THE KNOWLEDGE OF SOCIAL WORKERS IN PRIVATE PRACTICE REGARDING HUMAN SEXUALITY AND SEX THERAPY

by

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SUMMARY

Title: **The knowledge of social workers in private practice regarding human sexuality and sex therapy**

by

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Department: **Social Work**
Degree: **Magister Artium in Social Work**

Sexual problems or dysfunctions remain one of the prominent reasons for marital and relationship problems, often resulting in divorce. Sexuality is however only one of many components of a marriage or of a committed relationship. Relationship problems and sexual problems are often interlinked. The fact that sexual problems are often only symptoms of deeper relationship issues, makes the social worker the ideal person to treat these sexual problems from a holistic perspective and within a relationship context.

The nature of this research study evolves around the proposed lack of knowledge of social workers in private practice, and who specialise in couple therapy, regarding human sexuality and sex therapy. This research study is valuable for the social work profession as the knowledgebase of social work is extended. Social workers come into close contact with individuals seeking couple therapy. Social workers might often be required to assist individuals or couples with sexual problems, as relationship difficulties and sexual problems often co-exist. This study is further of value because the importance of the integration of sex therapy and couple therapy is shown.

A qualitative research approach is used, and applied research is conducted. An exploratory research design is utilised and a self-constructed, mailed questionnaire is used as method of data collection.

The following conclusions can be drawn and the following recommendations made:

- There exists an interaction between sexual difficulties and relationship problems.

- Sexual dysfunctions do not occur in a vacuum, and must be viewed within the context of the total system of the client.

- The social worker is the ideal person to deal with sexual difficulties, as he or she is well trained in the dynamics of marriage and relationship therapy.

- An integrative, holistic and post-modernistic approach to therapy for sexual difficulties has emerged.

- There is a movement today toward the combination of sex therapy and couple/relationship therapy.

- There are concerns that social workers in private practice specialising in couple therapy, may have a lack of knowledge regarding human sexuality and sex therapy. The respondents in this study answered only 58.53% of the knowledge based questions correctly.

- There is a need for specialised education and training of social workers in the field of human sexuality and sex therapy.

- Training in human sexuality and sex therapy should be included in the undergraduate, post-graduate and continuing education levels of social work-training.

- This research study supplies a basis for future research studies. The content of the study can aid in the development of a course in human sexuality and sex therapy aimed at social workers specifically.

OPSOMMING

Titel: Die kennis van maatskaplike werkers in privaatpraktyk rakende menslike seksualiteit en seksterapie

deur

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Seksuele probleme of disfunksies is steeds van die mees prominente redes vir verhoudingsprobleme. Seksuele probleme is waarskynlik dié enkele faktor wat paartjies finaal laat skei.

Seksualiteit is egter net een van die vele komponenete van 'n verhouding. Verhoudingsprobleme en seksuele probleme is dikwels verwant aan mekaar. Die feit dat seksuele probleme dikwels bloot simptomaties is van dieperliggende verhoudingsprobleme, maak die maatskaplike werker die ideale persoon om hierdie probleme, holisties en vanuit 'n verhoudingskonteks te behandel.

Die aard van die navorsing het gehandel rondom die beweerde gebrek aan kennis van die maatskaplike werker in privaatpraktyk, wat spesialiseer in verhoudingsterapie, rakende menslike seksualiteit en seksterapie.

Die waarde van hierdie navorsing lê daarin dat die professie maatskaplike werk se kennisbasis uitgebrei is. Maatskaplike werkers het dikwels kontak met paartjies wat verhoudingsterapie verlang. Daar mag dus dikwels van die

maatskaplike werker verwag word om paartjies met seksuele probleme by te staan aangesien verhoudingsprobleme en seksueleprobleme nou verwant is.

Toegepaste navorsing, vanuit 'n kwantitatiewe benadering is onderneem en die verkennende navorsingsontwerp is gebruik. 'n Selfontwerpte posvraelys is gebruik as wyse van data insameling.

Die volgende gevolgtrekkings en aanbevelings kan gemaak word:

- Daar bestaan 'n wisselwerking tussen seksuele probleme en verhoudingsprobleme.

