GOOD SEX IS AS EASY AS PIE - THE ROLE OF PERMISSION, INFORMATION AND EMPATHY IN BRIEF SEX THERAPY

MARGUERITE WEAVER MOREHEAD

Good Sex is as Easy as PIE -
The Role of Permission, Information, and Empathy in Brief Sex Therapy

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An Abstract

Presented to

the Graduate Council of

Austin Peay State University

In Partial Fulfillment

of the Requirements for the Degree

Master of Arts

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by

Marguerite Weaver Morehead

June 1977

ABSTRACT

This study was based on the hypothesis that a program of brief sex therapy, characterized by permission, information, and empathy, could be effective in enabling a couple to achieve a more satisfying and pleasurable sexual relationship.

The subjects were eighteen clients (nine couples) of the Sexual Counseling and Education program, a division of the Social Work Services at the Ft. Campbell Army Hospital, Ft. Campbell, Kentucky. The mean age of the women was 29 years, of the men, 32 years.

Statistical analysis was based on a within-subjects design, using a pre- and post-test to test for changes in degree of sexual satisfaction. With an N of 18, Wilcoxon Matched-Pairs Signed-Ranks Test, one-tailed, was significant at the .005 level. It is therefore suggested that the PIE model for brief sex therapy was an effective catalyst for improving clients' sexual relationships.

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June 1977

To the Graduate Council:

I am submitting herewith a Thesis written by Marguerite Weaver Morehead entitled "Good Sex is as Easy as PIE - the Role of Permission, Information and Empathy in Brief Sex Therapy." I recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Arts, with a major in Psychology.

John D. Martin
Major Professor

We have read this thesis and recommend its acceptance:

Linda Rudolph
Second Committee Member

Garland E. Blair
Third Committee Member

Accepted for the Council:

Wayne C. Stamp
Dean of the Graduate School

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CHAPTER I

INTRODUCTION

Sex was simpler when its point was children. But in a culture where so many people practice birth control and rarely have sex with the intention of creating children, fewer and fewer people seem inclined to settle for mechanical, non-pleasurable sex. And, while it is obvious that good sex may not be the heart and soul of a good relationship, bad sex can ruin it. There is much support and encouragement today for working out satisfying sexual relationships - for making bad sex good and good sex better.

It is commonly assumed that sex improves with practice and is enhanced by openness. Indeed, when couples drop inhibitions and overcome embarrassment, they find that many sexual concerns become less of a problem (Suid & Bradley, 1976). Simple openness, however, is not enough to solve more serious sexual problems such as impotence or orgasmic dysfunction. For those concerns professional assistance is more appropriate and has become more widely accepted and more effective.

Historically, when individuals first began to turn to therapists for help with their sexual conflicts, their dysfunction was usually considered to reflect a deep-seated personality disorder. As a result, the therapy

was generally psychoanalytic in approach. Freud was one of the first professionals who listened to patients with sexual difficulties and attempted to interpret such difficulties therapeutically in the context of their past lives (Belliveau & Richter, 1970). His approach did not focus on their current behavioral deficits or relationship dynamics but on the unconscious determinants of the current symptoms. Such psychoanalytic treatment for sexual dysfunction traditionally has not been very successful (Lorand, 1934; Moore, 1961), and is both lengthy and expensive. For example, Bergler (1947, 1951) has stated, "an appointment several times a week for a minimum of eight months" is necessary for treatment of orgasmic dysfunction. An exception to the poor treatment record of psychoanalysis in sex therapy is to be found today in the person of Helen Singer Kaplan (1975), one of the most distinguished of the second generation Masters and Johnson-trained therapists. Her approach to sex therapy is grounded in psychoanalysis but reflects more directly her study under Masters and Johnson.

Over the last few years, an emphasis on learning theory approaches to human behavior has led to new, direct treatments for sexual dysfunctions (Wolpe & Lazarus, 1966; Masters & Johnson, 1970; Pion & Anon, 1974). In the behavioral approach, the specific dysfunction is seen as a behavioral deficit, caused by

lack of skills and knowledge, anxiety about performance, and guilt induced by societal conditioning. Treatment does not focus on uncovering childhood events, lifting repressions, and working through the transference, but on providing information, changing attitudes, and teaching new and adaptive sexual behaviors and skills. Unlike the psychoanalytic treatment, behavioral therapy for sexual dysfunction has been found effective (Lobitz & LoPiccolo, 1972; Masters & Johnson, 1970; Obler, 1973; Pion & Anon, 1974), and can be completed in as little as two weeks when patients are seen daily (Masters & Johnson, 1970).

