt. He had felt he really did not need treatment and that he could handle the situation now that he a contraceptive. He related that after an hour or two of foreplay (Miss Ivy later said it was more like half an hour) he found himself with sufficient erection to attempt entry. He had gone to the bathroom to put on a condom but when he returned to the bed

he had lost his erection again. He was disappointed and they had gone for a walk and returned later. Again he achieved a partial erection during foreplay but as soon as he attempted entry he immediately ejaculated. He felt discouraged and decided that he might need "some sort of help" after all. E again stressed that they discontinue sexual relations at the present time and Mr. Inn appeared to strongly agree. However, as he later reluctantly reported, that very afternoon after his interview he and Miss Ivy had gone to his home for lunch together. Mr. Inn said that they did not plan to have any sort of relations, they just wanted to lay in bed together nude. They did and Mr. Inn again found himself getting aroused. He put on a condom and made insertion after some difficulty. He felt an ejaculation approaching so he held perfectly still but to no avail ejaculation occurred "automatically." When he removed the condom he was frightened to see that he had again started to bleed. He was referred for medical examination to a clinic physician. The report from the examining physician revealed that the previous injury had not had sufficient time to heal but that it should heal normally if future contact were avoided for a few weeks. The physician also could find no indications of physical or endocrine factors that might be contributing to his early ejaculation or erectile failures.

Mr. Inn was only partially relieved to find that there was no evident physical cause for his complaint. He reported that he could now see that it must be "in his head" and

he feared that something was abnormally wrong with him. E used this opportunity to offer a possible explanation of what had happened by using learning theory as a frame of reference. He seemed to want to accept the suggested interpretation but was doubtful that it applied in his case. Later E discovered that he had proceeded to "test" the interpretation himself. That afternoon he had once more gone to bed with Miss Ivy but with a definite intention of not having relations. He was amazed to find that he soon had a strong erection. With such a strong erection he thought that perhaps he could function all right after all. He turned to embrace Miss Ivy but was aware of immediate feelings of anxiety, and, as he phrased it, "it promptly went limp right before my eyes." However, rather than feel upset, he reported that he felt relieved. He now thought that perhaps it was true that he had learned to respond with anxiety to such situations and that the anxiety inhibited his arousal. He agreed to cooperate in any ways that he could in the future. He was advised to refrain from any type of contact that might bring on strong erections and to discontinue masturbation as well until his injury had full opportunity to heal. Assessment continued without any further reported incidents.

At the completion of assessment Mr. Inn listed some definite goals that he hoped to achieve: a) being able to engage in sexual relations with Miss Ivy while free of any anxiety or fear; b) strong, full erections, free of pain;

c) being able to delay ejaculation at least ten minutes after making insertion. He also very much hoped that Miss Ivy would be able to thoroughly enjoy having relations with him and that she would ultimately be able to reach orgasm. His strong concern over Miss Ivy being able to reach orgasm was explored further. It seemed that his feelings about himself as a "man" were directly contingent upon Miss Ivy experiencing a climax. It was suggested to him that this feeling on his part might be one of the factors responsible for his continued anxiety in the sexual situation. It was pointed out that most men would probably learn to respond with anxiety in a sexual situation if they thought that their "manhood" was at stake each time they entered a woman. The possibility was also suggested that Miss Ivy's sexual behavior, like his, was the result of her past experiences rather than his "lack of manhood." Mr. Inn had not thought of it in this manner before and he seemed quite struck with the possibility that it might be true. However, he still had a feeling that there must be something "psychologically" wrong with him that had started somewhere back in his childhood.

Miss Ivy's sexual history indicated that she had never had any homosexual contacts, had never experimented with masturbation, and had had no dreams to orgasm. She could only recall having approximately three dreams with any erotic content and those were limited to kissing and body contact while fully clothed. She had her first kiss with a boy

when she was fifteen and she recalled thinking, "is that all there is to it?" At sixteen she found kissing somewhat more arousing with a second "boyfriend" but had allowed him to go no further. At nineteen she had her first "serious" boyfriend with whom she had had sexual intercourse on three different occasions. On the first occasion entry had been made after about two hours of heavy petting. She found the experience very pleasant and arousing but was unable to achieve a climax after approximately a half hour of intercourse. On the second opportunity she recalled having relations for approximately an hour but she still was unable to reach an orgasm. She also described the experience as much less arousing than the first. On the final occasion she stopped trying after about half an hour, deciding that there was something wrong with her. She had no further experience until she met Mr. Inn about a year later.

Mr. Inn had first experimented with masturbation around the age of eight or nine. He learned from watching his male friends. About the same time he began his first heterosexual explorations with neighborhood girls and found them highly pleasant. He would use them in his masturbatory fantasy. At about the age of ten he had his first experience with heterosexual intercourse with a neighbor girl. He found it highly arousing and they met almost daily for about a month until caught by the girl's maid. He was very frightened that the maid would tell his parents and he stopped having relations with her. However, he continued masturbating to

her image with a frequency of about twice a month. He achieved his first orgasm through masturbation at around age fourteen and his frequency increased to about once a week until he met Miss Ivy at which time he stopped completely. He said he had no difficulty stopping for he felt it was no longer necessary. His imagery had been limited to girls he knew or pictures from Playboy. He recalled that his erections seemed firm and it usually took him from five to ten minutes to reach orgasm. Since stopping masturbation he had noticed that his dreams to orgasm occurred about three or four times a month. His dreams mainly centered around Miss Ivy or some particularly attractive woman he had met during the day. Though he said he had had opportunity he had never engaged in intercourse again until he met Miss Ivy. He said that he had held back because he was afraid of different girls' expectations of him and his performance. When he met Miss Ivy he felt that he could have attempted contact sooner but he was fearful that she was more experienced than he and would compare him to other men. (Miss Ivy recalled his apparent reluctance to take advantage of earlier opportunities but had assumed that something was wrong with her.)

After several months of dating, during which time contact was limited to kissing and light petting, they both agreed to spend a few days with each other while on vacation. Both were highly anxious about the situation but neither mentioned it to the other. Their first night together they went to bed wearing their underclothes. They spent about

an hour in kissing and petting at which time Mr. Inn, highly aroused and with a firm erection, attempted to remove Miss Ivy's panties. Miss Ivy became anxious and said she would do it, but later. She found her own arousal had been turned off and she remained passive. Mr. Inn thinking he was doing something wrong stopped and left the bed and started writing. Miss Ivy felt hurt and angry and eventually fell asleep. Mr. Inn became angry when she did not call him back and he wrote until dawn at which time he quietly crawled into bed with her and fell asleep. When he awoke he touched her and was delighted to find tha she was nude. He became highly aroused and after about fifteen minutes of foreplay he made entry and immediately ejaculated. Miss Ivy had been too anxious to realize what had happened except that he had suddenly stopped his movements. She was also thinking of the possibility of pregnancy and had not felt any arousal at all. When he stopped she began crying believing that her lack of arousal and his stopping were due to her "frigidity." Mr. Inn felt that her lack of arousal was due to his own clumsiness and inexperience and he vowed to do better next time. That night was their last night, and once more he started foreplay which lasted for about thirty minutes. Miss Ivy was anxiously awaiting for some response on her part, but could feel nothing. Mr. Inn highly aroused and with a strong feeling that he just "had to last" for her benefit, finally made entry. He ejaculated after only a few thrusts and felt miserable. He apologized saying that he was tired and



that he would do better next time. Miss Ivy, in tears, said it was her fault not his.

They had attempted relations approximately five times since that first vacation together, and each time the situation grew worse. For example, the following time they were in his bedroom at his home and just as he made entry his mother called him and there was a mad scramble for their clothes. The occasion after that he found himself bleeding upon withdrawal. Then Miss Ivy realized that she was a week late with her menstrual period. Throughout these contacts the strength of Mr. Inn's erection became less and less until he was finally unable to make entry at all. At the same time Miss Ivy's arousal became less until the whole situation became one of acute anxiety for her.

Mr. Inn's scores on the Sexual Fear Inventory compared to those of the male norm group may be seen in Table 20.

TABLE 20

## MR. INN'S SEXUAL FEAR INVENTORY SCORES

Category	Mr. Inn	Male Norm Group	
		$\bar{X}$	SD
Total Score	342	239.59	67.71
General:	82	51.41	13.71
Personal:	89	58.09	13.40
Social:	46	32.41	8.55
Contact:	125	97.69	40.05

Mr. Inn's scores are clearly higher than the mean scores of the norm group in all categories. It seems that Mr. Inn's

reported anxiety responses are not limited to contact items alone, but appear to have generalized to other sexual areas as well. By comparison, Miss Ivy's response on the Sexual Fear Inventory are quite similar to the mean responses of the single female norm group (refer to Table 21). Although Miss Ivy's reported fear score to contact items is considerably higher than Mr. Inn's score, and somewhat higher than

TABLE 21

## MISS IVY'S SEXUAL FEAR INVENTORY SCORES

Category	Miss Ivy	Single Female Norm Group	
		$\bar{X}$	SD
Total Score:	290	290.00	87.23
General:	49	64.26	19.44
Personal:	60	62.06	19.59
Social:	33	31.14	10.55
Contact:	148	132.54	51.41

the norm group, it is still within one standard deviation of the norm group mean score. These data suggest that Miss Ivy's fear responses may be more situation specific than those of Mr. Inn's.

Similar findings appear in relation to general fears. Table 22 shows the scores of both Mr. Inn and Miss Ivy on the Composite Fear Inventory as compared to the norm group. Again Mr. Inn shows greater reported fear responses than Miss Ivy whose scores are quite similar to the mean norm group scores. Examination of individual responses shows no clear cut category being responded to more than others.

TABLE 22

## MR. INN AND MISS IVY'S COMPOSITE FEAR INVENTORY SCORES

Scale	Mr. Inn's Score	Miss Ivy's Score	Norm Group	
			$\bar{X}$	SD
CFI Total Score:	534	380	387.38	87.07
Geer Scale:	168	123	122.99	27.73
Suinn Scale:	284	213	206.60	50.03

On the Sexual Behavior Inventory both Mr. Inn and Miss Ivy had indicated that they had engaged in 9 of the 21 behavior items as compared to a mean of 11 reported by Bentler (1968a, 1968b) for comparable norm groups. Results of the Sex Knowledge Inventories indicated that both were knowledgeable with vocabulary and anatomy (Mr. Inn, 76th percentile and Miss Ivy 86th percentile) but less so in general sexual knowledge (Mr. Inn, 52nd percentile; and Miss Ivy, 69th percentile).

From careful examination of all the assessment material the decision was made to attempt to countercondition their anxiety in the sexual situation by the use of sexual responses and to increase their sexual behavior repertoire by the use of successive approximation. These procedures were selected for a number of reasons. Mr. Inn's own attempts during assessment indicated arousal was still present for him when his anxiety provoking "demand for performance" thought was absent. For Miss Ivy it was hoped that contraceptive planning, assigned readings, and suggestions by E would change the discriminative value of the sexual situation enough to

allow her to enter into it. Once in the situation carefully graded task levels would be introduced so that new behaviors could be tried in a non threatening atmosphere. Inasmuch as they both had been on a deprivation schedule of sexual contact, it was assumed that arousal might increase in reinforcing value. By highly structuring the situation in an attempt to avoid their performing anxiety conditioned behaviors and by carefully scheduling behaviors progressively designed to elicit arousal, it was hoped that their new behaviors would become positively conditioned by arousal. After the new behaviors had been attempted over many trials and followed by positive consequences, ultimately satisfactory orgasm for both, it was assumed that they would probably be maintained. Another factor that was considered important was that the sexual behaviors that lead to anxiety had been recently learned (their mutual experiences had taken place within the past month and a half) and therefore they had not been exposed to many learning trials. Another advantage was that Mr. Inn had recently mentioned the possibility of having the use of a friend's apartment while his friend was away on the mainland for a month. Mr. Inn had hoped that treatment might be hurried so that he could take advantage of the apartment before his friend returned. This would reduce their responding with conditioned anxiety to various stimuli present in Mr. Inn's home where his family was usually present. To give as clear a picture as possible as to how such treatment is presented and modified depending upon

the responses of the people involved the descriptions of the sessions and the reported experiences of Mr. Inn and Miss Ivy will be given in some detail.

At the first joint treatment session E briefly traced their history of mutual sexual experience and pointed out how each had ended in some sort of dissatisfaction (e.g., arguments, lack of orgasm, erectile failure, bleeding, possible pregnancy, etc.). Under such circumstances it would only be reasonable to expect that such a situation had become highly anxious for both of them. They agreed completely. Inasmuch as both had evidenced a strong interest in learning more about "sexual technique" during assessment this concept was used to introduce the suggested treatment program. The program was explained as a method designed to allow them to learn various techniques and methods that were pleasing to them in a situation that was as free from anxiety and discomfort as possible. It was suggested that it could be looked upon as a plan of re-education that would allow them to experiment and learn together. Both appeared highly in favor of the suggestion. E then asked about the possibility of their using Mr. Inn's friend's apartment where they would have privacy. To Mr. Inn's surprise and apparent delight, Miss Ivy was very much in favor of the idea saying that she was never able to relax at Mr. Inn's home for fear of some kind of interruption from his parents.

Examination of both their work schedules indicated

that they had two mornings and one night a week that they could spend together on a regular basis. Interviews with E were scheduled on a twice a week basis to allow close monitoring of their progress. This would allow E to suggest immediate changes in case of complications and hopefully prevent their new experience from becoming anxiety conditioned. To help their new situation become a discriminative stimulus for approach, and to orient them to some of the treatment aspects, they were given two articles from the lay press on Masters and Johnson's work with couples. To support E's suggestion that some of the attitudes they had learned at an earlier time may no longer be appropriate for their present situation they were given a copy of McCary's (1967) chapter on sexual attitudes and behavior. Miss Ivy was also given Wright's (1969) book to help her to discover more about her own responses. In addition, their Sexual Knowledge Inventories were returned to them for mutual review.

On their first morning they were to spend the first half hour arranging the apartment and becoming familiar with it. They were then to review their inventories together and note down any questions they had for later discussion, as well as discuss the articles and how they felt about them with each other. They were then to disrobe and begin their first sensate session together along the lines described previously. Mr. Inn was to sensate Miss Ivy first and they were to both avoid touching each others genitals or Miss

Ivy's breasts. They were to just explore what was pleasurable to them and to each other for as long as it was pleasing to them both. They were then to stop and have lunch together of food that they liked (suggested by E, based on information taken from their Reinforcement Survey Schedules). They were to then exchange articles and come for their joint session with E.

It was also suggested that they attempt to communicate as much as possible with each other, both verbally and non-verbally, as to what they were experiencing and what they found pleasing. It was stressed that this would be most helpful in learning what each other actually preferred rather than assuming that they knew. To stress the point a small example from their individual assessment materials of lack of communication in the past was given. Mr. Inn had always tried to play soft romantic music during his previous sexual relations with Miss Ivy, believing that she preferred that type of music. For himself he found Rock music much more arousing. In actuality, Miss Ivy also found Rock music highly arousing but she had never mentioned this to Mr. Inn, thinking that he must prefer romantic music as he always played it while with her (this was the only information shared with them both that E had obtained from their individual sessions; though both, after careful thought, had given E permission to share whatever he thought might be of help with the other.) Both appeared quite surprised to hear this information and they left the interview eagerly discussing

what records they would each take to the apartment.

At their second interview Miss Ivy reported that she had visited the Planned Parenthood Agency and had received a thorough examination and had been supplied with the contraceptive of her choice. The medical evaluation revealed no apparent anatomical functional cause for her apparent lack of response. She seemed quite relieved about this information and about her "not having to worry about pregnancy until she chose to." They had met at the apartment and arranged it to their taste. They had read the articles and traded them that morning but had not had time to read each other's articles. Both responded positively to the articles on Masters and Johnson. Mr. Inn said that he now did not feel so "freakish" about his problem. Miss Ivy felt it was too bad there were no "male surrogates" for the women. The articles were discussed as well as several areas relevant to their responses on the Sexual Knowledge Inventories.

Mr. Inn had sensated Miss Ivy for approximately 15 minutes and then they changed places. Miss Ivy found it very pleasing and also arousing. Mr. Inn had a similar reaction. In fact, he became extremely aroused and experienced a strong erection. He felt some initial embarrassment which subsided when he saw that Miss Ivy did not become embarrassed. She chuckled and replied, "What do you think got me so aroused?" It seemed that they had both become so aroused that they had a difficult time not going any further. In fact, they both took turns laying on one another and moving their bodies,



but being careful not to "touch" each other with their hands (literally, E's directions). They finally both agreed to stop. E verbally praised them for their control and for their telling him of the situation. Mr. Inn felt that the time was too short and he admitted that he kept thinking of going all the way. He wanted to try it again only without the time pressure. Miss Ivy also mentioned the time factor as pressuring her. It was suggested that they could begin their sessions at an earlier hour on that particular day.

They had not shared much of their feelings with one another until the joint interview and some time was spent in discussing what they had actually experienced and what prevented them from revealing it to each other. They had an opportunity to be together five times prior to the next interview, and as a way of attempting to relieve some of the "time pressure" E suggested that they spend a minimum of three sessions in sensate experiences and the rest as they wished. The first session was to be similar to the one they had just experienced. The second they were to let themselves have fun and experiment with the mouth, teeth, and tongue in addition to their hands and fingers. At the third session they were asked to try a variety of different positions and locations in the apartment such as sitting and standing or using the shower together (something checked as reinforcing to them both).

During the following interview both had a number of questions pertaining to orgasm and clitoral function.

After some discussion Miss Ivy reported that she had read Wright's articles but was worried because she couldn't find her "unique rhythm." She also said that it felt like she was "masturbating" and she made a wry face. E used her reaction as an example of her apparent emotionally conditioned response to a word. She laughed and agreed. E then suggested that she was learning about herself so that she would be able to help Mr. Inn learn what pleased her. She agreed to continue her self exploration.

They reported having four sessions together during the past few days, each lasting from three to five and a half hours. Both reported a change from embarrassed feelings to feelings of naturalness and being comfortable. They also reported feeling pleasure in just giving pleasure to the other whereas initially they had felt it was more like "waiting their turn." They had gone through their suggested explorations and found them highly enjoyable. E could find no signs of hesitancy or anxiety in their reports, and they had only one more session available before the next joint interview, so it was considered appropriate to suggest that they move to the next stage. They were now to include genital and breast contact. They were cautioned to only move into this area after going through their sensate explorations first. They were not to directly start with a new behavior but to build on what they had learned previously. Each was instructed to guide the other into what was pleasing for each of them. A range of possible ways of giving pleasure was

discussed. Because at this point it was considered probable that Mr. Inn might experience an ejaculation they were both carefully instructed in squeeze technique procedures (Masters and Johnson, 1970). They were given diagrams of the suggested position and, with the use of a life sized model, Miss Ivy was shown where and how to apply the technique. E also cautioned them that if things did not go quite as expected not to worry about it but look at it as an opportunity to learn and explore together.

When they appeared for their next interview, both appeared glum. They reported that things did not go too well. Mr. Inn had some anxiety about going into the next stage. Miss Ivy had initially felt forced into the situation as though their "sessions were all they ever did!" She too did not feel like entering into the session and Mr. Inn had agreed (but he openly admitted that he planned to push her into it later if necessary). However, they had gone to the apartment with the "intention" of just resting together. However, after a while Mr. Inn had started sensating Miss Ivy and she responded (she claimed that for some reason she felt less forced after a while). Their sensating one another was very positive for both and Mr. Inn became highly aroused with a firm erection. At that point they decided to proceed to genital contact for Mr. Inn and they moved to another bed with a headboard for Miss Ivy to lean against. By the time they had gotten into position Mr. Inn had lost his erection. He suggested she continue to sensate him but did not offer to

guide her. She felt clumsy and was not certain of what to do but tried. Eventually Mr. Inn achieved a partial erection but he felt disappointed. Because of his lack of erection Miss Ivy assumed that she must be doing something wrong and began to feel anxious. Finally, she asked if she should stop and he agreed and said he would sensate her. They switched positions, but she did not guide him. He started directly to touch her clitoris but then recalled E's advice and switched to her breasts. She helped guide his hands there and found it to be very pleasant, however, when he started stroking her clitoris it became less pleasant due to the friction she experienced. They both noticed that she had no lubrication and he tried harder and she waited expectantly. Finally they mutually agreed to stop and they began reading one of the articles that E had given them. Mr. Inn soon began kissing Miss Ivy's thighs and suddenly found himself with a strong erection. He quickly got into position and she fondled him at his direction. He suddenly realized he was going to ejaculate and he gave her a "now" sign but she was too late in applying pressure. They both felt defeated. He went to take a shower, and then they both just rested together until it was time to come to their interview.

E admitted that he had probably contributed to the situation by overburdening them with expectations. He carefully went over the whole experience with them pointing out how different factors may have contributed to what had happened. The importance of stopping when either felt anxious or

uncomfortable was stressed, as well as the necessity of sharing their feelings and reactions with one another. They were again reminded that they could not "will" erection or lubrication but that these functions would happen by themselves during the natural course of events. As an example, it was pointed out how Mr. Inn was unable to achieve an erection when he felt it was "necessary" but that it happened automatically when he was not thinking of himself and kissing Miss Ivy. The similar situation with Miss Ivy and her lack of lubrication was also mentioned. The importance of each guiding the other in showing what was pleasing to them was also stressed so that one partner did not have to guess or feel clumsy or inadequate. They were advised not to explore independently at this time but to help one another learn what was pleasurable for each.

To remove the "forced" feeling from Miss Ivy they were told to take a vacation during the next few days and spend time together doing other activities that they enjoyed (those that E knew highly reinforcing for both were suggested). They were only asked to have just one session prior to the next interview and not to worry about secretions or erections but to just take the experience as it happened. If Mr. Inn did have an erection and they both felt comfortable they knew what to do but not to feel that they must reach a certain goal each time. It was stressed that there was no hurry, there was always tomorrow or the next day. It was again suggested that they look upon their sessions together as an

opportunity for mutual exploration in an atmosphere as free from anxiety and discomfort as possible, and if at any time they felt fatigued or preoccupied or uncomfortable they were to stop.

At their next interview they reported that immediately after the interview described above they had returned to the apartment for another session. They had undressed and while they were both laughing and chatting Mr. Inn had started to sensate Miss Ivy. He quickly found he had a firm erection, and feeling in a good mood he made entry. Miss Ivy wanted to continue, but she felt it might lead to complications and suggested they not go that far. Mr. Inn reluctantly agreed and withdrew. They continued to enjoy sensating one another until Mr. Inn became aware he was about to ejaculate, and again he was too late in informing Miss Ivy. He said he felt disappointed but he did not see it as such a big tragedy as before.

Two nights later they met at the apartment during the evening. Both felt somewhat nervous and they took separate showers and began reading together. Mr. Inn was feeling in a good mood, and he had decided that that night he was going to "go all the way and the heck with waiting." He had not told Miss Ivy his intentions. They had started sensating one another and after awhile Mr. Inn was stunned to see the amount of lubrication that Miss Ivy was producing. He immediately felt a "demand for performance" on himself, and he stopped and started talking about San Francisco. Miss Ivy

was puzzled wondering if she had done or said something wrong and she slowly lost her aroused state. Neither shared their feelings or thoughts. After some time, Miss Ivy said that she was tired and wanted to rest awhile. Mr. Inn agreed and pretended to sleep. Miss Ivy then felt playful and began fondling him and eventually rolled over on him. Mr. Inn again felt a demand upon him but he tried to respond. Eventually he had an erection but was fearful of what might happen. He was hoping he could last a long time and he told her to be careful and not touch him, but she snuggled up against him and he immediately had an ejaculation. He was discouraged and disgusted and he went to the shower to clean himself up. When he returned he was surprised to see that Miss Ivy still seemed in a good mood. She did not seem to mind what had happened. He then recalled E's advice about sharing his feelings and he forced himself to begin talking about what he had been experiencing. As he talked, he found it easier and eventually told her everything that he had been thinking and feeling. She had responded with acceptance and apparent understanding which surprised him. They talked several hours and both reported feeling very close.

That morning prior to their interview they had had one more session, and again Mr. Inn was too late in his warning, and he ejaculated. Miss Ivy had also started her menstrual period and felt very uncomfortable about guiding Mr. Inn. Careful questioning revealed that Mr. Inn did not mind Miss Ivy's menstrual period at all. Conversely, Mr. Inn was

relieved to discover that Miss Ivy did not mind his ejaculation and, in fact, wished he would not always jump up to take a shower immediately after but stay and hold her awhile.

Mr. Inn said that he felt a lot more comfortable about the situation. Miss Ivy was told that she did not have to worry about guiding for the present but that she could use verbal and nonverbal body movements to communicate her pleasure to Mr. Inn (she literally heaved a sigh of relief).

Some time was spent in exploring Mr. Inn's reported sensations prior to ejaculation, and it was decided that he was aware much sooner than he realized. He was asked to signal as soon as he felt the very first sensation. He was also again told to just take the situation as it happened and not to have any expectation of himself. It was stressed that they continue to practice only as long as it was enjoyable to both and to continue to share their feelings.

At their following session Miss Ivy had sensated Mr. Inn for about fifteen minutes but he did not have an erection. However, he did not worry about it too much. He then started sensating Miss Ivy and soon found himself with a strong erection. Miss Ivy then sensated him for about ten minutes and to his surprise he had no ejaculation urge. Eventually he lost his erection, but he felt more comfortable about it. Afterwards, he asked Miss Ivy if it bothered her that he did not have an ejaculation and when she said no, he revealed that it had bothered him some but he felt much better to find that it did not disturb her.



Due to an emergency, E was unable to see them at their next appointment. They had a number of interesting events to report at their next interview one week later. They had had three sessions and Mr. Inn was reporting what had happened at their first one when he casually mentioned that he had brought Miss Ivy to a climax by using an oral approach. E interrupted to make certain that he had heard correctly. Both appeared surprised at E's question. It seemed that Miss Ivy had been experiencing orgasm on a number of occasions, and both had taken it for granted that E was aware of the fact. E replied that he was not, but he did not want to make an issue of it and he asked Mr. Inn to continue.

Mr. Inn reported that the squeeze technique had worked very well. He had been brought to the point of orgasm four different times during the session and Miss Ivy had successfully stopped him. However after the last time, he had been sitting on the floor and Miss Ivy had sat on his lap facing him. Her movements and direct genital contact had brought him to the point of orgasm quickly, and he had ejaculated before he could warn her. Afterward, he thought about the situation and decided it should not have ended that way, and he told her not to be so obvious when she was aroused. She agreed at the time but had mixed feelings which she did not share with him. During the next few days the more she thought of the demand on his part the more frustrated and angry she became.

On their second occasion he sensated her, and she found

herself in a constant battle to try and keep herself from becoming aroused. She finally stopped him by asking if she could sensate him which he agreed to. She did and he had a firm erection. However, after fifteen minutes of stimulation he discovered that he still had not had an ejaculation urge and he felt disappointed because he was looking forward to practicing the squeeze technique (E pointed out the paradox of his complaining about this kind of reaction in light of his original complaint of too early ejaculation, and he appreciated the difference but still felt some disappointment). He then started sensating her, but her frustration became too great and she finally stopped him and told him of her frustration and anger. They talked for sometime and he apologized for his demand and recognized what it had done. At their third session Miss Ivy felt much more relaxed and she easily reached orgasm through his manual stimulation. Mr. Inn then had an erection for "sometime" but without any ejaculation urge whatsoever.

E complimented them on their progress and the way that they had handled the situation by themselves, particularly in Miss Ivy's revealing her frustrations in the situation, and Mr. Inn's awareness of how such a demand could backfire. It then appeared appropriate to suggest the possibility of the next sequence and the use of the female superior position was carefully explained and demonstrated for them with mannikins. It was pointed out how this position offered Miss Ivy the freedom to continue to use her control technique. She

was to make insertion, but not to move but allow Mr. Inn to adapt to the sensation. If he felt an urge she could easily move forward and apply the squeeze technique, then reinsert again. They were told that this was really no more than an extension of what they had already done when Miss Ivy had made genital contact previously. However, unlike the previous situation they now had additional information of how to handle Mr. Inn's ejaculation urge should it happen. They were advised to "flow" into the position only after having practiced the squeeze technique several times, or after Mr. Inn had an erection for at least ten minutes without any urge. They were also advised that they did not need to immediately attempt the position at their next meeting, or the next one. There was no rush. They were just to allow it to become a logical extension of their feelings when it felt appropriate to both. However, both reported feeling some time pressure. Mr. Inn's friend was returning in a week or so, school was going to start shortly, and E was going to be out of the state for two weeks. They were reassured that they were making good progress which they could see for themselves, but that it was not wise to attempt to rush too soon into any particular demand situation. E also reassured them that he would make arrangements for their continued progress while he was gone.

At their next interview they reported two sessions, both very positive. They had started mutual sensate and Mr. Inn had an erection which lasted twenty minutes (they had both

laughingly noted the time for E who was always asking "how long!") During that time Mr. Inn had two urges, both of which were easily controlled. They then went into the female superior position and intromission. Initially, Mr. Inn did not think he had made entry but as he slowly moved he realized he had and he found it very satisfying. He increased his movements and began pulling Miss Ivy with his rhythm. Miss Ivy remembering E's directions, told him to stop moving. However, he continued for about five minutes without an ejaculation urge. Satisfied, he then withdrew and they both had a shower and something to eat. Mr. Inn felt very confident and even though they had to leave in a few moments he started sensating Miss Ivy and making full body contact with her in a superior position. After some time he felt an urge approaching and he attempted to use the squeeze technique himself but was not successful. However, this he reported, did not mar his day. As he phrased it, "Miss Ivy was more concerned about whether I was concerned than I was."

At their second session, they both felt well rested and in good moods. They took turns sensating one another and Miss Ivy was brought to orgasm manually. Mr. Inn, wanting to repeat his previous day's performance (and thereby setting a demand upon himself) got into position but his erection was insufficient to make entry. He tried to not think about it but was unsuccessful. They then had mutual oral genital contact which Miss Ivy stopped because she felt she was getting to highly aroused and she might not be able to stop

from having complete intercourse (which she had been thinking about). They had then stopped for lunch, after which they engaged in mutual sensate and during which Mr. Inn maintained a full erection for some time. They both felt highly positive about the whole situation.

E went over the sessions in detail with them congratulating them on their control but warning them of the expectation problem. However Mr. Inn recognized what he had done to himself and said he was through with all "that past business". E then outlined a suggested program for the following two weeks while he was to be away. They were told to proceed at their own pace, and it was not necessary to even start the program during the next two weeks unless they both felt that they were ready and without expectations. It was suggested that their next step would be to continue as they had until they had achieved containment, then to hold all movement. Mr. Inn was then to move slowly and explore his own feelings and sensations and to give Miss Ivy the signal if there was any hint of an urge. During that time Miss Ivy was to hold as still as possible and to experience her own feelings. When they felt comfortable and had been able to do this to their satisfaction on several occasions, then Mr. Inn was to hold still while Miss Ivy started slow movement. Their next stage would be slow mutual movement. They were to go no further than this and cautioned to keep their movements slow. If they happened to progress as far as mutual movement, they could then start

practicing a teasing technique. That is, they were to do all of the above and then withdraw and relax so that Mr. Inn could lose his erection. Later, if both felt comfortable they could start again. Mr. Inn was to experiment with losing and regaining his erection as long as he felt comfortable and positive about the experience. Again they were cautioned to stop if either felt the slightest bit of tension or demand. They both appeared eager and said that they would follow the plan. Mr. Inn was also requested to write down a running record of their sessions so as not to have to rely on memory (also, so that if something did go wrong it would be easier to trace).

Two weeks later they reported that they had had an opportunity for five sessions. The day of their first session Mr. Inn had received a letter that his friend was coming back shortly and they had only one more day to use the apartment. Mr. Inn promptly took off from work, Miss Ivy left school, and they spent the entire day at the apartment. This was their first session after their last interview with E and they proceeded to use all the suggestions they had been given. They had first cleaned the apartment and had breakfast then started mutual sensate. Entry was made with Miss Ivy in the superior position and Mr. Inn began slow movements. Miss Ivy suggested he keep still a while, but he found it difficult to do so. He continued slow movements for about five minutes then they rested on their sides. He had no ejaculation urge. They then separated and began mutual

sensate and entry was made again, this time with Mr. Inn in the superior position. After a few minutes of movement on his part he felt an urge and he remained still for a few minutes then resumed slow movement again. Once more he remained still when he felt an urge. He continued this sequence for about twenty minutes. They then separated and began to wash the dishes and straighten out the last remaining articles in the apartment.

Later they again began mutual sensate of breasts and genitals and entry was made after about fifteen minutes. For ten minutes they took turns alternating movements with no urge experienced on his part. They then started simultaneous movement and stillness for another ten minutes. Finally he began hard thrusting for about five minutes at which time he felt an urge which was only partially stopped. They both felt positive about the experience and somewhat sad about leaving the apartment but it was then time for them to go to the airport to pick up his friend.

The remaining four occasions were at Mr. Inn's house, though Miss Ivy still felt reticent about going there too often. Descriptions of these occasions indicated that Mr. Inn was still attempting to live up to his "all day" performance and he had mixed success. It was also too dark for Miss Ivy to see to be able to apply the squeeze technique properly and their sessions were beginning to bring on signs of anxiety. Several alternatives (Mr. Inn moving into his own apartment, renting a place on an occasional basis, etc.)

were discussed but none were acceptable to both. Miss Ivy finally agreed to use his home on occasion. E suggested that they buy a small dimmer that could be applied to his bed lamp for improving the light and installing a lock on his door. Both these suggestions were taken and they both felt much more comfortable. Mr. Inn still showed signs of anxiety over losing his erection so the teasing technique was reintroduced as well as the suggestion that they stop at the first sign of anxiety or discomfort on either part. Interviews were changed to a once a week basis because contact sessions between them were dependent on factors beyond their control (e.g., what time his parents were coming home, whether his sister had friends over, etc.).

During the following two weeks they had several opportunities, and both showed good progress. On one occasion they had mutual sensate and entry lasting for about an hour and fifteen minutes during which time Miss Ivy only had to institute the squeeze technique twice. Mr. Inn, recalling E's suggestion to practice the teasing technique, stopped several times and rested but was surprised and disappointed to find that he did not lose his erection. The paradox of his complaint was pointed out to him and they were moved to the next stage of the lateral side position that would allow them both full freedom of movement control.

During their next session after mutual sensate and some practice of the teasing technique, Mr. Inn made entry in the superior position and with rapid movement brought on an



ejaculation in five minutes. He purposefully did not want to warn Miss Ivy and wanted to have a climax but he withdrew at the moment of ejaculation. He was asked his reasons and he explained that he still felt fearful of possible pregnancy. He was assured that Miss Ivy's contraceptive was highly effective and cautioned that continued withdrawal under those circumstances could set up an unwanted pattern of response. Miss Ivy also said she preferred for him to maintain entry.

At their following sessions they spent about thirty minutes practicing the teasing technique then moved into the lateral side position. However, they did not maintain it for very long and began to experiment with a wide variety of positions. Miss Ivy reached a climax and Mr. Inn continued on for another twenty minutes. They both reported enjoying the experience tremendously. Mr. Inn, after resting awhile, then again started sensate and made entry and hard thrusting until he achieved an ejaculation. They then rested together in each others arms. They both reported that the only thing they felt a little guilty about was their failure to practice the lateral side position for E.

At this time E felt it was appropriate to suggest that they begin to think about termination. Their progress was reviewed over the course of treatment and they were asked to evaluate whether they felt they had attained some of their goals. Both felt they had accomplished much more than they had expected. Mr. Inn felt his only remaining problem was learning to relax more. He said he still felt the pressure

of time and his own expectations but was much more comfortable with his behavior. It was agreed to meet again the following week at which time termination would again be considered depending upon their progress.

At their next interview, (which was their 12th treatment session) they both reported good continued progress. They had had two sessions together and felt highly positive about both. Mr. Inn's written record of their last session was as follows (with only minor additions for clarity):

"Slow undress (extremely pleasant), entry after five minutes. Movement sitting up, ten minutes. Roll over to side (great effort, ejaculation hint, lay still) then I assume superior. Various movements (half Hour). Withdraw one minute. Enter with me on top (her guiding). Five minutes. Withdraw. Sensate each other's genitals (five minutes). Entry with me on top. Her first orgasm. Hop to my knees and sensate clitoral area, five minutes. Her second orgasm. Entry and resume movement on my part in prone position. Ejaculation (slightly negative--wanted to do teasing more, etc.). Whole experience about fifty to fifty-five minutes.) Three hours sleeping, talking, etc. About to leave but start sensate. Erection returns so enter again me on top, edge of bed (uncomfortable). Move to floor, enter, her on my lap. Fall to floor me superior, up and down movement for one or two minutes. Release. No particular desire to prolong it--very enjoyable)."

It was mutually agreed upon to terminate our interviews with the provision that they were to feel free to make immediate contact if anything went wrong or became disturbing to them in the future. They were supported in their progress and reminded that they now had their own ways of handling most similar problems that might come up in the future. It was suggested that they continue to practice the squeeze technique, particularly after any prolonged separation. The possibility of using the time during Miss Ivy's menstrual

period was suggested as an easy way of remembering. They were then asked to again fill out the Inventories and they readily agreed. Both appeared in high spirits and looking forward to their continued exploration together.

Mr. Inn's pre and posttreatment scores on the Composite Fear Inventory as compared to the mean scores obtained by the norm group may be seen in Table 23. The scores show a drop on all three scales. His post treatment scores all fall within one standard deviation of the norm group suggesting the

TABLE 23

## MR. INN'S PRE AND POST COMPOSITE FEAR INVENTORY SCORES

Scale	Mr. Inn's Scores		Norm Group	
	Pretreatment	Posttreatment	$\bar{X}$	SD
CPI Total Score:	534	463	387.38	87.07
Geer Scale:	168	150	122.99	27.73
Suinn Scale:	284	254	206.60	50.03

possibility of a generalized reduction in fear. There was also a small reduction on his reported scores obtained on the Reinforcement Survey Schedule from 391 to 370.

Table 24 shows Mr. Inn's pre and posttreatment scores obtained on the Sexual Fear Inventory as compared with the mean scores obtained by the male norm group. Again there is a marked reduction in his obtained scores with his post treatment scores quite similar to the mean scores obtained by the male norm group.

As would be expected, both Mr. Inn and Miss Ivy showed a marked increase in the number of behaviors engaged in on

TABLE 24

## MR. INN'S PRE AND POST SEXUAL FEAR INVENTORY SCORES

Category	Mr. Inn's Scores		Male Norm Group	
	Pretreatment	Posttreatment	$\bar{X}$	SD
Total Score:	342	240	239.59	67.71
General:	82	56	51.41	13.71
Personal:	89	63	58.09	13.40
Social:	46	38	32.41	8.55
Contact:	125	83	97.69	40.05

The Heterosexual Behavior Inventory. Mr. Inn increased from 9 to 18, and Miss Ivy from 9 to 19 of the 21 behaviors listed as compared to a mean score of 11 reported by Bentler (1968a, 1968b) for comparable norms groups.

Miss Ivy's pre and posttreatment scores on the Composite Fear Inventory as compared to the norm group scores may be seen in Table 25. It is interesting to note that her scores show a slight increase although her post treatment scores are

TABLE 25

## MISS IVY'S PRE AND POST COMPOSITE FEAR INVENTORY SCORES

Category	Miss Ivy's Scores		Norm Group	
	Pretreatment	Posttreatment	$\bar{X}$	SD
CPI Total Scores:	380	401	387.31	87.07
Geer Scale:	123	126	122.99	27.73
Suinn Scale:	213	227	206.60	50.03

still within one standard deviation of the norm group mean scores. As did Mr. Inn, Miss Ivy also showed a decline in her reported score on the Reinforcement Survey Schedule from

385 to 351.

Perhaps the most interesting finding are Miss Ivy's scores on the Sexual Fear Inventory as compared to mean scores obtained by single and married females (refer to Table 26).

TABLE 26

MISS IVY'S PRE AND POST SEXUAL FEAR INVENTORY SCORES

Category	Miss Ivy's Scores		Single Females		Married Females	
	Pretreatment	Posttreatment	$\bar{X}$	SD	$\bar{X}$	SD
Total Score:	290	232	290.00	87.23	225.09	54.64
General:	49	44	64.26	19.44	51.00	11.47
Personal:	60	48	62.06	19.59	53.00	14.82
Social:	33	26	31.14	10.55	33.09	9.64
Contact:	148	114	132.54	51.41	88.00	29.61

While her pretreatment scores were similar to the mean scores of the single female norm group, her posttreatment scores are more similar to the mean scores of the married female norm group.