The literature specifies major strategies for behavioral treatment for sexual dysfunction (Hastings, 1963; Wolpe, 1968; Masters & Johnson, 1970; LoPiccolo & Lobitz, 1972, 1973; Lobitz & LoPiccolo, 1972; LoPiccolo, Stewart, & Watkins, 1972; Pion & Anon, 1974). However, these sources lack information on the specific tactics of therapy. Kaplan (1975) is more conscientious in providing a therapeutic outline but even her approach gives one the impression that the behavioral program is rather invariant for all clients: the client presents the problem, the therapist gives a standardized set of instructions for new behaviors to be instituted, the client follows these instructions, and the client is cured. The literature neglects such issues as the

appropriateness of program modification to fit the uniqueness of a particular client/situation, what to do when the client resists or refuses treatment interventions (Kaplan does address this issue), what to do when the program is not producing results, and how to deal with attitudes, personality traits, or interpersonal problems which prevent the basic treatment from being effective. Notably little attention is directed to the relationship dynamics in the literature overall.

Even with the recent success of behavioral approaches to sex therapy, relieving the burdens of time and expense and offering more promising results, there is a clear need for a broad spectrum approach which allows clinicians a wide range of therapeutic procedures for implementing treatment strategies (Anon, 1975). What is needed is a flexible and comprehensive scheme that can be adapted to many settings and to whatever client/problem is presented. To be most effective such a plan should also be able to be used by a wide variety of people in the helping professions and allow for a range of treatment choices geared to the level of competence of the individual therapist (Anon, 1975). Ideally, the approach also needs to provide a framework for screening out and treating those problems that will be responsive to brief therapy approaches and those that may require intensive therapy.

In determining selection criteria for clients who will respond to brief therapy, David H. Malan (1976) in his book The Frontier of Brief Psychotherapy suggested thirty-five criteria. Based on a study with an N of 35, Malan found that only two criteria significantly affected the favorable outcome of brief therapy. He found that patients did best when the treatment focus was clear, when expectations were agreed upon, and when their motivation was high. These criteria were employed in the present study to screen clients, enabling only those who could best benefit from brief therapy to be included in the program.

An area of continued disagreement is whether or not relationship variables, such as "rapport" and "empathy," are necessary for therapists to be effective in their assessment and treatment procedures. Masters and Johnson (1964) feel that the necessity of rapport is a myth, and they stress quick assessment and treatment of specific 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, 1965; Kroger, 1969; Thorne, 1966). Truax (1966) has suggested that therapists high in empathy, warmth, and genuineness are more effective in psychotherapy because they elicit positive affect from their clients, and they themselves are personally more

potent positive reinforcers. Indeed, many authorities on psychotherapy attest to the crucial, pivotal role empathy can play in the success or failure of therapy (Fromm & Reichmann, 1950; Rogers, 1957; Patterson, 1960).

An interesting observation made, in reviewing the literature and researching approaches to sex therapy, was the glaring omission of empirical validation of the effectiveness of the various therapy models (a major exception being Masters and Johnson, who provide much data). Statistical analysis of sexual satisfaction does seem to be contradictory in concept and difficult to accomplish in fact. Nevertheless, the purpose of the present study was to develop a model for brief sex therapy, which would include the educational process and an integration of the relationship dynamics, and to test that model statistically. It was hypothesized that a program of brief sex therapy, characterized by permission, information, and empathy, could be effective in enabling a couple to achieve a more satisfying sexual relationship.

Development of the Model

Masters and Johnson (1970) estimated that at least half of the marriages in the United States are threatened by sexual problems. Nevertheless, recent research (Anon, 1974) has shown that very few people need intensive sex therapy; he reported less than 10%. Most sexual

difficulties are caused by attitudes and lack of information; relatively few problems can be traced to organic or emotional disorders (Masters & Johnson, 1970). In the course of the present study an attempt was made initially to select and use one therapeutic approach, but it became immediately obvious a single program or model would be too rigid and inadequate to treat effectively the variety of clients and client concerns. Given the decision to use a brief therapeutic model, the therapists in the present study developed an eclectic model drawing from the systems of Helen Kaplan, Masters and Johnson, and Jack Anon. An eclectic approach seemed justified because sexuality is so unique and individually defined, and the dynamics of each relationship and the interaction of sexuality therein are distinctly different from person to person. Perhaps in no other aspect of counseling can eclecticism be more comfortably defended than in sex therapy.