Contact sessions, from initial interview through assessment and treatment, totaled 21 for Mr. Inn and 19 for Miss Ivy. Eleven of the sessions were joint contacts. Time elapsed from initial interview to final treatment session was approximately four months.

Follow up note: Two months after their last session Miss Ivy and Mr. Inn made a follow up appointment with E and they both reported continued good progress. Mr. Inn had moved from his parents home and was now sharing an

apartment with a friend (the apartment that Mr. Inn and Miss Ivy used during treatment). They now had opportunity for privacy and frequent contact and both reported feeling comfortable and relaxed in their general relationship as well as their sexual one. They had not practiced the squeeze technique because they did not find it necessary. As Miss Ivy phrased it, "I almost always have at least one orgasm before him." Mr. Inn reported some minor concern over "not always lasting quite as long as I would like" but appeared to accept this variability as normal. Even though they had increased their frequency of sexual contact over the past two months they both reported that their sexual relationship was experienced as only a part of their ongoing relationship. They had had a few arguments over nonsexual matters but had resolved them and reported that things were going better with both of them than they had ever gone in the past. Both were now looking forward to spending part of their summer on a brief vacation together.

#### A Pedophilic Problem

The case of Mr. Jones. Because Mr. Jones' sexual history has several important theoretical implications, and because the case clearly illustrates the development and application of learning treatment procedures after an initial comprehensive theoretical analysis, presentation will be deferred to the final section where it will exemplify the approach suggested by the results obtained from the present research program.

## DISCUSSION AND CONCLUSIONS

The first part of the discussion will be primarily concerned with the implications of the present research for technique. Next an examination of the theoretical implications of the research will be made. Finally, the case of Mr. Jones will be presented to exemplify the approach suggested by the results obtained from the present research. This will be done by describing the development and application of learning treatment procedures based upon a careful theoretical analysis of Mr. Jones' problem in terms of the A-R-D system.

### Implications for Technique

#### The Therapeutic Use of Masturbation.

One of the most promising therapeutic techniques derived from the present research appears to be the self-regulated use of masturbation by the subject. As described previously, this use may involve the fantasy used, the behavior itself, or both.

The importance of masturbatory fantasy in therapy has long been stressed by the psychoanalytic school. Murphy (1965), for example, sees masturbatory fantasies as developing from extremely intense Oedipal longings. Others (Eidelberg, 1945; Hammerman, 1961) use the concept of unconscious masturbatory fantasies. In his review of the psychoanalytic literature in this area, Bonime (1969) notes that this later view, that fantasies represent the unconscious, is the most prevalent one. He goes on to point

out that the literature stresses the strong association between the unconscious masturbatory fantasy and the pathological character structure. In his view the fantasy is seen as an emotional metaphor for a wide range of interpersonal practices of which the person using the fantasy is unaware. Clinical use of this material is similar to the use of symbolic dreams. For example, affective association to the fantasy is used to help the patient arrive at insightful experiences (Bonime, 1969).

From a learning point of view McGuire, Carlisle and Young (1965) have advanced the hypothesis that continual masturbation to a fantasy may play an important role in the formation and shaping of sexually deviant behavior itself. It is their position that the orgasm experienced during masturbation provides the critical reinforcing event for the conditioning of the fantasy preceding or accompanying masturbation. They argue that what particular fantasy is used may be arbitrarily determined by a random experience to which an individual was subjected at some point in his life. One of the many implications of this theory is that it allows for the acquisition of any sexual deviation. In support of their theory they cite numerous case histories that illustrate the possibility of such conditioning.

Evans (1968) attempted to indirectly test this hypothesis with two groups of exhibitionists, one with normal masturbatory fantasies and the other with deviant fantasies. With the use of emotive imagery and aversive conditioning



he attempted to decondition exhibitionistic behavior in the two groups. As was predicted, the deviant behavior of acting out (and the urge to do so) was deconditioned significantly more rapidly in the normal fantasy group (median of 4 weeks) than the deviant fantasy group (median of 24 weeks).

Further support for the theory may be found in the present research. The sexual histories of Mr. Chan and Mr. Doi indicated exclusive use of male imagery from their first experience onward. A similar history was seen in the case of Mr. Brown, with the exception of one attempt at female imagery--which he discontinued because the image was too "fuzzy." On the other hand, Mr. Adam had used males exclusively until his first successful experience with a female, after which he began to use females as frequently as males in his fantasies. As would be predicted, when he entered treatment he reported arousal to both males and females--in direct contrast to the other males seen. It is also important to note that by the end of therapy, Mr. Adam reported that the use of male fantasy had gradually declined and then stopped all together--without any special intent on his part and without suggestions by E. The case of Miss Han lends additional support to the theory when it is remembered that within a few weeks of her changing her masturbatory fantasy to dogs, she made her first two attempts at actual physical contact with dogs.

It is interesting to point out that perhaps the greatest

case support for this theory may be found in the psychoanalytic literature. Many of the carefully detailed psychoanalytic histories of masturbatory fantasies provide excellent illustrations of how sexually deviant behavior may have been learned through such conditioning. Excellent examples of such histories may be found in Berest's (1970) report on a case of sadism; Friedmann's (1966) description of two cases of male transvestism; McCawley's (1965) paper on cases of exhibitionism; Shenken's (1964) account of bestiality cases; or Yalom's (1960) study of cases of voyeurism.

Of course, direct experimental testing of the theory is not ethically possible though Rachman (1966), and Rachman and Hodgson (1968), demonstrated that it is possible to experimentally condition arousal in males to previously neutral stimuli (slides of black boots) by pairing their presentation with sexually arousing stimuli (colored slides of nude women). It seems reasonable to assume that the orgasm experience would be an extremely effective reinforcing event for any stimuli preceding or accompanying the occasion. Furthermore, as Staats (1970) has recently pointed out in another context, each instance of a sexual act constitutes a whole series of classical conditioning trials since a sexual act extends over a considerable length of time.

Unfortunately, the clinical implications of this theory have either been largely overlooked by learning oriented therapists, or have been used in a relatively

unsophisticated manner. In their original theoretical paper, McGurie, Carlisle and Young (1965) mention three implications for treatment: (a) because original conditioning was carried out to fantasy alone, treatment could deal with fantasy (this was their basis for the use of aversion therapy); (b) patients could be warned about the possible conditioning effects of their masturbatory practices, and (c) positive conditioning to heterosexual stimuli could be carried out along lines similar to the manner that the deviant stimuli were conditioned. The authors make a brief mention of successful results by having their patients use imagery of normal sexual intercourse in the five seconds preceding orgasm--regardless of the initial stimuli used. Unfortunately, they provide no further details. Their procedure does not take into account the possibility of the whole series of classical conditioning trials that may take place to the deviant stimuli prior to the five second period before orgasm. From the present research, it also seems probable that many subjects with homosexual problems have had no opportunity, or interest to take advantage of opportunity, to discover specific details of female anatomy. It would be expected that their attempts at such imagery would be "fuzzy" and difficult to obtain without some further help in addition to being told to "imagine heterosexual intercourse."

One of the first reports in the literature on the attempted use of masturbation conditioning was by Thorpe,

Schmidt and Castell (1963) with a homosexual patient. The patient was asked to stand in a small dark room where he was told to masturbate to whatever fantasy he wished, but at the point of orgasm he was to signal by saying "now." At that point a picture of a scantily clad female was lighted on the wall opposite him. By the eleventh session there was no change in the patient's masturbation fantasy which was entirely homosexual. They next illuminated the picture at random intervals during the patients masturbation, but the patient reported using homosexual fantasies during the period of darkness and concentrating on parts of the picture, such as the buttocks, that would be part of his homosexual fantasy. They then started using aversion treatment by having the patient receive shock from a grid under his feet while watching male nudes. This treatment alternated with the previously described one for positive conditioning. He received 100 aversive trials and 38 positive trials, after which he reported using female fantasy for masturbation on a somewhat regular basis. On an eighth month follow up the patient reported one attempt at intercourse and several homosexual experiences. He also reported a few minor attempts at exhibitionism, but he now considered persons of both sexes rather than young men and boys alone, as had been his practice previously.

It appears that, regardless of the methodological difficulties, the positive conditioning was more successful than the aversive conditioning. It also appears that, with

this patient, attempts to change attitudinal response to males and females was not sufficient to help the patient learn new behaviors in the natural environment.

The following year Thorpe, Schmidt, Brown and Castell (1964) report giving pictures of attractive females to patients and asking them to use them in their fantasies. This was done in conjunction with aversion treatment. Their overall reported results were much more encouraging.

In 1968, Davison reported the elimination of a sadistic fantasy in a client through use of a number of procedures, the primary one being client-controlled masturbation sessions. The client had been masturbating to sadistic fantasies for ten years. Davison had suggested that he use his sadistic fantasy initially then switch to pictures from Playboy magazine as soon as possible. At the following session the client reported success on three different occasions, however he also reported "breaking down" a few times and using his sadistic fantasies (from the results of the present research it appears that this "breaking down" may be an indication that the provided stimuli are too distant in arousal value from the highly arousing sadistic fantasy). Davison then attempted to move the client up to the use of real-life pictorial stimuli of girls in bathing suits or lingerie, with the Playboy pictures as back up stimuli. The client was also instructed in various ways of making actual contact with girls. At the following session the client reported only one successful use of bathing suit pictures in

masturbation and the time took even longer than with the previously used Playboy pictures. The client had once more relied almost exclusively on his sadistic fantasies. This apparent reluctance on the part of the client to give up his sadistic fantasies prompted Davison to institute a form of covert sensitization to the sadistic fantasies, along with instructions on continuing to masturbate to pictures of girls in bathing suits. By the end of the sixth session the client reported that the sadistic fantasies had dropped out and he was using real-life and imaginal appropriate sexual stimuli for his fantasies. However, he was not dating girls and two more sessions were held in an attempt to stress the importance of his seeking out normal sexual outlets. A one month follow up indicated that the client was no longer using the sadistic fantasies, but he had still not gotten around to dating. It is interesting to speculate on what the outcome might be in cases similar to this when a more explicit and carefully graded series of pictorial sexual stimuli is used in conjunction with specific behavior rehearsals of dating behaviors and homework assignments. However, the theoretical explication of this type of approach will be more fully discussed in the next section.

Two more recent studies further illustrate the possible effectiveness of using masturbatory conditioning. Jackson (1969) reports the successful treatment of voyeurism after eight sessions by asking his client to masturbate to the most exciting pornographic pictures he could

find with particular concentration at the point of orgasm. He was instructed to do this every time he felt an urge to peep. After two weeks Jackson moved him to the use of nude pictures from Playboy. From that time progress was rapid and the client reported no urges to peep and two satisfactory heterosexual relations. A nine month follow up showed continued gains. In contrast to the Davison (1968) procedures, Jackson first used stimuli that were sexually arousing to the client before moving him to general Playboy nudes, and he did not use covert sensitization or other aversive techniques for the peeping behavior.

Most recently, Gray (1970) reported using a number of procedures in the treatment of a client with homosexual fantasies and heterosexual anxiety. One of his procedures was to request that the client stop using homosexual masturbatory fantasies and switch to a heterosexual fantasy. Apparently, in this case, the client was able to achieve this on his own by the 15th session. At this point Gray instituted a number of other procedures such as covert sensitization, thinking about men a few minutes after masturbation when he reported no sexual arousal, and mentally undressing women he observed. Fortunately, the client was also closely involved with a young woman who was aware of his problem and who apparently contributed immeasurably to the treatment. The client initially reported no arousal to the young woman and was able to experience arousal only after a series of invivo desensitization procedures. It

is puzzling why there was no attempt to have the client use the woman in his masturbatory fantasies thus increasing the probability of arousal to her.

As may be seen by this brief overview the therapeutic use of masturbation has been limited and somewhat fragmented. The present research, in conjunction with previous work in this area, suggests a number of implications for technique, both in the actual physical behavior itself and in the imagery used.

In regard to the behavior itself, unlike other therapeutic orientations that may see masturbation as pathological or distorted (see Marmor, 1969), a learning based approach places no value judgement on the behavior. The activity itself is seen as neither bad nor good except in relation to the goals of the client or the laws of the society of which he is a member. Therefore, suggesting masturbation to a client--provided it is acceptable to him--is seen as therapeutically appropriate as any other theoretically grounded, researched based, procedure. That the activity itself may have therapeutic benefit may be seen from the case of Mrs. Goo, where, through the use of masturbation, she was able to experience an orgasm for the first time. Though this was only a first step, she reported that she then felt like a sexually normal woman for the first time in her life. Others (Clark, 1968b; Hastings, 1963) have reported similar positive results.

Another possible use of the activity itself is



demonstrated in the case of Miss Han, where, through small successive steps, direct clitoral stimulation was eventually extended so that vaginal penetration became equally satisfying (and more closely approximating stimulation from sexual intercourse). In addition other bodily postures were suggested that more closely approximated a position of sexual intercourse. It was unfortunate that in the present case the bridge of the behavior to the male partner was not completed, however, there appears to be no theoretical reason why such an extension would not work in other similar cases.

Hastings, (1963) has reported somewhat similar procedures with successful results, though his steps were not as small and successive as was attempted in this research.

At this time, the use of imagery in masturbation appears to offer the most potential for therapeutic use. The present research seems to have clearly demonstrated the possibility of conditioning arousal, through masturbation, to previously neutral pictorial and imaginary stimuli. The case of Mr. Doi illustrates the use of imagery only. Mr. Doi could not recall ever having experienced any arousal towards female stimuli of any type. At the beginning of training, he was not asked to use imagery of heterosexual intercourse with which he was totally unfamiliar, but to use features of his past imagery with males in combination with females. In other words, his past behavior and masturbatory fantasy had always involved having a male perform fellatio on him or he engaging in anal intercourse with a

male as the receiver. He was asked to merely substitute females performing these same behaviors in his fantasy. This did not require any new knowledge of female anatomy or use of imagery that was beyond him. Even at this, however, he still described his first attempt as seeing the females in a somewhat "fuzzy" situation. He also felt "strange and alienated", which seems to be a common first reaction. In this case continued practice lead him to feel proud, then finally aroused. More important, his arousal appeared to generalize to the actual environment when he discovered himself aroused to the point of erection when looking at a real woman--a completely new experience for him. This all happened within a one week period.

By contrast, the case of Mr. Brown illustrates the use of controlled pictures in place of pure imagery. Mr. Brown was given a series of pictures to use according to the degree of interest that he showed in them (i.e., close ups of female genitals, then breasts and genitals, then full body pictures, then couples engaging in intercourse, and finally films of the latter). Here too, Mr. Brown described a series of responses starting with a "strange" feeling, eventually a "warm" feeling, and finally a high degree of arousal.

The case of Miss Han also illustrates the power of suggesting small successive changes in imagery. In her case the imagery sequence went from animals, to large groups of men in improbable situations, to smaller groups of men in

such situations, to single men in such situations, to single men in probable situations, and finally to Mr. Ho in a probable situation. The strength of the conditioning may be judged by her report when--angry with both E and Mr. Ho--she had reverted to her former fantasies and was quite upset to find that they were no longer very arousing, and even more upset when she found that the imagery of Mr. Ho was more arousing than ever before.

On the basis of the findings of the present research a number of further considerations appear important. If the client reports failure in his imagery and reversal to previous imagery, it may be taken as an indication that the therapist has suggested stimuli that might be anxiety provoking or, because of lack of familiarity, stimuli that are too difficult to imagine without specific training procedures being instituted. Various training procedures in imagery are used with systematic desensitization when the client reports difficulty in imagery, and there is no reason to believe that such procedures would not be effective in the present situation. Supplying the client with pictorial materials that are individually selected by the client as eliciting asome degree of interest seems to be one promising approach. If questioning reveals some anxiety response to the materials, then perhaps systematic desensitization to the material may be necessary before such positive conditioning procedures are initiated.

In order to help the client experience as much success

as possible and to prevent regression to his previous fantasies, it also seems important to keep in close contact with the client. This may mean that when such treatment is initiated, daily contacts may be necessary so that any reversals or other difficulties can be examined and alternate procedures immediately suggested. In the present research starting with three contacts a week then two a week seemed to be sufficient.

The eventual goal of this treatment procedure when working with homosexual problems is to have the client experience arousal to real life heterosexual stimuli. It seems important that the therapist suggest any procedures that he feels might be of aid to the particular client in helping him to generalize his response whatever the procedure (whether it is "mentally undressing" women he sees, or whether he is given homework assignments of noticing and recording the different shapes and sizes of female breasts, or just looking for the "female butt of the week"), the important point is that he attempt to orient himself to those real life stimuli that he has been using in his imagery or pictures during masturbation. Further illustration of this procedure, along with many of the other procedures mentioned above, will be provided later during the presentation of the case of Mr. Jones.

Finally, it should be pointed out that successful results from the application of this technique will rarely mean that treatment is complete. The previously mentioned case of

voyeurism by Jackson (1969) appears to be an extremely rare exception. In working with homosexual problems, for example, sexual arousal to heterosexual stimuli might be seen as a good starting point (it appears to have a strong reinforcing effect on the client who usually reports a positive feeling of "normality" and generally sees "hope" for himself for the first time). However, numerous other difficulties remain, such as the possibility of his continued arousal response to same sex stimuli, or major deficits in appropriate heterosexual social behaviors. On the other hand, changes in the client's attitudinal response to heterosexual stimuli does appear to affect related functions of these stimuli for the client. Further explication of this change in relationship will be given later during the theoretical discussion.

Experimental research in this area would be of great help to the practicing clinician. Research is needed as to the lasting effects of such conditioning and to the most effective method for establishing it.

#### Use of Client Self-Recording Measures.

While the behavioral sciences have always stressed the importance of careful observation and recording of responses of interest by an outside observer, clinicians have attempted to extend various aspects of this procedure to the subject himself. The technique of asking the client to keep a record of his thoughts, feelings, or actions has been used by therapists of many persuasions for a considerable length of time.

The importance and use of such self-recordings in clinical work has also been stressed by a number of learning oriented therapists and researchers (e.g., Barlow, Leitenberg, & Agras, 1969; Goldiamond, 1965; Wolpe & Lazarus, 1966, Etc.).

The learning therapist generally differs from his colleagues of other orientations in the type of responses he asks for, the manner in which he would like them recorded, and the use to which he puts the information collected. The type of response the learning therapist is interested in may range from a passing thought or felt emotion to a complicated behavioral action. Whatever the response of interest, his main effort is usually spent in operationally defining the response with his client. He is usually also interested in what happened just prior to and immediately following the response.

The manner of recording may range from a simple frequency count on a hand tally counter to an extended written narrative of thoughts, feelings, and actions surrounding the response. The use of such recordings by the therapist may vary with the individual case, but, generally, they are used to facilitate assessment and evaluate treatment. Self-recording during assessment is usually requested either to help clarify specific stimuli or situations which elicit a given response, or to clarify the contingencies associated with a given response, or both. This material is also frequently used to provide a baseline from which to gauge the effect of any future intervention. Recordings during

treatment are usually requested to help determine the effectiveness of a particular treatment procedure. In other words, does the treatment intervention appear to have any functional relationship to the behavior of interest? This, hopefully, allows the therapist to quickly adjust his treatment program where appropriate.

Unfortunately, a perusal of the case histories reported in the current literature indicates that the use of such self-recordings in clinical practice is not widespread. Although there are obvious limitations to such recordings, the current research reported here indicates a number of useful advantages to such a procedure.

Asking Mr. Adam to keep a record of the occasions when he felt a sudden increase in anxiety (description of incident, along with his thoughts and feelings connected with the incident, as well as what preceded the incident and what followed the incident) greatly facilitated the clarification of his reported "general state of anxiety", (i.e., primarily associated with his training working, his office, and interpersonal encounters where he failed to express his feelings). Once this clarification was made, appropriate treatment could proceed. Asking him to keep a record of positive experiences not only helped clarify reinforcing events for him, but provided him with feedback that helped him become aware that he was not "always" as anxious as he had thought.

Another use of such notebook keeping may be seen in

the case of Mr. Brown who was asked to note down all occasions when he felt "homosexual" (in this case E was unable to operationalize this term, but Mr. Brown was emphatic in that he knew he could recognize the feeling when he felt it). This procedure resulted in the recognition of specific behaviors or occasions that brought on this feeling and resulting self-labeling (e.g., lack of arousal when meeting an attractive girl, raise in the pitch of his voice when talking with other males, his acquiescence to the demands of males when contrary to his own feelings, etc.). Once these situations were clarified, appropriate measures could be taken to provide alternate responses or behaviors (i.e., use of masturbation to condition arousal to females, practice with voice control, assertive training, etc.).

The above examples are directly related to initial assessment. The case of Miss Han offers an example of how the use of such a notebook procedure applies during the ongoing treatment program. Miss Han was asked to keep a record of her masturbatory behavior by noting the frequency, imagery used, specific behavior used, and length of time to orgasm. This record not only reduced the vagaries of recall but enabled E to determine possible reasons for variations in progress (which were discussed with Miss Han and alternate suggestions made where it seemed appropriate). As the case history shows there were several setbacks which necessitated changes in the program based on the written record supplied by Miss Han. Without such a record reasons for variations



would have been extremely difficult, if not impossible, to determine.

Another use of record keeping during treatment is seen in the case of Mr. Inn and Miss Ivy. When it became necessary for E to be out of the state for two weeks, Mr. Inn was asked to keep a record of his ongoing contacts with Miss Ivy. Upon his return E was then able to read what had happened at each occasion during his absence, instead of relying on the recall of the couple at the time of his return.

A related example is the case of Mr. Adam who left the state for several weeks. Through the use of a prearranged code, Mr. Adam was able to send back information as to the frequency of arousal to males, the number of tranquilizers or sleeping pills he took on a given night, whether he used relaxation for sleep, a hot drink, a hot shower, and the degree of sleep he experienced that night. He was able to send back two weeks of information on a single postcard. This enabled E to keep a close watch on his progress and prepare possible treatment changes in preparation for his return.

Other examples of self-recording measures during treatment are those where a number of subjects were asked to keep daily frequency counts on the response of interest. These measures, it will be recalled, covered a wide range of responses from frequency of daily masturbation, anxiety reactions, and sexual arousal to heterosexual physical contacts and pill taking. Generally it was found that an

attractive golf counter on a key chain was the most preferred form of measurement by both sexes.

It should be noted that even though the majority of the responses recorded were of a very personal nature none of the subjects in the present research program refused to keep such records. Though there is no direct evidence, it is E's opinion that this is largely due to the early orientation of the subject to the general principles of learning theory in relation to the subject's problem. Once this is accomplished, by using appropriate examples from the subject's own history to illustrate the possibility of various principles, it is natural step to request the keeping of such records. Such requests are usually accepted by the subject as being entirely appropriate and logical. Others (i.e., Davison, 1968; Klein, Dittman, Parloff, and Gill, 1969) have noted similar experiences; with the additional benefit that the client, who usually regards himself as "sick" or different from "normals", begins to see his maladaptive behavior may be the product of "normal" psychological processes rather than the result of a disease or his "abnormal unconscious." Unfortunately, there is no direct evidence for this assumption and it would certainly be valuable to attempt to research this area (undoubtedly, there is the possibility of a strong demand characteristic operating).

On the other hand, two of the subjects did report "forgetting" to keep their records, or losing the counters given them. In one case this was followed up by directly

confronting the issue and discussing the possible reasons for such "forgetting" (the case of Mr. Jones to be discussed). Henceforth, the subject did not forget again or lose his counter. In the second case the subject eventually withdrew from treatment (Mr. Chan). It is an interesting thought that this type of failure in record keeping may be a predictor of failure in treatment, but this is another question for future research. In conclusion, though the validity and reliability of self-recording may be open to question, its use in a clinical setting has a number of advantages and appears to be a step in the right direction.

Use of Questionnaires and Inventories.

A number of learning oriented therapists and researchers have advocated the use of questionnaires and inventories in the initial assessment of clients (e.g., Bentler, 1968a, 1968b; Cautela and Kastenbaum, 1967; Wolpe & Lazarus, 1966, etc.). However, the current use of such assessment measures seems to range from the use of no measure at all to the indiscriminate use (or shotgun approach) of a large number of measures. The intent of the present research was to develop a battery that would be appropriate to the area of concern, namely the treatment of sexual problems. Judging the importance of a particular form for the present research was difficult to assess in some cases and easier in others. It was a lack of criteria for such judgement that makes the subsequent observations highly subjective. Each form will be discussed in turn.

The Life History Questionnaire (LHQ) that was developed was found to be generally useful in obtaining a somewhat superficial overview of the subject. Using it as the first form for follow up inquiry provided an opportunity for the subject to elaborate on his past history. It was E's feeling that by the time this form had been gone over with the subject a good degree of rapport had been developed. In relation to the specific sexual problem of the subject, the form, with one exception, was of little use. For the married couples the section on Marital History proved very helpful, particularly their responses to the areas of compatibility and incompatibility. Elaboration on this section with the subject gave E a surprisingly accurate picture of how each saw the other and areas of disagreement. Many of these areas proved critical to the treatment program.

The Behavior Assessment Form (BAF) was intended as a primary assessment form to help E obtain behavioral data that would determine his eventual course of action. Unfortunately, this did not prove to be true. Certain parts of the form (such as Part IV, The Analysis of Self-Control, and Part V The Analysis of Social Relationships) were found to be very helpful, but the form had many overlaps with some of the other inventories (e.g., the RSS, CFI, and SFI). The value of this form would be increased if it were used only with one other form (such as the LHQ or the CFI) for subjects with interpersonal relationship, or similar, problems. It seemed to be of little direct help in dealing

with the specifics of sexually related problems. Again the first two pages, dealing with behavioral excesses and deficits, were most helpful for married couples. The general orientation to behavioral repertoires did not prove helpful for much of the present research which continually dealt with cognitive and emotional aspects of the subject. At present it seems that the form would be most helpful when dealing with families where problems between children or parents are the main concern.

The Composite Fear Inventory (CFI) proved much more helpful in pinpointing stimuli that elicit anxiety than any previous version used. The wider choice of items, along with discussion of same, offered a fairly quick and easy method for determining clusters of fears and items for use in covert sensitization. Though the normative data was limited it was helpful in having some group scores for comparison with those obtained by the subjects. Whether the CFI will be helpful in measuring pre and posttreatment changes in generalized fear still remains to be seen. The limited data from the present research are conflicting in this area and future research will be necessary to explore its reliability and validity.

The Reinforcement Survey Schedule (Cautela & Kastenbaum, 1967) proved to be helpful in a number of ways: for use with Covert Reinforcement, setting up contingency situations with couples, and for assessing the subject's primary concerns upon entering treatment (this from the last page where the

subject lists the things he does or thinks about a certain number of times a day--by far, most were attitudinally negative). This inventory also needs further research, particularly in regard to normative data.

The Sexual Fear Inventory (SGI) proved extremely valuable in the analysis of sexual problems and concerns. Inquiry revealed a number of important historical facts behind a checked response that were not revealed in other assessment material. The limited normative data was also helpful for comparison purposes (as in the case of Mr. Adam). The different categories easily lent themselves as subscales for measuring ongoing changes (as in the case of Mr. Brown). Again, further research will be necessary to determine its reliability and usefulness as a measure of pre and post-treatment gains. Another potentially important use that was not taken advantage of in the present study was asking the subject to rate the items for the degree of joy or pleasurable feelings that the item elicits. This might prove extremely valuable in assessing attitudinal change (e.g., through the use of masturbation).

The Heterosexual Behavior Inventory (Bentler, 1968a, 1968b) was very helpful in obtaining a fairly accurate picture of the subject's experience compared to others of his age. Used in conjunction with the attitudinal responses to the same items reported on the SFI, E was able to quickly ascertain what the subject had sexually experienced and how he felt about it. This, of course, led to further discussion

and elaboration of the subject's sexual history which would have been missed by the other assessment materials.

The Sexual Knowledge Inventories (Form X, McHugh 1967; and Form Y, McHugh, 1955) proved valuable in establishing the depth and quality of sexual knowledge held by the subject. It was an effective way of discovering certain gaps in the subject's knowledge that might be crucial to treatment but overlooked (e.g., Mr. Brown's prior belief that the "clitoris" was the medical term for the female belly-button). In contrast to the SFI the normative data was not particularly helpful in the present research (e.g., Mr. Brown scored in the 87th percentile on the vocabulary and anatomy form). In addition, the forms provided an ideal opportunity for couples to begin communication with one another about sexual matters.

The Sexual History Form (SHF), as would be predicted, proved to be the most valuable in obtaining a fairly complete sexual history of each subject. The main limitations of the form appear to be its primary stress on quantity (total number of partners in pre-marital coitus) rather than description (what did you do, what did your partner do, how did you feel about it, etc.). However, as the research progressed and E became more experienced, these questions were incorporated. In further revisions of the form the stress should be on the developmental sequence of experiences rather than quantative data by category. For example, it would be important to know the masturbatory fantasies that were used in

conjunction with his exposure to other sexual experiences such as contact with same sex, other sex, animals, and so forth. It would also be necessary to obtain more detailed information on the masturbatory images used rather than whether a category had been used or not (i.e., not whether a male uses heterosexual imagery or not, but how often relative to other categories, what are the specific stimuli associated with the imagery, etc.).

Additional categories of assessment information that would be most helpful in the analysis of sexual problems will be suggested in the theoretical discussion.

#### Additional Implications for Technique.

In treating problems of sexual incompatibility, Masters and Johnson (1970) refuse to treat an individual spouse, stating that there is no such thing as an "uninvolved" partner in a marriage with some form of sexual inadequacy. Madsen and Ullmann (1967) also suggest the use of the husband in the therapy room when treating the wife for frigidity (involving the husband in hierarchy construction, presenting the items, Etc.). In the present research, two of the four cases treated for sexual incompatibility lend support to such a procedure (Mr. and Mrs. Frost; Mr. Inn and Miss Ivy); while the remaining two do not (Mr. and Mrs. Goo; Mr. Ho and Miss Han). These results suggest that while the assumption that there is no uninvolved partner may be correct, it does not necessarily follow that joint treatment is automatically called for. Not only may the assumption of inevitable



joint treatment be unwarranted, but in some cases contraindicated as well (e.g., Mrs. Goo appeared to be more sensitized to her husband's touch when she left treatment than when she entered). Under what circumstances is joint treatment most likely to be of benefit? When might it be harmful? What are the indications that might suggest to the clinician that he interrupt joint treatment--or start it? What does the clinician do when another partner is not available or inappropriate? The present research findings do not provide answers to these questions, but they do caution the clinician to be alert to the problem until further research is done.

The results of the present research offer a number of additional cautions for the behavioral clinician who attempts to work with complex sexual problems. One is overreliance on a particular technique such as desensitization, covert reinforcement, or successive approximation. In moving from the straightforward treatment of simple phobias or enuretic problems to more complex problems it behooves the behavioral therapist to be familiar with and experienced with as many therapeutic techniques as he can master. A related caution is directed at working with only one aspect of the sexual problem with no attention to related components. For example, a therapist who worked only with behavioral deficits or excesses, and eventually helps a client with a homosexual problem to become socially sophisticated with women is running the risk of failure. What if his client still has no

arousal to women? What about his possible continued arousal to males? On the other hand, working exclusively with attitudinal responses (e.g., systematic desensitization, covert reinforcement, masturbation, etc.) can also run the risk of failure if the client does not have the appropriate behavioral repertoire. While occasionally working only with one aspect of a sexual problem may be highly effective (e.g., Jackson, 1969), more generally it may not be adequate (e.g., Davies and Morgenstern, 1960; Freund, 1960; Feldman & McCulloch, 1965).

The present research attempted to demonstrate the advantages of using a wide number of techniques for different aspects of a sexual problem. The case of Mr. Adam, for example, illustrates the use of systematic desensitization, covert sensitization, impulse-response chaining, assertive training, successive approximation and other techniques to effect changes in attitudinal responses as well as behavioral repertoires.

Another area that was only partially explored was the attempt to deal with cognitive aspects of a sexual problem through the use of reading and discussions supplemented by charts, diagrams, and models. The design of the study did not offer a means of empirically evaluating the effectiveness of these procedures, but the subjective responses of the subjects suggest that this may be another fruitful area for further research.

The most difficult task of the present research was

not a lack of techniques in handling different aspects of a problem, but what method of analysis would be most fruitful in suggesting an appropriate treatment program. How does the clinician go about analyzing the problem, and once it is analyzed, where does he begin and how does he proceed? This will be the primary concern of the theoretical discussion.

One final aspect of technique should be noted. The majority of the treatment techniques used in this program were controlled by the subject. The stress of the program was not on what the client learned or experienced in the consulting room, but on what he did and experienced outside the office. While a certain amount of systematic desensitization, covert sensitization, and behavioral rehearsal techniques were used in the consulting room, the majority of them (e.g., masturbation, assertive training, successive approximation, covert sensitization, impulse-response control, etc.) were controlled by the subject outside the office. It was up to him whether he practiced relaxation or not, whether he used the suggested images during masturbation, or whether he counted the frequency of his arousal responses to males. Stress was placed on the subjects freedom to choose E's suggestions or not. When positive results were obtained, E pointed out that the subject was directly responsible, for it was he who controlled his own behavior. When negative results occurred, E took the responsibility for the failure provided that the client was following the suggested

procedure. It was E's task to evaluate what had happened and make alternate suggestions. In sum, the stress was on self-regulation by the client in working with his attitudes and behaviors directly in the real life situation.

### Major Theoretical Implications

One of the main tasks of the present study was the development of a conceptual scheme for the ordering of sexual problems and their treatment. This was a constant concern throughout the research and various aspects of different conceptual frameworks dealing with assessment and treatment were examined and tested.

The initial assessment framework used was patterned after the behavioral diagnostic scheme advanced by Kanfer and Saslow (1969). Further modification and refinement of the scheme was made by incorporating some of the proposals for assessment made by Bijou, Peterson, Harris, Allen and Johnson (1969) and by Wolpe and Lazarus (1966).

As the research progressed a number of inadequacies with the ongoing development of the scheme became apparent. The analysis used was very effective in assessing areas of marital discord and suggesting appropriate treatment targets; however, it seemed to lack scope in dealing with specific sexual problems. The system's stress on overt behavior suggested no way of handling the emotional and cognitive aspects associated with the problems. The A-R-D system suggested by Staats (1968b) appeared to offer a way of organizing the type of attitudinal analysis that seemed necessary, and the

application of certain parts of the system was explored.

Initially, the only implication for the present research program that was recognized in the A-R-D system was its behavioral rationale for the development and use of the Sexual Fear Inventory. Later, the attitudinal function of the A-R-D system was seen as highly relevant. However, it was still difficult to see how the remaining functions of the system could be incorporated into the analysis of sexual problems. Somewhat late in the research program a further detailed explication of the system became available (Staats, 1970) and the completed case material on hand at that time was re-examined from an A-R-D viewpoint. It was apparent that not only did the system offer a strong theoretical base for what had been done in various cases, but it also suggested possible approaches that had not been considered. Fortunately, a final case was referred which offered an opportunity for analysis and treatment entirely from within the A-R-D framework. The case provided an excellent illustration of the advantages of using this conceptual scheme. Although the case results reported previously are generally described in A-R-D terms, it should be pointed out that the entire system itself was not used in their initial analysis and treatment (which may account for some of the equivocal results in some cases).

Anticipating the conclusions, it may be said that an A-R-D analysis followed by a behavioral diagnosis of relevant behavioral repertoires, offers the most promising conceptual

scheme for the ordering of sexual problems and their treatment. To support this conclusion a description of the main features of the system will be given, followed by a discussion of previously presented case material reordered so as to offer examples of the three functions of the A-R-D system. Finally, the case of Mr. Jones will be presented to exemplify the use of this framework in assessment and treatment.

#### The A-R-D System.

The A-R-D system, (Staats, 1968, 1970) is advanced as a human motivational system. The A-R-D stands for the three functions that a single stimulus may acquire (A--the attitudinal or emotional functions; R--the reinforcing function; and D--the discriminative function). For example, consider a nude woman as a stimulus. Her sudden appearance before a male would most likely elicit an attitudinal or emotional response in him (e.g., arousing and highly positive, or possibly anxious and highly negative). The same woman would also have a reinforcing value. Her appearance following certain instrumental behaviors by the man, would increase the probability of his performing those behaviors in the future or possibly her withdrawal would increase the probability of his performance. Finally, the same woman would serve a discriminative or controlling function for the male. Her sudden appearance might elicit strong approach behaviors on the part of the male, or possibly bring on strong avoidance and escape behaviors. Thus it

can be seen that the same stimulus may serve three different motivational functions. It may now be understood why it would be important to discover the attitudinal value such a stimulus may have for a client with a homosexual problem.

The formation of an individual's particular A-R-D system is seen by Staats to be largely dependent upon classical conditioning principles rather than operant ones (though, of course, the initial formation of the Discriminative function is through operant principles). The system is described as first developing through the pairing of previously neutral stimuli with stimuli that elicits emotional responses on an unlearned basis (e.i., sexual stimulation, air, food, etc.). Elaboration of the system proceeds through extensive first-order and higher-order classical conditioning, with language eventually playing a central role in such conditioning. The implications for treatment are straightforward: if the formation of a system is through classical conditioning principles, then alterations in the system may follow along the same lines.

The model that Staats proposes is seen as a system because various elements in the system interact with one another. One mode of interaction is involved in the hierarchical nature of the system. Staats suggests that there are subsystems within a given system, and therefore, a given stimulus may have relative, as well as absolute, reinforcing intensity compared to a stimulus in another system, or within the same system. Deprivation or satiation procedures

could alter the reinforcing intensity of a given stimulus in treatment. For example, in an individual's sexual A-R-D system deprivation of all sex reinforcers would suggest that the absolute value of the entire class of sex reinforcers would increase. Within the class of sex reinforcers, deprivation of a strong member of the class, say the unavailability of a woman in a prison system, would increase the relative reinforcing value of previously weaker members, (e.g., other men, or masturbation).

Another mode of interaction, with strong implications for treatment, is directly concerned with the three A-R-D functions of a given stimulus. Changing the value of one function also affects the other two functions that is, changing the attitudinal or emotional value of a stimulus will also change its reinforcing and discriminative properties. For example, it would be expected that, with the use of classical conditioning procedures, changing the emotional response of a male to females would not only change the reinforcing value of females for him, but that females would elicit different behaviors from him.

Another important implication of the system is that once a stimulus comes to elicit an emotional response, thereby becoming a reinforcer, it will continue to do so unless further conditioning or extinction procedures are encountered. In treating homosexual problems this would suggest that altering a client's response to members of the opposite sex, along with acquisition of appropriate heterosexual behavior,



would have little effect on the client's responses to members of the same sex. This, perhaps, suggests why some clients are reported as leaving treatment as "bisexuals".

It can be seen that the A-R-D interaction system is complex, and an analysis of such relationships is important when dealing with complex human behaviors. Of further importance are deficits and inappropriacies in the A-R-D system. Again, it should be stressed that this discussion is concerned with the individual's A-R-D system and not his instrumental behaviors. By deficits in the system, Staats means that stimuli which should elicit positive or negative attitudes do not do so (e.g., female sexual stimuli do not elicit positive responses from a male). Stimuli which should not elicit positive or negative attitudes but do so, are seen as inappropriacies in the system (e.g., male sexual stimuli elicit positive responses from a male).

The effect of either a deficit or an inappropriacy in an individual system may be seen in any of the three functions of the A-R-D stimuli. There can also be interactions of the deficit and inappropriate aspects of a system (e.g., a male who has not learned appropriate heterosexual emotional responses, may learn to emotionally respond inappropriately to other potential sex reinforcers).

In summary, an abnormal A-R-D system will have three effects: (a) an abnormal conditioning history will affect abnormal emotional responses to stimuli which confront the individual; (b) a conditioning history which is abnormal

will result in abnormalities in the stimuli which will reinforce the individual; and, (c) abnormal conditioning will result in abnormalities in the stimuli for which the individual will strive for or against.

It can be seen why an analysis of instrumental behaviors alone would prove inadequate in suggesting a treatment program for complex sexual problems. Of great importance to the present research goal is the relationship between the A-R-D system and instrumental behavior repertoires. As Staats notes, ". . . the nature of the individual's A-R-D system will heavily determine the type of instrumental behaviors he will display; thus, the A-R-D system is a determinant of what is called personality (1970, p. 139)." However, there are interactions between the two as well. Staats notes, "the male with deficits in social behavior may not be able to interact with normal women and thereby experience the sexual reinforcement necessary to develop his learned 'sexual' A-R-D system (p. 139)."

The assumption that the A-R-D system is a strong determinant of overt behavior has many important implications for treatment. Altering the individual's A-R-D system may induce changes in his instrumental behavior repertoire. For example, altering the attitudinal response of a male to a female from negative to positive, might change her discriminative value to elicit approach behaviors, the frequency of which would increase as a function of her increased reinforcing value. On the other hand, altering

a male's A-R-D system in relation to females will not be sufficient if he has obvious deficits in his heterosexual behavior repertoire. In other words, simply changing his attitudinal responses does not automatically give him behaviors he has never acquired. However, an important theoretical point is that altering such an attitudinal response may facilitate the acquisition of such behaviors inasmuch as the female now has increased reinforcing value for learning new behaviors as well as a different discriminative value. 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.

The present discussion offers theoretical support for the previous caution against the restrictive use of one procedure with only one aspect of a problem. It is suggested that those psychotherapies and learning therapies that are concerned only with the way the client "feels and thinks" about certain events or things are working only with the attitudinal part of the A-R-D system. In simple cases such as clear cut fears this may be all that is necessary but it may not be sufficient in more complex problems. Treatment that deals only with the modification of instrumental behaviors through contingency management primarily relies upon using the reinforcers already existing in the individual's

A-R-D system. The system itself is usually not dealt with (e.g., deficiencies in the reinforcer system are generally, ignored, changing the absolute or relative reinforcing value of a stimulus is seldom done, etc.).

Staats (1968b, 1970) has thoroughly described the limitations and dangers involved with these restricted approaches and further discussion will not be done here. His main point is that unsophisticated behavioral analysis will lead to the unsuccessful treatment of complex behavior problems. In relation to the present research it is suggested that a careful analysis of a client's sexual A-R-D system and its manner of origin, followed by an analysis of instrumental behaviors where appropriate, offers the most promising conceptual scheme for organizing sexual disorders and their treatment.

To illustrate the scope and applicability of this scheme some of the procedures and results of the present research will be briefly discussed from the point of view of the three functions of the A-R-D system.

The Attitudinal Function. Attitudinal or emotional responses to stimuli are believed to be formed through the process of classical conditioning. Procedures that would be used in an attempt to change such emotional responding would be those based upon the same principle, such as aversion treatment, systematic desensitization, or covert sensitization. Changing one aspect of the system, such as the attitudinal response, is expected to change the other two aspects

of the system. Thus, as Staats (1970) has pointed out, while many conditioning procedures are applied to the attitudinal responses to stimuli, the ultimate success of the treatment is generally dependent upon changes in the discriminative function of the stimuli. For example, in the case of a homosexual problem, changing a males A-R-D system so that "female" stimuli no longer elicit a negative emotional response is not the goal of treatment. It is hoped that the discriminative value of the female stimuli has changed so that such stimuli no longer elicit escape or avoidance behaviors in the real life setting.

A number of procedures were used in the present research in an attempt to change the emotional responses of the subjects to different stimuli. Systematic desensitization was used with Mr. Adam to reduce his negative anxiety responses to different aspects of his training and his office work. Covert sensitization was used in an attempt to reduce his positive arousal responses to certain male stimuli. Both of these procedures are examples of higher order conditioning of attitudinal responses, but the goal was a change in the discriminative control of the stimuli (i.e., that training and office stimuli would elicit appropriate work behaviors--without anxiety; and that male stimuli would elicit appropriate interpersonal behaviors--without arousal).

The interaction of the A-R-D system with the learning of new skills may be seen in the case of Mr. and Mrs. Goo. Teaching them various communication skills had no affect on

their emotional responses to certain situations such as Mr. Goo's comments on his wife's diet, or Mrs. Goo's nagging of her husband to prepare for their social dates. By using mutually agreed upon contracts, these occasions no longer elicited negative emotional responses and for the first time they reported that they were able to begin using their previously learned communication skills upon such occasions. A similar situation was encouraged when the couple was attempting to increase their sexual behavior repertoire. Mrs. Goo was unable to learn the new behaviors due to the high degree of anxiety elicited by her husband's touch. Systematic desensitization was then begun to alter her emotional response but was unsuccessful. A careful A-R-D analysis would have suggested desensitization prior to the learning of the new behaviors and might have proved more successful. A similar analysis would have suggested alterations in Mr. Ho's sexual A-R-D system prior to his entering into overt behavior with Miss Han and might have prevented many of the complications that were encountered.

The use of successive approximation of sexual responses with Mr. and Mrs. Frost and Mr. Inn and Miss Ivy are further examples of counterconditioning attempts at changing negative anxiety responses to sexual stimuli. On a broader scale, suggesting that the couples engage in mutually reinforcing activities together immediately after engaging in sexual encounters was another procedure designed to change the emotional responses of the couples to the sexual

situations.

The use of masturbation by Miss Han to condition emotional responses to Mr. Ho was another instance of an attempt to change the attitudinal function of an A-R-D system. That such conditioning was successful can be seen by Miss Han's report when she attempted to revert to her previously used imagery.

Masturbation is a promising procedure for changing attitudinal sexual responses. The cases of Mr. Brown and Mr. Doi suggest that such conditioning is usually experienced as a progression from no feelings, to "strange" or "alienated" feelings, to warm feelings, and finally to strong arousal. Of more importance is the apparent generalization of the arousal response from either pictorial material (Mr. Brown) or imagery (Mr. Doi) to actual females in the natural environment.

Interaction of the three functions is supported by the experiences of Mr. Doi. After two masturbatory sessions to the imagery of females it became apparent that the discriminative function of females had changed for him. He spontaneously reported that he discovered himself actually seeking out females to look more closely at them. Furthermore, when encountering a good looking male in the company of two females, he found himself paying the females equal attention. Further examples of such interaction will be noted in the subsequent sections.

The Reinforcing Function. It should be pointed out

that each example given in the preceding section that demonstrated an attempt at changing the attitudinal value of a stimulus, is also an example of how the reinforcing value of that stimulus may be changed. In other words to create a reinforcer out of a previously neutral stimulus, or to change the reinforcing value of a stimulus, it should be paired with a stimulus that already has a reinforcing value. Such a procedure is followed in the operant conditioning approach of contingency management. It has seldom been taken advantage of however, with the rare exception of such work as that reported by Tharp and Wetzel (1969). For example, after the performance of an instrumental behavior, the subject is immediately rewarded by the prompt presentation of a reinforcer. From a classical conditioning viewpoint, certain behaviors or certain situational stimuli that are present immediately preceding the presentation of the reward will, through repeated pairings, become reinforcing themselves. This close interrelationship of classical and operant conditioning is important to keep in mind when planning a particular treatment program that utilizes overt and covert reinforcers for learning instrumental behaviors (e.g., dating and social behaviors, sexual behaviors, etc.).

Apart from conditioning procedures, deprivation and satiation may be used to change the reinforcing value of a stimulus, either in an absolute or relative sense. In the present research the use of this knowledge was limited to deprivation procedures. For example, couples were asked



to refrain from sexual intercourse for an undetermined length of time. It was hoped that this would increase the reinforcing value of sexual intercourse in particular and other sexual contacts in general. This appeared to raise the absolute value of the whole class of sex reinforcers for them. Support for this observation came from their unsolicited remarks that they soon found that they were constantly preoccupied with sexual thoughts and were embarrassed to realize how much they had been talking about sexual matters with all their friends. As Mrs. Goo explained it, "lately we can't seem to go anywhere with anyone without bringing the conversation around to sex. Is there something wrong with us? It was never this way before." In general, it seemed that the females reported more preoccupation than the males. It would have been interesting to find out if there was an increase in frequency of masturbation for the males (with the exception of Miss Han, none of the females in the present study used this outlet). Unfortunately, E was unaware of the theoretical implications at the time and these aspects were not investigated.

Two problem areas were encountered in the present research with the use of such deprivation schedules. One is that the reinforcing value is affected only temporarily. Once deprivation is stopped the reinforcing value of the outlet seems to assume its normal position in the sexual reinforcing hierarchy. This was seen in the case of Miss Han who was not only asked to refrain from sexual intercourse,

but from masturbation as well. Masturbation with her new imagery became highly arousing and satisfactory, but shortly thereafter she reported less satisfaction and arousal. Deprivation might be a good procedure to help a client initially start with new imagery. Another use might be the temporary deprivation of sex reinforcers for the client who reports little or no arousal to sexual situations (this procedure will be described more clearly in the case of Mr. Jones).

The second problem encountered with the use of deprivation procedures is seen in the case of Mr. and Mrs. Goo. Because of numerous complications previously described this couple did not engage in complete sexual intercourse for several months. Other sexual outlets such as masturbation and mutual petting to a climax were used and both seemed satisfied. However, according to Mrs. Goo's report at her final session her husband was constantly asking her when they were going to have complete sexual relations, and he appeared irritable and moody. Unfortunately, E was unaware of this state of affairs and there is no way of knowing whether their sexual deprivation was the cause of Mr. Goo's behavior. Analysis in A-R-D terms suggest that such a situation was possible if not probable.

The Discriminative or Controlling Function. It is important to note the different distinguishing characteristics of a discriminative stimulus and a reinforcing stimulus. The effects of a reinforcing stimulus involves

strengthening future occurrences of a behavior. The reinforcing stimulus is presented after the occurrence of a specific response. On the other hand, a discriminative stimulus elicits, or brings on, a response. As an example of the formation of such a discriminative stimulus, assume that conversation with a female has a high reinforcing value for a young male. Assume, further that at some social occasion, an unknown female smiles at the male. Hesitant and uncertain he gradually approaches the female and eventually has a long pleasant conversation with her. At another time another unknown female smiles at him, and eventually he engages her in conversation and is able to make a date with her. On future occasions it will be likely that a female smile will be a discriminative stimulus for approach behaviors on the part of the young man. In other words, a stimulus in the presence of which a response is reinforced will come to control or elicit that response.

As with the other functions of a stimulus, the discriminative value of a stimulus will increase according to classical conditioning variables as well as deprivation satiation conditions. Furthermore, objects or situations with which an individual has not had previous direct contact may take on discriminative value immediately through various mediated generalization mechanisms such as language. Staats offers a clear example of this, "after the word 'food' has come to be a conditioned reinforcer (through classical conditioning and also a discriminative stimulus for striving

behavior, a new stimulus that is labeled by the word food will thereby immediately gain discriminative control (1970, p. 133)." The important clinical implication here is that language can play a part in changing the discriminative value of a stimulus or a given situation. For example, telling an impotent male and his partner that for the following week they may engage in any sexual behavior together that they wish but under no circumstances are they to have sexual intercourse, may change the discriminative value of the sexual situation from one of avoidance to one of approach for the male. An example of such a procedure may be recalled from the case of Mr. Inn and Miss Ivy.

Another example from the present research where language apparently changed the discriminative value of a stimulus can be seen in the case of Mrs. Goo who was given several articles explaining the methods and advantages of masturbation. After reading the articles, the thought of masturbation brought on an attempt of the behavior, whereas, prior to reading the articles the thought of masturbation brought on avoidance behavior. It is theoretically interesting that nothing was done about changing the apparent negative attitudinal response that Mrs. Goo had to this thought. It seems that the change in discriminative value also might have affected some change in attitudinal value, or more possibly, that the change in attitudinal value did not take place until Mrs. Goo actually attempted the behavior. The change in attitudinal value could then be explained on

the basis of classical conditioning.

All three functions of the A-R-D system can be assessed from observation only of the discriminative value of a stimulus. Responding to test items by checking or writing like, dislike, and so on, is seen by Staats (1968b) as measuring the discriminative function of the stimulus. Such ratings are seen as indices to emotional or attitudinally conditioning, as well as indices of reinforcing value. This was the behavioral rationale behind the construction of the Sexual Fear Inventory. Support for such responses being seen as measures of the functions of the A-R-D system is found in the case of Mr. Brown who was asked to rate the social contact items over time. Predicted decreases in his fear ratings were noted.

An attempt in this research to change the discriminative value of a stimulus is seen in the case of Mr. and Mrs. Frost who were asked to engage in mutually reinforcing activities together after some degree of sexual contact. It was hoped that the association of pleasant experiences immediately after their sexual contacts would change the discriminative value of sexual contact to one of approach for Mrs. Frost, (it was also hoped that at the same time positive attitudinal conditioning was taking place).

The case of Mr. Brown offers a theoretically interesting example of related changes within the A-R-D system as well as an illustration of the need for direct work with a behavioral repertoire. It will be recalled that Mr. Brown

had only limited experience with females, experienced no arousal toward them, and had a limited knowledge of sexual matters and techniques. Initially he had no desire to engage in sexual relations with a woman and he avoided such possibilities by avoiding close interpersonal relationships. When, occasionally, a casual relationship looked like it might become something more he would escape from the situation. In an attempt to change the discriminative value of sexual relations from avoidance to approach E first concentrated on supplying Mr. Brown with appropriate information as to female sexual anatomy and function. Through the use of reading, diagrams, charts and models, Mr. Brown became quite knowledgeable in this area, and he mentioned the possibility of trying such a situation now that he "knew what to expect." However, he felt he still would not know how to perform in such a situation. He was then given further information as to various appropriate sexual behaviors. At this point it was clear that the discriminative value of sexual relations with a female had changed. He talked about wanting to be with a woman so that he could experiment with all he knew. He proudly passed on part of his knowledge to his friends when he found that he knew more than they did on the subject. However, it appeared that this change in discriminative function had not affected his attitudinal response to women. As he put it, with a shrug, "they just don't turn me on. What a waste of all my new knowledge." However, he assured E that he would no longer

fear getting into a sexual situation with a woman for he felt confident of his ability.

About this time the use of masturbation to pictorial stimuli was instituted. Shortly thereafter Mr. Brown began to experience arousal to females in the real life situation. However, even though he now was eager to have sexual relations with a female his deficit in social and dating behaviors prevented him from further progress. As Mr. Brown so aptly put it, "I want to--and I know what to do when I get them there--but how in the hell do I get them to bed?" At this time behavior rehearsal and successive approximation of social contacts was begun.

Analysis from within the A-R-D framework would have suggested a possibly more fruitful sequence of working with his attitudinal response first, followed by behavioral training of social skills along with cognitive information pertaining to sexual knowledge and skills. It is interesting to note that Mr. Chan, who withdrew after completion of assessment, returned later in a highly anxious state asking for pictures and books on sexual intercourse.

The present research suggests that altering the attitudinal function of a system first has more direct influence on changing the discriminative function than altering the latter aspect first does on the emotional function. Further research that would directly test this would offer clinicians a clearer understanding of where to begin. Additional research would also be helpful in determining the exact role that

language and other cognitive factors play in relation to the discriminative value of the A-R-D system.

The case of Mr. Jones will now be presented to exemplify the conceptual scheme suggested by the results obtained from the present research. The case will also offer further examples of the use of a number of procedures for different aspects of a complex sexual problem.

#### The Case of Mr. Jones

Mr. Jones, a tall lean Caucasian male in his early thirties, had just returned to the state after a few years absence. When here previously, he had gone to a mental health agency for individual and group therapy for a total of 18 contacts.

Upon his return he once more went to the agency and requested an appointment with Miss Kato, the social worker who had been a co-leader of his previous therapy group. At his initial interview with Miss Kato he talked vaguely of experiencing difficulties in readjusting to his return, however, at the close of the session he revealed that he had a basic "sex problem" which he had never fully disclosed to anyone before. He did not want to go further into the matter at the time, but he said he would talk more about it at his next appointment.

At his next interview, he hesitantly revealed that he felt his sexual development was abnormally different from other males around him in that he had always been attracted to little girls since his early teens (i.e., attracted to



eight and nine year old girls). He had once shared this "secret" with one of his older brothers, but his brother had laughed and told him "not to make up stories." His only other attempt at disclosure had been with a psychologist in private practice in California after a two week basic encounter experience. Evidently the psychologist had assumed that he was only talking about fantasies, and he had been told to "ignore the problem and it would gradually disappear." He had not attempted to discuss the matter with anyone again until the present time.

Mr. Jones reported a history of arousal and mutual exploratory behaviors with young girls ranging in age from two to twelve. He said that he had never gone as far as intromission, but that he would become highly aroused during such encounters and then go off alone and masturbate to the fantasy. His current masturbatory fantasies mainly involved young girls, occasional dissociated flashes of a penis or testicles, and adult females in "sadistic" situations. He reported that he was currently involved in an affair with an older woman who had several children. He felt repulsed by the woman but highly attracted to her young girls.

He had recently been reading some case histories of similar "abnormal" people and he had become highly anxious about his "sickness" as well as the possibility of being eventually caught and thrown into a prison or a mental hospital. He reported that he was repulsed by his own behavior and desperately wanted help, but he felt his situation was

hopeless. His "secret" goal was to eventually marry and have a family of his own but, under the circumstances, he felt such a dream was impossible for him. Miss Kato mentioned the nature of E's research program, but Mr. Jones said that he did not want to involve anyone else though he did say that he would not mind if she consulted with him about his problem.

After an initial consultation, E agreed to work on an ongoing basis with Miss Kato in the handling of the case. Though it was late in the research program, the case presented an ideal opportunity for applying an A-R-D analysis from the beginning and thus hopefully developing a more effective treatment program than had been possible in the past. It was also hoped that the case would demonstrate that the usefulness of the assessment procedure was not dependent upon the individual who conducted the assessment. Accordingly, Miss Kato was given the initial inventory battery along with careful explanations and suggestions for its use. Mr. Jones readily agreed to cooperate with this approach and assessment procedures were started. The initial assessment took nine sessions with three more subsequent sessions of follow up inquiry in areas suggested by E (necessitated by E's lack of foresight in stressing the behavioral specifics needed for such assessment--an approach that Miss Kato was relatively inexperienced with).

Base line procedures were instituted and Mr. Jones was asked to keep a record of the frequency of his arousal

responses to children and adult females as well as to note down the content of his masturbatory fantasies. Miss Kato also gave Mr. Jones articles from Ullmann and Krasner (1967) to orient him toward other possible alternate explanations for his sexual behavior and to provide him with a framework for understanding future suggested treatment procedures. She went over Mr. Jones' SKI's with him discussing some of the various questions that he had and supplying appropriate information. Altogether, this took an additional five sessions.

Mr. Jones obtained scores on the various inventories, along with appropriate normative data, may be seen in Table 27. Mr. Jones reported fear scores are around one standard deviation less than those obtained by comparable norm groups. His heterosexual behavioral experiences, as measured by the HBI, are generally greater than other college males. However, examination of individual responses as indexes of A-R-D value led to some interesting findings.

TABLE 27

## MR. JONES' INITIAL INVENTORY SCORES

Scale	Mr. Jones' Scores	Normative Scores	
		$\bar{X}$	$\sigma$
Reinforcement Survey Schedule:	329		
Composite Fear Inventory:			
Total Score:	274	387.38	87.07
Geer Scale:	76	122.99	27.73
Suinn Scale:	160	206.60	50.03

Sexual Fear  
Inventory:

Total Score:	170	239.59	67.71
General:	34	51.41	13.71
Personal:	46	58.09	13.40
Social:	27	32.41	8.55
Contact:	63	97.69	40.05
Heterosexual Behavior Inventory:	19	14.48	6.15

On the RSS only two items were rated "Very much": taking a shower and children. Nude women were only rated "A fair amount". His fears were generally low except for two main categories: enclosed dark places and spiders of any kind (related to several childhood experiences with both items). The majority of his ratings on the SFI were "Not at all" thus providing a relatively flat profile. None of his ratings were in the "Very much" category, and the only items marked in the "Much" category pertained to being seen nude and homosexual contact. It would appear that items marked "A little" and "A fair amount" offered the only leads to possible areas of negative A-R-D value. In the general items, only vagina, sexual words, and animals having relations were so marked. His responses in the personal category were centered around disclosing himself to others, homosexual contacts, and the size of his penis. On the social items he checked "asking a female for a date, a female asks you for a date, a female says she finds you attractive, and the two homosexually related items. Physical contact items were all

marked "Not at all" except for oral genital contacts with a female, sexual intercourse, being bitten by a female, and the homosexually related items. It appeared that negative value was associated with homosexual behaviors, adult female sexual behavior, and certain social behaviors associated with adult females. Female children seemed the primary stimuli for positive arousal responses. His sexual history indicated the usual amount of heterosexual exploration with neighborhood children between the ages of six and thirteen. He then reported no further sexual contact until age 19 when he had his first adult intercourse experience with a prostitute. Since that time he reported having affairs with three or four adult women--none of which were very positive for him. Mr. Jones' overt experiences with young girls were primarily centered around his former work as a medical technician for a large Canadian corporation. At twenty Mr. Jones had entered the company and been trained as a medical assistant. He did well in his training and was given his choice of assignments from the company's different locations around the world. He had chosen to work in South America where he was responsible for taking routine medical tests for the company's employees and their dependents. He also did volunteer work in the pediatric section of a local hospital. It was here that he managed to come into almost daily contact with young children (such as handling their genitals when he would run routine tests).

It was suggested to Miss Kato that she attempt to

obtain further information about Mr. Jones negative responses to adult female sexual stimuli, female social contacts, and homosexual contacts. She was also asked to further investigate his masturbatory fantasies and behavior.

Discussion with Mr. Jones revealed that he felt sexual intercourse was "dirty." He particularly thought the adult female vagina was repulsive to look at. He said he wished that he had no sexual feelings at all and could become "ascetic." He also found it difficult to discuss his past and present masturbatory behavior with Miss Kato and he reported that he experienced himself "closing up" when attempting to discuss the subject. He saw it as a solitary form of sexual outlet and did not feel it important. However, he did report that about 90% of his fantasies were heterosexual ones, with the remaining ten percent being to flashes of female underclothes and male penises. At this point Mr. Jones revealed discouragement with his progress, revealing that he had been secretly hoping that something could be done very quickly to "cure" him of his problem. However, he said he did enjoy coming in and seeing Miss Kato and sharing his feelings with her. He further reported that he had "broke down" and saw his female "friend" again for sex, but that it was mainly a "release." She had invited him to move in with her and her children, but he was afraid of being trapped in the situation as he found her two young daughters very cute and attractive. He had decided that he did not want to see her anymore. He had also thought of

leaving Hawaii again, but then he changed his mind saying, "I think I'll stay so I can remain in the therapeutic relationship with you." Miss Kato saw his behavior as wanting "safe" dependence on her and she questioned his motivation for real movement in therapy.

It was suggested that Miss Kato stress the importance of obtaining the necessary background information from him so that an appropriate program could be devised. She was to look further into his description of "heterosexual fantasy" and use of lingerie images during masturbation, as well as explore his actual responses to adult females in his every day situations (it was predicted that his fetishistic lingerie images might be the result of actual masturbation with such items.)

It was found that by "heterosexual" fantasy, Mr. Jones primarily meant sexual relations with young girls between the ages of 6 and 12. The lingerie fantasies began when he found some bras and panties in a laundromat and had taken them home where he would fondle and touch them while he masturbated. He had thrown them away some time previously, but the images still "came back". He also admitted to reading pornographic books that described relations with young girls while he masturbated--sometimes taking up to half an hour. He was currently taking one graduate course at a local college and he said that he had been seeing a lot of "cute and attractive" girls on campus, but he had made no attempt to make contact with them. He said that when they came out of

classes in crowds he would look at their breasts and bottoms, but that he was not aroused by them. He found himself spending more and more time in the public libraries when public school let out so that he could see female children. Miss Kato gave him encouragement and support in trying to initiate contact with some of the women in his classes, as well as suggesting that his continued reading of pornographic books was not helping his situation. Miss Kato again made the suggestion that he consider E entering directly into the treatment process, but he resisted by saying that their relationship had been built over a long period of time and he was reluctant to expose himself to another person. He asked more time to think about the situation.

Mr. Jones had only been keeping occasional records of his arousal which seemed to average once or twice a day to female children. He reported no arousal to adult females. At his following session he again reported no arousal to adult females and he had lost his notebook. One night he had visited the home of some married friends and he had played with their four year old daughter by showing her magic tricks. During this time he had managed to touch her underpants and buttocks and felt quite aroused. He said he had also talked with the adults but would have much preferred to have spent his time with the child.

Miss Kato again brought up the subject of having E enter into the program and again Mr. Jones resisted, asking Miss Kato if she felt that she could not handle him herself.



Miss Kato explained that it would be to Mr. Jones' benefit in that both she and E could work with different aspects of the problem, and he finally agreed to an initial joint meeting.

At this point analysis seemed to indicate negative attitudinal responses to adult heterosexual stimuli and sexual words, as well as homosexual contacts. The reinforcing value of adult heterosexual stimuli and social contacts appeared much lower than that associated with young females. Social contact with adult females seemed to be a discriminative stimulus for avoidance behaviors. There also appeared to be a deficit in his social behavior repertoire with adult females. His attitudinal responses appeared to offer the most appropriate target for initial intervention. To change his attitudinal responses to adult female sexual stimuli and to increase their reinforcing value for him, the initial use of conditioned masturbation to such stimuli was considered, but not used for two reasons. If he had just reported no arousal to such stimuli such a procedure might have been used. However, he reported definite negative responses to the stimuli and it was felt that this would increase the difficulty of his following the procedure as well as increasing the probability of returning to his previous fantasies and thus reinforcing further regression. Most important, the A-R-D analysis indicated that his sexual behavior hierarchy appeared to be ranked as following: a) masturbation to young female fantasies; b) physical contact with young

females (which also appeared to act as a discriminative stimulus for further genital contact followed by masturbation), and, much lower, adult heterosexual contact.

It was feared that if he were asked to discontinue using young females in his fantasies, and to start using stimuli that had negative value for him, masturbation would lose its reinforcing value and thus possibly increase the reinforcing value of actual contact with children (and before his contact with adult females might increase). Furthermore, there was no adult female available to him at this time, and he did not appear to have the behavioral repertoire necessary to initiate such contacts.

It was decided to first attempt to reduce his negative attitudinal responses to female sexual stimuli through the use of systematic desensitization, followed by attempts at positive conditioning to such stimuli through carefully graded changes in his masturbatory fantasies. Social behavior training to increase his heterosexual social behavior repertoire would then be carried out. Once the reinforcing value of adult heterosexual contact had increased and he had acquired some appropriate behaviors to increase the probability of such contact, aversive conditioning to young female stimuli could be instituted. The predicted effect of these proposed treatment procedures on the A-R-D values of young girls and adult females for Mr. Jones may be seen in schematic form in Figure 3. The interaction of the three functions is also shown by corresponding changes in two functions (points

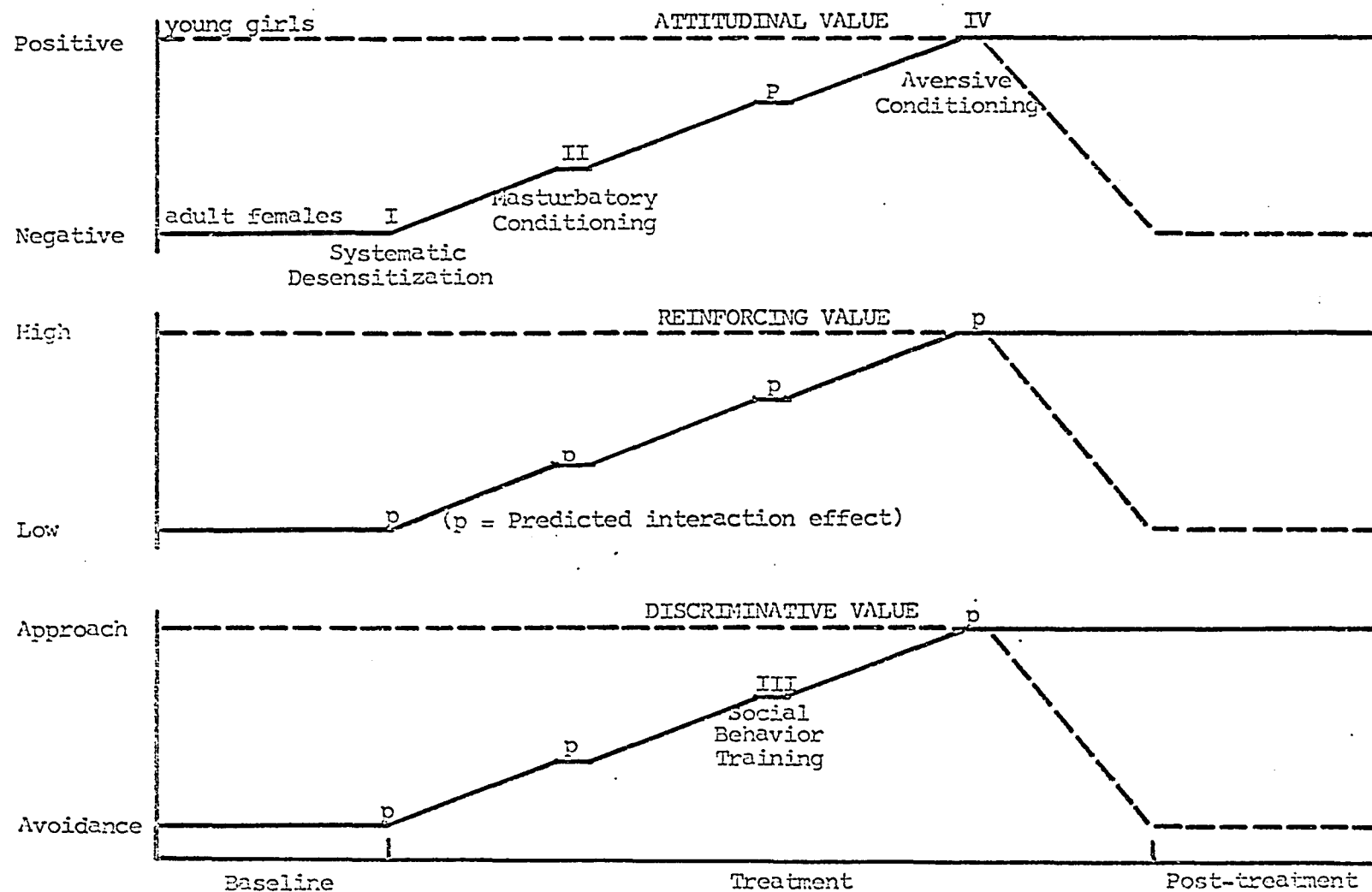


Figure 3. Theoretical treatment plan for Mr. Jones.

"p") when the third function is treated. It should be pointed out that this is a theoretical projection of treatment and it is not meant to imply that a true one-to-one correspondence exists between the three functions.

It was apparent that contact with Miss Kato had high reinforcing value for Mr. Jones, and, therefore, it was decided to have her carry out the desensitization procedures. If Mr. Jones agreed to the entry of E into the treatment program, it was hoped that he would then feel more comfortable in discussing his masturbatory fantasies and other sexual behaviors. While Miss Kato was training him in relaxation procedures and thereby possibly increasing her reinforcing value, E would be attempting to desensitize his negative response to the use of sexual words by talking with him about sexual topics in a confidential, "man to man" atmosphere. Miss Kato's eventual use of such words during desensitization was seen as the first step in the successive approximation training of Mr. Jones in the handling of sexual-social situations with adult females.

No plans were made to attempt to change Mr. Jones' attitudinal response to homosexual contacts or female lingerie. His reported responses to homosexual experiences appeared similar to other males (compared to the normative data on the SFI) and he said that he did not see such experiences as "his cup of tea." It was hoped to take advantage of his positive attitudinal response to lingerie by providing for their use in his masturbatory imagery with adult females

later in the program.

The theoretically based treatment plan proposed in Figure 3 will provide the framework within which the remainder of Mr. Jones case description will be presented. The baseline period and the four phases of treatment (indicated by roman numerals in Figure 3.) will be used to order the sequences of the presentation. However, once a treatment phase was initiated it did not end before another phase was started. Therefore, the case will generally be described in chronological sequence to best illustrate the interaction and resulting modification of some of the treatment procedures.

#### Baseline Period

During this phase the treatment rationale was explained to Mr. Jones, baseline measures were instituted, and more detailed information necessary to the treatment procedures was obtained. A more precise sexual history was also secured which lent further support to the masturbatory conditioning hypothesis of McGuire, Carlisle and Young (1965).

Mr. Jones appeared somewhat sullen and uncommunicative at the start of his first meeting with Miss Kato and E, so E did most of the talking, generally explaining the background of his approach and how it had application to Mr. Jones' current situation. He gradually seemed to take more interest and asked a number of questions as to what his particular treatment program would entail. He was given a general description of what would be initially attempted but stress

was placed on the need for his active cooperation and participation. By the end of the discussion Mr. Jones had admitted that he initially had felt very hostile to E, but that he now felt quite different and he would like very much to have E involved in the program. Further time was spent in helping Mr. Jones to clarify his goals in treatment, which he saw as: a) more close interpersonal involvement with adult females, particularly in the sexual area; and, b) more "control" in changing his behavior toward female children. It seems that he feared "losing control" and that he might "force" himself on a child and hurt her. E stressed that one of the main goals of treatment would be to help him to learn various ways that he could control his own behaviors and that in actuality he had ultimate responsibility for the consequences of his actions. It would be the therapists' job to help him see this relationship and to help him to learn the alternative responses and behaviors that were available to him. This approach appealed to him and he was scheduled to see Miss Kato on a twice a week basis to start learning the relaxation procedures while he saw E on a once a week basis for exploration of possible sexual hierarchies.

First, because she was unfamiliar with them, Miss Kato was given an intensive course in relaxation training and desensitization procedures. With the help of agency secretaries, who volunteered to serve as subjects, Miss Kato quickly acquired skill in relaxation training and she began

such training with Mr. Jones. During this period she was also doing appropriate reading and gaining additional experience in desensitization procedures with E. At the same time E began exploring different areas of concern with Mr. Jones.

Mr. Jones did not feel that his fear of spiders and darkness was of unmanageable proportion and he felt alright in handling it himself. He also felt that he could handle his concern over his thinness and wanting to gain weight by more exercise when he had the opportunity and by more balanced meals. His predominant concern was with his sexual problem.

In relation to adult females it appeared that he experienced little if any arousal to their breasts or buttocks, but he reported no negative responses. His most negative response was to the "overstatement and grossness" of the adult female vagina. He also reported negative reactions to kissing, as well as oral-genital contact and intercourse. Looking at a nude female also elicited a certain degree of negative feelings on his part. Several hierarchies were seen as offering good possibilities (kissing, seeing nude females, adult female genitals, etc.), on different dimensions (e.g., age: younger to older; situation: petting, kissing, oral-genital contact, sexual intercourse; and sense dimension: seeing, touching, smelling, tasting). In order to more quickly facilitate the use of masturbatory fantasy, it was suggested to Miss Kato that she begin to work on the

construction of an adult female genital hierarchy.

Mr. Jones was requested to once more resume keeping a record of his arousal responses to young and adult females as well as any behaviors with them. He noted a distinction between his responses to children, in that many times it started by a form of "attention" rather than "arousal" to them. It appeared that seeing a young girl was a discriminative stimulus for a brief fantasy of engaging in contact with her, which then lead to arousal and more effort to see her hips or underpants. Later he would masturbate to the image of the girl he had seen previously. He reported a masturbation frequency of about seven to twelve times a week. It was considered important to stop his continued reinforcement of child imagery, but it appeared more important to first desensitize his response to adult stimuli so that he would have some imagery available with which to replace his child images. More overt acting out with children was still seen as a possible consequence if such a sequence was not followed.

It seemed reasonable to assume that Mr. Jones continued contact with children since he was 20, in conjunction with his masturbation practice, might account for their strong reinforcing value for him. However, what was not clear was why he reported "always" being attracted to children as long as he could remember. This was the main support for the "disease" interpretation that he placed on his own feelings and behavior. It will be recalled that except for his early



exploratory behavior with neighborhood children, Mr. Jones had reported that his first heterosexual experience had not been until he was 19 at which time he had engaged in relations with a prostitute. Prior to becoming directly involved in the treatment program, E had, on the basis of the sexual learning model previously discussed, hypothesized the following: Mr. Jones had numerous experiences with young girls his own age between the ages of six and twelve. He had no further overt sexual experiences until the age of 19. He had begun masturbation at around age 15 or 16. What imagery had he used? It seems reasonable to assume that he would probably have used imagery of the only sexual contacts that he had had experience with, namely, prepuberal females. Continual use of such fantasy, supported by his adding images of young girls that he might see each day, might possibly account for his strong attraction by age 20. However, because Mr. Jones was reluctant to discuss his masturbation activity with Miss Kato this possibility could not be explored until later when E had entered into the program.

E shared some of his own early sexual experiences and fantasies, and Mr. Jones found it much easier to talk about his past experiences. Several sessions were used in getting a comprehensive sexual history which not only provided needed information but also gave Mr. Jones an opportunity to use sexual words and engage in sexual conversation in a comfortable and accepting atmosphere. His masturbatory history gave direct support for E's prior hypothesis. Because his

history offers an excellent illustration of how such pedophilic responses and behavior might have been acquired through general learning principles, it will be described in some detail.

Between the ages of six and twelve Mr. Jones lived with his two older brothers in a small Canadian town. There were many young girls and boys in his neighborhood and they used to engage in a number of mutual sexual activities. One of their favorite pasttimes was to have the girls put on a "strip tease show" for the boys after which the boys would chase the nude girls through the woods. Once caught the boys would engage in a variety of behaviors with the girls, but mainly limited to mutual manipulation of genitals and some oral-genital contact. Mr. Jones enjoyed these activities very much, particularly with twin girls who happened to be about two years younger than he.

At age 12 his family moved to a larger city where there were no further opportunities for the types of activities that he had been exposed to for six years. At age of 15 he learned about masturbation from some neighborhood boys. He reported that his first experience was extremely pleasant and that he began to masturbate once or twice a day. At first he had no image, but as he continued he remembered his previous sexual experiences, particularly the twin girls, and he began to fantasy the genitalia of 9 year old girls. He reported using this imagery for over a year, on a two or three time a day basis.

At age 16 he met a ten year old female cousin, and she strongly reminded him of the type of girls he was using in his fantasies. He eventually began to engage in mutual genital manipulation with her resulting in his experiencing an orgasm while his penis was external to her stomach. This was highly positive to both of them, but she shortly moved away, much to his regret. From that time forward, for the next five years, she was his main fantasy. In addition, he would include girls he would see during the day of the same general age. He found himself avoiding contacts with girls his own age and continually watching for and closely observing girls of nine and ten.

By his nineteenth birthday, he left home and was working and supporting himself, and he thought it high time he had sexual intercourse with an adult female. He drank quite heavily and eventually made contact with a prostitute whom he judged to be about 45 years old. He recalled numbly feeling distaste toward all the "black hair" on her genitals but he succeeded in making intromission. However, he was unable to experience an orgasm. He felt very embarrassed when he finally stopped and left, but she was recalled as being "very kind" about the situation. He continued his usual masturbatory fantasies.

His next experience was a year later with his boss's family. His boss evidently liked Mr. Jones and had taken him into the family so to speak. His boss had a wife and a 12 year old daughter, and Mr. Jones was encouraged to

associate with them. In fact, the family seemed to pride themselves on their sexual honesty and openness, and Mr. Jones was told he could have sexual relations with the wife anytime he wanted. The wife made numerous advances to Mr. Jones, undressing in front of him, rubbing against him or touching him, but he was afraid of the situation and "turned off" by the woman. The twelve year old daughter exhibited similar behaviors toward him and he reported that he would kiss and fondle her "quite a bit", but he could not bring himself to having complete sexual relations with her. This situation lasted for about half a year and he continually used the daughter in his masturbatory fantasies particularly after having engaged in mutual genital petting with her.

At this point Mr. Jones received his training as a medical specialist. He spent a half a year in South America working in the company clinic and the nearby hospital. He was assigned to a ward where he had daily physical contact with children between the ages of two and four. He would take smears, give them shots in their buttocks, and engage in other behaviors where he could fondle and caress their genitals and buttocks while doing his assigned duties. Occasionally he would try oral-genital contact on the smaller girls of 2, but he was fearful of being caught. He would become so aroused that at times he would excuse himself and go into the bathroom and masturbate to the fantasy of the children.

After 6 months he was transferred to another company

clinic in South America and he once more was eagerly accepted as a voluntary technician in a nearby hospital. because of his previous experience he was again assigned to work with children only this time they were mainly between the ages of 12 and 16. He also found that he had to be much more careful because often the parents were present during his taking of paps, skin tests, and blood samples, and again he managed to get away with "quite a bit." As before he preferred the younger girls and would continue to masturbate to what he had seen and experienced during the day. This period lasted for about two years.

When he was 23 and just prior to his return to Canada, he met a divorced woman in her early forties who had two young daughters seven and eight years old. Initially he found himself quite attracted to the woman, but after their first sexual encounter he found his interest declining. He also had his first experience with oral-genital contact with the woman and he found himself repulsed by the hair and grossness of her vagina, which seemed to generalize to the smell and taste also. He feared oral contact from her because he thought she might be "too rough." He found that he was only continuing to have relations with her so that he could be near her daughters. With them he would wrestle and "rough house", occasionally experiencing an orgasm from the frictional contact. His fantasies would center around the daughters. He then left to return to Canada.