The eclectic approach was developed with a guiding structure based on three essential components - permission, information, and empathy. These components are reflective of the three major schools of psychology today: permission - psychoanalytic school; information - behavioristic school; empathy - humanistic school. The major goals of the Permission - Information - Empathy (PIE) model for sexual counseling were permission - to enable the persons

seeking help to become freed from past conditioning and to become more comfortable with their sexuality; to help them accept their sexuality as a natural part of their endowment as human beings; information - to provide them with a clearer perspective of the sex roles that men and women fulfill, ideally self-defined; to give them a better understanding of the wide range of forms of sexual expression and the relationship of sexuality as an integral part of the total relationship; empathy - to facilitate effective therapy by developing a warm, growing, helping relationship, characterized by empathy, sensitivity, respect and concern for other persons, effective communication skills, openness, acceptance, and trust.

CHAPTER II

METHOD

Subjects

The study was conducted in a clinical setting: the Sexual Counseling and Education Program, Social Work Services, Ft. Campbell Army Hospital, Fort Campbell, Kentucky. The subjects were members of the military and their spouses referred by self or another source (physician, chaplain, social worker) because of specific sexual problems. The sample consisted of eighteen persons (nine couples). The mean age of the women was 29 years, of the men, 32 years.

Treatment

Although the statistical analysis was based on each person's degree of sexual satisfaction before and after therapy, the subjects were seen in therapy as couples. Central to effective sex therapy is the treatment of couples, not just one partner or another. Masters and Johnson contend there is no such thing as an uninvolved partner in any marriage in which there is some form of sexual inadequacy. "Isolating a husband or wife in therapy not only denies the concept that both partners are involved in the sexual inadequacy, but also ignores the fundamental fact that sexual response represents

interaction between people" (Masters & Johnson, 1970). The relationship is therefore a crucial factor.

Procedure

A dual therapy modality was chosen for working with the subjects based on the premise that each partner of a heterosexual couple could relate better with a therapist of the same sex and that each therapist could serve as a gender model for the client of the same sex (Masters & Johnson, 1970; Hartman & Fithian, 1972). Masters and Johnson preferred that one of the co-therapists be a physician, primarily for the physical examinations often indicated, and for the teaching of the physiological and sexual responses of males and females. The educational function was effectively assumed by the co-therapists in the present study, and an obstetrician/gynecologist and urologist on the hospital staff cooperated in the requested examinations.

The initial intake process included the couple's meeting both therapists and discussing in general terms their presenting concern(s) and hopes or expectations for therapy. The initial session also served as an opportunity for the therapists to view how each of the partners felt about the problem and to gain some insight into what degree of conflict existed between the couple. The therapists discussed some of their fundamental expectations for the couple as well; specifically, that

each had a responsibility to work at the problem, that each was involved in contributing to the problem (no blame was assigned), and that both partners should agree on the nature of the problem before they could begin to work toward a satisfactory resolution.

Following the introductory discussion, the couple would separate and each would go with the same-sex therapist for taking the sexual problem history and the social history with the emphasis on psychosexual development. In the field of psychotherapy there is disagreement as to exactly what form the initial client assessment should take. Some feel that there is little need for a past social history because the therapist will work primarily with the immediate problem without necessarily knowing how it came about (Phillips & Weiser, 1966). Others feel such a history is only necessary in certain cases (Rachman, 1963). However, the strongest case is made by those who believe that a past history is essential for effective understanding and treatment of the current problem (Birnbrauer, Burchard & Burchard, 1970; Staats, 1968; Staats & Staats, 1963), and it is this approach that was adopted for the present study.

In the conduct of the initial interview the therapists operated out of an informed understanding of sexuality and a resolution of their own anxieties and inhibitions concerning sexuality. This frame of

reference was important for a relaxed and effective interview facilitating honest patient response. Even when the therapist is reasonably comfortable with and generally knowledgeable about sexual matters, it is important that he or she be aware of the extent to which open communication can be blocked by cross-cultural, ethnic, age, and social differences (Hartman & Fithian, 1972). A successful interview about sexual problems can be, in itself, therapeutic, since it permits ventilation of difficulties the client has perhaps been heretofore unable to assess, share, or even to put into words. The Sexual Responsiveness Inventory (Anon, 1974) was filled out separately by each partner during the initial session. Twenty questions from this inventory served as the pre- and post-test (see Chapter III and the Appendix).