A few years later he had another relationship with an

adult female whom he had met in an "encounter group" while attending college in California. The first sexual encounter was very pleasing to him (her vagina was smaller and less hair) but subsequent sexual relations lost their appeal. They used no contraceptives and the girl would constantly withdraw from him when she thought he was going to reach a climax. In addition, she had bad breath, and he did not like kissing her. He felt that from that time forward kissing lost much of its appeal for him. In an attempt to control his sexual longing for young girls and his anxiety to adult females, he spent a year working in a remote district of Canada with a construction crew. There were no women available, except for rare trips to the nearest city a few hundred miles away. He concentrated on learning to hunt and trying to develop his physical strength and stamina. He had no sexual contacts during this time but he would purchase and read books about men having relations with children--themes that he constantly masturbated to on the average of two or three times a day.

He had saved considerable money and he decided to travel around the world. It was at this time that he first came to Hawaii but he moved on to the Orient after a few months of idleness. He lived in Tokyo for a half a year where he met various families that would invite him into their homes. He had numerous opportunities for adult female contact, but he would not pursue them. He then moved to Italy for a half year where he was accepted into different

homes "like a relative." Again he refused overtures from women but was greatly attracted to children, whom he continued to use exclusively in his masturbatory fantasies. He became particularly friendly with one large family that had a five year old girl and an 18 month old boy, among older siblings. He noticed that the girl seemed sexually "precocious" in flirting with him and exposing her vagina to him--which appeared red as though from constant rubbing. For the following five months he fondled and petted the girl whenever he had the opportunity, always masturbating to her image. On one occasion he found himself with the boy, and he attempted to perform fellatio on him, but he gave up in self disgust. At this time a "beautiful" woman of about 25 who lived down the street from him, began showing an interest in him. He would eat with her and she would engage him in kissing and light petting. At one point she did a striptease for him, and he described her as having the most beautiful and well proportioned body he had ever seen. However, he felt no arousal whatsoever. He described this time as the lowest point in his life. He seriously considered suicide. Looking at his behavior with the five year old girl and his "disgusting" attempt with the 18 month old boy, and his complete inability to be aroused by the most beautiful woman he had ever seen were all seen as indications of how far his "sickness" had spread. He decided to return to Hawaii, a place he remembered as offering some peace of mind, and attempt to throw himself into work. He was going to try

and give up sexual relations completely.

However, shortly after returning to Hawaii he became acquainted with the divorcee with two children described previously and he had entered into a relation with her hoping to turn "normal". Unfortunately, his early arousal left him quickly. He also saw her as being too tied up with sexual problems of her own (passive and unresponsive and saying she was incapable of achieving orgasm). When Mr. Jones realized how attracted he was becoming to her daughters he saw his previous history repeating itself and he decided not to have further contact with her.

His only sexual release presently was through masturbation, mainly to imagery of children or his self labeled "neurotic" images. His imagery had been slowly declining in arousal for him and in an attempt to make it more arousing he began to pull in any images he could. He felt they were getting extremely sadistic in that he would use imagery suggested by his reading historical accounts of various tortures being inflicted on women. He pictured himself ripping and tearing at female anatomy such as their arms, breasts, or hair. All this imagery he saw as the continued spread of his sickness. His masturbation had begun to loose interest for him as well and he reported that he was only doing it from habit and as a release. He regretted giving up his books for Miss Kato and was beginning to consider obtaining new ones. The only future he could see was prison or a mental hospital.

In relating the final points of this history, Mr. Jones



was in tears. He reported that it had been a long time since he had "felt" any real emotion, and even the tears made him feel a little more human. E spent considerable time with him at this point carefully describing the treatment program suggested and the rationale behind it. It was stressed that there were no "guarantees" or "magic pills", but that there were possibilities that his situation could be considerably improved with hard work and effort on his part. His sexual history was also gone over with him, reinterpreting his experiences from within a learning framework. He listened attentively and asking for an occasional clarification of certain points. He seemed particularly struck by the possibility of his conditioning his response to children through the use of masturbation, and he showed "insightful" understanding when he, somewhat sheepishly, revealed that he had used fantasies of children even while engaged in actual sexual intercourse with an adult female. Though still somewhat reluctant to completely accept the possibility that his problem might be the result of his previous experience rather than his "sickness", he seemed eager to cooperate in whatever treatment was suggested.

#### Phase I: Systematic Desensitization

This phase extended for a considerable period through treatment. The first hierarchy to be used were stimuli pertaining to adult female genitals. Ongoing evaluation suggested the use of an additional procedure (guided imagery) and the development of a new procedure (arousal

reinforcement). Finally desensitization procedures were again applied to a hierarchy of heterosexual stimuli involved in kissing.

Miss Kato encountered a number of difficulties with Mr. Jones in initiating systematic desensitization. First, he reported problems in learning the relaxation techniques, but by extending the procedures and increasing his practice sessions he was eventually able to report good results.

He also reported difficulty with imagery, and Miss Kato had to start imagery training. Ongoing analysis of his daily social behavior with females suggested using a form of guided imagery (Wolpin, 1969) of casual social contacts in the hope that this might also change his attitude toward such contacts as well as improve his imagery (e.g., walking across campus chatting with a female classmate, or studying with a female friend and showing her various books in his apartment).

Next Miss Kato experienced problems in attempting to construct a female genital hierarchy for use in desensitization. It seems that Mr. Jones reported an "all or none" responses to various suggested stimuli dimensions. He had a difficult time discriminating degrees of response. E then attempted the hierarchy construction but had similar difficulties, until he thought of another approach. Mr. Jones was given a book (Benedict, 1970) which photographically illustrated female genitalia showing a wide range of variations. Mr. Jones immediately reported definite negative responses to some of the pictures and some slight arousal to

others (as would be expected, those with little pubic hair and where only the labia majora were visible--these pictures were later used in masturbatory conditioning). Mr. Jones was instructed to take the book home and go through it and look for those pictures which brought a definite negative response from him. He was to then write a one line objectively descriptive sentence of each picture. Next he was to rank these sentences according to the degree of discomfort they provoked and then give them to Miss Kato for use in systematic desensitization. It was stressed to him that his descriptions be as objective as possible with enough detail so that they could be recalled.

At his next session with Miss Kato, Mr. Jones gave her five ranked descriptions of female genitalia. Systematic desensitization was then begun to the first two descriptions. Following the session Miss Kato consulted with E and showed him the descriptions. It was immediately apparent that Mr. Jones' "objective" descriptions were highly influenced by his attitudinal responses. His descriptions, in increasing degree of unpleasantness, were as follows:

1. The lack of smoothness and symmetry destroys the concept of beauty.
2. The black thick pelt of hair reminds me more of a beard than of a female.
3. With three fingers in place I would doubt my ability to please her (the picture was illustrating the distensibility of the vagina by showing the insertion of three fingers).
4. The grossness of the labia minora reminds me of sickness.

5. The worst looking flabby caricature of a female sex organ to be seen--active revulsion.

Miss Kato had begun her presentations with, "see a vagina where . . . " She had presented the first two items, four times each, and Mr. Jones had not signalled. However, Miss Kato had noticed that at various times his breathing increased, his mouth would twitch, or he would swallow. Afterwards, he reported that he had felt "uptight" throughout the presentations and had blocked out the pictures. It seemed possible that, apart from the pictures, the words used in the description itself were negatively conditioned. It was suggested that Miss Kato go over the hierarchy with him and attempt to change the descriptions to objective and hopefully more neutral words. Numerous changes were made during the next sessions in an attempt to neutralize the descriptions. First medical terms were used such as "labia minora" and "genitalia" but this failed to evoke clear imagery. Attempts at using his own words such as "cunt" and "bush" were found to be too embarrassing for him. Finally, the following descriptions, which evoked clear imagery, were arrived at:

1. See a vagina asymmetrically developed with a darkening and wrinkling of the inner lips.
2. See a vagina with a heavy growth of black pubic hair that obscures the outline of the genitals.
3. See an exposed vagina large enough for three fingers to be inserted.
4. See a vagina with particularly large inner lips that are apparently rough and darkened.

5. See a vagina with enlarged and drooping inner lips.

An additional advantage gained from this hierarchy construction was the apparent desensitization that Mr. Jones experienced to using sexual words. By the time that systematic desensitization was begun, Mr. Jones was able to discuss these terms with Miss Kato with apparent naturalness and without anxiety (Miss Kato noted similar changes in her own responses).

Further support that Mr. Jones was seldom aroused by female genitals was shown by a statement to E prior to his beginning desensitization. Mr. Jones related an incident concerning a male friend and his girlfriend, whom Mr. Jones liked very much. The three had gone hiking together and in the process of climbing a wall Mr. Jones had noticed that the girl was not wearing panties, and he had seen her exposed genitals. He reported experiencing no arousal, only a sort of "detached interest."

Changes in Mr. Jones attitudinal responses to female genitalia began to occur approximately one month after desensitization was begun (which was also two weeks following the start of masturbatory conditioning). During one of his sessions with E, Mr. Jones had casually mentioned experiencing arousal to one of the item presentations made by Miss Kato during desensitization. Further inquiry revealed that he had started experiencing occasional arousal to the images several sessions earlier. In order to prevent possible counter

conditioning to arousal instead of anxiety, and in an attempt to reinforce these arousal responses, some changes were made in the systematic desensitization procedure. Mr. Jones was instructed to signal anxiety with his left hand, and arousal with his right. If he signalled anxiety, Miss Kato would proceed as usual. If he signalled arousal, Miss Kato would immediately respond with a comment such as, "Very good. Just continue to enjoy the feeling and let me know by signalling when it begins to subside." When Mr. Jones would again signal, Miss Kato would then ask him to let go of the image, give him further relaxation suggestions, and then present the image again. She was to try, if possible, to always end the session after he had signalled arousal to a presentation.

Support for generalization of his responses to actual stimuli was seen around this same time when going over his notebook of arousals with E. Apart from his usual arousal responses to children, he reported one to the girlfriend of the couple mentioned earlier. She had climbed into the back seat of Mr. Jones' car and again he had seen her exposed genitals. To Mr. Jones' apparent surprise he found himself highly aroused.

In addition to her systematic desensitization work with Mr. Jones, Miss Kato continued to discuss other areas of concern with him centering around sexual information as well as social contacts with girls. For example, she discussed the various myths associated with penis size and showed

him research and models to illustrate her points. She also discussed masturbation in general with him and gave him various articles to read. These discussions not only gave Mr. Jones opportunity to receive further practice in using sexual words, but the information and discussion also appeared to help change some attitudinal responses as well (e.g., he reported to E that he was greatly relieved to understand the commonality of masturbation, and he no longer was concerned over the size of his penis.)

Phase II: Masturbatory Conditioning

This phase started with the use of adult female imagery only. Pictorial stimuli were introduced when problems were encountered with imagery. Ongoing evaluation indicated the necessity of constant change of the pictorial stimuli. By the end of the procedure Mr. Jones was successfully moved to the use of adult female imagery only. Ongoing evaluation again prompted the use of an additional procedure (impulse-control) and the development of a new technique (fantasy masturbation to overt stimuli).

E began working with masturbation procedures shortly after Miss Kato reported that Mr. Jones was not reporting anxiety responses to the first two items on his hierarchy. First, Mr. Jones' previous masturbation history was again discussed with him suggesting how he may have conditioned his present responses. He was then asked to stop reinforcing his imagery with children and to stop his "neurotic" fantasies. He was asked to attempt to use only adult females.

He agreed to try that night and he was scheduled to return the following day to discuss the results with E. The next day he reported that it had taken him longer than usual and there were brief intrusions of young girls, but he managed to keep them out. He said that the imagery was fairly good and he did not think that he would have any problems in the future. E was uncertain as whether to supply pictorial structure, but Mr. Jones seemed confident of his ability to handle the imagery. E suggested he concentrate on imagery of girls with small breasts, and a light amount of pubic hair. He was to attempt to put himself into the situation as much as possible by concentrating on his feelings of pleasure with the image of the women.

E's error was apparent when Mr. Jones came in four days later. He reported that he had used adult imagery twice the first day but that by the second time it was difficult to actually imagine what a woman "really looked like." He avoided masturbation the following day. The third day he was in a local art gallery when he noticed some young girls walking through. He found himself highly aroused and he began following them down the halls with the intention of striking up a conversation with them. However, he had checked himself and with a great effort he left. He then went to a bookstore with the intention of buying some science fiction to read, but he found himself looking for books concerning relations with children. He finally "broke down" and bought one. He used the book with masturbation twice that night



and two times the following morning. Prior to coming for his appointment, he had once more tried to use adult imagery and was eventually successful. He made the last attempt because of his guilt over using the book. He also reported that though he found the book arousing it was not quite as exciting as it had been in the past prior to his use of adult imagery. He felt very dejected about his "failure" and he apologized for his "lack of will power." E told him that in this case the responsibility for failure was his and not Mr. Jones. It was also suggested that it was not his lack of will power, but E's suggesting a step that was obviously too ineffective to counteract the effect of his years of conditioning. Mr. Jones was then supplied with several magazines containing pictures of nude women engaging in a variety of activities. From these magazines pictures were selected by Mr. Jones that aroused some "interest" on his part, mostly of young women in the eighteen to twenty range, with small breasts and light pubic hair. E excluded those pictures that showed pre-teenage girls, but he did allow Mr. Jones to take several where breast development had just begun or where the initial stage of pubic hair was beginning. It was hoped that these would serve as a first step in successive approximation to adult females. In addition it was suggested that he imagine himself engaging in fondling and petting behaviors with the women in the pictures, similar to those behaviors he had used with children previously. At the point of orgasm he was to concentrate on imagining intromission

with all its unique, warm, smooth sensations.

Mr. Jones soon reported that he had been able to use the pictures exclusively though they were not particularly arousing. It was pointed out to him that the pictures were not expected to be arousing initially, but that the intent of the procedure was eventually to help them to become arousing. He was verbally reinforced for his exclusive use to the pictures and he was given new pictures to use. This time E excluded some of the youngest females who were just beginning puberty changes.

At his next session Mr. Jones reported that he had continued to use only the pictures and it was a little easier to imagine the situations. However, he was having difficulty imagining intromission--he could not get a clear image of the genitals. He also reported an incident of sitting in a doctor's office and seeing a young nine or ten year old girl sitting across from him. He could see her panties and had become aroused. He finally approached her and began talking with her, and he eventually patted her on the arm and shoulder before it was time for his appointment.

As had previously predicted, it appeared that as the reinforcing value of masturbation was lowered the probability of acting out behaviors with children increased. In an attempt to counteract this behavior while Mr. Jones was learning new masturbatory imagery, E introduced the technique of impulse-control (Bergin, 1969). First, his scene in the doctors office was carefully analyzed as to the events and

impulses immediately preceding his arousal response (e.g., notice the girl--see hair--impulse to look down--see panties --imagine vagina--arousal). He was then instructed in the various means of interrupting such chains by switching his eyes away, changing thought, or engaging in other behaviors. He was instructed to start this interruption of the chain at the first awareness of such a sequence. He was to pay close attention to environmental situations, and his personal reactions that might start off such chains and to interrupt them as quickly as possible, and to avoid situations or experiences that had provoked such chains in the past. This procedure was explained to him as a way of giving him control over his own behavior and its consequences as had been discussed at the beginning of treatment. He liked the concept of having control over his own behavior and he looked forward to using the procedure. Finally, to help his imagery of intromission, he was given a number of pictures which showed clear close up details of femal genitals (those that had been mentioned previously during hierarchy construction).

Mr. Jones reported success with his impulse-control technique having interrupted several situations satisfactorily before arousal. On one occasion he had found himself in his elevator with a young girl. He began chatting with her and carefully watching his own reactions. He was surprised to find that he did not experience any arousal at all. Though he had thought of the possibility of initiating

contact for future occasions, he decided that it was not necessary and he got off at his floor feeling quite proud of himself. E verbally reinforced his behavior and suggested he was displaying good control over his own responses, the very goal he had been seeking in the past. He was asked to continue in his impulse control as often as possible. He further reported finding the imagery with adult females much easier than in the past. It was at this time that he also mentioned experiencing arousal to the item presentation with Miss Kato though he had not reported any arousals to adult females in the natural environment as of yet.

Continued changes in his masturbatory imagery followed along lines described previously. Each session Mr. Jones would receive new pictures to replace the ones he had used previously. The selection offered usually included those showing women wearing or holding lingerie. By his fifth session he was selecting rather large breasted women with well developed genitals of about twenty years of age. At his twelfth session he reported a "breakdown". He had used his pictures but had not felt the usual "release". He slept for half an hour and then started again, but he found himself remembering a story of a man abducting two young girls and sexually using them and he began to use the fantasy himself. However, to his surprise and disappointment, he found the experience was not as arousing and satisfying as had been the one with adult fantasy previously. He was also beginning to report arousal to older girls between 16 and 18

years of age, particularly those with breast development.

At this time Mr. Jones was moved to pictures of couples engaging in petting and intercourse and he soon reported these as being very arousing. He found them much easier to use in his imagery, always substituting himself for the male partner in the pictures. He was next moved to pictures of couples engaging in oral-genital contact, and he soon said that he experienced a high degree of arousal to such thoughts himself. He even reported that he was looking forward to engaging in such behavior himself. Apparently not only had his attitudinal response to oral-genital contact changed, but the discriminative value had altered as well.

### Phase III: Social Behavior Training

A variety of procedures were used in this phase, ranging from general discussions to highly structured techniques. The beginning threads could be seen in Miss Kato's general interactions with Mr. Jones and in her use of guided imagery. However, the more formal aspects began with the use of successive approximation principles, and extended through behavior rehearsal and role playing with the use of video tape feedback.

Successive approximation of social contacts was introduced after Mr. Jones had experienced success with successive approximation principles applied to another problem. He had had an important research paper to prepare for his class and he was having extreme difficulty in completing his assignment. He had been asked to start by only working on the paper for

five minutes a day. He had initially thought this ridiculous but agreed to do it. Every few days his time was gradually extended until he was eventually spending several hours a day on his project. He was extremely happy and impressed with his progress.

It was suggested to him that this model could also help him acquire social contact behaviors with females. He was started by being asked to smile at least once a day at any female that he might recognize from one of his classes. He was next asked to smile at unknown females. Next he was to start small comments with fellow classmates, then asking them for coffee dates. Next he was asked to make "study" dates with girls for final preparation. When finals were completed he was asked to throw a party for some of the girls he had met and studied with. However, he not only asked four girls, but he also asked five of his male friends as well. The party had turned out well, and he had noticed three strong arousals to two girls in particular. Unfortunately, the next day when he started to follow up with one girl he was turned down on his date request. The others left for the holidays and there appeared to be no females available for continued contact.

At this time Mr. Jones had completed his systematic desensitization and arousal training with Miss Kato and she also left on vacation. Without opportunity for continued social contacts with females and with most of his friends leaving the island, Mr. Jones progress appeared to reach

a plateau. However, E continued to see him on a once a week basis. At this point he was reporting that he was really finding himself interested in looking at adult females. He seldom experienced arousal, but he felt himself "liking" women much more than in the past. His masturbatory imagery was now mainly centered around women in the 18 to 25 age range, with average to large breast development, and a medium amount of pubic hair. He was continuing to receive new pictures each week, and he had not reported any further regressions in his fantasy. He also had visited a special school for children to see how he would respond. He had just looked for a while and found no arousal, though he did feel interested. He found that he could hold the jump rope for the children and still not feel arousal or any particular discomfort. He had enjoyed himself very much and he left feeling good with himself. He also reported enjoying conversations with his friend's girlfriend. He liked her in a "general" way and found that he particularly admired her body, her long hair, and her large breasts. However, he had experienced no further arousal to adult women since his party. During this period he went for three weeks without reporting any arousal to adults or children. His only arousal was to his imagery while masturbating. During this time also he reported feeling very lonely and somewhat depressed. E had been intending to institute aversive treatment to his arousal to children, but due to his apparent depression and lack of reported arousal it was decided to postpone starting this

procedure. Instead E spent the time in "bull" sessions discussing various ways for continuing and increasing his social skills during the following semester, as well as exploring his future vocational goals.

The beginning of the new semester saw abrupt changes in a number of areas. Mr. Jones came in and enthusiastically reported running into a woman from London that he had met in Hawaii the year before. They had previously become fairly good friends, though they had never had any sexual contact. He now saw her as a possible "test case" for him. She was described as in her middle forties, with a "good figure" (e.g., large breasts, well shaped hips and legs) but a somewhat "homely" face. Some time was spent in talking about his "test case" expectations. It was stressed that what was important was the opportunity for learning new social skills in meeting people and in asserting himself, not in proving any particular point about himself. The importance of making as many new female adult contacts as possible was stressed, as well as the reestablishment of previous relationships. However, E also supported his desire to begin a relationship with the woman and suggested he continue to make contact with her (there was also an uncertainty of how Mr. Jones would respond sexually to this older woman in view of his comparatively recent efforts at conditioning response to younger adult women).

He also reported arousal to an adult female that he saw waiting for a bus and another to a young school girl. At



this time he was asked to write down a careful description of the circumstances surrounding any arousal to children for future use in aversive conditioning. He was told to try and think of possible aversive situations that had happened in the past and really bothered him and whose thought still brought on some discomfort.

At his next appointment he reported arousal to seeing a young girl of about 13 walking down the street toward him wearing tight pants. He found that he immediately looked at her crotch and experienced an arousal, which increased once he noticed it. For the next half hour until he had gotten home he noticed arousal to almost any child or adult female he saw. However, that night he did not use fantasy of the girl, but remained with his pictures. The following three nights he used the pictures again supplemented by his own imagery of adult women. The third day he noticed a "general" arousal to children on a playground and another brief response to an adult female. That day he made a date with Janice, the woman from London, and he took her out that evening. They had a pleasant time at a motion picture theatre and when he took her home he gave her a kiss goodnight. He reported that he felt no arousal to the kiss, but it was "pleasant" and he was looking forward to taking her out again the next day. That night he masturbated to the imagery of Janice's body and found it very pleasant and arousing. The following night, after their date, he went into her apartment and they started kissing and engaging in mutual

petting over their clothes. He found himself aroused and with a firm erection, but it was late and he did not attempt to go any further. Later, at home, he masturbated again to her imagery and again found it highly satisfying.

The next day he hoped to have intercourse with her that night and while they were out he found himself methodically planning what he would do. At her home while they were kissing and petting he discovered some resistance to going further on her part. He immediately felt rejected and lost his arousal. However she went on to explain that it was her "fertile" time and that she did not have any contraceptives available, and she did not want to see him end up frustrated. He replied that it was alright with him if he could give her satisfaction, and they resumed petting. Through manual stimulation he brought her to a climax which was apparently highly satisfactory to her. For himself he did not recall feeling "much at all." He mainly remembered observing what he was doing and watching her responses to his actions (he reported learning a "helluva lot" from the books and pictures he had been using). Later at home, he felt somewhat disappointed with the evening and he had tried to masturbate to her image, but it was not as satisfying as it was previously so he switched to other adult women in general.

The following day he went to the beach with Janice but he found himself being "ornery" with her. He found more enjoyment in watching the young "nymphets" on the beach

(between 11 and 12 years of age). When he took her home that evening he attempted to kiss her but found that he was responding negatively to the kissing so he stopped and said good night.

He felt very disappointed with his "failure" and lack of progress, feeling that things had not changed very much at all for him since the beginning of treatment. E spent considerable time pointing out the good progress he had made so far and that this one occasion did not change it. Mr. Jones said that he had mainly wanted to have sexual relations with Janice, but he saw the situation as similar to his other experiences where he had been turned down after the first arousing attempt. He also felt manipulative and guilty about "using" her in the way he had been intending. In addition he now found that she was demanding a lot of his time, and he was looking for ways of avoiding her. At this point he brightened up and wondered about the possibility of ending the relationship by telling her he was coming to the agency for help with a "sexual problem." He was asked what sort of relationship he really wanted with her and he admitted that it was primarily for sexual release. He did not want to become involved with a long term commitment. He also reported feeling positive about a girl in her late twenties named Sue who was the sister of a girl he had met last semester. He said he really liked her and saw that relationship as much more promising. He was asked to imagine what his feeling would be if after a few days or

weeks of courting, Sue suddenly agreed to sleep with him. After some hesitation, he replied that they would probably be positive as she was much closer to his age, more warm, and much more attractive than Janice. At this point he was confused and he directly asked what E felt he should do about Janice.

He was asked to consider possible ways of how he might turn his relationship with her from a negative one into a positive one. He could tell her that he was having some problems concerning interpersonal relationships and was working on them with some help from people at the agency. It would be important that he explain that he was not ready to enter into any long term committment at this time or even in the near future. He might also attempt to explain his feeling guilty over what he considered his "manipulation" of the relationship because of his strong desire to enter into a sexual relationship with her. He could mention that, at this point, he did not want to continue to see her under false pretenses, but that he did feel attracted to her sexually and in other areas, but as to where the relationship would lead at this time he was uncertain. It was stressed that the important point was that he be as open and honest with her about his feelings as he could and then to allow her to make her own choice as to whether she wished to continue to see him under such circumstances.

Mr. Jones felt very positive about this approach, seeing that no matter how it turned out it would at least be an

improvement over the present situation. He felt he could also gain experience in openly sharing his feelings with a woman and he would feel more comfortable about himself. If she choose not to continue seeing him then he had at least been open with her and he could then devote his energy to other social contacts. It was stressed that if she elected to continue seeing him, it would be even more important that he continue being open and honest with her (it was felt that if, under the circumstances, she did choose to continue seeing him she might eventually offer to cooperate in the treatment program on a more formal basis--perhaps through in vivo desensitization.) At this point Mr. Jones admitted that he had not really had the nerve to take a really close look at her genitals, but that her body was really "great." He also wondered why he still was "turned off" to kissing.

E suggested that Mr. Jones continue systematic desensitization with Miss Kato, who had recently returned from her vacation. In addition to once more going over the genital hierarchy they could move on to work with items involving his kissing a female. He readily agreed and an appointment was scheduled for him with Miss Kato. In addition, he was to continue writing down details of arousal responses to children for use in aversive conditioning.

He then met with Miss Kato and they began working on the construction of a kissing hierarchy and relaxation instruction were resumed. He also reported to her that possibly the main reason he was feeling turned off to

Janice was her age and the fact that he felt he had manipulated her.

At his next meeting with E he reported his first "break-down" in some time. He had gone to get a safety sticker for his car and found that he needed over \$300 worth of repairs. This meant he had to borrow the money from his father in Canada--his only resource and something he was loath to do. Following his writing him a letter he had been feeling very upset while he drove to the postoffice. On his return home he happened to see one of the daughters of the woman with whom he had had his previous affair walking down the street. Feeling like he "didn't give a damn" he returned home and masturbated to her image. It was satisfying, but he felt depressed afterwards.

The following day he reported two arousals to children. One was in a bank where he saw a young girl's body silhouetted through her dress with the sun behind her. The second occasion was interesting in that he had been walking down the street when he noticed this young girl wearing cut-off levis, with long black hair, walking toward him. She seemed to have all the cues that normally aroused him (e.g., youthful features, tan, straight hips, etc.), but it was only when she drew along side of him and he noticed that she had breast development that he experienced an arousal. That same afternoon he also experienced arousal to an adult female but he had failed to note down the circumstances. In addition, he had asked a girl from one of his classes for a date to go to

a movie and later he had casually brushed his hand against her hips. He found it pleasant but not "exactly arousing." He had masturbated to pictures of adult females since his breakdown and had found them "OK". The last two days he reported masturbating without the pictures and he found that he could retain his imagery of adult females fairly well now, but he still felt it was a long way from the actual situation.

He reported that he had seen Janice on two different occasions, but she had been studying for her courses and he did not feel the situation was appropriate to discuss his feelings with her. E did not push him but agreed to his following his own feelings. He was also given support for his apparent progress in "dating" behaviors. He was cautioned about expecting too much of himself or the situation and to look at each occasion as an opportunity to learn something more about interpersonal relationships. He was given a book with photos mainly centered around oral-genital contacts (he reported these pictures as highly arousing to him) with the suggestion that he use it whenever he felt it would be helpful during his masturbation. However, at this stage, he was also congratulated on his ability to use imagery alone, and he was encouraged to continue to do so as often as he could. The remainder of his sessions was spent in going over past and present aversive situations for possible use in covert sensitization.

In his meeting with Miss Kato he reported that his

date with Janice had turned out to be a "bummer." She had gone to a lecture that day and the subject had been homosexuality. The manner in which she discussed the subject with Mr. Jones was highly negative to him, and he decided against discussing his personal concerns with her. He did report having several double dates with Sue and her sister, but had not been able to date Sue by herself. At this point he and Miss Kato had completed work on the kissing hierarchy, which went as follows (in increasing order of anxiety arousal):

1. Kissing a girl during intercourse.
2. Being kissed by a girl during intercourse.
3. Kissing a girl during foreplay.
4. Just kissing the lips of a girl.
5. Kissing the breasts of a girl.
6. Kissing the genitals of a girl.
7. Kissing a girl after intercourse.

Systematic desensitization was begun to this hierarchy in a manner similar to that used for the genital items. By the second session Mr. Jones was reporting arousal responses to the lower items, particularly when he used specific girls such as Sue in his imagery. He also found that Sue was having certain "problems" of her own, reporting strong fears to unusual situations. He was fearful that he might slip into the role of "therapist" with her and it was suggested that he avoid such a role and perhaps suggest that Sue might find it helpful to talk with someone at the



agency. He was further encouraged by Miss Kato to continue his efforts in the heterosexual area with as many women as possible. He was happy to report that he had recently obtained the phone number of a new classmate, and he was planning to call her for a date. He said that he was now talking with many girls in his classes, and he was certainly not the "wallflower" of the past semester.

During the following week, Miss Kato reported that something seemed to be happening to Mr. Jones' responses to the hierarchy items. He had not reported either a negative or positive response to any of the items presented and she had completed the hierarchy presentation in two sessions. At his meeting with E, he reported only one "general" arousal during the past week. He had just "discovered" himself with an erection while driving, and he then began noticing females of all ages as he drove. Later in masturbating he had had difficulty in keeping intrusions of young girls from his imagery. He had then returned to the use of the book given him and found it highly satisfactory. He was asked to show which pictures he found most arousing, and the one he reported responding to most showed a full breasted woman in her early twenties with long black hair. She was engaging in oral genital contact with a male with her hand pulling on his penis. It was interesting to note that the picture that Mr. Jones reported most arousing depicted behavior that he originally reported as being highly aversive to him. However, his arousal responses at this point seemed

to be limited to his masturbatory activity.

He reported numerous opportunities for arousal such as seeing a young school girl sitting on the grass with her legs spread. He had begun to "zero" in on her crotch but caught himself and looked away. He reported no arousal to a number of female adult stimuli--only a "strange" curiosity. For example he had seen a girl sitting opposite him in class wearing a short skirt and with her legs open revealing her sheer underpants. He could clearly see the outlines of her vagina but he felt no arousal nor anxiety. Later at the beach with his male friend and his girlfriend he had had numerous opportunities to see the nipples of her breast beneath her loose halter, and to catch occasional glimpses of her genitals beneath the loose legs of her bathing suit. Again he felt no arousal, or anxiety, only "interest." It appeared that his arousal was limited only to specific items that he could select during his masturbation. He did not report feeling depressed, and he was continuing to make fairly good progress with his dating.

At this point he had been masturbating from five to twelve times a week for the past four months. According to A-R-D theory deprivation of one class of sexual behaviors should increase the reinforcing value of the other classes of sexual behavior, as well as raise the reinforcing value of the whole system of sex reinforcers. It was hoped that past procedures had changed the discriminative value of adult females so that they would now elicit approach

responses. Accordingly, Mr. Jones was asked to take a vacation from masturbation and to not look for anything special, but just take things as they came. E was aware that his sexual responses to children might also increase, but covert sensitization was going to be initiated to these responses the following week. This would allow Mr. Jones a chance to write down his specific reactions under such circumstances for use in covert sensitization.

Mr. Jones past avoidance of Janice was discussed with him, and the possibility of him renegotiating their relationship, or at least letting her know where he stood, was again suggested. He said that he would call her and attempt to explain the situation to her, though he was uncertain as to how he was going to go about it. Miss Kato was appraised of the deprivation schedule and she was asked to once more go over both hierarchies with him the following week to see if there were any reported responses.

As predicted, the deprivation schedule appeared to raise the value of the entire class of sex reinforcers for Mr. Jones. The following week he reported that he had been constantly thinking about sexual matters, though there had been no arousal associated with the thoughts. For the first time in months he reported having at least three highly erotic dreams which were mainly concerned with his manipulation of young girls genitals as in the past. He did not make intromission in any of the dreams nor did he experience an orgasm. In the random presentation of items from his

genital and kissing hierarchies by Miss Kato, Mr. Jones responded with arousal to about a third of the items. He further reported two arousals to adult females during the week, both of which surprised him. Most interesting was his report of no arousal to young girls during the entire week. On the fifth day of his deprivation schedule he had gone to a rock concert on the beach with his male friend and his girl friend. He had seen numerous girls ranging in age from two to over thirty, in various states of dress and postures, but he experienced no arousal. He found himself watching them dance and move but he constantly shifted his eyes from one scene to another "as though to gather it all in at once", but he felt only "interest." He also saw numerous adult female stimuli such as bare nipples, half covered bottoms, and occasional glimpses of genitals, but again no arousal. However, that night at home he "broke down" and masturbated. He was surprised to find himself using imagery of Janice, particularly her vagina throughout the whole process. He found the experience extremely satisfying.

The following day he visited Janice in her room and was able to express some of what he had been feeling to her. He did tell her that he was primarily interested in having sexual relations with her but that he was not ready for any type of firm commitment. He was unable to tell her much more at the time. She also became more open with him, admitting that she had tried to avoid having sexual relations

with him previously by pretending she forgot to take her pills. She eventually joined him on the couch, and he found himself feeling mildly aroused and he began stroking her hips and concentrating on his own feelings instead of watching for her responses. However, he still had not been completely open with her, and he decided not to push the matter further at that time. He kissed her and returned home. He felt no arousal during the kiss. That night he "broke down" again and this time he found himself masturbating to the images of adult females that he recalled from the beach concert two days earlier. He found the experience highly arousing and satisfying.

Mr. Jones was asked to reexamine the situations with young girls that he had been exposed to during the past week in an attempt to try and find out what was happening then that was different from his previous experiences. By carefully going over the details of several incidents it soon became apparent what Mr. Jones had been doing. He realized that he had been purposefully stopping himself from continuing his usual impulse-response chains. For example, while in a supermarket he had seen a child sitting with her legs apart in a shopping basket. He noticed how he would start to drop his eyes toward her underpants, but he would abruptly force himself to look away and go to another part of the store. He recalled telling himself that he was half way through his thirties and his behavior was not appropriate and lead "nowhere." His current treatment had shown him

that he could control himself if he wanted to, and he recalled feeling "really committed" to the program and wanting to try and do something about himself. His other experiences were in a similar vein, in that almost without awareness he would interrupt his usual response chains.

Mr. Jones was warmly congratulated for his behavior and he was told that this was exactly what covert sensitization would attempt to work with and perhaps make it much easier for him. He had made a list of incidents that had been arousing to him in the past as well as a list of aversive situations, and E took the material to create scenes for use with covert sensitization which would start at their next meeting. In the meantime, it was suggested that he might cut down the frequency of his masturbation so that when he did the scenes would have much more reality and satisfaction for him. It was also suggested that he attempt to use imagery of adult females from the natural setting whenever possible.

#### Phase IV: Aversive Conditioning

Covert sensitization was selected for use as the aversive conditioning procedure. To facilitate the effects of treatment, covert reinforcement procedures were also used. This phase proved to be the shortest of the treatment program.

It was decided to apply covert sensitization to three main areas: a) general areas which were limited to Mr. Jones merely observing children; b) actual contact areas where Mr. Jones actually touched children such as in

wrestling play or genital manipulation; and c) the area of masturbation where Mr. Jones would use child imagery.

In the general area the situation to be used, in descending order of the probability of their occurrence, were: walking home, walking by a school, in the library, on the beach, and in a public building. His behaviors were looking from the child's face to hair, legs, hips, and crotch. The girls that seemed most attractive to him were described as cute, tan, with long black hair and graceful smooth legs. The most frequent attire was tight pants or levis or sheer dresses. Activities most frequently observed were running, standing, stooping over, squatting, and sitting with legs spread open exposing tight underpants.

In contact area the situations were in a friend's home, at a pool or beach, or alone with a girl. Behaviors were wrestling, having a child sit on his lap, patting her fanny, touching her hair, touching her buttocks and vagina, and the friction of rubbing his penis against her body. In masturbation the scenes were reading a book describing someone else's experiences with children, the girl in Italy, and smooth hairless vaginas.

The aversive scene to be used was one where he was caught, yelled at, laughed at, insulted, and arrested. A second possible aversive scene was his being in a small dark room filled with crawling spiders.

It was decided to make an addition to the theoretically derived treatment program by using covert

reinforcement procedures to increase the probability of his learning new responses antagonistic to his approach behaviors toward children. In A-R-D terms this could be seen as an attempt at changing the discriminative stimulus value of children.

Another change in the program was the decision to apply covert sensitization to the discriminative rather than the attitudinal function of young girls for Mr. Jones. Covert sensitization has usually been applied to attitudinal responses (such as arousal) to a stimulus, but this was not considered an appropriate procedure at this time for Mr. Jones. He had not reported arousal for some time to young children, and to suggest such an arousal response might run the risk of increasing such a response in the natural setting. It was decided to first attempt to apply sensitization to certain cognitive and behavioral responses. More specifically to his thoughts and actions. Support for this approach may be found in Wisocki's (1970) recent report on a similar approach in the treatment of obsessive-compulsive behaviors. Wisocki has pointed out that such scenes may be divided into each of three parts: intention, precipitation and action. In other words, thinking about performing a behavior, just about to perform the behavior, and finally performing the behavior. It was felt that this particular approach would more closely fit in with the impulse-response chain breaking technique that Mr. Jones had been performing (another way of describing the approach might be training in response



differentiation).

Accordingly, Mr. Jones was scheduled to be seen on a twice a week basis by E. At his next meeting he was allowed to relax himself by whatever means he had used in the past with Miss Kato and when he felt completely relaxed he was instructed to signal E. At that time E continued the suggestions of relaxation then presented the following typical scenes:

"It is a nice day and you are walking along the sidewalk (pause for signal of clear image). Off in the distance you see a mother and her young daughter walking toward you (pause for signal of clear image). As they come closer you notice the sunlight is behind them and shining through the little girl's sheer dress. You THINK about dropping your eyes and looking closer. You are ABOUT to drop your eyes. You DO--you look at her hips and zero in on her crotch. Immediately the little girl screams and points at you. The mother grabs her daughter in terror and screams for help. People come running from all directions yelling and screaming at you. You're trapped. You can't escape. In anger they grab and tear at your clothes and beat your head and naked body. You feel hurt and trapped and desperately try to get away but you can't. You are bleeding from your wounds and people continue to hit you and call you "skinny bastard" and child molester". Several big policemen arrive and start beating on you and they put handcuffs on you. You feel alone and defenseless and hurt and bleeding."

Following this presentation, he was then told to let go of the scene and he was given relaxation instructions. Next, in order to check his imagery and give him practice for his own use in the natural environment, he was told to go through the whole scene by himself, starting with it being a nice day and he is walking down the street. He was to signal when he had finished the entire scene.

After he signalled, he was once more given relaxation

instructions and then presented with an escape scene which started the same as the above but which supplied an alternative response to his looking behavior. A typical scene went as follows:

" . . . you think about dropping your eyes and looking closer. You are about to drop your eyes--but you DON'T. You look away and notice the beautiful clouds and trees around you. You begin thinking of an attractive woman you saw in class that day. You barely notice as the mother and daughter pass you and you think of what a beautiful day it is and how good you feel as you continue walking peacefully down the sidewalk."

Again he was instructed to let go of the scene and once more relax. He was told to go through the previous scene by himself, starting with it being a nice day and he is walking down the street. He was to signal when he had finished the entire scene.

The above sequence was repeated two more times with first E presenting the aversive consequences and then Mr. Jones doing it himself, followed by E presenting the escape scene and then Mr. Jones doing it himself. However, on the last trial, in place of the escape scene, E tested the use of covert reinforcement as follows:

" . . . you think about dropping your eyes and looking closer. You are about to drop your eyes--but you don't. Immediately you are out in the country camping on a splendid day. You are thoroughly enjoying yourself as you admire the beautiful country around you."

After further relaxation, Mr. Jones was then instructed to present such a sequence to himself. Up to this point, except for a slight sign of brow tension, Mr. Jones had shown no overt signs of anxiety. It was E's feeling that

he might be having trouble with imagery or that the aversive scenes were not aversive enough so he stopped the procedure to get some feedback from him.

He reported clear imagery at all times. He also reported that the aversive scene was a "real shocker" and he was surprised at the vividness of the whole picture and at his high degree of anxiety to the situation. He said that the scenes were clearer when E presented them, but that when he presented them to himself he could select the parts that were most upsetting to him such as the anger, the pointing, and the insults. Evidently E's description was too long and after a while Mr. Jones had felt some parts were just too "comical" like the "police" and "loosing all his clothes." He was instructed to use those aspects that were most aversive to him and that E would attempt to do likewise in the future. He further reported that at first he had a difficult time presenting the aversive scene to himself, but he forced himself anyway. The escape scene he reported as a "great relief". However, he noticed that during the scene he would "grab a quick look" just before looking away from the girl. He was instructed that if he found himself doing such a thing while practicing or even if E were presenting the escape scene, he was to immediately bring in the aversive scene. The importance of not rewarding himself for "taking a quick look" was stressed and he appeared to recognize this.

The reinforcement scene appeared to be very clear and

easy for him to bring in. He reported no difficulty in suddenly finding himself in the woods and the scene was vivid. In fact, he said he had "bawled" out his friends for making the fire too big, but it was all in a "bantering" manner.

He appeared to be responding well to the procedure and he was given the homework assignment of practicing the presentations himself ten pairs a day. He was to first use an aversive scene, then either an escape scene or a reinforcement scene. Again the importance of immediately changing to an aversion scene if he found himself attempting to take a "quick look" before escaping was stressed.

He was also told to use the procedures for any encounter he actually experienced in the natural environment. In other words, if he came across a young girl and found himself looking at her he was to immediately imagine the aversive consequences. On the other hand if he averted his look and thought of other things he was to reward himself with a pleasant consequence (i.e., scenes that had been previously found to be highly reinforcing such as taking a pleasant shower, hiking, camping, riding across the country on horseback, etc.).

Mr. Jones previously reported that adult female sexual stimuli in the natural environment often interested him but did not usually bring on any arousal. Yet later, when masturbating to the stimuli he had seen during the day, he found them highly arousing. In an attempt to help him

generalize his arousal he was also asked that whenever he encountered such stimuli in the natural setting he was to imagine that he was using them in his masturbation at that time. Inasmuch as the thought of masturbation appeared to be a discriminative stimulus for arousal and actual masturbation, it was hoped that by pairing this thought with actual stimuli these stimuli would become conditioned to arousal.

Further discussion centered around ways of increasing his social behaviors and using covert reinforcement in the process. By the end of the session Mr. Jones appeared eager to put his new "self-control" procedures into practice and left in an apparently good mood.

He reported good progress at his next session. He had mainly used avoidance and escape scenes in the natural setting, finding them easier to use than self reinforcement. He experienced some tension when averting his gaze from particularly appealing situations, such as noticing some young girls standing on a balcony over him, but he was always able to resist. He also described an encounter with a woman and her two "really beautiful" young daughters at his place of employment. He reported the girls as being the "types" that he would have always attempted to approach and fondle in the past, but on this occasion he limited himself to politely asking their names and then he ignored them and talked with the mother. He said it was difficult for him but he felt proud that he had been able to carry through. He experienced no arousal. He was verbally reinforced for his handling of

the situation and it was suggested that in the future on such an occasion that he actually reward himself by splurging on a movie or some other reinforcing event. This idea appealed to him and he promised to put it into practice.

He found it extremely difficult to practice his covert sensitization at home. However, by applying approximation principles he progressed from only two scene pairs the first day to ten scene pairs four days later. He also reported two general arousals of an hour each to adult females. He had sat in the park and associated his masturbatory image to various women that he saw walking by him. He was encouraged in his attempts at generalization but it was suggested that he reserve such pairings for actual female sexual stimuli that he encountered such as seeing a female exposed breast or panties. He also reported spontaneously using COR to occasional flashes of little girls during masturbatory fantasies and found it "quite effective."

Because he experienced difficulty in alternating between COS and COR scenes, a new pattern of presentation was tried in the office. He was first presented with four different COS situations. alternating with a self presentation of his own for a total of eight aversive pairings. This was then followed by eight COR and escape situations to the same scenes. Finally, he was given COR for thinking the following thoughts: "I don't need to look at little girls any longer" and, "I enjoy being with adult women." This was done in an attempt to increase the use of such covert responses

(Wisocki, 1970).

For his homework it was suggested that he continue to practice 10 pairs a day, using situations that he experienced that day or that might come up in the near future.

Mr. Jones soon related experiences similar to those reported by Mr. Adam in that he began having problems in discriminating and in responses differentiation. He found it difficult to look at "any" girl or woman for fear of finding that they were actually too young upon closer examination. He also felt that he was no longer experiencing arousal to any little girls but just some kind of "attention" or "interest" response. It was suggested that he start his discriminating at extreme ends, looking at obviously older women and avoiding obviously little girls, while only ignoring those in between. By now he was using COS constantly during the day in actual situations. For example, he described walking through a supermarket crowded with young children. He had to constantly pull in aversion scenes of being attacked by everyone in the store. He found it much easier to use escape scenes after quick avoidance. He was congratulated on his good progress and encouraged to continue using what ever he found most effective.

He was then given 10 COS scene pairs, followed by 10 COR and escape scenes, and, finally, presented with COR for the following thoughts that he himself had reported at various time in the past: "I am over 30 years old and I don't need to look at little girls any longer", "looking

and thinking about little girls leads nowhere," and "I can thoroughly enjoy making love to women." He was asked to think each thought twice and reinforced with various positive scenes.

Mr. Jones reported continued good progress with his use of COS in the natural setting. However, he was experiencing difficulties in his private practice sessions at home. He was beginning to feel a great deal of anger in his aversive imagery and he was now fighting back strongly at the crowds that would attack him. It appeared that he was becoming habituated to the original aversive scene and he had extended the scene where he had to be ripped apart, stabbed, shot and mangled by the crowd. To stop this use of extreme sadistic imagery the use of "spiders in a closed dark room" was tried as the aversive stimulus. Afterward, he reported that the scene was very effective but by the fourth presentation he found himself pulling in even bigger spiders and having them bite him. It was suggested that he attempt to sue such scenes during his private practice and continue to use the insult scenes during in vivo practice (he reported no feelings of anger or extension to sadistic proportions in this practice).

By his next session he reported the effects of spiders rapidly diminishing. He returned to the use of crowds and concentrated on insults and ridicule rather than actual fighting and found himself considerably less angry. However, he said that the scenes were not as aversive as they had



been originally.

It has been suggested by several workers in the field (Cautela, 1970a, 1970b; Wisocki, 1970) that a variety of reinforcers are necessary when using Covert Reinforcement in order to avoid the problem of satiation. However, there appears to be no mention in the covert sensitization literature that a variety of aversive images may be necessary to avoid the problem of habituation, though such a problem has been noted in the punishment literature (Rachman and Teasdale, 1969).

It was decided to try another change in the COS procedure. Mr. Jones was presented with three different scenes for COS. After the first he was presented with a detailed spider scene; next, with key phrases only ("dark--webs--spiders--crawl"); and finally, with two words (spiders--dark). He reported that the scenes got progressively more aversive. He had been told to concentrate on "just feelings" associated with the words. He reported no detailed imagery but just a mass of uncomfortable feelings that really "shook him up."

Another change was made in the Escape and COR scenes. This time when he avoided the described scene he was immediately told, "you feel very proud of yourself and you think that you really do have a choice in how you behave." In the last scene he was presented with his most difficult in vivo situation and for the first time, he was allowed to go further in his approach behavior:

You are sitting in the public library leafing through an interesting art book. You glance up and you see two little girls bending over a shelf with their underpants showing. You look at them for a moment, then you casually return to your reading, feeling proud that you don't have to dwell on them any longer.

Mr. Jones appeared surprised and quite proud when he reported that he was actually able to visualize what was suggested with no problem. He had always reported difficulty in the library situation and yet he found that it was fairly easy to look back to his book without feeling any arousal whatsoever, even though he stared at their underpants for a few moments.

#### Phase V: Treatment Withdrawal

It was decided to stop COS and COR and withdraw all treatment procedures so that the effectiveness of the treatment program could be evaluated. This was done at this time for a number of reasons. Mr. Jones appeared to be adapting to the aversive stimulus though he seemed to have made good progress. However, it was still not known how effective the aversive treatment had been. He had not reported any arousal responses to children for sometime, but what would happen if he were free of all instruction? Would it, perhaps, be necessary to bring in stronger aversive stimuli such as shock? It would be difficult to answer these questions unless treatment were withdrawn so that Mr. Jones responses and behaviors in the natural environment could be assessed.

Another reason that this was seen as an appropriate time for treatment withdrawal was that he was also completing his

treatment plan with Miss Kato, who was shortly leaving the agency to move to another state. At the time E began aversive conditioning, Miss Kato was just completing systematic desensitization to Mr. Jones' kissing hierarchy. At the session following completion of the hierarchy, she randomly presented all items from his kissing and genital hierarchies. He signalled two brief anxiety responses to two of the kissing items which quickly subsided on the second presentation. However, he signalled five arousal responses to other items (four from the kissing hierarchy and one from the genital hierarchy).

In the three sessions that they had remaining Miss Kato was asked to work with behavior rehearsal and role playing of heterosexual social situations. Mr. Jones had been making good progress in his initial contacts with women, but he appeared to have reached a plateau. Miss Kato was asked to concentrate on two new areas. One was asking a woman he knew for an initial date. The other was attempting to move beyond the "superficial conversation level" to one of a more meaningful relationship. With the use of video tape feedback Miss Kato role played various women that Mr. Jones knew while he tried out various dating and other interpersonal behaviors. By the end of their rehearsals Mr. Jones had advanced to the point where he not only appeared comfortable in initiating various dating behaviors but he began asking Miss Kato about her personal sexual experiences.

It was at this time that he was told of the plan to

withdraw all treatment procedures. He was asked to just take things as they came without any particular expectations or instructions. He responded positively to the suggestion, saying that he had been thinking about asking for a vacation for some time (he had been coming to the agency for treatment on an average of four times a week). He was asked only to temporarily refrain from masturbation. It was hoped that this would raise the reinforcing value of sexual stimuli so that the relative values of little girls and adult women could be compared. He left in apparent high spirits. Four days later he reported that he had asked a girl for a date, "just like he had practiced with Miss Kato", but she had politely refused. He felt somewhat hurt but decided he would try again in the future. That same day he also went out of his way to observe a good looking woman bending over her bike. He had seen a "beautiful bottom in sheer lace panties" and he had been highly aroused. That night, at a local tavern, he had "impulsively" ran his finger across the bare back of a waitress who had been leaning over the table next to his. She had responded positively and he had later danced with her.

In regard to young girls he reported that it was difficult to know what "to do." For example, he had seen a girl of about 12 wearing tight levis with a "beautiful butt" walking down the street. He had first looked away, but then realized he could now look, so he returned his gaze. He thought it was "interesting" but he turned away again

reporting no arousal. Now that he did not have to use COS he found that he would look away anyway, though "not as fast" as he had done in the past. He had still not masturbated and was surprised that he had been able to refrain for so long. He reported one general arousal response to some young women walking on campus.

The morning prior to his appointment he had met a woman of about 25 with a young eight year old boy at his place of employment. She was on her way to Samoa with the boy after a divorce from her husband. She was looking for a place to stay and he had offered the use of his apartment, which she accepted. In talking of his teaching the boy to play chess and of playing catch with him, it was pointed out that he sounded "like a father." This brought tears to his eyes and he agreed that it really felt "good and right". However, he saw "daughters" as another problem. He was stopped and asked to examine this statement in light of his behavior of the past week and he paused and then said that he had realized that it might be possible for him to have interaction with girls without complications, particularly if there were adult women that he could relate to. He said that he really felt hopeful for the future at this point and he was looking forward to taking the woman and her boy around the island. It was also suggested that he not forget to keep his contacts that he had made previously. He was asked to continue as he had been and to also continue to refrain from masturbation.

Three days later he reported that he had had a good time escorting the woman and her son around the island, taking them to the zoo, the beach, and just generally sight-seeing with them until they left that morning. He said that he had been able to open up with her about some of his own feelings and she had done likewise. He was sorry to see her go but he also was behind in his studies and he was looking forward to catching up on his work.

He also described an "interesting" experience while at the zoo with the woman and her boy. He had been in one of the buildings when a little girl of about eight came over to say hello to the boy. Mr. Jones had casually said "hello" to her, then turned away to the exhibits. A short moment later it appeared that the girl had realized that she had lost her mother for Mr. Jones suddenly heard her let out a yell and start crying and screaming for her mother. He had immediately responded with shudder and a flash of anxiety. He reported it to be a very "vivid" reaction and said, "That conditioning really must work." He said that he was "damned if he was going to turn around or look at her or get involved and he kept walking.

He also reported having a very vivid sexual dream about a woman in one of his classes. She was described as having a very pockmarked face but a nice body. He had dreamt that he was kissing her and felt highly aroused but also "turned off by her face." He had progressed to kissing her breasts and manipulating her genitals which he described as

"extremely clear and highly arousing." He still reported no arousals to young girls, saying that he found it less tense to look at them now and easier to look away. He was asked about his social contacts and suggestions were made as to initiating further contacts.

At his next session he reported that he had finally broken down and masturbated after holding off for 11 days. He reported that he found himself using Janice in his imagery and that it was very vivid and highly arousing. A day later he made a date with Janice for dinner at her apartment.

During the day he had gone driving with a friend and he found himself starting to "get a little scared" when he kept seeing so many young girls on the street. He found himself "really staring" at one who was bending over "just like old times." He forced his gaze away, only to return it again. Then he decided that he had to get over it and he forced his gaze away. The whole situation "shook him up" in that he thought he was over it all but they still were "attractive" to him, though he did not experience any arousal whatsoever. It was pointed out to him that he could "re-learn" to respond to young girls as he had in the past if he elected to return to his previous behaviors and masturbatory fantasies. However, it was stressed that he now had alternate ways of behavior if he chose to use them and it was his responsibility for the choice. He was encouraged to continue his interaction with adult females and to just continue to "let things happen."

He reported that his dinner with Janice had turned out extremely well. It was a very good dinner and they had done the dishes and then went for a walk on the beach to admire the sunset. At her apartment later they had danced and they had then sat on the couch where he engaged in light petting. He fondled her pubic area and breasts, feeling highly aroused but proceeding at an easy pace. As soon as he began to experience the slightest anxiety or concern he would stop and return to an easier stage (recalling what E had suggested a long time back). Finally, when it was late and time for him to leave he kissed her at the door and had said, "I guess the only thing left is to go to bed together." Janice appeared to be somewhat "unsettled" but she replied that it did seem "inevitable," but she was not quite ready. However, she did not press him to leave. He then "opened" with her and told her that he too did not feel the situation was ripe for him, and they both began discussing their feelings toward the situation and each other. They eventually kissed some more but the situation was left at that. He felt very good about the evening. The next morning he recalled some sort of a "sexual dream" but could not remember the content.

His progress was pointed out to him and it was suggested that he could justly feel proud of his behavior. He admitted that things were looking very good at present and more hopeful than ever. He was now told that he could resume his masturbation whenever he wished, but that it would perhaps be most helpful if he spaced it out a little more than



he had in the past. He agreed.

When next seen, he said that while sitting in the waiting room prior to seeing E he had suddenly wondered what he was going to do when the treatment program was over and he encountered just the "usual everyday problems of work and college." This was the first time he had made any reference to "after treatment." He was assured that E would make arrangements for him to see someone on the agency staff should such problems occur.

He had masturbated twice during the week. To his surprise he found himself using the image of the woman with whom he had had his first sexual experience (the divorcee with the young children). He said that she had liked oral-genital contact and he had used oral imagery with her and found it very vivid and highly satisfying. He added with a laugh, "Too bad I don't see her now, she always liked the oral stuff and now we could really have a ball together." This was in obvious marked contrast to his reported attitude when first starting treatment. He further described the following dream: He was some sort of a taxi driver, and he was to take a little girl somewhere in town. He recalled picking her up to put her in the car and he noticed her body as he lifted her. She immediately began to accuse him of being interested in her. He ignored her and looked away and saw another man off in the distance. He told her it was not him but that other guy, and that he did not want anything to do with her. The dream ended at that point.

He further mentioned that his daily encounters with little girls had changed somewhat in that he neither "zeroed in" on them, nor "immediately looked away." He now had a feeling of just "lack of interest" and he still had no arousals to report. He described several positive social contacts with adult females, having made two dates for the following week. He began to talk about his future and what he planned to do when he completed his advanced degree. He initially felt that "regular" marriage was going to be too difficult for him in that he would not be able to live up to the sexual demands of "regular" women. He thought that his best chance might be in some sort of "communal marriage" where the demands would be less. It was suggested that his frequencies of sexual outlet were well within the usual range, particularly when his masturbatory behavior was taken into account. It was further suggested that he really had no basis upon which to base his "frequency" with an adult woman for he had had no opportunity to explore a meaningful ongoing relationship free of his former preoccupation with little girls. This suggestion seemed to make a strong impression on him and considerable time was devoted to a discussion of the great range of behaviors and frequencies that men and women could adapt to. At the end of the discussion he reported feeling much better about the whole area and that he would just "take things as they came and see what happened." At this point he was asked to retake the CFI, RSS, and SFI in order to see how things appeared to him

nowadays. He readily agreed.

When he brought in his forms the following week, he reported several interesting events. On one day, deciding it was about time to really get started on the "social bit" he had asked three different women for a date and the third had accepted. He had an enjoyable evening with her and had really "opened up" to her, as she apparently did with him. The second girl he had asked he had never talked with before. He recognized her from one of his classes and he had offered her a ride which she accepted. During their conversation he had asked her if she cared to see a movie that evening with him. As he described it, "Actually, it just slipped out before I knew what I was asking." He felt comfortable but she had declined, saying that she had a previous date. He had also experienced a strong arousal to her and planned to ask her again in the future.

He described again encountering the woman with the "attractive daughters", and this time he found himself feeling friendly and somewhat "detached" with the little girls. He felt no arousal, just comfortable and natural.

He then reported an experience which at first he was not going to tell, but he had changed his mind. One evening, after work he had walked out on the balcony of his apartment and saw a "parade of little girls walking down the street." He had looked at them for a moment and, as he described it, he "suddenly realized that he really did not care anymore." He somehow felt "beyond it all" and they just did not mean

anything to him. He found it easy to turn away and return inside. He later thought that he would not tell E because E might tell him that treatment was through and that he did not need to come in anymore. After thinking about the implications of this, he finally decided that maybe he did not need treatment and if E suggested stopping then he would accept it.

E informed him that he felt very encouraged about his good progress, but that, regardless of how well things were going, he would like to continue seeing him for the next month or two so that he could be available to discuss any new developments that Mr. Jones might have some questions about. He appeared very satisfied with this suggestion and he was told that they would go over his recently completed inventories at their next session.

Mr. Jones' initial inventory scores and those obtained seven months later, along with normative scores, are shown in Table 28.

TABLE 28

## MR. JONES' PRE AND POST INVENTORY SCORES

Scale	Initial Score 7 Months Later		Normative Scores	
			$\bar{X}$	SD
Reinforcement Survey Schedule:	329	295		
Composite Fear Inventory:				
Total Score:	274	230	387.38	87.07
Geer Scale:	76	60	122.99	27.73

Suinn Scale:	160	139	206.60	50.03
Sexual Fear Inventory:				
Total Score:	170	161.5	239.59	67.71
General:	34	41.5	51.41	13.71
Personal:	46	35.5	58.09	13.40
Social:	27	24	32.41	8.55
Contact:	63	60.5	97.69	40.05

Though Mr. Jones' initial fear scores were around one standard deviation less than those obtained by comparable norm groups, his scores obtained seven months later are even lower. A similar decrease is seen on the RSS scores. Examination of individual responses as indices of A-R-D value lead to some interesting findings.

Mr. Jones obtained an initial score of 21 on the five items from the RSS that were used for covert reinforcement procedures (e.g., camping, hiking, taking a shower, etc.). Seven months later he obtained a score of 10 on the same items, indicating an average drop of two points in reinforcing value. This finding lends support to the possible satiation effects of covert reinforcement procedures. His response to babies dropped from "Much" to "A little", and his response to children dropped from "Very much" to "A fair amount."

Mr. Jones obtained an initial score of 46 on the 12 items from the CFI that were used for covert sensitization procedures (e.g., spiders, dark places, enclosed places,

being physically assaulted, angry people, etc.). Seven months later he obtained a score of 23 on the same items, indicating an average decrease of almost two points in rated fear value. This finding lends support to the possible adaptation or "implosive" effects of covert sensitization procedures. His response to sexual inadequacy dropped from "a fair amount" to "a little," and his response to masturbation dropped from "a fair amount" to "not at all."

In general his responses to homosexual items on the SFI remained the same. On the SFI social items his responses to a female says she finds you attractive and a female asks you for a date decreased from "A little to "Not at all"; and his response to asking a female for a date dropped from "A fair amount" to "not at all." On the heterosexual physical contact items he response to Engaging in mutual mouth-genital manipulation with a female increased from "Not at all" to "a little."; while his responses to being bitten by a female, engaging in sexual intercourse with a female, and a female manipulating your genitals with her tongue decreased from "A little" to "not at all." All other contact responses remained the same. Finally, his sexual fear response to nude children increased from "not at all" to "a fair amount."

Figure 4 shows Mr. Jones' arousal record to young girls and adult females before, during and after treatment procedures. The data, along with that provided by Mr. Jones' inventories, largely supports the predictions made from the theoretical treatment plan that was developed from the

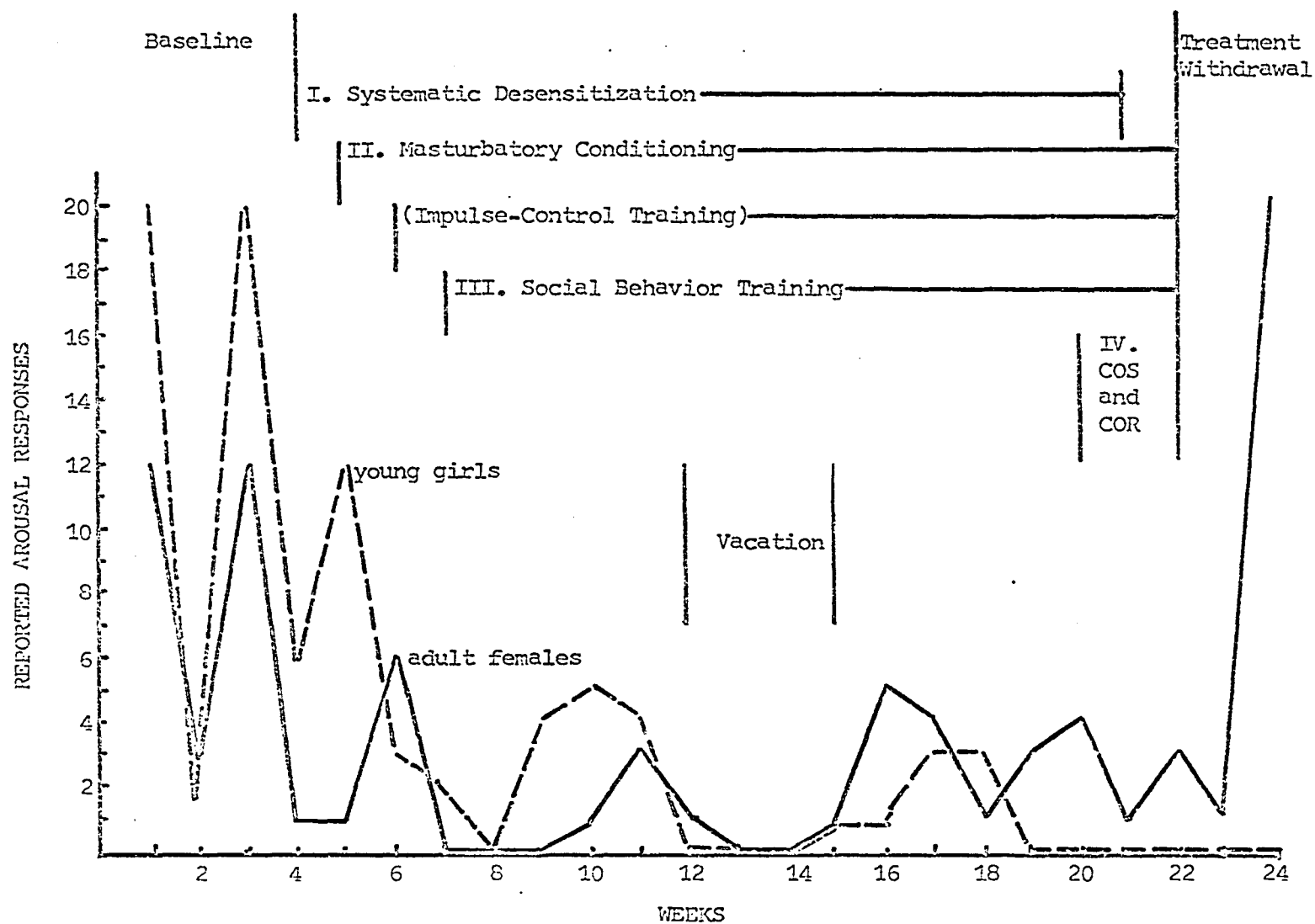


Figure 4. Mr. Jones' arousal record.

initial A-R-D analysis. It should be pointed out that the high number of arousals to adult females during the final week largely occurred during the evening that Mr. Jones spent with his friend Janice. However, some stable separation between his arousal to little girls and adult females seems to be present. Most important, he had not reported an arousal response to a little girl for the last six weeks of his program.

At this time it is not anticipated that any further behavioral treatment techniques will be used. He will continue to be seen for another four to six weeks in order to help him consolidate what he has learned and to monitor his continued progress. Further treatment procedures will be instigated if found to be necessary.

From his initial interview with Miss Kato to the last described consultation, Mr. Jones had seen Miss Kato 48 times, E 30 times, and both one time, for a total of 79 contact sessions. Time elapsed from initial interview with Miss Kato to his last session was approximately seven and a half months.

### Conclusions

The major conclusion of the present research is that an initial analysis of a client's sexual problem from within the A-R-D framework, followed by a behavioral diagnosis of relevant behavioral repertoires, offers the most promising conceptual scheme for the ordering of sexual problems and the development of appropriate treatment procedures.



This conclusion is based upon a number of considerations. The use of this scheme offers a plan for the simultaneous consideration of the full range of the client's circumstances. Such an approach also allows for the ordering of priorities for intervention and provides guidance for the timing of multiple interventions. Finally, the use of such a conceptual scheme is not tied to any particular behavioral technique or procedure, but fosters the development of appropriate procedures based upon theoretical analysis. Arousal reinforcement and fantasy masturbation to overt stimuli are two examples of the development of such theoretically based procedures found in the present research.

The current stress by many behavior therapists on a broad-spectrum approach to treatment has no virtue unless there is some theoretically based plan for ordering their various interventions. Without such a plan broad-spectrum treatment is just as much a shotgun approach as is using the same one or two procedures for all problems. The results of the present research suggests one conceptual framework for the ordering of sexual problems and their treatment. Further research is needed to determine whether such an approach is applicable to other problems as well.

## APPENDIX A

## APPENDIX A

DATE: \_\_\_\_\_

CODE NUMBER: \_\_\_\_\_

## LIFE HISTORY QUESTIONNAIRE

The purpose of this questionnaire is to obtain a comprehensive picture of your background, in order to assist in the formation of an individual treatment program designed for your particular situation. By completing these questions as fully and as accurately as you can, you will facilitate your therapeutic program. This questionnaire will save you both time and expense. You are requested to answer these routine questions in your own time instead of having to use your actual consulting time.

All material is confidential and no one, not even your closest relative or family doctor, is permitted to see this material without your written permission. If you are particularly troubled by any question and do not desire to answer it, merely write in "Do not care to answer."

## I. GENERAL

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Racial extraction: \_\_\_\_\_

City and State where born: \_\_\_\_\_

Rural or urban background: \_\_\_\_\_

Religious background: \_\_\_\_\_

Degree of adherence at present: \_\_\_\_\_

Marital status (single, married, etc.): \_\_\_\_\_

Approximately how long have you lived in this city:

\_\_\_\_\_ State: \_\_\_\_\_

## II. FAMILY

Give a description of your father's personality and his attitude towards you (Past and present): \_\_\_\_\_

Give a description of your mother's personality and her attitude towards you (Past and present): \_\_\_\_\_

Give an impression of your home atmosphere in which

you grew up. Mention state of compatibility between  
parents and children: \_\_\_\_\_

Were you able to confide in your parents? \_\_\_\_\_

Please supply the following information about your par-  
ents and siblings: (If no parent, then stepparent,  
etc.) Write in relationship in column on left.

How do (or did)  
you get along  
with them?

Do you see  
or write  
often?

If dead,  
what year  
& cause?

Live in  
what  
city?

Age

Relationship

Father:

Mother:

Brothers:

Sisters:

Father's occupation: \_\_\_\_\_

Mother's occupation: \_\_\_\_\_

Father's health (Past and present) \_\_\_\_\_

Mother's health (Past and present) \_\_\_\_\_

If you were not brought up by your parents, who did  
bring you up and between what years \_\_\_\_\_

Are there any other members of your family about whom  
information is relevant: \_\_\_\_\_

Anything you would care to add about your family his-  
tory: \_\_\_\_\_

### III. EDUCATION

Age of beginning school: \_\_\_\_\_ Age of fin-

ishing school: \_\_\_\_\_ Completed grammar

school: \_\_\_\_\_ High School: \_\_\_\_\_ College:

\_\_\_\_\_ Major in college: \_\_\_\_\_

Highest degree: \_\_\_\_\_

Any special, technical, professional training: \_\_\_\_\_

If so, of what nature: \_\_\_\_\_

Special honors or activities in school: \_\_\_\_\_

Any armed service (if so, what branch, rank, specialty)

### IV. OCCUPATION

Age of starting work: \_\_\_\_\_ Present occupation: \_\_\_\_\_

\_\_\_\_\_ Positions held (in chronological

order), duties, and reason for change: \_\_\_\_\_

Does your present work satisfy you? (If not, in what ways are you dissatisfied?): \_\_\_\_\_

What do you earn: \_\_\_\_\_ How much does it cost you to live: \_\_\_\_\_ If unemployed, source of income at present: \_\_\_\_\_

Ambitions: \_\_\_\_\_

V. MARITAL

How long did you know your marital partner before marriage: \_\_\_\_\_ For how long were you engaged? \_\_\_\_\_

Spouse's age: \_\_\_\_\_ For how long have you been married: \_\_\_\_\_

Your age at marriage: \_\_\_\_\_ Spouse's age at marriage: \_\_\_\_\_ Spouse's religious affiliation: \_\_\_\_\_ Spouse's educational history: \_\_\_\_\_

Spouse's occupational history: \_\_\_\_\_

How do you get along with your in-laws (including brothers, sisters, etc. ): \_\_\_\_\_

In what areas is there compatibility between you and your spouse: \_\_\_\_\_

In what areas is there incompatibility between you and your spouse: \_\_\_\_\_



Are there any major difficulties between you and your spouse in regard to the manner or methods of raising your children? (If so, what are they?): \_\_\_\_\_

\_\_\_\_\_  
Character of place where you are currently living (apartment, house, etc.): \_\_\_\_\_

\_\_\_\_\_  
How long have you lived there: \_\_\_\_\_

\_\_\_\_\_  
How long do you plan to reside in this state: \_\_\_\_\_

#### VI. CLINICAL

How were you referred here (or how did you happen to come in): \_\_\_\_\_

State in your own words the nature of your chief complaint: \_\_\_\_\_

Give a brief account of the history and development of your complaint (from onset to present): \_\_\_\_\_

\_\_\_\_\_  
Whom have you previously consulted about your present problem (date, length of time, type of treatment): \_\_\_\_\_

\_\_\_\_\_  
Whom have you previously consulted for other problems (dates, length of time, type of treatment): \_\_\_\_\_

\_\_\_\_\_  
How strongly do you want treatment for your problem (check): ( ) Very much ( ) Much ( ) Moderately ( ) Could do without it, if necessary ( ) Do not want treatment



## APPENDIX B

## APPENDIX B

DATE: \_\_\_\_\_

CODE NUMBER: \_\_\_\_\_

## BEHAVIOR ASSESSMENT FORM

## I. PROBLEM ANALYSIS

- A. Behavioral excess: (Behaviors which occur and are described as problematic by client or informant because of excess in 1) frequency, 2) intensity, 3) duration, or 4) occur under nonsocially sanctioned conditions.)

If  
changedWho  
supportsWho  
objects

Definition

Behavior

Occurs under what conditions  
Response  
Consequent event

Antecedent event

## I. PROBLEM ANALYSIS

B. Behavioral deficit: (Behaviors described as problematic by someone because they fail to occur 1) with sufficient frequency, 2) with adequate intensity, 3) in appropriate form, or 4) under socially expected conditions.)

If  
changed

Who  
supports

Who  
objects

Definition

Behavior

Antecedent event      Fails to occur under what conditions      Response      Consequent event

## I. PROBLEM ANALYSIS

C. Behavioral asset: (Nonproblematic behaviors that client does well.)

1. Special talents (painting, drawing, sculpture, writing, acting, dancing, singing, etc.)

2. Special skills (carpentry, driving, swimming, crafts, etc.)

3. Social behaviors (fluency in speech, manners, sense of humor, etc.)

4. Other assets

## II. MOTIVATIONAL ANALYSIS:

Games and interests during childhood (including make-believe): \_\_\_\_\_

Interests and hobbies during adolescence: \_\_\_\_\_

Present interests, hobbies, activities (Or primary items from Reinforcement Survey Schedule): \_\_\_\_\_

Under what specific conditions do each of these reinforcers arouse goal-directed behavior: \_\_\_\_\_

Which persons or groups have the most effective and widespread control over current behavior: \_\_\_\_\_

Aversive stimuli: In what ways was client punished by parents as a child: \_\_\_\_\_

What does client find aversive in immediate day-to-day (Fear Survey Schedule): \_\_\_\_\_

In the future: \_\_\_\_\_

Which events of known reinforcing or aversive value can be utilized for learning new interpersonal skills or self-attitudes during treatment: \_\_\_\_\_

In what areas and by what means can positive consequences be arranged to follow desired behaviors, replacing earlier aversive consequences: \_\_\_\_\_

### III. DEVELOPMENTAL ANALYSIS

#### A. Biological changes:

Health during childhood: \_\_\_\_\_

Health during adolescence: \_\_\_\_\_

Surgical operations: \_\_\_\_\_

Accidents: \_\_\_\_\_

What are limitations in client's biological equipment which may affect his current behavior (e.g., defective

vision, hearing, residual illness, etc.): \_\_\_\_\_

When and how did they develop (consequences on attitude--what was done by whom): \_\_\_\_\_

How do these conditions limit response to treatment or resolution of problem: \_\_\_\_\_

B. Sociological changes:

Present sociocultural milieu (urban vs rural; religious; economic status; ethnic affiliation; educational background; etc.): \_\_\_\_\_

Have there been changes pertinent to current behavior (marriage, moving, etc.): \_\_\_\_\_

Are his roles in various social setting congruent: \_\_\_\_\_

How can sociological factors in the problematic behavior be brought into relation with a treatment program: \_\_\_\_\_

C. Behavioral changes:

Prior to coming in, did client's behavior show deviations in behavioral patterns compared with developmental and social norms: (If so, what was nature of changes in social behaviors, self-care, attitudes, etc.): \_\_\_\_\_

Under what conditions were these changes first noted: \_\_\_\_\_

What conditions seem to bring about changes: 1) in the emergence of new behaviors \_\_\_\_\_

2) changes in intensity or frequency of established behaviors: \_\_\_\_\_

3) non-occurrence of previous behaviors: \_\_\_\_\_

Which conditions can be brought into relation with a treatment program: \_\_\_\_\_

#### IV. ANALYSIS OF SELF-CONTROL

In what situations can client control problem behaviors (and how): \_\_\_\_\_

Acquired some measures of self-control in avoiding situations conducive to execution of his problematic behavior (how): \_\_\_\_\_

What conditions, persons, or reinforcers tend to change client's self-controlling behavior (e.g., school setting, out with boys, etc.): \_\_\_\_\_

To what extent can client's self-controlling behavior be used in a treatment program: \_\_\_\_\_

#### V. ANALYSIS OF SOCIAL RELATIONSHIPS

Who are the most significant people in the patient's current environment: \_\_\_\_\_

To which is he most responsive (who facilitates, who provokes): \_\_\_\_\_

In these relationships, by use of what reinforcers do the participants influence each other: \_\_\_\_\_

What does client expect of these people in words and action: \_\_\_\_\_

What do they expect of client: \_\_\_\_\_

How can they participate in treatment program: \_\_\_\_\_



## APPENDIX C

## APPENDIX C

DATE: \_\_\_\_\_

CODE NUMBER: \_\_\_\_\_

## COMPOSITE FEAR INVENTORY

The items in this questionnaire refer to things and experiences that may cause fear or other unpleasant feelings. For each item, place a check (✓) in the box under the column that describes how much you are disturbed by it nowadays.