Following the interview the therapists and clients returned to a brief joint meeting to discuss the continuation of therapy. The couple was then given their first assignment: to discuss with each other the Sexual Responsiveness Inventory, as much as they could remember and/or felt comfortable sharing. This assignment was given to raise questions perhaps never before discussed by the couple, and to begin to open up or to renew the lines of communication in the area of sexuality, anticipating future therapy sessions and assignments.

The procedure following the first session was very

individualistic and determined by the needs of the clients. A co-therapy model was used for the duration of the treatment program. Therapy cases varied from four sessions to fifteen, usually held once a week. All persons were evaluated through the post-test (the same twenty questions from the Sexual Responsiveness Inventory, which had served as the pre-test) at the conclusion of therapy or after the fifteenth session, whichever came first. Four couples required therapy beyond fifteen sessions because of the presence of marital pathology, but it was felt that the definition of brief sex therapy should require that therapy be limited to three months. Each session was based on individual and/or couple needs, interspersed with assigned exercises executed at home. Reactions to the exercises often determined the course of further treatment. The three methods for dealing with adverse reactions to the exercises included repetition, insight, or bypass (Kaplan, 1975).

Specifically, the three components of the PIE model were present in the treatment of every couple but to varying degrees according to the individual's history and progress in therapy. A more detailed explanation of the three components follows:

Permission, true to the psychoanalytic approach to therapy, consisted of exploring a person's past to determine: (a) the impact of their sex education or lack of

it, (b) early impressions of parental attitudes on nudity, expression of affection, masturbation, reproduction, etc., (c) dating experiences, and (d) early phases of the relationship with the partner. The permission phase of therapy was intended, in other words, to explore with the client relevant background factors and how the present concerns may be a reflection of the past. It was the intent of the therapists to enable the client to recognize and understand the past without being bound by it. Permission was given to change, to grow beyond the past teachings. For women, permission was especially given to enjoy sex. Fischer (1973) reported that the most important causes of orgasmic dysfunction for women are shame, guilt, and fear. For men, permission was especially given to feel and express emotion and affection, a characteristic seemingly even more absent within the military than in the general male populace.

Information, reflective of the behavioristic approach to therapy, emphasized redefining the sexual relationship, unlearning old behavior patterns and attitudes and learning new ones. The sexual interaction of the couples expresses and reinforces a rich variety of aspects of their shared lives. Thus the couple was encouraged to see the sexual aspect of their relationship as not something separate, but an integral part of the whole, and therefore sex will be good when all else is good.

Specific exercises were assigned for implementing between sessions as a way of learning what was discussed in therapy as well as uncovering feelings and attitudes previously unrecognized. All couples were assigned the pleasuring exercises (Kaplan, 1975), termed sensate focus by Masters and Johnson. In these exercises they learned to touch and explore for pleasure and with new appreciation for each other without expectations of intercourse. The exercises are characterized by the absence of pressure and anxiety, and by the sensation of holding, touching, expressing affection without "sex." In addition to the initial pleasuring exercises, the assignments included others in the sensate focus series, viz. nondemand coitus, the squeeze technique, the bridge maneuver (Kaplan, 1975). The exercises were selected according to the specific complaint or dysfunction. The sexual dysfunctions were classified accordingly: women - preorgasmic (3 couples), orgastic dysfunction (4 couples), vaginismus (did not have a case); men - impotence (2 couples), premature ejaculation (2 couples), retarded ejaculation (did not have a case).

Empathy, the cornerstone of the humanistic approach to psychotherapy, was ever-present in the therapeutic relationship. It represented support, sensitivity, caring and establshed a model for the couple to assimilate into their own relationship. Manifesting understanding,

honesty, openness, and spontaneity, the therapists encouraged the clients to adopt these characteristics as their own. Empathy is especially important in sexual counseling because of the sensitivity of the subject matter. True reflection of feelings and genuine acceptance are perhaps never more appreciated. The client can feel that the therapists share at an emotional level his or her experiences, trust is built, progress is possible. Above all, the therapists must be nonjudgmental, genuinely accepting and respecting the couple and their problem, understanding their concerns and conflicts, and supporting them emotionally (Schiller, 1973).