Items	Not at all	A little	A fair amount	Very Much much
1. Beetles				
2. Getting lost				
3. Gnats				
4. Taking tests				
5. Roaches				
6. The unknown				
7. Horses				
8. Cows				
9. Being put under pressure				
10. Policemen				
11. Frogs				
12. Being disfigured				
13. Storms				
14. Fish				
15. Being punished				
16. Members of the opposite sex				
17. Turtles				
18. Old people				
19. Lizards				
20. Foreigners				
21. Monkeys				
22. Physical illness				
23. Non-poisonous spiders				
24. Looking down from high buildings				
25. Losing control				
26. Loud voices				
27. Feeling angry				
28. Sick people				
29. Angry people				
30. Feeling disapproved of				
31. One person bullying another				
32. Noise of vacuum cleaners				

Items	Not at all	A little	A fair amount	Much	Very much
33. Speaking in public					
34. Crossing streets					
35. Open wounds					
36. Receiving injections					
37. Animal blood					
38. Witnessing surgical operations					
39. Dead animals					
40. Dead people					
41. Seeing other people injected					
42. Human blood					
43. Medical odors					
44. Falling					
45. Being in a strange place					
46. Entering a room where other people are already seated					
47. Darkness					
48. Automobiles					
49. Being teased					
50. Failure					
51. Dentists					
52. Thunder					
53. Sirens					
54. Mice					
55. People who seem insane					
56. Imaginary creatures					
57. Strangers					
58. Journeys by train					
59. Journeys by bus					
60. Parting from friends					
61. Journeys by car					
62. People in authority					
63. Sudden noises					
64. Dull weather					
65. Crowds					
66. Large open spaces					
67. Cats					
68. Tough looking people					
69. Birds					
70. Prospect of surgi- cal operation					
71. Sight of deep water					
72. Being watched work- ing					
73. Weapons					
74. Dirt					

	Items	Not at all	A little	A fair amount	Much	Very much
75.	Ugly people					
76.	Fire					
77.	Dogs					
78.	Strange shapes					
79.	High places on land					
80.	Nude men					
81.	Nude women					
82.	Enclosed places					
83.	Being in an elevator					
84.	Airplanes					
85.	Being ignored					
86.	Premature heart beats (missing a beat)					
87.	Lightning					
88.	Doctors					
89.	People with deform- ities					
90.	Sight of fighting					
91.	Flying insects					
92.	Bats					
93.	Harmless snakes					
94.	Crawling insects					
95.	Cemeteries					
96.	Worms					
97.	Being alone					
98.	Being criticized					
99.	Making mistakes					
100.	Looking foolish					
101..	Feeling rejected by others					
102.	Crowded places					
103.	Seeing a fight					
104.	Being with a drunk					
105.	Deep water					
106.	Swimming alone					
107.	Boating					
108.	Stinging insects					
109.	Rats and mice					
110.	Snakes					
111.	Spiders					
112.	Being a leader					
113.	Meeting authority					
114.	Meeting someone for the first time					
115.	Being with a member of the opposite sex					
116.	Being self-conscious					
117.	Speaking before a group					

Items	Not at all	A little	A fair amount	Much	Very much
118. Death					
119. Death of a loved one					
120. Auto accidents					
121. Losing a job					
122. Suffocating					
123. Untimely or early death					
124. Mental illness					
125.. Illness or injury to loved ones					
126. Being in a fight					
127. Illness					
128. Being misunderstood					
129. Failing a test					
130. Not being a success					
131. Being a passenger in a car					
132. Thunderstorms					
133. Heights					
134. Hypodermic needles					
135. Driving a car					
136. Strange dogs					
137. Blood					
138. Closed places					
139. Being a passenger in a plane					
140. Dead bodies					
141. Dark places					
142. Sharp objects					
143. God					
144. Arguing with parents					
145. Life after death					
146. Roller coasters					
147. Unclean silverware in restaurants					
148. Odors					
149. Being bullied by someone					
150. Dirty restrooms					
151. Loud noises					
152. Becoming mentally ill					
153. Falling down					
154. Loud sirens					
155. High places					
156. Guns					
157. Being in closed places					
158. Being cut					
159. Being physically					

	Items	Not at all	A little	A fair amount	Much	Very much
	assaulted					
160.	Cuts					
161.	Sharp objects (knives, razor blades, scissors)					
162.	Riding a roller coaster					
163.	Going into a theatre alone					
164.	Harmless spiders					
165.	Thought of having a defective child					
166.	Thoughts of suicide					
167.	Leaving home					
168.	Thoughts of being mentally ill					
169.	Leaving the gas on					
170.	Giving off an offensive odor					
171.	Being punished by God					
172.	Homosexual thoughts					
173.	Sexual inadequacy (impotence or frigidity)					
174.	Masturbation					
175.	Seeing a psychol- ogist or psychiatrist					

## APPENDIX D

DATE: \_\_\_\_\_

CODE NUMBER: \_\_\_\_\_

## FEAR INVENTORY DATA SHEET

<u>Data</u>	<u>Norms</u>
1. FSS-II (Geer, 1965) 51 items. #95 through #146; minus #101: _____	1. (Geer, 1965) 161 male college students: $\bar{X}$ : <u>75.78</u> SD: <u>33.84</u> 109 female college students: $\bar{X}$ : <u>100.16</u> 2. (Bernstein & Allen, 1969) 946 male college students: $\bar{X}$ : <u>81.81</u> SD: <u>33.64</u> 868 female college students: $\bar{X}$ : <u>108.47</u> SD: <u>36.78</u> 1814 total sample: $\bar{X}$ : <u>98.64</u> SD: <u>38.47</u> (Important note: Norms based on a 1 through 7 rating scale; instead of 1 through 5 scale of present inventory.)
2. FSS-III (Wolpe & Lang, 1964) 76 items. #26 through #101. _____	1. (Wolpe & Lang, 1964) No norms provided. Offer 6 categories for items, but not clear. Possible score ranges: <u>76 to 380</u> . A #3 (fair amount) rating on each item would produce a score of <u>228</u> . 2. (Manosevitz & Lanyon, 1965) 64 male college students: $\bar{X}$ : <u>188.6</u> 49 female college students: $\bar{X}$ : <u>207.8</u> (Important note: An additional 23 unspecified items were added to the FSS-III to provide this data.)
3. FSS (Wolpe & Lazarus, 1966) 78 items. #24 through #101 _____	1. (Wolpe & Lazarus, 1966) No norms provided, but is the Wolpe & Lang, 1964 FSS-III, with 2 additional items. Possible score ranges: <u>78 to 390</u> . A #3 (fair amount) rating on each item would produce a score of <u>234</u> .





DATE: \_\_\_\_\_

## FEAR INVENTORY DATA SHEET

CODE NUMBER: \_\_\_\_\_

475

<u>Data</u>	<u>Norms</u>
6. FSS (Bernstein & Allen, 1969) 33 items. #96 through #130; minus #97, #101.	1. (Bernstein & Allen, 1969) Factor analyses FSS-II. Gave 5 factors with each sex, with 33 items. No norms.
<u>Males</u>	<u>A #3 rating</u> <u>Possible score range</u>
I: Death and illness (8) #118-#125: _____	<u>24</u> <u>8 - 40</u>
II: Social interaction (7) #98; #112-#117: _____	<u>21</u> <u>7 - 35</u>
III: Negative social evaluation (7) #98-#100; #116; #128- #130: _____	<u>21</u> <u>7 - 35</u>
IV: Live organisms (5) #96; #108-#111: _____	<u>15</u> <u>5 - 25</u>
V: Violence (3) #102-#104: _____	<u>2</u> <u>3 - 15</u>
<u>Females</u>	
I: Social interaction (6) #98; #113-#117: _____	<u>18</u> <u>6 - 30</u>
II: Death, illness, injury (8) #120-#127: _____	<u>24</u> <u>8 - 40</u>
III: Live organisms (5) #96; #108-#111: _____	<u>15</u> <u>5 - 25</u>
IV: Negative social evaluation (6) #98-#100; #128-#130: _____	<u>18</u> <u>6 - 30</u>
V: Fear of water (3) #105-#107: _____	<u>2</u> <u>3 - 15</u>
7. TFSI (Braun & Reynolds, 1969) 100 items. Between #25 and #162.	1. (Braun & Reynolds, 1969) The temple fear survey inventory is 100 items compiled from previous surveys.

Data

#s: 25;27;29;30;31;32;  
 34;36;38;39;41;45;46;49;  
 51;52;55-60;62;63;64;66;  
 68;69;70;72;74;75;76;80;  
 81;83;85-89;91;92;94-110;  
 112;114-122;126-131;135;  
 136;137;139;140;141;143;  
 144;147-162

Norms

Factor analyses of responses of 435 college students yielded 21 interpretable factors within each sex. Sixteen were similar across sex. No norms. Possible score ranges: 100 to 500. A #3 (fair amount) rating on each item would produce a score of 300.

8. 15 items to which normal students respond with "A fair amount" of fear:  
 #s: 30;31;40;50;60;70;80;100;101;110;119;120;125;140;150: (Numbers in the inventory followed by a colon (:) indicate "A fair amount" of fear responses by females. Numbers followed by two periods (..) indicate "A fair amount of fear responses by both females and males.)

1. (Bernstein & Allen, 1969; Geer, 1965; Manosevitz & Lanyon, 1965) One or more of these studies reported 3 plus (or its equivalent) responses by the average college students used in their research samples for these items. (There are most likely others, such as: "being disfigured", etc., but these appear to be the only items for which such responses have been reported to date.)

Additional Data

## APPENDIX E

## APPENDIX E

DATE: \_\_\_\_\_

CODE NUMBER: \_\_\_\_\_

## REINFORCEMENT SURVEY SCHEDULE

The items in this questionnaire refer to things and experiences that may give joy or other pleasurable feelings. Check (✓) each item in the column that describes how much pleasure it gives you nowadays.

Items	Not at all	A little	A fair amount	Much	Very much
1. EATING					
a. ice cream					
b. candy					
c. fruit					
d. nuts					
e. pastry					
f. cookies					
2. BEVERAGES					
a. water					
b. milk					
c. soft drink					
d. tea					
e. coffee					
3. ALCOHOLIC BEVERAGES					
a. beer					
b. wine					
c. hard liquor					
4. BEAUTIFUL WOMEN					
5. HANDSOME MEN					
6. SOLVING PROBLEMS					
a. crossword puzzles					
b. mathematical problems					
c. figuring out how something works					
7. LISTENING TO MUSIC					
a. classical					
b. show tunes					
c. western country					
d. rhythm & blues					
e. rock & roll					
f. jazz					
g. folk					
h. popular					
8. NUDE MEN					
9. NUDE WOMEN					
10. ANIMALS					
a. dogs					
b. cats					

	Items	Not at all	A little	A fair amount	Much	Very much
	c. horses					
	d. birds					
11.	WATCHING SPORTS					
	a. football					
	b. baseball					
	c. basketball					
	d. track					
	e. golf					
	f. swimming					
	g. running					
	h. tennis					
	i. pool					
	j. other					
12.	READING					
	a. adventure					
	b. mystery					
	c. famous people					
	d. poetry					
	e. travel					
	f. true confessions					
	g. politics & history					
	h. how to-do-it					
	i. humor					
	j. comic books					
	k. love stories					
	l. spiritual					
	m. sexy					
	n. sports					
	o. medicine					
	p. science					
	q. science-fiction					
	r. newspapers					
	s. other					
13.	LOOKING AT INTEREST- ING BUILDINGS					
14.	LOOKING AT BEAUTIFUL SCENERY					
15.	TV, MOVIES, OR RADIO					
16.	LIKE TO SING					
	a. alone					
	b. with others					
17.	LIKE TO DANCE					
	a. ballroom					
	b. discotheque					
	c. ballet or inter- pretive					
	d. square dancing					
	e. folk dancing					
	f. other					
18.	PERFORMING ON A					

	Items	Not at all	A little	A fair amount	Much	Very much
	MUSICAL INSTRUMENT					
19.	PLAYING SPORTS					
	a. football					
	b. baseball					
	c. basketball					
	d. track & field					
	e. golf					
	f. swimming					
	g. running					
	h. tennis					
	i. pool					
	j. boxing					
	k. judo or karate					
	l. fishing					
	m. skin-diving					
	n. auto or cycle racing					
	o. hunting					
	p. skiing					
	q. surfing					
20.	SHOPPING					
	a. clothes					
	b. furniture					
	c. auto parts & supply					
	d. appliances					
	e. food					
	f. new car					
	g. new place to live					
	h. sports equipment					
	i. hobby equipment					
	j. other					
21.	GARDENING					
22.	PLAYING CARDS					
23.	HIKING OR WALKING					
24.	COMPLETING A DIFFI- CULT JOB					
25.	CAMPING					
26.	SLEEPING					
27.	TAKING A BATH					
28.	TAKING A SHOWER					
29.	BEING RIGHT					
	a. guessing what some- body is going to do					
	b. in an argument					
	c. about your work					
	d. on a bet					
30.	BEING PRAISED					
	a. about your appear- ance					

Items	Not at all	A little	A fair amount	Much	Very much
b. about your work					
c. about your hobbies					
d. about your phys- ical strength					
e. about your athlet- ic ability					
f. about your mind					
g. about your per- sonality					
h. about your moral strength					
i. about your under- standing of others					
31. HAVING PEOPLE SEEK YOU OUT FOR COMPANY					
32. FLIRTING					
33. HAVING SOMEBODY FLIRT WITH YOU					
34. TALKING WITH PEOPLE WHO LIKE YOU					
35. MAKING SOMEBODY HAPPY					
36. BABIES					
37. CHILDREN					
38. OLD MEN					
39. OLD WOMEN					
40. HAVING PEOPLE ASK YOUR ADVICE					
41. WATCHING OTHER PEOPLE					
42. SOMEBODY SMILING AT YOU					
43. MAKING LOVE					
44. HAPPY PEOPLE					
45. BEING CLOSE TO AN ATTRACTIVE MAN					
46. BEING CLOSE TO AN ATTRACTIVE WOMAN					
47. TALKING ABOUT THE OPPOSITE SEX					
48. TALKING TO FRIENDS					
49. BEING PERFECT					
50. WINNING A BET					
51. BEING IN CHURCH OR TEMPLE					
52. SAYING PRAYERS					
53. HAVING SOMEBODY PRAY FOR YOU					
54. PEACE AND QUIET					



# Situations I would like to be in

How much would you enjoy being in each of the following situations?

1. You have just completed a difficult job. Your superior comes by and praises you highly for "a job well done." He also makes it clear that such good work is going to be rewarded very soon.  
 not at all ( )      a little ( )      a fair amount ( )  
                          much ( )      very much ( )
2. You are at a lively party. Somebody walks across the room to you, smiles in a friendly way, and says, "I'm glad to meet you. I've heard so many good things about you. Do you have a moment to talk?"  
 not at all ( )      a little ( )      a fair amount ( )  
                          much ( )      very much ( )
3. You have just led your team to victory. An old friend comes over and says, "You played a terrific game. Let me treat you to dinner and drinks."  
 not at all ( )      a little ( )      a fair amount ( )  
                          much ( )      very much ( )
4. You are walking along a mountain pathway with your dog by your side. You notice attractive lakes, streams, flowers, and trees. You think to yourself, "It's great to be alive on a day like this, and to have the opportunity to wander out in the countryside."  
 not at all ( )      a little ( )      a fair amount ( )  
                          much ( )      very much ( )
5. You are sitting by the fireplace with your loved one. Music is playing softly on the phonograph. Your loved one gives you a tender glance and you respond with a kiss. You think to yourself how wonderful it is to care for someone and have somebody care for you.  
 not at all ( )      a little ( )      a fair amount ( )  
                          much ( )      very much ( )
6. As you are leaving your place of worship, a woman turns to you and says, "I want you to know how much we appreciate all that you did for us in our time of trouble and misery. Everything is wonderful now. I'll always remember you in my prayers."  
 not at all ( )      a little ( )      a fair amount ( )  
                          much ( )      very much ( )

List things you do or think about more than:

5

10

15

20 times a day?

## APPENDIX F

## APPENDIX F

DATE: \_\_\_\_\_

CODE NUMBER: \_\_\_\_\_

## SEXUAL FEAR INVENTORY--MALE

The items in this questionnaire refer to sexual related things and experiences that may cause fear or other unpleasant feelings. For each item, place a check (✓) in the box under the column that describes how much you are disturbed by it nowadays.

This inventory has been devised for single, young, and sexually inexperienced persons as well as for married and sexually experienced persons. In addition, there are great differences between people in sexual behavior preference. Thus, you may find sexual behaviors described which you have not engaged in. However, it is not necessary for you to have actually experienced each situation. The question is: "If you were today confronted by such a situation, would you expect to be fearful or anxious?"

Item	Not at all	A little	A fair amount	Very Much	Very much
1. Nude art					
2. Contraceptives					
3. Prostitutes					
4. Nudity in a motion picture					
5. Breasts					
6. Sex jokes					
7. Erotic photographs and drawings					
8. A penis					
9. Premarital sexual intercourse					
10. Extramarital sexual intercourse					
11. A vagina					
12. Wife swapping					
13. Burlesque shows					
14. Exotic dancers					
15. Testicles					
16. A sex orgy					
17. Sanitary napkins					
18. Homosexual males					
19. Homosexual females					
20. Buttocks					
21. Nudist camps					
22. Vulgar words on public walls					
23. Animals having					

	Item	Not at all	A little	A fair amount	Much	Very much
	sexual relations					
24.	Venereal disease					
25.	Nude men					
26.	Nude women					
27.	Nude children					
28.	Pubic hair					
29.	Sex play with animals					
30.	Sexual words					
31.	Having erotic dreams					
32.	Seeing your own genitals					
33.	Touching your own genitals					
34.	Listening to a discussion of sex					
35.	Talking to others about sex					
36.	Failure or diffi- culty in achieving an erection					
37.	Reading erotic stories or books					
38.	Seeing erotic movies					
39.	Masturbation					
40.	Daydreams about sex					
41.	The size of your penis					
42.	Having sexual thoughts about women					
43.	Having sexual thoughts about men					
44.	Being seen nude					
45.	Nocturnal emissions (wet dreams)					
46.	Seeing a woman un- dress					
47.	Getting a female pregnant					
48.	Reaching an orgasm too quickly or too slowly during mas- turbation or sexual intercourse					
49.	Undressing in front of a female					
50.	Seeing the genitals of a female					
51.	Seeing the genitals of a male					

Item	Not at all	A little	A fair amount	Much	Very much
52. Seeing a nude female statue					
53. Wearing the clothes of the opposite sex					
54. Using a public toilet					
55. Forgetting to pull up the zipper on your pants					
56. Visiting a nudist camp					
57. Seeing a female use the toilet					
58. Using sexual words					
59. Seeing a female's panties exposed					
60. Experiencing unusual sexual fantasies					
61. Calling a female on the phone					
62. Asking a female for a date					
63. A female asks you into her house					
64. A male asks you into his house					
65. Sitting in a movie with a female during a hot love scene					
66. Sitting in a movie with a female during a hot love scene and taking her hand					
67. A female smiles at you					
68. A male smiles at you					
69. Lying on the beach next to a female					
70. Lying on the beach next to a male					
71. Starting a conversation with a female					
72. A female says she finds you attractive					
73. A male says he finds you attractive					
74. Getting a drink for a female					
75. Lying on a couch beside a female					
76. Lying on a couch					

	Item	Not at all	A little	A fair amount	Much	Very much
	beside a male					
77.	Talking alone with a female					
78.	Having a female flirt with you					
79.	A female asks you for a date					
80.	Taking a female home after a date					
81.	Kissing a female goodnight					
82.	Accidentally bumping into a female					
83.	Sitting in a car in front of a female's house with your arm around her					
84.	Sitting in a car in a remote location with your arm around a female					
85.	Putting your hand on a female's shoulder					
86.	Putting your hand on a male's shoulder					
87.	Dancing with a female					
88.	Experiencing an erection while danc- ing with a female					
89.	Putting your arm around a female					
90.	Taking off a female's clothes					
91.	Biting a female					
92.	Being bitten by a female					
93.	Pressing your body against a female					
94.	Contact of tongues while kissing a female					
95.	Caressing the but- tocks and thighs of a female					
96.	Kissing a female's neck and ears					
97.	Caressing a female's shoulders and back					
98.	Caressing a female's hair and face					

Item	Not at all	A little	A fair amount	Much	Very much
99. Having a female take your hand					
100. Kissing the lips of a female for one minute continuously					
101. Engaging in sexual intercourse with a female					
102. Manipulating the genitals of a female with your tongue					
103. Manipulating the breasts of a female with your hands underneath her clothes					
104. Manipulating the genitals of a female with your hand over her clothes					
105. A female manipulat- ing your genitals with her tongue					
106. Engaging in mutual hand-manipulation of genitals with a female					
107. Kissing the nipples of the breasts of a female					
108. Engaging in mutual mouth-genital manip- ulation with a female to the point of her orgasm and your ejaculation					
109. Manipulating the genitals of a female with your hand under- neath her clothes					
110. A female manipulat- ing your genitals with her mouth to the point of your ejaculation					
111. A female manipulat- ing your genitals with her hand over your clothes					
112. Engaging in					

	Item	Not at all	A little	A fair amount	Much	Very much
	heterosexual inter- course using rear entry to the vagina					
113.	Touching the geni- tals of a female with your lips					
114.	A female touching your genitals with her lips					
115.	Engaging in mutual mouth-genital manip- ulation with a female					
116.	Manipulating the genitals of a female with your hand to the point of massive secretions from her genitals					
117.	A female manipulat- ing your genitals with her hand to the point of ejaculation					
118.	A female manipulat- your genitals with her hand underneath your clothes					
119.	Engaging in mutual hand-manipulation of genitals with a female to the point of her orgasm and your ejaculation					
120.	Manipulating the breasts of a female with your hands over her clothes					
121.	Having anal inter- course with a female					
122.	Mutual masturbation with the same sex					
123.	Having sexual inter- course with the female sitting on your lap					
124.	Having sexual inter- course with a female in the dining room or living room					



Item	Not at all	A little	A fair amount	Much	Very much
125. Changing positions during sexual inter- course with a female					
126. Engaging in mouth- genital contact with the same sex					
127. Genital-genital con- tact with a female without entry					
128. Rubbing the tip of your penis against the female clitoris					
129. In bed with a female who is aroused and eager and you have an erection					
130. In bed with a female who is aroused and eager and you can't get an erection					

## APPENDIX G

## APPENDIX G

DATE: \_\_\_\_\_

CODE NUMBER: \_\_\_\_\_

## SEXUAL FEAR INVENTORY--FEMALE

The items in this questionnaire refer to sexual related things and experiences that may cause fear or other unpleasant feelings. For each item, place a check (✓) in the box under the column that describes how much you are disturbed by it nowadays.

This inventory has been devised for single, young, and sexually inexperienced persons as well as for married and sexually experienced persons. In addition, there are great differences between people in sexual behavior preference. Thus, you may find sexual behaviors described which you have not engaged in. However, it is not necessary for you to have actually experienced each situation. The question is: "If you were today confronted by such a situation, would you expect to be fearful or anxious?"

Item	Not at all	A little	A fair amount	Very Much	Very much
1. Nude art					
2. Contraceptives					
3. Prostitutes					
4. Nudity in a motion picture					
5. Breasts					
6. Sex jokes					
7. Erotic photographs and drawings					
8. A penis					
9. Premarital sexual intercourse					
10. Extramarital sex- ual intercourse					
11. A vagina					
12. Husband swapping					
13. Burlesque shows					
14. Exotic dancers					
15. Testicles					
16. A sex orgy					
17. Sanitary napkins					
18. Homosexual males					
19. Homosexual females					
20. Buttocks					
21. Nudist camps					
22. Vulgar words on public walls					
23. Animals having sexual					

Item	Not at all	A little	A fair amount	Much	Very much
relations					
24. Venereal disease					
25. Nude men					
26. Nude women					
27. Nude children					
28. Pubic hair					
29. Sex play with an- imals					
30. Sexual words					
31. Having erotic dreams					
32. Seeing your own genitals					
33. Touching your own genitals					
34. Listening to a discussion of sex					
35. Talking to others about sex					
36. Failure or difficulty in achieving orgasm					
37. Reading erotic stories or books					
38. Seeing erotic movies					
39. Masturbation					
40. Daydreams about sex					
41. The size of your breasts					
42. Having sexual thoughts about men					
43. Having sexual thoughts about women					
44. Being seen nude					
45. Dreaming to orgasm					
46. Seeing a man un- dress					
47. Getting pregnant					
48. Reaching an orgasm too quickly or too slowly during mas- turbation or sexual intercourse					
49. Undressing in front of a male					
50. Seeing the genitals of a male					
51. Seeing the genitals of a female					
52. Seeing a nude male statue					

	Item	Not at all	A little	A fair amount	Much	Very much
53.	Wearing the clothes of the opposite sex					
54.	Using a public toilet					
55.	Forgetting to pull up the zipper on your dress					
56.	Visiting a nudist camp					
57.	Seeing a male use the toilet					
58.	Using sexual words					
59.	Seeing a male's underwear exposed					
60.	Experiencing un- usual sexual fantasies					
61.	Being called by a male on the phone					
62.	Being asked by a male for a date					
63.	A male asks you into his house					
64.	A female asks you into her house					
65.	Sitting in a movie with a male during a hot love scene					
66.	Sitting in a movie with a male during a hot love scene and he takes your hand					
67.	A male smiles at you					
68.	A female smiles at you					
69.	Lying on the beach next to a male					
70.	Lying on the beach next to a female					
71.	Starting a conver- sation with a male					
72.	A male says he finds you attractive					
73.	A female says she finds you attractive					
74.	Receiving a drink from a male					
75.	Lying on a couch					

	Item	Not at all	A little	A fair amount	Much	Very much
	beside a male					
76.	Lying on a couch beside a female					
77.	Talking alone with a male					
78.	Having a male flirt with you					
79.	Asking a male for a date					
80.	Being taken home by a male after a date					
81.	Kissing a male good- night					
82.	Accidentally bumping into a male					
83.	Sitting in a car in front of your house with a male's arm around you					
84.	Sitting in a car in a remote location with a male's arm around you					
85.	A male puts his hand on your shoulder					
86.	A female puts her hand on your shoulder					
87.	Dancing with a male					
88.	Experiencing a male's erection while he dances with you					
89.	A male puts his arm around you					
90.	A male taking your clothes off					
91.	Biting a male					
92.	Being bitten by a male					
93.	A male presses his body against you					
94.	Contact of tongues while kissing a male					
95.	Having your buttocks and thighs caressed by a male					
96.	Having your neck and ears kissed by a male					
97.	Having your shoulders and back caressed by a male					

	Item	Not at all	A little	A fair amount	Much	Very much
98.	Having your hair and face caressed by a male					
99.	Taking a male's hand					
100.	Kissing the lips of a male for one minute continuously					
101.	Engaging in sexual intercourse with a male					
102.	A male manipulating your genitals with his tongue					
103.	A male manipulating your breasts with his hands underneath your clothes					
104.	A male manipulating your genitals with his hands over your clothes					
105.	Manipulating the genitals of a male with your tongue					
106.	Engaging in mutual hand-manipulation of genitals with a male					
107.	A male kissing the nipples of your breasts					
108.	Engaging in mutual mouth-genital manipulation with a male to the point of his ejaculation and your orgasm					
109.	A male manipulating your genitals with his hands underneath your clothes					
110.	Manipulating the genitals of a male with your mouth to the point of his ejaculation					
111.	Manipulating the genitals of a male with your hand over his clothes					
112.	Engaging in					

Item	Not at all	A little	A fair amount	Much	Very much
heterosexual inter- course with the male using a rear entry to your vagina 113. A male touching your genitals with his lips					
114. Touching the geni- tals of a male with your lips					
115. Engaging in mutual mouth-genital manip- ulation with a male					
116. A male manipulating your genitals with his hands to the point of your orgasm, or of mas- sive secretions from your genitals					
117. Manipulating the genitals of a male with your hand to the point of his ejaculation					
118. Manipulating the gen- itals of a male with your hand underneath his clothes					
119. Engaging in mutual hand-manipulation of genitals with a male to the point of his ejaculation and your orgasm					
120. A male manipulating your breasts with his hands over your clothes					
121. Having anal inter- course with a male					
122. Mutual masturbation with the same sex					
123. Having sexual inter- course while sitting on a male's lap					
124. Having sexual inter- course with a male in the dining room or living room					



Item	Not at				
	all	A little	A fair amount	Much	Very much
125.	Changing positions during sexual intercourse				
126.	Engaging in mouth-genital contact with the same sex				
127.	Genital-genital contact with a male without entry				
128.	A male rubbing the tip of his penis against your clitoris				
129.	In bed with a male who is aroused and eager and has an erection				
130.	In bed with a male who is aroused and eager and he can't get an erection				

## APPENDIX H

## APPENDIX H

DATE: \_\_\_\_\_

CODE NUMBER: \_\_\_\_\_

## HETEROSEXUAL BEHAVIOR INVENTORY--MALE

On the following pages you will find a series of statements which describes various sexual behaviors which a male may have engaged in. Read each statement and decide whether or not you have experienced the sexual behavior described. Then indicate your answer.

If you have engaged in the sexual behavior described in a statement at any time since your 12th birthday, circle YES. If you have never engaged in the behavior since then, circle NO. Most items refer to your behavior with other individuals; you should consider these items as referring to any individuals who were also over 12 years old.

This inventory has been devised for young and sexually inexperienced persons as well as for married and sexually experienced persons. In addition, there are great differences between people in sexual behavior preference. Thus, you will find sexual behaviors described which you have not engaged in. Please note you are asked to indicate only whether or not you have ever taken part in the sexual behavior--you are not asked for your attitude or feelings.

Copyright (c) 1967

by

P. M. Bentler, Ph.D.

All rights reserved

Heterosexual Behavior

- |        |    |  |
|--------|----|--|
| YES NO | 1. | I have kissed the lips of a female for one minute continuously.                            |
| YES NO | 2. | I have engaged in sexual intercourse with a female.  |
| YES NO | 3. | I have manipulated the genitals of a female with my tongue.                                |
| YES NO | 4. | I have manipulated the breasts of a female with my hands underneath her clothes.           |
| YES NO | 5. | I have manipulated the genitals of a female with my hand over her clothes.                 |
| YES NO | 6. | A female has manipulated my genitals with her tongue.                                      |
| YES NO | 7. | I have engaged in mutual hand-manipulation of genitals with a female.                      |
| YES NO | 8. | I have kissed the nipples of the breasts of a female.                                      |
| YES NO | 9. | I have engaged in mutual-genital manipulation with a female to the point of her orgasm and |

- my ejaculation.
- YES NO 10. I have manipulated the genitals of a female with my hand underneath her clothes.
- YES NO 11. A female has manipulated my genitals with her mouth to the point of my ejaculation.
- YES NO 12. A female has manipulated my genitals with her hand over my clothes.
- YES NO 13. I have engaged in heterosexual intercourse using rear entry to the vagina.
- YES NO 14. I have touched the genitals of a female with my lips.
- YES NO 15. A female has touched my genitals with her lips.
- YES NO 16. I have engaged in mutual mouth-genital manipulation with a female.
- YES NO 17. I have manipulated the genitals of a female with my hand to the point of massive secretions from her genitals.
- YES NO 18. A female has manipulated my genitals with her hand to the point of ejaculation.
- YES NO 19. A female has manipulated my genitals with her hand underneath my clothes.
- YES NO 20. I have engaged in mutual hand-manipulation of genitals with a female to the point of her orgasm and my ejaculation.
- YES NO 21. I have manipulated the breasts of a female with my hands over her clothes.

## APPENDIX I

## APPENDIX I

DATE: \_\_\_\_\_

CODE NUMBER: \_\_\_\_\_

## HETEROSEXUAL BEHAVIOR INVENTORY--FEMALE

On the following pages you will find a series of statements which describe various sexual behaviors which a female may have engaged in. Read each statement and decide whether or not you have experienced the sexual behavior described. Then indicate your answer.

If you have engaged in the sexual behavior described in a statement at any time since your 12th birthday, circle YES. If you have never engaged in the behavior since then, circle NO. Most items refer to your behavior with other individuals; you should consider these items as referring to any individuals who were also over 12 years old.

This inventory has been devised for young and sexually inexperienced persons as well as for married and sexually experienced persons. In addition, there are great differences between people in sexual behavior preference. Thus, you will find sexual behaviors described which you have not engaged in. Please note you are asked to indicate only whether or not you have ever taken part in the sexual behavior--you are not asked for your attitude or feelings.

Copyright (c) 1967

by

P. M. Bentler, Ph.D.

Heterosexual Behavior

- |        |     |  |
|--------|-----|--|
| YES NO | 1.  | I have kissed the lips of a male for one minute continuously.  |
| YES NO | 2.  | I have engaged in sexual intercourse with a male.  |
| YES NO | 3.  | A male has manipulated my genitals with his tongue.  |
| YES NO | 4.  | A male has manipulated my breasts with his hands underneath my clothes.  |
| YES NO | 5.  | A male has manipulated my genitals with his hand over my clothes.  |
| YES NO | 6.  | I have manipulated the genitals of a male with my tongue.  |
| YES NO | 7.  | I have engaged in mutual hand-manipulation of genitals with a male.  |
| YES NO | 8.  | A male has kissed the nipples of my breasts.   |
| YES NO | 9.  | I have engaged in mutual mouth-genital manipulation with a male to the point of his ejaculation and my orgasm. |
| YES NO | 10. | A male has manipulated my genitals with his  |

- hand underneath my clothes.
- YES NO 11. I have manipulated the genitals of a male with my mouth to the point of his ejaculation.
- YES NO 12. I have manipulated the genitals of a male with my hand over his clothes.
- YES NO 13. I have engaged in heterosexual intercourse with the male using a rear entry to my vagina.
- YES NO 14. A male has touched my genitals with his lips.
- YES NO 15. I have touched the genitals of a male with my lips.
- YES NO 16. I have engaged in mutual mouth-genital manipulation with a male.
- YES NO 17. A male has manipulated my genitals with his hand to the point of my orgasm, or massive secretions from my genitals.
- YES NO 18. I have manipulated the genitals of a male with my hand to the point of his ejaculation.
- YES NO 19. I have manipulated the genitals of a male with my hand underneath his clothes.
- YES NO 20. I have engaged in mutual hand-manipulation of genitals with a male to the point of his ejaculation and my orgasm.
- YES NO 21. A male has manipulated my breasts with his hands over my clothes.

## APPENDIX J



## APPENDIX J

DATE: \_\_\_\_\_

CODE NUMBER: \_\_\_\_\_

## SEXUAL HISTORY FORM

## I. PHYSICAL AND PHYSIOLOGIC DATA

## 1. General

How would you describe your health: (Physical)

\_\_\_\_\_  
(Emotional) \_\_\_\_\_

When were you last examined by a physician: \_\_\_\_\_

\_\_\_\_\_  
For what condition: \_\_\_\_\_

Results: \_\_\_\_\_

Medical evaluation for present problem: \_\_\_\_\_

Date: \_\_\_\_\_ Results: \_\_\_\_\_

## 2. Adolescence: ages at onset of:

Erotic responsiveness

First orgasm (and its source)

Pubic hair growth

Breast development (Females)

Breast knots (adolescent knots in males)

Menstruation

Voice change

Onset of rapid growth

Completion of growth

## 3. Menstruation

Age at menarche

Length and regularity of menstrual cycle

Duration of flow

Pains

Emotional changes

## II. SEX EDUCATION

## 1. Sources of knowledge, ages when learned

Pregnancy

Coitus

Fertilization

Menstruation

Venereal disease

Prostitution  
Contraception  
Masturbation  
Abortion  
Male erection (Females)

2. Parental contribution to
3. Experience in observing sex behavior
4. Experience with graphic depictions  
of sexual activity
5. Attitudes on nudity  
of parents  
of client

III. NOCTURNAL SEX DREAMS

1. Ages involved
  2. Frequencies of dreams with orgasm
  3. Frequencies of dreams without orgasm
  4. Content of dreams \_\_\_\_\_
- 

IV. MASTURBATION (Any self stimulation which is deliberate and designed to effect erotic arousal)

1. Ages involved, pre- and post-adolescent
2. Sources of learning  
Conversation and reading  
Observation  
Participation  
Heterosexual  
Homosexual  
Self discovery
3. Frequencies  
Maximum per week  
pre-adolescent  
adolescent  
current
4. Techniques  
For male  
Manual  
Frictional  
Oral  
Special devices

Urethral insertions  
 For Female  
 Manual breast  
 Clitoral  
 Vaginal insertion  
 Frictional  
 Thigh pressure  
 Urethral insertions  
 With devices

5. Time required for orgasm
6. Accompanying imagery
  - Self
  - Homosexual
  - Heterosexual
  - Zoo-erotic
  - Sado-masochistic
  - Other
7. Client's evaluation
  - Period involving fear or conflict
  - Sources of resolution of conflict
  - Rejection, period involved, reasons for

#### V. HETEROSEXUAL HISTORY

1. Pre-adolescent play
  - Ages involved, frequencies
  - Companions: ages and number
  - Techniques
    - Exhibition
    - Physical exploration
    - Vaginal insertion
    - Urethral insertion
    - Mouth-genital contact
    - Coitus
2. Pre-marital petting (any sort of physical contact which does not involve a union of genitalia but in which there is a deliberate attempt to effect erotic arousal)
  - Ages involved
  - Frequencies
  - Companions
    - # Grade school
    - # High school
    - # College
    - # Prior to marriage
  - Techniques
    - General body contact
    - Lip kissing

- Tongue kissing
- Breast manipulation, manual
- Breast manipulation, oral
- Manual manipulation, male genitalia
- Manual manipulation, female genitalia
- Mouth-genital contact
  - On male
  - On female
- Genital apposition without entry
- Orgasm without intercourse
  - In males
  - In females
- Frequencies
- Ages involved
- After effects
  - Nervous disturbance
  - Genital cramps
  - Masturbation

### 3. Attitudes on pre-marital coitus

- Sources of restraint
  - Moral
    - Lack of opportunity
    - Lack of interest
    - Fear of pregnancy
    - Fear of venereal disease
    - Fear of social disapproval
- Desire for virginity in fiancée
- Desire for marriage
- Desire for children, number desired
- Intention to have, or continue coitus
- Evaluation of own coital experience

### 4. Experience in pre-marital coitus

- Ages involved
- First experience
  - Age and nature of partner
  - Virginity of partner
  - Speed of orgasm
  - Physical satisfaction
- Frequencies in coitus
- Partners
  - Total number
  - Prostitutes or companions
  - Age range
  - Youngest since client was 18
  - Age preference
  - Marital status
  - Consanguinity
  - Virginity
- Resulting pregnancies, births, abortions
- Arrangements
  - Places utilized for coitus

## Opportunity and desire for nudity

5. Marital intercourse (Separate for each marriage)
  - First experience
  - Age of each spouse
  - Virginity of each partner
  - Speed of orgasm
  - Physical satisfaction
  - Lapse between marriage and first coitus
  - Frequencies
  - Maximum ever
  - Means at various periods
  - Relation of sexual and marital adjustment
6. Extra-marital relations
  - Ages involved
  - Partners
  - Number
  - Age range
  - Marital status
  - Companions or prostitutes
  - Frequencies
  - Extra-marital coitus
  - Extra-marital petting w/o intercourse
  - Spouse's knowledge of the intercourse
  - Effect on marriage
  - Desire for further experience
7. Post-marital intercourse
  - Ages involved
  - Partners
  - Number
  - Age range
  - Marital status
  - Companions or prostitutes
  - Frequencies
8. Intercourse with prostitutes
  - Ages involved
  - #
  - Frequencies
  - Mouth-genital techniques
9. Coital techniques
  - Pre-coital play
  - Duration
  - Lip kissing
  - Tongue Kissing
  - Breast manipulation: manual
  - Breast manipulation: oral
  - Genital manipulation: manual
  - by male

- by female
- Genital manipulation: oral
- by male
- by female
- Frequency of orgasm
- Physical satisfaction
- Coital positions: relative frequencies and preferences
  - Male superior
  - Female superior
  - Side
  - Sitting
  - Standing
  - Rear entry
  - Anal
  - Other variations
- Male orgasm
  - Duration of intromission
  - Multiple orgasm
- Female orgasm
  - Frequency
  - Multiple orgasm
  - Date of first orgasm in coitus
  - Relation to coital techniques
- Nudity
  - Frequency
  - Attitude
- Preference for place
- Preference for light or dark
- Fantasies during intercourse

10. Contraceptive history: pre-marital, marital, extra-marital;  
Techniques employed

11. Group heterosexual activities
 

- Circumstances, frequencies
- Number and nature of partners
- Participation in strip poker
- Fraternal and other group initiation activities
- Observation of coitus
  - of parents
  - of friends
  - of professional exhibitionists

## VI. ANIMAL CONTACTS

1. Ages involved
2. Frequencies
  - with orgasm
  - w/o orgasm

3. Animal species involved, with preference

4. Techniques

Masturbation of animal

Vaginal coitus

Mouth-genital contact

Passive

Active

## VII. HOMOSEXUAL HISTORY

1. Pre-adolescent play

Ages involved, frequencies

Companions

Ages

Number

Techniques

Exhibition

Manual manipulation

Vaginal or urethral insertions

Mouth-genital contact

Anal

2. Post-adolescent experiences

Ages involved

First experience

Age

Partner

Race

Relation to client

Circumstances

Place

Initiation of approach

Techniques employed (passive, active, mutual)

Financial arrangements

Satisfaction for client

Age of first experience with each technique, passive and active

Manual

Oral

Anal

Breast (For female)

Femoral

Full body contact

Frequency

During first year

Maximum, ever, per day

Maximum, ever, per week

Average per week, for each year

Total number of contacts

Partners

#

Age range

- Comparison with age of client
- Age preference
- Reasons
- Social position of partners (students, professional, etc.)
- Relation involving love and affection
- Percentage of approaches rejected
- Techniques
  - Petting, passive and active
  - Lip kissing
  - Tongue kissing
  - Body kissing
  - Breast manipulation, manual
  - Breast manipulation, oral
  - Genital manipulation, manual
  - Genital manipulation, oral
  - Flagellation on back, buttocks, genitalia
  - Urethral insertions
  - Anilinctus
  - Nudity
  - Positions involved
  - Condition (place, light, dark, etc.)
- Client's orgasm
  - (Frequency by each technique or by spontaneous ejaculation)
- Partner's orgasm
  - (Frequency by each technique or by spontaneous ejaculation)
- 3. Psychic reactions
  - Prefences for:
    - Type
    - Height
    - Weight
    - Complexion
    - Hair
    - Genital characteristics
    - Reaction to odor and taste (genitalia and semen)
- 4. Sources of contacts
  - Personal friends
  - Pick-ups (Circle)
    - Street, park, hotel, theatre, tavern, night club, restaurant, beach, transportation terminal, public bath, toilets, hitch hiking
    - other places:
- 5. Social conflicts
  - Difficulties met in home, school, community, business
  - Arrests, convictions, etc.
  - Blackmail



## Robbery

7. Client's self analysis
  - Carriage and movement
  - Voice
  - Hip movement
  - Walk
  - Dress
  - Make-up
  - Interest in transvestism
  - Other qualities