CHAPTER III

RESULTS

Statistical analysis was based on a within-subjects design because of the small N and because a within-subjects design avoids the need for a control group, thereby eliminating the ethical concern of denying or postponing treatment for anyone. Each subject was administered the Sexual Responsiveness Inventory (Anon, 1974) as a pre-test, followed by therapy. The same Inventory was given as a post-test. Possible responses to twenty questions on the test were on a continuum (0-7) indicating degrees of comfort or satisfaction with various aspects of the sexual relationship. The data were treated as ordinal data, and the Wilcoxon Matched-Pairs Signed-Ranks Test was used to determine statistical significance. This test is for nonparametric data chosen because of the small sample and because normality of distribution could not be assumed given the manner in which the subjects were "selected" for the study. The Wilcoxon test allowed the magnitude of scores to be taken into account as well as the direction of the difference for each subject. Statistical significance was obtained at the .005 level ($T = 0.00$, one-tailed).

The data for the subjects in the study are summarized

below. As can be seen by the data, there were no negative ranks, thereby producing the T = 0.00 result. All subjects experienced an improvement in their overall sexual satisfaction.

Subject	Total Score Pre-Test	Total Score Post-Test	Difference	Rank of Absolute Difference
1	68	129	61	18.0
2	105	131	26	8.5
3	52	76	24	6.5
4	78	105	27	10.5
5	93	126	33	14.5
6	109	128	19	3.0
7	50	97	47	17.0
8	87	115	28	12.0
9	110	123	13	1.0
10	93	126	33	14.5
11	101	131	30	13.0
12	98	133	35	16.0
13	76	93	17	2.0
14	81	102	21	4.5
15	86	112	26	8.5
16	93	120	27	10.5
17	100	121	21	4.5
18	95	119	24	6.5

CHAPTER IV

DISCUSSION

The present limited study of sexual dysfunction and a derived eclectic approach to brief sex therapy has confirmed a broader hypothesis than the one statistically tested. That is, that poor sexual adjustment is often caused by ignorance about human sexuality and is compounded by lack of communication between partners. A corollary is that improvements in the sexual response are seen as part of the improvement in the total relationship.

Again, intensive sex therapy is not indicated as often as is a provision of basic information, correction of distortions about sexual functions, dispersement of myths, and support for sexual feelings, needs, and fantasies. Following the educational process most sexual problems can be traced to twin obsessions with performance and technique on the part of both sexes, resulting in anger, confusion, hurt, disappointment and frustration. The women are waiting to be turned-on and fulfilled; the men believe earnestly it is their job to arouse and satisfy their partner. Couples today need to be told to put away the sex manuals, and they need to be supported in new or renewed efforts in communicating likes and

dislikes in a constructive, nonthreatening manner.

Emphasis must be placed upon involvement of both partners, blame placed on neither; both are involved in the problem and in the treatment. Therapy encourages expression of their natural feelings, the importance of learning, and the redefinition of a sexual relationship in a nurturing environment. Ultimately, the sexual relationship is reflective of self-esteem. Low self-esteem weakens the basis of the relationship; high self-esteem provides a foundation for risk-taking, growth, and sensitivity to one's partner, traits that are nurturing to any relationship. In working to strengthen the relationship through increased sexual satisfaction, each person's self-concept must be an essential consideration of the therapist. It would be interesting to conduct further research correlating the degree or rapidity of success in sex therapy with the client's self-esteem at the onset of therapy.

The strength and self-confidence of the individuals define the strength of the relationship. As reported in the literature and confirmed in the present study, when a sexual concern is presented, the difficulty can indeed often be traced to the relationship. The psychosexual difficulties that frustrate sexual performance are seldom rooted in any mechanical problem (Mace, 1975). They more often represent the inability of the person concerned to

become involved in a shared life with the spouse. A wife suffering from vaginal orgasmic difficulty may well be saying to her husband, "I am afraid or reluctant to let you come fully into my life by opening myself so freely with you"; the impotent husband, "I can't come too close to you, because I am threatened or do not feel accepted for who I am." The unfaithful spouse may be saying, "When I try to enter fully into your life, I feel that I am only conditionally accepted, and I cannot meet your conditions, so I am turning to someone else for the experience of intimacy that I cannot find with you." The treatment of these problems is therefore most effective when undertaken in a relational context.