## VIII. EROTIC RESPONSIVENESS

1. Auto-erotic
  - Observing self in mirror
  - Observing genitalia
  - Exhibitionistic behavior
2. Hetero-erotic
  - Thinking of other sex
  - Observing other sex
  - Nude art
  - Burlesque shows
  - Erotic pictures
  - Obscene stories
  - Erotic literature
  - Moving pictures
  - Dancing
  - Physical contacts
  - Biting
  - Being bitten
3. Homo-erotic
  - Thinking of own sex
  - Observing own sex
  - Observing erect genitals
  - Observing buttocks
  - Burlesque shows
  - Nude art
  - Obscene stories
  - Erotic literature
  - Erotic moving pictures
  - Erotic photos and drawings
  - Dancing
4. Zoo-erotic
  - Observing animal coitus
  - Physical contacts with animals
5. Non-sexual stimuli
  - Music
  - Alcohol
  - Motion

Pain  
Sadistic situations  
Masochistic situations  
Other emotional situations

6. Other

IX. ADDITIONAL DATA

## APPENDIX K

# APPENDIX K

## MEANS, STANDARD DEVIATIONS, AND t TESTS FOR THE COMPOSITE FEAR INVENTORY DATA

### Total Sample By Class

#### Means and Standard Deviations

Scale	Class I (N=37)		Class II (N=19)		Class III (N=21)	
	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD
Total CFI Score	401.297	101.394	369.00	61.775	379.476	74.319
Geer Scale Score	128.054	32.040	115.421	19.514	120.905	23.763
Suinn Scale Score	216.216	58.943	193.263	33.201	201.714	41.372

#### t Tests Between Classes\*

Scale	Classes I and II (df=54)		Classes II and III (df=38)		Classes I and III (df=56)	
	<u>t</u>	<u>P</u>	<u>t</u>	<u>P</u>	<u>t</u>	<u>P</u>
Total CFI Score	1.250	NS	0.470	NS	0.849	NS
Geer Scale Score	1.548	NS	0.773	NS	0.877	NS
Suinn Scale Score	1.546	NS	0.690	NS	0.980	NS

### Male Sample By Class

#### Means and Standard Deviations

Total CFI Score	Class I			Class II			Class III		
	N	$\bar{X}$	SD	N	$\bar{X}$	SD	N	$\bar{X}$	SD
Single Males	10	404.60	97.415	7	357.857	37.832	11	396.00	73.519

Married Males	3	392.00	99.422	1	341.00	-----	0	-----	-----
All Males	13	401.692	98.025	8	355.75	35.825	11	396.00	73.519

t Tests Between Classes\*

Total CFI Score	Classes I and II			Classes II and III			Classes I and III		
	<u>t</u>	<u>df</u>	<u>P</u>	<u>t</u>	<u>df</u>	<u>P</u>	<u>t</u>	<u>df</u>	<u>P</u>
Single Males	1.134	15	NS	1.197	16	NS	0.218	19	NS
Married Males	0.363	2	NS	-----	--	--	-----	--	--
All Males	1.212	19	NS	1.353	17	NS	0.152	22	NS

Female Sample By Class

Means and Standard Deviations

Total CFI Score	Class I			Class II			Class III		
	N	$\bar{X}$	SD	N	$\bar{X}$	SD	N	$\bar{X}$	SD
Single Females	20	405.25	111.243	6	389.333	91.782	9	363.889	74.254
Married Females	4	380.25	38.350	5	365.80	39.392	1	338.00	-----
All Females	24	401.083	103.172	11	378.636	73.740	10	361.30	70.870

t Tests Between Classes\*

Total CFI Score	Classes I and II			Classes II and III			Classes I and III		
	<u>t</u>	<u>df</u>	<u>P</u>	<u>t</u>	<u>df</u>	<u>P</u>	<u>t</u>	<u>df</u>	<u>P</u>
Single Females	0.307	24	NS	0.550	13	NS	0.983	27	NS
Married Females	0.488	7	NS	0.576	4	NS	0.853	3	NS
All Females	0.631	33	NS	0.521	19	NS	1.082	32	NS

# Combined Sample

## Means and Standard Deviations

Sample	N	Total CFI Score		Geer Scale Score		Suinn Scale Score	
		$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD
Single Males	28	389.536	78.859	122.857	24.764	206.571	43.813
Married Males	4	379.250	88.889	123.250	23.594	193.00	46.728
All Males	32	388.250	80.254	122.906	24.622	204.875	44.415
Single Females	35	391.886	101.183	124.771	32.910	210.257	59.063
Married Females	10	368.80	38.935	117.00	11.950	199.30	25.338
All Females	45	386.756	91.608	123.044	29.741	207.822	53.634
All Single	63	390.841	91.941	123.921	29.583	208.619	52.863
All Married	14	371.786	57.988	118.786	16.402	197.50	33.023
Total	77	387.377	87.072	122.987	27.729	206.597	50.031

## t Tests Between Samples\*

Samples	df	Total CFI Score		Geer Scale Score		Suinn Scale Score	
		$\underline{t}$	$\underline{P}$	$\underline{t}$	$\underline{P}$	$\underline{t}$	$\underline{P}$
Male Vs's Female	75	0.073	NS	0.021	NS	0.252	NS
Single Vs's Married	75	0.734	NS	0.621	NS	0.746	NS
Single Males Vs's Married Males	30	0.232	NS	0.029	NS	0.556	NS
Single Females Vs's Married Females	43	0.691	NS	0.717	NS	0.559	NS

\*All tests were two tailed

## APPENDIX L

# APPENDIX L

## MEANS, STANDARD DEVIATIONS, AND $t$ TESTS FOR SEXUAL FEAR INVENTORY DATA

### Total Sample By Class

#### Means and Standard Deviations

SFI Scales	Class I (N=38)		Class II (N=19)		Class III (N=21)	
	$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD
T - Score	272.763	83.351	257.368	85.401	239.905	64.022
G - Score	59.079	19.295	54.00	16.287	56.381	14.477
P - Score	60.895	18.489	56.842	15.971	58.095	14.246
S - Score	32.237	11.120	33.947	9.162	29.571	6.207
C - Score	120.553	48.826	112.579	51.667	95.857	38.776

#### t Tests Between Classes\*

SFI Scales	Classes I and II (df=55)		Classes II and III (df=38)		Classes I and III (df=57)	
	$\underline{t}$	$\underline{P}$	$\underline{t}$	$\underline{P}$	$\underline{t}$	$\underline{P}$
T - Score	0.641	NS	0.718	NS	1.543	NS
G - Score	0.968	NS	0.477	NS	0.550	NS
P - Score	0.802	NS	0.256	NS	0.592	NS
S - Score	0.569	NS	1.738	NS	0.998	NS
C - Score	0.560	NS	1.135	NS	1.963	NS



Male Sample By Class

Means and Standard Deviations

Total SFI Score	Class I			Class II			Class III		
	N	$\bar{X}$	SD	N	$\bar{X}$	SD	N	$\bar{X}$	SD
Single Males	10	250.80	72.023	7	243.429	60.604	11	232.909	59.236
Married Males	3	241.00	89.129	1	170.00	-----	0	-----	-----
All Males	13	248.538	76.424	8	234.250	61.672	11	232.909	59.236

t Tests Between Classes\*

Total CFI Score	Classes I and II			Classes II and III			Classes I and III		
	t	df	P	t	df	P	t	df	P
Single Males	0.208	15	NS	0.343	16	NS	0.593	19	NS
Married Males	0.563	2	NS	-----	--	--	-----	--	--
All Males	0.425	19	NS	0.045	17	NS	0.529	22	NS

Female Sample By Class

Means and Standard Deviations

Total SFI Score	Class I			Class II			Class III		
	N	$\bar{X}$	SD	N	$\bar{X}$	SD	N	$\bar{X}$	SD
Single Females	20	302.650	80.789	6	306.500	108.899	9	250.889	71.003
Married Females	5	216.200	56.651	5	235.400	56.248	1	218.00	-----
All Females	25	285.360	84.019	11	274.182	95.708	10	247.600	68.078

t Tests Between Classes\*

Total CFI Score	Classes I and II			Classes II and III			Classes I and III		
	<u>t</u>	<u>df</u>	<u>P</u>	<u>t</u>	<u>df</u>	<u>P</u>	<u>t</u>	<u>df</u>	<u>P</u>
Single Females	0.090	24	NS	1.115	13	NS	1.598	27	NS
Married Females	0.481	8	NS	0.253	4	NS	0.026	4	NS
All Females	0.342	34	NS	0.691	19	NS	1.230	33	NS

Combined Sample

Means and Standard Deviations

Sample	N	T - Score		G - Score		P - Score	
		$\bar{X}$	SD	$\bar{X}$	SD	$\bar{X}$	SD
Single Males	28	241.929	64.884	52.714	13.533	58.536	13.067
Married Males	4	223.250	83.085	42.250	11.256	55.00	15.149
All Males	32	239.594	67.711	51.406	13.713	58.094	13.396
Single Females	35	290.00	87.123	64.257	19.440	62.057	19.590
Married Females	11	225.091	54.642	51.00	11.465	53.00	14.820
All Females	46	274.478	85.182	61.087	18.734	59.891	18.959
All Single	63	268.635	81.60	59.127	18.007	60.095	16.948
All Married	15	224.600	63.490	48.667	12.048	53.533	14.935
Total	78	260.167	80.340	57.115	17.516	59.154	16.923

Sample	N	S - Score		C - Score	
		$\bar{X}$	SD	$\bar{X}$	SD
Single Males	28	32.714	8.892	97.964	37.771
Married Males	4	30.250	5.068	95.750	53.293
All Males	32	32.406	8.547	97.688	40.048
Single Females	35	31.143	10.551	132.543	51.412
Married Females	11	33.091	9.643	88.00	29.613
All Females	46	31.609	10.375	121.891	50.812
All Single	63	31.841	9.879	117.175	48.967
All Married	15	32.333	8.754	90.067	37.579
Total	78	31.936	9.675	111.962	48.191

t Tests Between Samples\*

Samples	df	T - Score		G - Score		P - Score		S - Score		C - Score	
		$\bar{t}$	p	$\bar{t}$	p	$\bar{t}$	p	$\bar{t}$	p	$\bar{t}$	p
Male Vs's Female	76	1.910	NS	2.465	<.05	0.456	NS	0.354	NS	2.224	<.05
Single Vs's Married	76	1.931	NS	2.113	<.05	1.361	NS	0.175	NS	1.98	<.05
Single Males Vs's Married Males	30	0.502	NS	1.428	NS	0.480	NS	0.525	NS	0.100	NS
Single Females Vs's Married Females	44	2.281	<.05	2.101	<.05	1.381	NS	0.533	NS	2.676	<.05

\*All tests were two tailed

## REFERENCES

- Abarbanel-Brandt, A. Homosexuals in hypnotherapy. Journal of Sex Research, 1966, 2, 127-132.
- Abel, G. G., Levis, D. J., & Clancy, J. Aversion therapy applied to taped sequences of deviant behavior in exhibitionism and other sexual deviations: a preliminary report. Journal of Behavior Therapy and Experimental Psychiatry, 1970, 1, 59-66.
- Akutagawa, D. A study in construct validity of the psychoanalytic concept of latent anxiety and a test of a projection distance hypothesis. Unpublished Doctoral Dissertation, University of Pittsburgh, 1956.
- Alexander, J. Clinical experiences with hypnosis in psychiatric treatment. International Journal of Neuropsychiatry, 1967, 3, 118-124.
- Alexander, L. Conditioned reflexes as related to hypnosis and hypnotic techniques. Journal of the American Society of Psychosomatic Dentistry and Medicine, 1966, 13, 35-53.
- Alexander, L. Psychotherapy of sexual deviation with the aid of hypnosis. American Journal of Clinical Hypnosis, 1967, 9, 181-183.
- Alpert, R. Drugs and sexual behavior. Journal of Sex Research, 1969, 5, 50-56.
- Andriola, J. Criteria for success or failure in the treatment of hospitalized sex offenders. Corrective Psychiatry and Journal of Social Therapy, 1966, 12, 323-326.
- Apperson, L. B., & McAdoo, W. G. jr. Parental factors in the childhood of homosexuals. Journal of Abnormal Psychology, 1968, 73, 201-206.
- Apter, I. M. On the psychotherapy of psychogenic impotence. In R. B. Winn (Ed.) Psychotherapy in the Soviet Union. New York: Grove Press, 1961. Pp. 89-93.
- August, R. V. Libido altered with the aid of hypnosis: a case report. American Journal of Clinical Hypnosis, 1959, 2, 88.
- Ayllon, T., & Azrin, N. The token economy: a motivational system for therapy and rehabilitation. New York: Appleton-Century-Crofts, 1968.

- Ayllon, T., Haughton, E., & Hughes, H. B. Interpretation of symptoms: fact or fiction? Behaviour Research and Therapy, 1965, 3, 1-7.
- Ayllon, T., & Michael, J. The psychiatric nurse as a behavioral engineer. Journal of Experimental Analysis of Behavior, 1959, 2, 323-334.
- Bachrach, A. J. Some applications of operant conditioning to behavior therapy. In J. Wolpe, A. Salter, and L. J. Reyna (Eds.), The Conditioning Therapies: the Challenge in Psychotherapy. New York: Holt, Rinehart & Winston, 1964. Pp. 62-78.
- Bancroft, J. H. J., Jones, H. G., & Pullan, B. R. A simple transducer for measuring penile erection, with comments on its use in the treatment of sexual disorders. Behaviour Research and Therapy, 1966, 4, 239-241.
- Bandura, A. Principles of behavior modification. New York: Holt, Rinehart and Winston, 1969.
- Bandura, A., & Menlove, F. L. Factors determining vicarious extinction of avoidance behavior through symbolic modeling. Journal of Personality and Social Psychology, 1968, 8, 99-108.
- Barker, J. C. Behaviour therapy for transvestism: a comparison of pharmacological and electrical aversion techniques. British Journal of Psychiatry, 1965, 111, 268-276.
- Barker, J. C., Thorpe, J. G., Blakemore, C. B., Lavin, N. I., & Conway, C. G. Behaviour therapy in a case of transvestiam. Lancet, 1961, 1, 150.
- Barlow, D. H., Agras, W. S., & Leitenberg, H. A preliminary report on the contribution of therapeutic instructions to covert sensitization. Paper presented at the meeting of the Association for the Advancement of Behavior Therapy, Miami, September, 1970.
- Barlow, D. H., Leitenberg, H., & Agras, W. S. Experimental control of sexual deviation through manipulation of the noxious scene in covert sensitization. Journal of Abnormal Psychology, 1969, 74, 596-601.
- Basil, J. Homosexuality. In C. G. Costello (Ed.) Symptoms of Psychopathology: a handbook. New York: Wiley & Sons, 1970. Pp. 574-593.
- Beigel, H. G. Three transvestites under hypnosis. The International Journal of Clinical and Experimental

- Hypnosis, 1965, 13, 71-82.
- Benedict, W. F. (Ed.) Woman: her sexual variations and functions. Los Angeles: Private Collectors, P. O. Box 46608, L. A., Calif., 90046. 1970.
- Benjamin, H. Newer aspects of the transsexual phenomenon. Journal of Sex Research, 1969, 5, 135-144.
- Bentler, P. M. Heterosexual behavior assessment--I. Males. Behaviour Research and Therapy, 1968, 6, 21-25. (a)
- Bentler, P. M. Heterosexual behavior assessment--II. Females. Behaviour Research and Therapy, 1968, 6, 27-30. (b)
- Bentler, P. M., & Prince, C. Personality characteristics of male transvestites: III. Journal of Abnormal Psychology, 1969, 74, 140-143.
- Bentler, P. M., & Prince, C. Psychiatric symptomatology in transvestites. Journal of Abnormal Psychology, 1970, 76, 434-435.
- Berest, J. J.- Report on a case of sadism. Journal of Sex Research, 1970, 6, 210-219.
- Bergin, A. E. A self-regulation technique for impulse control disorders. Psychotherapy: Theory, Research and Practice, 1969, 6, 113-118. (a)
- Bergin, A. E. A technique for improving desensitization via warmth, empathy, and emotional reexperiencing of hierarchy events. In R. D. Rubin and C. M. Franks (Eds.), Advances in Behavior Therapy 1968. New York: Academic Press, 1969. (b)
- Bergin, A. E. Brief note: A note on dream changes following desensitization. Behavior Therapy, 1970, 1, 546-549.
- Bernstein, D. A., & Allen, G. J. Fear survey schedule (II): normative data and factor analyses based upon a large college population. Behaviour Research and Therapy, 1969, 7, 403-407.
- Bieber, I. The meaning of homosexual trends in therapy: a round table discussion. American Journal of Psychoanalysis, 1964, 24, 60-76.
- Bijou, S. Implications of behavioral science for counseling and guidance. In J. D. Krumboltz (Ed.) Revolution in

Counseling: Implications of Behavioral Science.  
Boston: Houghton Mifflin, 1966, Pp. 27-48.

Bijou, S. W., Peterson, R. F., Harris, F. R., Allen, K. E., & Johnson, M. S. Methodology for experimental studies of young children in natural settings. The Psychological Record, 1969, 19, 177-210.

Birk, L. Behavior therapy-integration with dynamic psychiatry. Behavior Therapy, 1970, 1, 522-526.

Birnbrauer, J. S., Burchard, J. D., & Burchard, S. N. Wanted: behavior analysts. In R. H. Bradfield (Ed.) Behavior Modification: The Human Effort. San Rafael, Calif.: Dimensions Publishing Co., 1970. Pp. 19-71.

Blakemore, C. B., Thorpe, J. G., Barker, J. C., Conway, C. G., & Lavin, N. I. The application of faradic aversion conditioning in a case of transvestism. Behaviour Research and Therapy, 1963, 1, 29-34. (a)

Blakemore, C. B., Thorpe, J. G., Barker, J. C., Conway, C. G., & Lavin, N. I. Follow-up note to: The application of faradic aversion therapy conditioning in a case of transvestism. Behaviour Research and Therapy, 1963, 1, 191. (b)

Blend, D. The impotent male. In W. A. R. Thomson (Ed.), Sex and Its Problems. London: G. & S. Livingstone, 1968. Pp. 24-31.

Bond, I. K., & Evans, D. R. Avoidance therapy: its use in two cases of underwear fetishism. Canadian Medical Association Journal, 1967, 96, 1160-1162.

Bond, I. K., & Hutchison, H. C. Application of reciprocal inhibition therapy to exhibitionism. Canadian Medical Association Journal, 1960, 83, 23-25.

Bonime, W. Masturbatory fantasies and personality functioning. In J. H. Masserman (Ed.) Science and Psychoanalysis. Dynamics of deviant Sexuality. New York: Grune & Stratton, 1969. Pp. 32-50.

Bradfield, R. N. (Ed.) Behavior modification: the human effort. San Rafael, Calif.: Dimensions Publishing Co., 1970.

Brady, J. P. Brevital--relaxation treatment of frigidity. Behaviour Research and Therapy, 1966, 4, 71-77.

Branson, H. K. Frigidity is a mutual fault. In Sex Education Library. New York: Health Publications, 1966.

Pp. 14-16.

- Braun, P. R., & Reynolds, D. J. A factor analysis of a 100-item fear survey inventory. Behaviour Research and Therapy, 1969, 7, 399-402.
- Brecher, E. M. The sex researchers. Boston: Little, Brown & Co., 1969.
- Brown, D. G. Female orgasm and sexual inadequacy. In R. Breecher and E. Breecher (Eds.) An Analysis of Human Sexual Response. New York: New American Library, 1966. Pp. 125-174.
- Brown, P. T. On the differentiation of homo- or hetero-erotic content in the male: an operant technique in a case of a motor cycle fetishist. Behaviour Research and Therapy, 1964, 2, 31-35.
- Brown, J. S. A behavioral analysis of masochism. Journal of Experimental Research in Personality, 1965, 1, 65-70.
- Brown, J. S. Responses of a non clinician to stimuli provided by behavior therapists. In D. J. Levis (Ed.) Learning Approaches to Therapeutic Behavior Change. Chicago: Aldine, 1970. Pp. 245-256.
- Bruck, M. Behavior modification theory and practice: a critical review. Social work, 1968, 13, 43-55.
- Bucher, B., & Lovaas, O. I. Operant procedures in behavior modification with children. In D. J. Levis (Ed.) Learning Approaches to Therapeutic Behavior Change. Chicago: Aldine, 1970. Pp. 36-64.
- Buss, A. N. Psychopathology. New York: John Wiley & Sons, 1966.
- Cabeen, C. W., & Coleman, J. C. Group therapy with sex offenders: description and evaluation of group therapy program in an institutional setting. Journal of Clinical Psychology, 1961, 17, 122-129.
- Cahoon, D. D. Symptom substitution and the behavior therapies: a reappraisal. Psychological Bulletin, 1968, 69, 149-156.
- Carter, R. D., & Stuart, R. B. Behavior modification theory and practice: a reply. Social Work, 1970, 15, 37-50.
- Cautela, J. H. Desensitization and insight. Behaviour Research and Therapy, 1965, 3, 59.



- Cautela, J. R. A behavior therapy treatment of pervasive anxiety. Behaviour Research and Therapy, 1966, 4, 99-109.
- Cautela, J. R. Covert sensitization. Psychological Reports, 1967, 20, 459-568.
- Cautela, J. R. Behavior therapy and self control: Techniques and implications. In C. M. Franks (Ed.) Behavior Therapy: Appraisal and Status. New York: McGraw-Hill, 1969. Pp. 323-340.
- Cautela, J. R. Covert reinforcement. Behavior Therapy, 1970, 1, 33-50. (a)
- Cautela, J. R. (Chm.) Covert sensitization. Symposium presented at the meeting of the Association for the Advancement of Behavior Therapy, Miami, September, 1970. (b)
- Cautela, J. R., & Kastenbaum, R. A reinforcement survey schedule for use in therapy, training and research. Psychological Reports, 1967, 20, 1115-1130.
- Cautela, J. R., & Wisocki, P. A. The use of male and female therapists in the treatment of homosexual behavior. In R. D. Rubin and C. M. Franks (Eds.), Advances in Behavior Therapy 1968. New York: Academic Press, 1969. Pp. 165-174.
- Charatan, F. B., & Galef, H. A case of transvestism in a six year old boy. Journal of the Hillside Hospital, 1965, 14, 160-177.
- Clark, A. L., & Wallin, P. Women's sexual responsiveness and duration and quality of their marriages. American Journal of Sociology, 1965, 71, 187-196.
- Clark, D. F. Fetishism treated by negative conditioning. British Journal of Psychiatry, 1963, 109, 404-407. (a)
- Clark, D. F. Treatment of fetishism by negative conditioning --a further note. British Journal of Psychiatry, 1963, 109, 695-696. (b)
- Clark, L. (ed) Illustrated sex atlas. New York: Health Publications, 1963.
- Clark, L. 101 intimate sexual problems answered. New York: The New American Library, 1968. (a)
- Clark, L. The range and variety of questions people ask about sex. In C. E. Vincent (Ed.), Human Sexuality

- in Medical Education and Practice. Springfield, Ill.: C. C. Thomas, 1968. Pp. 552-565. (b)
- Clark, L. Is there a difference between a clitoral and vaginal orgasm? Journal of Sex Research, 1970, 6, 25-28.
- Coleman, J. C. Abnormal psychology and modern life. (2nd. ed.) Chicago: Scott, Foresman, 1956.
- Colton, H. Adults need sex education too. 1539 N. Courtney Ave., Los Angeles, Calif.: Family Forum, 1970.
- Cooper, A. J. A case of fetishism and impotence treated by behavior therapy. British Journal of Psychiatry, 1963, 109, 649-652.
- Cooper, A. J. A factual study of male potency disorders. British Journal of Psychiatry, 1968, 114, 719-731.
- Cooper, J. E. A study of behavior therapy in thirty psychiatric patients. Lancet, 1963, 1, 411-415.
- Coulton, D. Hypnotherapy in gynecological problems. American Journal of Clinical Hypnosis, 1960, 3, 95-100.
- Courtenay, M. Sexual discord in marriage: a field for brief psychotherapy. Philadelphia: J. B. Lippincott, 1968.
- Crider, B. Situational impotence. In M. F. DeMartino (Ed.) Sexual Behavior and Personality Characteristics. New York: Grove Press, 1963. Pp. 290-301.
- Curran, D., & Parr, D. Homosexuality: an analysis of 100 male cases. British Medical Journal, 1957, 1, 797-811.
- D'Alessio, G. R. The concurrent use of behavior modification and apychotherapy. Psychotherapy: Theory, Research and Practice, 1968, 5, 154-159.
- Davies, B. M., & Morgenstern, F. S. Journal of Neurology, Neurosurgery, and Psychiatry, 1960, 23, 247.
- Davison, G. Elimination of a sadistic fantasy by a client-controlled counterconditioning technique. Journal of Abnormal Psychology, 1968, 73, 84-90.
- Dean, R. B., & Richardson, H. Analysis of MMPI profiles of forty college-educated overt male homosexuals. Journal of Consulting Psychology, 1964, 28, 483-486.

- Dean, R. B., & Richardson, H. On MMPI high-point codes of homosexual versus heterosexual males. Journal of Consulting Psychology, 1966, 30, 558-560.
- Dengrove, E. Behavior therapy of sexual disorders. Journal of Sex Research, 1967, 3, 49-61.
- Dengrove, E. Sexual responses to disease processes. Journal of Sex Research, 1968, 4, 257-264.
- DeMartino, M. F. (Ed.) Sexual behavior and personality characteristics. New York: Grove Press, 1963.
- Denniston, R. H. Ambisexuality in animals. In J. Marmor (Ed.) Sexual Inversion: the Multiple Facts of Homosexuality. New York: Basic Books, 1965. Pp. 27-43.
- Diamond, M. A critical review of the ontogeny of human sexual behavior. Quarterly Review of Biology, 1965, 40, 147-173.
- DiCaprio, N. S. Essentials of Verbal satiation therapy: a learning-theory based behavior therapy. Journal of Counseling Psychology, 1970, 17, 419-424.
- Dickinson, R. L. The end of "hush and pretend." In D. D. Geddes and E. Curie (Eds.) About the Kinsey Report: Observations by 11 Experts on "Sexual Behavior in the Human Male." New York: Signet Books, 1948. Pp. 159-166.
- Di Scipio, W. J. Modified progressive desensitization and homosexuality. British Journal of Medical Psychology, 1968, 41, 267-272.
- Dollard, J., & Miller, N. E. Personality and Psychotherapy. New York: McGraw-Hill, 1950.
- Dupont, H. Social learning theory and the treatment of transvestite behavior in an eight year old boy. Psychotherapy: Theory, Research, and Practice, 1968, 5, 44-45.
- Eidelson, L. A contribution to the study of masturbatory phantasy. International Journal of Psychoanalysis, 1945, 26, 127-137.
- El Senoussi, A., Coleman, D. R., & Tauber, A. S. Factors in male impotence. Journal of Psychology, 1959, 48, 3-46.
- Ellis, A. The sexual psychology of human hermaphrodites. Psychosomatic Medicine, 1945, 7, 108-125.

- Ellis, A. The effectiveness of psychotherapy with individuals who have severe homosexual problems. Journal of Consulting Psychology, 1956, 3, 191-195.
- Ellis, A. Frigidity. In A. Ellis and A. Abarbanel (Eds.) The Encyclopedia of Sexual Behavior. Vol. I. New York: Hawthorne Books, 1961. Pp. 450-456.
- Ellis, A. Reason and emotion in psychotherapy. New York: Lyle Stuart, 1963.
- Ellis, A. Homosexuality: its causes and cure. New York: Lyle Stuart, 1965.
- Ellis, A. The treatment of frigidity and impotence. In H. Greenwald (Ed.) Active Psychotherapy. New York: Atherton Press, 1967. Pp. 328-336.
- Ellis, A. Homosexuality: the right to be wrong. Journal of Sex Research, 1968, 4, 96-107.
- Epstein, A. W. Relationship of fetishism and transvestism to brain and particularly to temporal lobe dysfunction. Journal of Nervous and Mental Disease, 1961, 133, 247-253.
- Evans, D. R. Masturbatory fantasy and sexual deviation. Behaviour Research and Therapy, 1968, 6, 17-19.
- Evans, D. R. Exhibitionism. In C. G. Costello (Ed.) Symptoms of Psychopathology: a Handbook. New York: John Wiley & Sons, 1970. (a)
- Evans, D. R. Subjective variables and treatment effects in aversion therapy. Behaviour Research and Therapy, 1970, 8, 147-152. (b)
- Evans, R. B. Childhood parental relationships of homosexual men. Journal of Consulting and Clinical Psychology, 1969, 33, 129-135.
- Evans, R. B. Sixteen personality factor questionnaire scores of homosexual men. Journal of Consulting and Clinical Psychology, 1970, 34, 212-215.
- Eysenck, H. J. (Ed.) Behaviour therapy and the neuroses. London: Pergamon Press, 1960.
- Eysenck, H. J. Behavior therapy and its critics. Journal of Behavior Therapy and Experimental Psychiatry, 1970, 1, 5-15.

- Eysenck, H. J., & Rachman, S. The causes and cures of neuroses. London: Routledge & Kegan Paul, 1965.
- Fast, J. What you should know about human sexual response. New York: Putnam's & Sons, 1966.
- Feingold, L. An illustration of the behavioral therapy approach in the treatment of social and sexual problems. Pennsylvania Psychiatric Quarterly, 1966, 6, 3-19.
- Feldman, M. P. Aversion therapy for sexual deviation: a critical review. Psychological Bulletin, 1966, 65, 65-79.
- Feldman, M. P., & MacCulloch, M. J. A systematic approach to the treatment of homosexuality by conditioned aversion: preliminary report. American Journal of Psychotherapy, 1964, 121, 167-171.
- Feldman, M. P., & MacCulloch, M. J. The application of anticipatory avoidance learning to the treatment of homosexuality. I. Theory, technique and preliminary results. Behaviour Research and Therapy, 1965, 2, 165-168.
- Feldman, M. P., MacCulloch, M. J., Mellor, V., & Pinschof, J. M. The application of anticipatory avoidance learning to the treatment of homosexuality. III. The sexual orientation method. Behaviour Research and Therapy, 1966, 4, 289-299.
- Ford, C. S. Sexual behavior among primitive peoples. In D. P. Geddes and E. Curie (Eds.) About the Kinsey Report Observations by 11 Experts on "sexual behavior in the human male." New York: Signet, 1948. Pp. 26-35.
- Ford, C. S., & Beach, F. A. Patterns of sexual behavior. New York: Harper & Brothers, 1951.
- Ford, D. H., & Urban, H. B. Psychotherapy. Annual Review of Psychology, 1967, 18, 333-372.
- Fox, R., & Di Scipio, W. J. An exploratory study in the treatment of homosexuality by combining principles from psychoanalytical theory and conditioning: theoretical and methodological considerations. British Journal of Medical Psychology, 1968, 41, 273-282.
- Frankel, A. A. Treatment of a multisymptomatic phobic by a self-directed, self-reinforced imagery technique. Journal of Abnormal Psychology, 1970, 76, 496-499.

- Franks, C. M. (Ed.) Conditioning techniques in clinical practice and research. New York: Springer, 1964.
- Franks, C. M. Reflections upon the treatment of sexual disorders by the behavioral clinician: an historical comparison with the treatment of the alcoholic. Journal of Sex Research, 1967, 3, 212-222.
- Franks, C. M. (Ed.) Behavior therapy: appraisal and status. New York: McGraw-Hill, 1969.
- Franks, C. M. Pavlovian conditioning approaches. In D. J. Levis (Ed.) Learning Approaches to Therapeutic Behavior Change. Chicago: Aldine, 1970. Pp. 108-143.
- Franks, S. The sexually active man past forty. New York: MacMillan, 1968.
- Frankl, V. E. Man's search for meaning: an introduction to logo therapy. (original copyright, 1959) New York: Washington Square Press, 1963.
- Frankl, V. E. Logotherapy and existential analysis--a review. American Journal of Psychotherapy, 1966, 20, 252-260.
- Freeman, H. (Ed.) Progress in behavior therapy. Bristol: John Wright & Sons, 1968.
- Friberg, R. R. Measures of homosexuality: cross-validation of two MMPI scales and implications for usage. Journal of Consulting Psychology, 1967, 31, 88-91.
- Friedman, D. The treatment of impotence by brevital relaxation therapy. Behaviour Research and Therapy, 1968, 6, 257-261.
- Freund, K. Some problems in the treatment of homosexuality. In H. J. Eysenck (Ed.) Behavior Therapy and the Neuroses. New York: Pergamon Press, 1960. Pp. 312-326.
- Freund, K. A laboratory method for diagnosing predominance of homo- or hetero-erotic interest in the male. Behaviour Research and Therapy, 1963, 1, 85-93.
- Freund, K. Diagnosing homo- or hetero-sexuality and erotic age-preference by means of a psychophysiological test. Behaviour Research and Therapy, 1967, 5, 209-228.
- Freund, K., & Costell, R. The structure of erotic preference in the non deviant male. Behaviour Research and Therapy, 1970, 8, 15-20.

- Friedman, L. J. Virgin wives, a study of unconsummated marriages. Springfield, Ill.: C. C. Thomas, 1962.
- Friedemann, M. W. Reflection on two cases of male transvestism. American Journal of Psychotherapy, 1966, 20, 270-283.
- Gagnon, J. H., & Simon, W. (Eds.) Sexual deviance. New York: Harper & Row, 1967.
- Garfield, Z. H., McBrearty, J. F., & Dichter, M. A case of impotence successfully treated with desensitization combined with in vivo operant training and thought substitution. In R. D. Rubin and D. M. Franks (Eds.) Advances in Behavior Therapy 1968. New York: Academic Press, 1969. Pp. 97-103.
- Gebhard, P. H. Situational factors affecting homosexual behavior. In F. A. Beach (Ed.) Sex and Behavior. New York: Wiley & Sons, 1965. Pp. 483-495.
- Gebhard, P. H. Human sex behavior research. In M. Diamond (Ed.), Perspectives in Reproduction and Sexual Behavior. Bloomington, Indiana: University of Indiana Press, 1968. Pp. 391-410.
- Gebhard, P. H. Fetishism and sadomasochism. In J. H. Masserman (Ed.) Science and Psychoanalysis. Vol. 15. Dynamics of Deviant Sexuality. New York: Grune & Stratton, 1969. Pp. 71-80.
- Geisinger, D. L. Controlling sexual interpersonal anxieties. In J. D. Krumbooltz and C. E. Thoresen (Eds.) Behavioral Counseling: Cases and Techniques. New York: Holt, Rinehart, & Winston, 1969. Pp. 454-469.
- Geer, J. H. The development of a scale to measure fear. Behaviour Research and Therapy, 1965, 3, 45-53.
- Gelder, M. G., & Marks, I. M. Aversion treatment in transvestism and transsexualism. In R. Green and J. Money (Eds.) Transsexualism and Sex Reassignment. Baltimore: John Hopkins Press, 1969. Pp. 383-413.
- Gelfand, D. M. (Ed.) Social learning in childhood: readings in theory and application. Belmont, Calif.: Brooks/Cole, 1969.
- Gelfand, D. M., & Hartmann, D. P. Behavior therapy with children: a review and evaluation of research methodology. Psychological Bulletin, 1968, 69, 204-215.

- Gersham, L. Case conference: a transvestite fantasy treated by thought-stopping, covert sensitization and aversive shock. Journal of Behavior Therapy and Experimental Psychiatry, 1970, 1, 153-161.
- Glynn, J. D., & Harper, P. Behaviour therapy in transvestism. Lancet, 1961, 1, 619.
- Gold, S., & Neufeld, I. L. A learning approach to the treatment of homosexuality. Behaviour Research and Therapy, 1965, 2, 201-204.
- Golden, J. S. Varieties of sexual problems in obstetrical and gynecological practice. In C. W. Wahl (Ed.) Sexual Problems: Diagnosis and Treatment in Medical Practice. New York: The Free Press, 1967. Pp. 53-61.
- Goldiamond, I. Self control procedures in personal behavior problems. Psychological Reports, 1965, 17, 851-868.
- Goldfried, M. R. On the diagnosis of homosexuality from the rorschach. Journal of Consulting Psychology, 1966, 30, 338-349.
- Gorman, G. F. Fetishism occurring in identical twins. British Journal of Psychiatry, 1964, 110, 255-256.
- Gray, B. B., & England, G. Stuttering and the conditioning therapies. Monterey Institute for Speech and Hearing, 969 Pacific St., Monterey, Calif., 1969.
- Gray, J. J. Case conference: behavior therapy in a patient with homosexual fantasies and heterosexual anxiety. Journal of Behavior Therapy and Experimental Psychiatry, 1970, 1, 225-232.
- Grossberg, J. M. Behavior therapy: a review. Psychological Bulletin, 1964, 62, 73-88.
- Gundlach, R. H. Childhood parental relationships and the treatment of gender roles of homosexuals. Journal of Consulting and Clinical Psychology, 1969, 33, 136-139.
- Hadden, S. B. Treatment of male homosexuals in groups. International Journal of Group Psychotherapy, 1966, 16, 13-22.
- Hadden, S. B. Group therapy for homosexuals. Medical Aspects of Human Sexuality, 1971, 5, 116.



- Haire, N. (Ed.) Encyclopedia of sexual knowledge. New York: Eugenics Publishing, 1937.
- Hall, M. H. A conversation with Masters and Johnson. Psychology Today, 1969, 3, 50.
- Hammerman, S. Masturbation and character. Journal of the American Psychoanalytic Association, 1961, 9, 287-311.
- Harper, R. A. Psychoanalysis and psychiatry: 36 systems. Englewood Cliffs, New Jersey: Prentice-Hall, 1959.
- Haslam, M. T. The treatment of psychogenic dyspareunia by reciprocal inhibition. British Journal of Psychiatry, 1965, 111, 280-282.
- Hastings, D. W. Impotence and frigidity. Boston: Little Brown & Co., 1963.
- Hastings, D. W. Can specific training procedures overcome sexual inadequacy? In R. Breecher and E. Breecher (Eds.) An analysis of Human Sexual Response. New York: New American Library, 1966. Pp. 221-235.
- Haynes, S. N. Learning theory and the treatment of homosexuality. Psychotherapy: Theory, Research and Practice, 1970, 7, 91-94.
- Hegeler, I., & Hegeler, S. An ABZ of love. New York: Medical Press, 1963.
- Hersen, M. The use of behavior modification techniques within a traditional psychotherapeutic context. American Journal of Psychotherapy, 1970, 25, 308-313.
- Hess, E. H., Seltzer, A. L., & Shlien, J. M. Pupil response of hetero- and homosexual males to pictures of men and women: a pilot study. Journal of Abnormal Psychology, 1965, 70, 165-168.
- Hirsch, E. W. Impotence and frigidity. New York: Citadel Press, 1966. (a)
- Hirsch, E. W. Why be impotent? In Sex Education Library. New York: Health Publications, 1966. Pp. 7-10. (b)
- Hoffman, M. Homosexual. Psychology Today, 1969, 3, 43.
- Hogan, R. A. Impulsively oriented behavior modification: therapy considerations. Behaviour Research and Therapy, 1969, 7, 177-183.

- Hooker, E. An empirical study of some relationships between sexual patterns and gender identity on male homosexuals. In J. Money (Ed.) Sex Research: New Developments. New York: Holt, Rinehart & Winston, 1965. Pp. 24-52.
- Hooker, E. Parental relations and male homosexuality in patient and nonpatient samples. Journal of Counseling and Clinical Psychology, 1969, 33, 140-142.
- Homme, L. How to use contingency contracting in the classroom. Champaign, Ill.: Research Press, 1970.
- Housden, J. An examination of the biologic etiology of transvestism. International Journal of Social Psychiatry, 1965, 11, 301-305.
- Huff, F. W. The desensitization of a homosexual. Behaviour Research and Therapy, 1970, 8, 99-102.
- Hussain, A. Behavior therapy using hypnosis. In J. Wolpe, A. Salter, & L. Reyna (Eds.), The Conditioning Therapies: the Challenge in Psychotherapy. New York: Holt, Rinehart & Winston, 1964. Pp. 54-61.
- Inglis, J. The scientific study of abnormal behavior: experimental and clinical research. Chicago: Aldine, 1966.
- Jackson, B. T. A case of voyeurism treated by counter-conditioning. Behaviour Research and Therapy, 1969, 7, 133-134.
- James, B. Case of homosexuality treated by aversion therapy. British Medical Journal, 1962, 1, 768-770.
- Johnson, J. Prognosis of disorders of sexual potency in the male. Journal of Psychosomatic Research, 1965, 9, 195-200.
- Johnson, J. Disorders of sexual potency in the male. New York: Pergamon Press, 1968.
- Johnson, V. E., & Masters, W. H. The treatment of the sexually incompatible family unit. Minnesota medicine, 1961, 44, 466-471.
- Johnson, V. E., & Masters, W. H. A team approach to the rapid diagnosis and treatment of sexual incompatibility. Pacific Medicine and Surgery, 1964, 72, 371-375.
- Jones, H. G. The application of conditioning and learning techniques to the treatment of a psychiatric patient. Journal of Abnormal and Social Psychology, 1956, 52,

414-420.