The PIE model, developed through the present study, provides an effective integration of the psychoanalytic, behavioristic, and humanistic aspects of sex therapy. Permission is given to overcome guilt resident in the past, allowing change in the here-and-now, enabling freedom in the future. Change occurs through Information - the factual component, the learning process, the substance the "work" of the therapeutic relationship. Empathy facilitates effectiveness on the part of the therapists, who provide the emotional support and validation of the client's personhood.

In closing, one cannot help but note that the necessity for developing a unique model for sex therapy

is evidence in itself that more research is essential in the comparison of systems, formats and therapy models in the area of sexuality and in the determination of the effectiveness and ultimate value of each.

Having discussed the study, specifically within the context of statistical significance, the researcher wishes to add a parenthetical, editorial comment. Some resistence is felt for this necessity for analytic reductionism in the understanding of mankind and, in this case, determining his sexual satisfaction. Too often the rich wholeness of our experience has been reduced by psychologists and psychiatrists to what can be easily observed - actions, words, movement, markings. This promotes a limited conception of human capacities and reduces personal experience and knowledge to objective words or numbers. Thus, man's full range of capacities has been reduced to what can be most conveniently measured and standardized. The process tends to produce a "lowest common denominator" concept of mankind. Whole areas of human experience are ignored by scholars because they are "difficult to measure." There is much about life, personhood, and society that can not yet be conveniently measured and graded, yet deserves serious attention and consideration. The area of human sexuality is not the least of those issues worthy of more study.

CHAPTER V

SUMMARY

The present study was based on the hypothesis that a program of brief sex therapy, characterized by permission, information, and empathy, could be effective in enabling a couple to achieve a more satisfying sexual relationship. The subjects were nine couples, clients of the Sexual Counseling and Education program, Social Work Services, at the Ft. Campbell Army Hospital, Ft. Campbell, Kentucky.

After thorough research into the various models being used for sex therapy, it was determined that a unique approach was needed, one which would combine attention to physiological sexual dysfunction with a concern for the dynamics of the relationship, and the overriding need for a permission-giving and re-educational process. This approach must of necessity be flexible in order to treat each client effectively and individually through acceptance and sensitivity to each client's personhood and life circumstances, without the compulsion to force the therapy process into a predetermined pattern. Thus the PIE model was developed as an eclectic approach to sex therapy, borrowing from each of the three major schools of psychology for the

three components of the model: permission (psychoanalysis), information (behaviorism), and empathy (humanism).

Nine couples were administered a pre-test, treated in brief sex therapy, with the maximum number of sessions being fifteen for purposes of the study, then administered the post-test to assess changes in degree of sexual satisfaction. Statistical analysis was based on a within-subjects design. With an N of 18, the Wilcoxon Matched-Pairs Signed-Ranks Test, one-tailed, was significant at the .005 level ($T = 0.00$). It is, therefore, assumed that the PIE model for brief sex therapy was an effective catalyst for improving the clients' sexual relationship.

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APPENDIX

APPENDIX

SELECTED QUESTIONS FROM SEXUAL RESPONSIVENESS INVENTORY

The Sexual Responsiveness Inventory, developed by Dr. Jack S. Anon in 1974, was used in the intake portion of the therapy. Twenty questions were selected to be used as a pre- and post-test to measure changes in degree of the client's sexual satisfaction. The clients were to respond to each question by indicating their response on a continuum, from 0-7, reflecting the degree of their own satisfaction with that particular aspect of their own sexuality or their sexual relationship. The subject matter of each of the twenty questions is listed below.

1. the means by which sexual arousal occurs
2. the frequency of the partner's orgasm
3. the frequency of the client's orgasm
4. acceptance of orgasm not with vaginal intercourse
5. frequency of partner's desiring sex when client does not
6. frequency of client's desiring sex when partner does not
7. degree of feigned arousal to please the partner

8. comfort with undressing, being nude with partner
9. comfort of partner with undressing, being nude with client
10. communication with partner about sexual matters
11. personal attitudes regarding self-stimulation
12. degree of sexual desire
13. degree of arousal without orgasm (self-stimulation)
14. degree of arousal without orgasm (with partner)
15. intensity of orgasm (self-stimulation)
16. intensity of orgasm (with partner)
17. satisfaction after sexual activity (self-stimulation)
18. satisfaction after sexual activity (with partner)
19. overall satisfaction with personal sexuality
20. overall satisfaction with sexual relationship