- Jones, M. C. A laboratory study of fear: the case of Peter. Pedagogical Seminary, 1924, 31, 308-315.
- Kaiser, R. Letting go. Playboy, 1969, 16, 80.
- Kamil, L. J. Psychodynamic changes through systematic desensitization. Journal of Abnormal Psychology, 1970, 76, 199-205.
- Kanfer, F. H. Self regulation: research issues and speculation. In C. Neuringer and J. Michel (Eds.) Behavior Modification in Clinical Psychology. New York: Appleton-Century-Crofts, 1970. Pp. 178-220.
- Kanfer, F. H., & Phillips, J. S. A survey of current behavior therapies and a proposal for classification. In C. Franks (Ed.), Behavior Therapy: Appraisal and Status. New York: McGraw-Hill, 1969. Pp. 445-475.
- Kanfer, F. H., & Saslow, G. Behavioral diagnosis. In C. Franks (Ed.), Behavior Therapy: Appraisal and Status. New York: McGraw-Hill, 1969. Pp. 417-444.
- Kant, F. Frigidity dynamics and treatment. Springfield, Ill.: C. C. Thomas, 1969.
- Kaufman, J. J. Organic and psychological factors in the genesis of impotence and premature ejaculation. In C. W. Wahl (Ed.), Sexual Problems: Diagnosis and Treatment in Medical Practice. New York: The Free Press, 1967. Pp. 133-148.
- Kelly, G. L. Impotence. In A. Ellis and A. Abarbanel (Eds.) The Encyclopedia of Sexual Behavior. Vol. I. New York: Hawthorn Books, 1961. Pp. 515-527.
- Kenyon, F. E. Studies in female homosexuality-psychological test results. Journal of Consulting and Clinical Psychology, 1968, 32, 510-513.
- Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. Sexual Behavior in the Human Male. Philadelphia: W. B. Saunders, 1948.
- Kinsey, A. C., Pomeroy, W. B., Martin, C. E., & Gebhard, P. H. Sexual Behavior in the Human Female. New York: Pocket Books, 1953.
- Kirkham, G. I., & Sagarin, E. Transsexuals in a formal organizational setting. Journal of Sex Research, 1969, 5, 90-107.

- Klein, M., Dittmann, A. T., Parloff, M. B., & Gill, M. M. Behavior Therapy: observations and reflections. Journal of Consulting and Clinical Psychology, 1969, 33, 259-266.
- Klemer, R. H. Female sexual conditioning. In R. H. Klemer (Ed.), Counseling in Marital and Sexual Problems: a Physician's Handbook. Baltimore: Williams & Wilkins, 1965. Pp. 106-107. (a)
- Klemer, R. H. Male sexual conditioning. In R. H. Klemer (Ed.), Counseling in Marital and Sexual Problems: a Physician's Handbook. Baltimore: Williams & Wilkins, 1965. Pp. 92-105. (b)
- Klemer, R. H. Talking with patients about sexual problems. In R. H. Klemer (Ed.), Counseling in Marital and Sexual Problems: a Physician's Handbook. Baltimore: Williams & Wilkins, 1965. Pp. 118-125. (c)
- Knight, R. P. Functional disturbances in the sexual life of women: frigidity and related disorders. Bulletin of the Menniger Clinic, 1943, 7, 25-35.
- Knowles, F. W. A note on hypnotherapy in sexual deviations: Report on two cases. American Journal of Clinical Hypnosis, 1965, 7, 353-354.
- Koenig, K. P. The differentiation of hetero- or homo-erotic interests in the male: some comments on articles by Brown and Freund. Behaviour Research and Therapy, 1965, 2, 305-307.
- Kolvin, I. Aversive imagery treatment of adolescents. Behaviour Research and Therapy, 1967, 5, 245-248.
- Kraft, T. A case of homosexuality treated by systematic desensitization. American Journal of Psychotherapy, 1967, 21, 815-821.
- Kraft, T. Behavior therapy and target symptoms. Journal of Clinical Psychology, 1969, 25, 105-109. (a)
- Kraft, T. Desensitization and the treatment of sexual disorders. Journal of Sex Research, 1969, 5, 130-134. (b)
- Kraft, T. Psychoanalysis and behaviorism: a false antithesis. American Journal of Psychotherapy, 1969, 23, 482-487. (c)
- Kraft, T. Treatment for sexual perversions. Behaviour Research and Therapy, 1969, 7, 215. (d)

- Kraft, T. Sexual factors in the development of the house-bound housewife syndrome. Journal of Sex Research, 1970, 6, 59-63. (a)
- Kraft, T. A short note on forty patients treated by systematic desensitization. Behaviour Research and Therapy, 1970, 8, 219-220. (b)
- Kraft, T. Systematic desensitization in the treatment of homosexuality. Behaviour Research and Therapy, 1970, 8, 319. (c)
- Kraft, T., & Al-issa, I. Behavior therapy and the treatment of frigidity. American Journal of Psychotherapy, 1967, 21, 116-120.
- Kraft, T., & Al-issa, I. The use of methohexitone sodium in the systematic desensitization of premature ejaculation. British Journal of Psychiatry, 1968, 114, 351-352.
- Krasner, L., & Ullmann, L. P. Research in behavior modification, new developments and implications. New York: Holt, Rinehart & Winston, 1965.
- Kroger, W. S. Comprehensive approach to ecclesiogenic neuroses. Journal of Sex Research, 1969, 5, 2-11.
- Krumboltz, J. D. (ed.) Revolution in counseling: implications of behavioral science. New York: Houghton Mifflin, 1966.
- Krumboltz, J. D., & Thoresen, C. E. Behavioral counseling: cases and techniques. New York: Holt, Rinehart & Winston, 1969.
- Kushner, M. The reduction of a long standing fetish by means of aversive conditioning. In L. P. Ullmann and L. Krasner (Eds.) Case Studies in Behavior Modification. New York: Holt, Rinehart & Winston, 1965. Pp. 239-242.
- L'abate, L. The continuum of rehabilitation and laboratory evaluation: Behavior modification and psychotherapy. In C. Franks (Ed.), Behavior Therapy: Appraisal and Status. New York: McGraw-Hill, 1969. Pp. 476-494.
- Lang, P. J., & Lazovik, A. D. Experimental desensitization of a phobia. Journal of Abnormal and Social Psychology, 1963, 66, 519-525.
- Larson, D. E. An adaption of the Feldman and MacCulloch approach to treatment of homosexuality by the application of anticipatory avoidance learning. Behaviour Research and Therapy, 1970, 8, 209-210.

- Lavin, N. I., Thorpe, J. G., Barker, J. C., Blakemore, C. B., & Conway, C. G. Behaviour therapy in a case of transvestiam. Journal of Nervous and Mental Disease, 1961, 133, 346-353.
- Laws, D. R., & Rubin, H. B. Instructional control of an automatic sexual response. Journal of Applied Behavior Analysis, 1969, 2, 93-99.
- Lazarus, A. A. Group therapy in phobic disorders by systematic desensitization. Journal of Abnormal and Social Psychology, 1961, 63, 504-510.
- Lazarus, A. A. The treatment of chronic frigidity by systematic desensitization. Journal of Nervous and Mental Disease, 1963, 136, 272-278.
- Lazarus, A. A. The treatment of a sexually inadequate man. In L. P. Ullmann and L. Krasner (Eds.), Case Studies in Behavior Modification. New York: Holt, Rinehart & Winston, 1965, Pp. 243-245.
- Lazarus, A. A. Behaviour rehearsal vs. non-directive therapy vs. advice in effecting behaviour change. Behaviour Research and Therapy, 1966, 4, 95-97.
- Lazarus, A. A. In support of technical eclecticism. Psychological Reports, 1967, 21, 415-416.
- Lazarus, A. A. Behavior therapy in groups. In G. M. Gazda (Ed.), Basic approaches to Group Psychotherapy and Group Counseling. Springfield, Ill.: C. C. Thomas, 1968. Pp. 149-175. (a)
- Lazarus, A. A. A case of pseudonecrophilia treated by behavior therapy. Journal of Clinical Psychology, 1968, 24, 113-114.
- Lazarus, A. A. Learning theory and the treatment of depression. Behaviour Research and Therapy, 1968, 6, 83-89. (c)
- Lazarus, A. A., & Abramovitz, A. The use of "emotive imagery" in the treatment of children's phobias. Journal of Mental Science, 1962, 108, 191-195.
- Lazarus, A. A., & Rachman, C. The use of systematic desensitization in psychotherapy. In H. J. Eysenck (Ed.) Behaviour Therapy and The Neuroses. New York: Pergamon Press, 1960. Pp. 181-187.
- Lazarus, A. A., & Serber, M. Is systematic desensitization being misapplied? Psychological Reports, 1968, 23,

215-218.

- Levanthal, A. M. Use of a behavioral approach within a traditional psychotherapeutic context: a case study. Journal of Abnormal Psychology, 1968, 73, 178-182.
- Levie, L. H. Phimosi. Journal of Sex Research, 1965, 1, 189-200.
- Levin, S. M., Hirsch, I. S., Shugar, G., & Kapche, R. Treatment of homosexuality and heterosexual anxiety with avoidance conditioning and systematic desensitization: data and case report. Psychotherapy: Theory, Research and Practice, 1968, 5, 160-168.
- Levis, D. J. Integration of behavior therapy and dynamic psychiatric techniques: a marriage with a high probability of ending in divorce. Behavior Therapy, 1970, 1, 531-537. (a)
- Levis, D. J. (Ed.) Learning approaches to therapeutic behaviour change. Chicago: Aldine, 1970. (b)
- Lewinsohn, R. A history of sexual customs. (Original edition in German 1956) New York: Bell Publishing Co., 1958.
- Lindsley, O. R. Operant conditioning methods applied to research in chronic schizophrenia. Psychiatric Research Reports, 1956, 5, 118-138.
- Litkey, I. J., & Feniczy, P. An approach to the control of homosexual practices. International Journal of Neuropsychiatry, 1967, 3, 20-23.
- Lukianowicz, N. A survey of various aspects of transvestism in the light of our present knowledge. Journal of Nervous and Mental Disease, 1959, 128, 36-64.
- MacCulloch, M. J., Feldman, M. P., & Pinshoff, J. M. The application of anticipatory avoidance learning to the treatment of homosexuality--II. Avoidance response latencies and pulse rate changes. Behaviour Research and Therapy, 1965, 3, 21-43.
- Madsen, C. H., & Ullmann, L. P. Innovations in the desensitization of frigidity. Behaviour Research and Therapy, 1967, 5, 67-68.
- Mandel, K. H. Preliminary report on a new aversion therapy for male homosexuals. Behaviour Research and Therapy, 1970, 8, 93-95.

- Manosevitz, M. Early sexual behaviour in adult homosexual and heterosexual males. Journal of Abnormal Psychology, 1970, 76, 396-402.
- Manosevitz, M., & Lanyon, R. I. Fear survey schedule: a normative study. Psychological Reports, 1965, 17, 699-703.
- Mantegazza, P. The sexual relations of mankind. (First published in 1885) North Hollywood: Brandon House, 1966.
- Marks, I. M., & Gelder, M. G. Transvestism and fetishism: clinical and psychological changes during faradic aversion. British Journal of Psychiatry, 1967, 113, 711-729.
- Marks, I. M., Rachman, S., & Gelder, M. G. Method for assessment of aversion treatment in fetishism with masochism. Behaviour Research and Therapy, 1965, 3, 253-258.
- Marmor, J. (Ed.) Sexual inversion. The multiple roots of homosexuality. New York: Basic Books, 1965.
- Marmor, J. Discussion of "masturbatory fantasies and personality functioning." In J. H. Masserman (Ed.), Science and psychoanalysis. Vol. 15. Dynamics of Deviant Sexuality. New York: Grune & Stratton, 1969, Pp. 47-50.
- Masserman, J. H. (Ed.) Science and psychoanalysis. Vol. 15. Dynamics of Deviant Sexuality. New York: Grune & Stratton, 1969.
- Master, W. H. The sexual response cycle of the human female: 1 gross anatomic considerations. Western Journal of Obstetrics & Gynecology, 1960, 68, 57-72.  
(a)
- Masters, W. H. The sexual response cycle of the human female: vaginal lubrication. Annals of New York Academy of Science, 1960, 83, 301-317.
- Master, W. H., & Johnson, V. E. The physiology of the vaginal reproductive function. Western Journal of Surgery, Obstetrics and Gynecology, 1961, 69, 105-120.
- Masters, W. H., & Johnson, V. E. The sexual response cycle of the human female II. The clitoris: anatomic and clinical considerations. Western Journal of Surgery, Obstetrics, and Gynecology, 1962, 70, 248-257.



- Masters, W. H., & Johnson, V. E. The sexual response cycle of the human male I. Gross anatomic considerations. Western Journal of Surgery, Obstetrics and Gynecology, 1963, 71, 85-95.
- Masters, W. H., & Johnson, V. E. Counseling with sexually incompatible marriage partners. In R. H. Klemer (Ed.), Counseling in Marital and Sexual Problems: a Physician's Handbook. Baltimore: Williams & Wilkins, 1965. Pp. 126-137. (a)
- Masters, W. H., & Johnson, V. E. The sexual response cycles of the human male and female: comparative anatomy and physiology. In F. A. Beach (Ed.), Sex and Behavior. New York: Wiley & Sons, 1965. Pp. 512-534. (b)
- Masters, W. H., & Johnson, V. E. Human Sexual Response. Boston: Little Brown & Co., 1966.
- Masters, W. H., & Johnson, V. E. Human sexual inadequacy and some parameters of therapy. In M. Diamond (Ed.), Perspectives in Reproduction and Sexual Behavior. Bloomington, Indiana: Indiana University Press, 1968. Pp. 411-415.
- Masters, W. H., & Johnson, V. E. Human Sexual Inadequacy. Boston: Little Brown, 1970.
- Matthews, J. Bisexuality in the male. Journal of Sex Research, 1969, 5, 126-129.
- Max, L. W. Breaking up a homosexual fixation by the conditioned reaction technique: a case study. Psychological Bulletin, 1935, 32, 734.
- McCarthy, B. W., & Messersmith, C. E. Sensitivity, desensitization: either--or? Psychotherapy: Theory, Research and Practice, 1970, 7, 243-244.
- McCawley, A. Exhibitionism and acting out. Comprehensive Psychiatry, 1965, 6, 396-409.
- McConaghy, N. A. A years experience with non-verbal psychotherapy. Medical Journal of Australia, 1964, 1, 831-837.
- McConaghy, N. A. Penile volume change to moving pictures of male and female nudes in heterosexual and homosexual males. Behaviour Research and Therapy, 1967, 5, 43-48.
- McConaghy, N. Penile response conditioning and its relationship to aversion therapy in homosexuals. Behaviour

- Research and Therapy, 1970, 1, 213-221.
- McGuire, R. J., Carlisle, J. M., & Young, B. G. Sexual deviation as conditioned behavior: a hypothesis. Behaviour Research and Therapy, 1965, 2, 185-190.
- McGuire, R. J., & Vallance, M. Aversion therapy by electric shock: a simple technique. British Medical Journal, 1964, 1, 151-153.
- McHugh, G. Sex knowledge inventory: Form Y: vocabulary and anatomy. Durham, North Carolina: Family Life Publications, Inc. Box 6725, Durham, North Carolina, 27708. 1955.
- McHugh, G. Sex knowledge inventory: Form X (revised) Durham, North Carolina: Family Life Publications, Inc. Box 6725, Durham, North Carolina, 27708. 1967.
- Mees, H. L. Sadistic fantasies modified by aversive conditioning and substitution: a case study. Behaviour Research and Therapy, 1966, 4, 317-320.
- Mehrabian, A. Tactics of social influence. Englewood Cliffs, New Jersey: Prentice-Hall, 1970.
- Menninger, K. A. Man against himself. New York: Harcourt, Brace & Co., 1938.
- Meyer, A. G. Psychoanalytic versus behavior therapy of male homosexuals; a statistical evaluation of clinical outcome. Comprehensive Psychiatry, 1966, 17, 110-117.
- Meyer, V. The treatment of two phobic patients on the basis of learning principles. Journal of Abnormal and Social Psychology, 1957, 55, 261-266.
- Meyer, V. Comments on A. J. Yates' "misconceptions about behavior therapy: a point of view." Behavior Therapy, 1970, 1, 108-112.
- Meyer, V., & Chessier, E. S. Behaviour therapy in clinical psychiatry. New York: Penguin, 1970.
- Michael, J. L. Rehabilitation. In C. Neuringer and J. L. Michael (Eds.), Behavior Modification in Clinical Psychology. New York: Appleton-Century-Crofts, 1970. Pp. 52-85.
- Michelmores, S. Sexual reproduction. New York: Natural History Press, 1964.

- Miller, W. G., & Hannum, T. E. Characteristics of homosex-  
ually involved incarcerated females. Journal of Con-  
sulting Psychology, 1963, 27, 277.
- Miitz, E. E. Overt male homosexuals in combined group and  
individual treatment. Journal of Abnormal Psychology,  
1966, 30, 193-198.
- Mirowitz, J. M. The utilisation of hypnosis in psychic  
impotence. The British Journal of Medical Hypnotism,  
1966, 17, 25-32.
- Money, J. Sex research: new developments. New York:  
Holt, Rinehart and Winston, 1965.
- Money, J. Sexual problems of the chronically ill. In C.  
W. Wahl (Ed.), Sexual Problems: Diagnosis and Treat-  
ment in Medical Practice. New York: Free Press,  
1967. Pp. 266-287.
- Money, J. Sexual dimorphism and homosexual gender identity.  
Psychological Bulletin, 1970, 74, 425-440.
- Montagu, M. F. A. Understanding our sexual desire. In D.  
R. Geddes and G. Curie (Eds.), About the Kinsey Report:  
observations by 11 experts on "Sexual Behavior in the  
Human Male." New York: Signet, 1948. Pp. 59-69.
- Moreno, J. L. Fundamental rules and techniques of psycho-  
drama. In J. H. Masserman and J. L. Moreno (Eds.),  
Progress in Psychotherapy. Vol. 3 Techniques of  
psychotherapy. New York: Grune & Stratton, 1958.  
Pp. 86-131.
- Morgenstein, F. S., Pearce, J. F., & Rees, W. L. Predicting  
the outcome of behavior therapy by psychological tests.  
Behaviour Research and Therapy, 1965, 2, 191-200.
- Mowrer, O. H. Learning theory and personality dynamics.  
New York: Ronald Press, 1950.
- Mowrer, O. H. The behavior therapies, with special refer-  
ence to modeling and imitation. American Journal of  
Psychotherapy, 1966, 20, 439-461.
- Mudd, E. H. Sex problems in marriage counseling. In R.  
Breecher and E. Breecher (Eds.), An Analysis of Human  
Sexual Response. New York: New American Library,  
1966. Pp. 237-250.
- Murphy, W. F. The tactics of psychotherapy. New York:  
International University Press, 1965.

- Naar, R. Client-centered and behavior therapies: their peaceful coexistence: a case study. Journal of Abnormal Psychology, 1970, 76, 155-160.
- Neuringer, C., & Michael, J. L. (Eds.) Behavior modification in clinical psychology. New York: Appleton-Century-Crofts, 1970.
- Oliver, W. A., & Mesher, D. L. Psychopathology and guilt in heterosexual and subgroups of homosexual reformatory inmates. Journal of Abnormal Psychology, 73, 323-339.
- Oneal, P., & Wesson, A. F. Frigidity: a suggested study of human sexual behavior. In G. Winkour (Ed.), Determinants of Human Sexual Behavior. Springfield, Ill.: C. C. Thomas, 1963.
- Osipow, S. H., & Walsh, W. B. Behavior change in counseling: Readings and Cases. New York: Appleton-Century-Crofts, 1970. (a)
- Osipow, S. H., & Walsh, W. B. Strategies in counseling for behavior change. New York: Appleton-Century-Crofts, 1970. (b)
- Ovesey, L., Gaylin, W., & Hendin, H. Psychotherapy of male homosexuality. Archives of General Psychiatry, 1963, 9, 19-31.
- Ovesey, L., & Myers, H. Retarded ejaculation, psychodynamics and psychotherapy. American Journal of Psychotherapy, 1968, 22, 185-201.
- Pare, C. M. B. Etiology of homosexuality: genetic and chromosomal aspects. In J. Marmor (Ed.), Sexual Inversion: the Multiple Roots of Homosexuality. New York: Basic Books, 1965. Pp. 70-80.
- Pasmore, J. The frigid female. In W. A. Thomson (Ed.), Sex and its problems. London: E. & S. Livingstone, 1968. Pp. 32-36.
- Paul, G. L. Insight vs. desensitization in psychotherapy: an experiment in anxiety reduction. Stanford, Calif.: Stanford University Press, 1966.
- Paul, G. L. Behavior modification research: design and tactics. In C. M. Franks (Ed.), Behavior Therapy: Appraisal and Status. New York: McGraw-Hill, 1969. Pp. 29-62.
- Pauly, I. R. Male psychosexual inversion: transsexualism: a review of 100 cases. Archives of General Psychiatry,

1965, 13, 172-181.

- Pardes, H., Steinberg, J., & Simon, R. C. A rare case of overt and mutual homosexuality in female identical twins. Psychiatric Quarterly, 1967, 41, 108-133.
- Perloff, W. H. Hormones and homosexuality. In J. Marmor (Ed.). Sexual Inversion: the Multiple Roots of Homosexuality. New York: Basic Books, 1965. Pp. 44-69.
- Phillips, E. L., & Weiner, D. N. Short term psychotherapy and structured behavior change. New York: McGraw-Hill, 1966.
- Pomeroy, W. B. Homosexuality. In R. W. Weltge (Ed.), The Same Sex: an Appraisal of Homosexuality. Boston: Pilgrim Press, 1969. Pp. 3-13.
- Popenoe, P. Marital counseling with special reference to frigidity. Publication No 502. 1945 American Institute of Family Relations, 5287 Sunset Blvd., Los Angeles, Calif. 90027.
- Proctor, S. Duration of exposure to items and pretreatment training as factors in systematic desensitization therapy. In R. D. Rubin and C. M. Franks (Eds.), Advances in Behavior Therapy, 1968. New York: Academic Press, 1969. Pp. 105-116.
- Quinn, J. T., Harbison, J. J. M., & McAllister, H. An attempt to shape human penile responses. Behaviour Research and Therapy, 1970, 8, 213-216.
- Rachman, S. Sexual disorders and behavior therapy. American Journal of Psychotherapy, 1961, 118, 235-240.
- Rachman, S. Introduction to behavior therapy. Behaviour Research and Therapy, 1963, 1, 3-15.
- Rachman, S. Aversion therapy: chemical or electrical? Behaviour Research and Therapy, 1965, 2, 289-299.
- Rachman, S. Sexual fetishism: an experimental analogue. The Psychological Record, 1966, 16, 293-296.
- Rachman, S. Systematic desensitization. Psychological Bulletin, 1967, 67, 93-103.
- Rachman, S. Phobias: their nature and control. Springfield, Ill.: C. C. Thomas, 1968.
- Rachman, S. Behavior therapy and psychodynamics. Behavior Therapy, 1970, 1, 527-530.

- Rachman, S., & Hodgson, R. J. Experimentally-induced "sexual fetishism": Replication and development. Psychological Record, 1968, 18, 25-27.
- Rachman, S., & Teasdale, J. Aversion therapy and behaviour disorders: an analysis. Coral Gables, Florida: University of Miami Press, 1969.
- Rado, S. Fear of castration in women. Psychoanalytic Quarterly, 1933, 2, 425-475.
- Ramsay, R. W., & VanVelzen, V. Behavior therapy for sexual perversions. Behaviour Research and Therapy, 1968, 6, 233.
- Randell, J. B. Transvestism and trans-sexualism: a study of 50 cases. British Medical Journal, 1959, 2, 1448-1452.
- Raymond, M. J. Case of fetishism treated by aversion therapy. British Medical Journal, 1956, 2, 854-856.
- Raymond, M. J. Treatment by revulsion. Mental Health, 1967, 26, 24-25.
- Raymond, M., & O'Keefe, K. A case of pin-up fetishism treated by conditioning. British Journal of Psychiatry, 1965, 111, 579-581.
- Reik, T. Masochism in sex and society. New York: Grove Press, 1941.
- Resnik, H. L. P., & Peters, J. J. Outpatient group therapy with convicted pedophiles. International Journal of Group Psychotherapy, 1967, 17, 151-158.
- Reuben, D. Everything you always wanted to know about sex: but were afraid to ask. New York: David McKay, 1969.
- Richardson, R. A. Hypnotherapy in frigidity. The American Journal of Clinical Hypnosis, 1963, 5, 194-199.
- Ritchie, G. G. The use of hypnosis in a case of exhibitionism. Psychotherapy: Theory, Research and Practice, 1968, 5, 40-43.
- Robertiello, R. C. Encouraging the patient to live out sexual fantasies. Psychotherapy: Theory, Research and Practice, 1969, 6, 183-187.
- Roen, P. R. Impotence, a concise review. New York State Journal of Medicine, 1965, 65, 2576-2583.

- Roper, P. The effects of hypnotherapy on homosexuality. Canadian Medical Association Journal, 1967, 96, 319-327.
- Rubin, B. M., Katkin, E. S., Weiss, B. W., & Efram, J. S. Factor analysis of a fear survey schedule. Behaviour Research and Therapy, 1968, 6, 65-75.
- Rubin, I. Homosexuality. Siecus Discussion Guide No. 2. Sex Information and Education Council of the United States, 1855 Broadway, New York, New York 10023, 1965. (a)
- Rubin, I. Sexual life after sixty. New York: New American Library (Signet edition), 1965. (b)
- Rubin, R. D., & Franks, C. M. (Eds.) Advances in behaviour therapy 1968. New York: Academic Press, 1969.
- Rubin, S. E., Lawlis, G. F., Tasto, D. L., & Namemek, T. Factor analysis of the 122 item fear survey schedule. Behaviour Research and Therapy, 1969, 7, 381-386.
- Salter, A. Conditioned reflex therapy, the direct approach to the reconstruction of personality. New York: Capricorn Books, 1961.
- Salzman, L. Premature ejaculation. Technical Journal of Sexology, 1954, 8, 69-76.
- Salzman, L. Masochism and psychopathy as adaptive behavior. Journal of Individual Psychology, 1960, 16, 182-188.
- Salzman, L. F. Systematic desensitization of a patient with chronic total impotence. In R. D. Rubin & C. M. Franks (Eds.), Advances in Behavior Therapy, 1968. New York: Academic Press, 1969. Pp. 131-137.
- Sandler, J. Masochism: an empirical analysis. Psychological Bulletin, 1964, 62, 197-204.
- Schapiro, B. Premature ejaculation: a review of 1130 cases. Journal of Urology, 1943, 374-379.
- Schaefer, H. H., & Martin, P. L. Behavioral therapy. New York: McGraw-Hill, 1969.
- Schaefer, L. C. Frigidity. In G. D. Goldman and D. S. Milman (Eds.), Modern Woman Her Psychology and Sexuality. Springfield, Ill.: C. C. Thomas, 1969. Pp. 165-177.

- Schmidt, E., Castell, D., & Brown, P. A retrospective study of 42 cases of behaviour therapy. Behaviour Research and Therapy, 1965, 3, 9-19.
- Schmidt, G., Sigusch, V., & Meyberg, V. Psychosexual stimulation in men: emotional reactions, change of sex behavior, and measures of conservative attitudes. Journal of Sex Research, 1969, 5, 199-217.
- Science News. 1969, 96, 45.
- Scott, T. R., Wells, W. H., Wood, D. Z., & Morgan, D. I. Pupillary response and sexual interests reexamined. Journal of Clinical Psychology, 1967, 23, 433-438.
- Seemans, J. H. Premature ejaculation: a new approach. Southern Medical Journal, 1956, 49, 353-362.
- Serban, G. The existential therapeutic approach to homosexuality. American Journal of Psychotherapy, 1968, 22, 491-501.
- Serber, M. Shame aversion therapy. Behaviour Therapy and Research, 1970, 1, 219-221. (a)
- Serber, M. Shame Aversion Therapy: a new aversive technique with sexual deviants. Film demonstration presented at the meeting of the Association for the Advancement of Behavior Therapy, Miami, September, 1970. (b)
- Shenken, L. I. Some clinical and psychopathological aspects of bestiality. Journal of Nervous and Mental Disease, 1964, 139, 137-142.
- Sherfey, M. J. The evolution and nature of female sexuality in relation to psychoanalytic theory. Journal of American Psychoanalytic Association, 1966, 14, 28-128.
- Shoor, M., Speed, M. H., & Bartelt, C. Syndrome of the adolescent child molester. American Journal of Psychiatry, 1966, 122, 783-789.
- Sidman, M. Tactics of scientific research. New York: Basic Books, 1960.
- Simon, R. I. A case of female transsexualism. American Journal of Psychiatry, 1967, 123, 1598-1601.
- Simon, W., & Gagnon, J. H. Homosexuality: the formulation of a sociological perspective. Journal of Health and Social Behavior, 1967, 8, 177-185.



- Simpson, S. L. Impotence. British Medical Journal, 1950, 1, 692-696.
- Singer, M., & Fisher, R. Group psychotherapy of male homosexuals by a male and female co-therapy team. International Journal of Group Psychotherapy, 1967, 17, 44-52.
- Skinner, B. F. Science and human behavior. New York: MacMillan, 1953.
- Sloane, B. Behavior therapy and psychotherapy: integration or disintegration. American Journal of Psychotherapy, 1969, 23, 473-481. (a)
- Sloane, B. The converging paths of behavior therapy and psychotherapy. American Journal of Psychiatry, 1969, 125, 49-57. (b)
- Smith, J. A. Psychogenic factors in infertility and frigidity. Southern Medical Journal, 1956, 49, 258-262.
- Smith, S., & Guthrie, E. Exhibitionism. Journal of Abnormal and Social Psychology, 1922, 17, 206-209.
- Snow, E., & Bluestone, H. Fetishism and murder. In J. H. Masserman (Ed.), Science and Psychoanalysis. Vol. 15. Dynamics of Deviant Sexuality. New York: Grune & Stratton, 1969. Pp. 88-97.
- Socarides, C. W. The overt homosexual. New York: Grune & Stratton, 1968 (a)
- Socarides, C. W. A provisional theory of aetiology in male homosexuality. International Journal of Psychoanalysis, 1968, 49, 27-37. (b)
- Solyom, L., & Miller, S. A differential conditioning procedure as the initial phase of the behaviour therapy of homosexuality. Behaviour Research and Therapy, 1965, 3, 147-160.
- Sonenschein, D. The ethnography of male homosexual relationships. Journal of Sex Research, 1968, 4, 69-83.
- Staats, A. W. Learning theory and "opposite speech." Journal of Abnormal and Social Psychology, 1957, 55, 268-289.
- Staats, A. W. (Ed.) Human Learning: studies extending conditioning principles to complex behavior. New York: Holt, Rinehart & Winston, 1964.

- Staats, A. W. Learning, language and cognition. New York: Holt, Rinehart, and Winston, 1968. (a)
- Staats, A. W. Social Behaviorism and human motivation: Principles of the attitude-reinforcer-discriminative system. In A. G. Greenwald, T. C. Brook, and T. M. Ostrom (Eds.), Psychological Foundations of Attitudes. New York: Academic Press, 1968. Pp. 33-66. (b)
- Staats, A. W. Development, use, and social extensions of reinforcer (motivational) systems in the solution of human problems. In Conference Proceedings of Progress in Behavior Modification: Program and Results. University of Hawaii: School of Social Work, Youth Development Center, University of Hawaii, 1969.
- Staats, A. W. Social behaviorism, human motivation, and the conditioning therapies. In B. A. Maher (Ed.), Progress in Experimental Personality Research. Vol. 5. New York: Academic Press, 1970. Pp. 111-168.
- Staats, A. W. & Staats, C. K. Complex human behavior: a systematic extension of learning principles. New York: Holt, Rinehart & Winston, 1963.
- Stafford-Clark, D. The etiology and treatment of impotence. Practitioner, 1954, 172, 397-404.
- Stampfl, T. G. Implosive therapy: an emphasis on covert stimulation. In D. J. Levis (Ed.), Learning Approaches to Therapeutic Behavior Change. Chicago: Aldine, 1970. Pp. 182-204.
- Stekel, W. Impotence and the male: the psychic disorders of sexual function in the male. Vol. 1. New York: Boni & Liveright, 1927.
- Stevenson, I., & Wolpe, J. Recovery from sexual deviations through overcoming non-sexual neurotic responses. American Journal of Psychiatry, 1960, 116, 737-742.
- Stokes, W. R. Inadequacy of female orgasm as a problem in marriage counseling. Journal of Sex Research, 1968, 4, 225-233.
- Stoller, R. J. The mother's contribution to the infantile transvestic behaviour. International Journal of Psychoanalysis, 1966, 47, 384-395.
- Stoller, R. J. Transvestite's women. American Journal of Psychiatry, 1967, 124, 333-339.

- Stone, A., & Levine, L. Group therapy in sexual maladjustment. American Journal of Psychiatry, 1950, 107, 195-202.
- Stone, W. N., Schengber, J., & Seifried, F. S. The treatment of a homosexual woman in a mixed group. International Journal of Group Psychotherapy, 1966, 16, 425-433.
- Strauss, E. B. Impotence. British Medical Journal, 1950, 1, 697.
- Suinn, R. M. The desensitization of test-anxiety by group and individual treatment. Behaviour Research and Therapy, 1968, 6, 385-387.
- Suinn, R. M. Changes in non-treated subjects over time: data on a fear survey schedule and the test anxiety scale. Behaviour Research and Therapy, 1969, 7, 205-206.
- Susskind, D. J. The idealized self-image (ISI): a new technique in confidence training. Behavior Therapy, 1970, 1, 538-541.
- Tharp, R. G., & Wetzel, R. J. Behavior modification in the natural environment. New York: Academic Press, 1969.
- Thoresen, C. E. The counselor as an applied behavioral scientist. Personnel and Guidance Journal, 1969, 47, 841-847.
- Thorne, F. C. Scales for rating sexual experience. Journal of Clinical Psychology, 1966, 22, 404-407.
- Thorpe, J. G., & Schmidt, E. Therapeutic failure in a case of aversion therapy. Behaviour Research and Therapy, 1964, 1, 293-296.
- Thorpe, J. G., Schmidt, E., Brown, P. T., & Castell, D. Aversion-relief therapy: a new method for general application. Behaviour Research and Therapy, 1964, 2, 71-82.
- Thorpe, J. G., Schmidt, E., & Castell, D. A comparison of positive and negative (aversive) conditioning in the treatment of homosexuality. Behaviour Research and Therapy, 1964, 1, 357-362.
- Thorpe, L. P., & Katz, B. The psychology of abnormal behavior. New York: Ronald Press, 1948.

- Tighe, T. J., & Elliott, R. A technique for controlling behavior in natural settings. Journal of Applied Behavior Analysis, 1968, 1, 263-366.
- Tinling, D. C. Auto-desensitization to phobic fears with an audio-visual instructional aid. In R. D. Rubin and C. M. Franks (Eds.), Advances in Behavior Therapy, 1968. New York: Academic Press, 1969. Pp. 11-15.
- Tinling, D. C. Cognitive and behavioral aspects of aversive therapy. Paper presented at the meeting of the Association for the Advancement of Behavior Therapy, Miami, September, 1970.
- Trainer, J. B. Physiologic foundations for marriage counseling. St. Louis: C. V. Mosby, 1965.
- Trethowan, W. H. The demonopathology of impotence. British Journal of Psychiatry, 1963, 109, 341-347.
- Truax, C. B. Some implications of behavior therapy for psychotherapy. Journal of Counseling Psychology, 1966, 13, 160-170.
- Ullmann, L. P., & Krasner, L. Case studies in behaviour modification. New York: Holt, Rinehart & Winston, 1965.
- Ullmann, L. P., & Krasner, L. A psychological approach to abnormal behavior. Englewood Cliffs, New Jersey: Prentice-Hall, 1969.
- Von-Schrenck-notzing, A. The use of hypnosis in psychopathia sexualis. (original copyright 1895 by F. A. Davis Co.) Re-issue with new introduction. New York: Julian Press, 1956.
- Watson, J. B., & Rayner, R. Conditioned emotional reactions. Journal of Experimental Psychology, 1920, 3, 1-14.
- Waxenberg, S. E. Psychotherapeutic and dynamic implications of recent research on female sexual functioning. In G. D. Goldman and D. S. Milman (Eds.), Modern woman her psychology and sexuality. Springfield, Ill.: C. C. Thomas, 1969. Pp. 3-24.
- Weltge, R. W. The same sex: an appraisal of homosexuality. Boston: Pilgrim Press, 1969.
- Wershub, L. P. Sexual impotence in the male. Springfield, Ill.: C. C. Thomas, 1959.
- West, D. J. Homosexuality. Chicago: Aldine, 1967.

- Wetzel, R. J., Baker, J., Roney, M., & Martin, M. Out-patient treatment of autistic behavior. Behaviour Research and Therapy, 1966, 4, 169-177.
- Wickramasekera, I. The application of learning theory to the treatment of a case of sexual exhibitionism. Psychotherapy: Theory, Research and Practice, 1968, 5, 108-112.
- Willis, S. E. Understanding and counseling the male homosexual. Boston: Little Brown, 1967.
- Willy, A., Vander, I., & Fisher, O. The illustrated encyclopedia of sex. (rev. ed.) New York: Cadillac Publishing, 1967.
- Wisocki, P. A. Treatment of obsessive-compulsive behavior by covert sensitization and covert reinforcement: a case report. Journal of Behavior Therapy and Experimental Psychiatry, 1970, 1, 233-239.
- Wittels, F. The sex habits of american women. New York: Eton, 1951.
- Wolberg, L. R. The technique of psychotherapy. New York: Gruene & Stratton, 1954.
- Wolfman, C., & Friedman, J. A symptom and its symbolic representation in earliest memories. Journal of Clinical Psychology, 1964, 20, 442-444.
- Wolpe, J. Experimental neuroses as a learned behaviour. British Journal of Psychiatry, 1952, 43, 243-268.
- Wolpe, J. Reciprocal inhibition as the main basis of psychotherapeutic effects. American Medical Association Archives of Neurological Psychiatry, 1954, 72, 205-226.
- Wolpe, J. Psychotherapy by reciprocal inhibition. Stanford, Calif.: Stanford University Press, 1958.
- Wolpe, J. Conditioning: the basis of modern psychotherapy. In L. D. Eron and R. Callahan (Eds.), The Relation of Theory to Practice in Psychotherapy. Chicago: Aldine, 1969. Pp. 1-20. (a)
- Wolpe, J. Forward. In C. M. Franks (Ed.), Behavior therapy: Appraisal and Status. New York: McGraw-Hill, 1969. Pp. ix-xiii. (b)
- Wolpe, J. The practice of behavior therapy. New York: Pergamon Press, 1969. (c)

- Wolpe, J., & Lang, P. A fear survey schedule for use in behaviour therapy. Behaviour Research and Therapy, 1964, 2, 27-30.
- Wolpe, J., & Lazarus, A. A. Behavior therapy techniques: a guide to the treatment of neuroses. New York: Pergamon Press, 1966.
- Wolpe, J., Salter, A., & Reyna, L. J. (Eds.) The conditioning therapies: the challenge in psychotherapy. New York: Holt, Rinehart & Winston, 1964.
- Wolpin, M. Guiden imagining to reduce avoidant behavior. Psychotherapy: Theory, Research and Practice, 1969, 6, 122-124.
- Wright, H. A contribution to the orgasm problem in women. The International Journal of Sexology, 1949, 3, 8-12.
- Wright, H. More about the sex factor in marriage. London: Ernest Benn Limited, 1969.
- Yalom, I. D. Aggression and forbiddenness in voyeurism. Archives of General Psychiatry, 1960, 3, 305-319.
- Yates, A. J. The application of learning theory to the treatment of tics. Journal of Abnormal and Social Psychology, 1958, 56, 175-182.
- Yates, A. J. Behavior therapy. New York: Wiley & Sons, 1970. (a)
- Yates, A. J. Misconceptions about behavior therapy: a point of view. Behavior Therapy, 1970, 1, 92-107. (b)
- Zucker, L. J. Mental health and homosexuality. Journal of Sex Research, 1966, 2, 111-125.
- Zucker, R. A., & Manosevitz, M. MMPI patterns of overt male homosexuals: reinterpretation and comment on Dean and Richardson's study. Journal of Consulting Psychology, 1966, 30, 555-557.