- Seksuele probleme kom nie in 'n vakuum voor nie, en moet gesien word vanuit 'n verhoudingkonteks en as deel van die kliënt se totale sisteem en funksionering.

- Die maatskaplike werker is 'n ideale persoon om seksuele probleme van kliënte aan te spreek, aangesien hy/sy goed opgelei is in die diamika van huweliks- en verhoudingsterapie.

- 'n Geïntegreerde, holistiese en post-moderne benadering tot terapie vir seksueleprobleme word vandag gevolg.

- Daar is ook vandag 'n neiging om seksterapie en verhoudingsterapie te kombineer.

- Daar bestaan kommer dat maatskaplike werkers in privaatpraktyk wat in verhoudingsterapie spesialiseer, 'n gebrek aan kennis rakende menslike seksualiteit en seksterapie mag hê, aangesien die respondente net 58.53% van die kennisgebasseerde vrae korrek beantwoord het.

- Daar bestaan 'n behoefte vir gespesialiseerde opleiding van maatskaplike werkers in menslike seksualiteit en seksterapie.

- Opleiding in menslike seksualiteit en seksterapie behoort op voorgraadse, nagraadse en deurlopende ontwikkelingsvlakke te geskied.

- Hierdie studie bied 'n basis waaruit toekomstige navorsingstudies kan vloei om 'n kursus in menslike seksualiteit en seksterapie, vir maatskaplike werkers spesifiek, te ontwikkel.

KEYWORDS	SLEUTELTERME
1. Sex therapy	1. Seksterapie
2. Human sexuality	2. Menslike seksualiteit
3. Sexual health	3. Seksuele gesondheid
4. Couple therapy	4. Verhoudingsterapie
5. Knowledge	5. Kennis
6. Comfort	6. Gemaklikheid
7. Social work	7. Maatskaplike werk
8. Social worker	8. Maatskaplike werker
9. Private practice	9. Privaatpraktyk
10. Sexual dysfunctions	10.Seksuele disfunksies

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CHAPTER 1

GENERAL INTRODUCTION AND OUTLINE OF STUDY

1.1 Introduction

In South Africa today, many marriages end in divorce. According to Statistics South Africa (1998:1), 66% of all first marriages end in divorce. Sexual problems or dysfunctions remain one of the prominent reasons for marital and relationship problems (Fourie, 1984:23). Research done by Mace (1958) and by Masters and Johnson (1970) confirms this statement and indicates that sexual difficulties may well be the most important single factor finally resulting in divorce. More recently, King (1999:310) refers to the fact that studies have shown that the most frequent reason given by couples for their divorce is the loss of sexual attraction, which also supports this notion. Sexual difficulties do not however occur exclusively in marital relationships. Couples in committed long-term relationships and even single people may experience sexual difficulties. Sexual dysfunctions and difficulties are also not exclusive to heterosexual couples, but may also occur in homosexual relationships.

Macklin (2000:1) states that although a contented sex life is a major key to a couple's emotional satisfaction, many therapists hesitate to address sexual issues in couple therapy. A small number of medical practitioners, social workers, psychologists and related professionals are able and/or willing to offer clients support with their sexual difficulties. An even lesser amount of professionals are able to provide professional sex therapy.

Sex therapy is multi-dimensional in nature and sex therapists originate from various professional fields such as social work, psychology and the medical fraternity. Sex therapy has been used professionally since the 1960s, but obtained mainstream recognition with the publications of Masters & Johnson (1966, 1970). These landmark publications as well as many others are viewed as classical works within the field of sex therapy. This study will therefore not be complete without referring to these classical works, although many of them may be more than ten years old.

Since the 1960s sex therapy has become a major specialty within the fields of psychology, psychiatry and medicine (Lopiccolo, 1978:ix). This view is shared by Weeks & Hof (1987:viii), who conclude that sex therapy shifted from being considered to be an individual problem, to being a couples problem and even a family problem, thereby becoming part of marital and couple therapy. When added to the fact that sex is not only important at an individual, personal level, but also socially and politically, Bancroft (1989:1) accentuates the importance of effective sex therapy in couple therapy.

Although the short-term, behaviourally oriented approach to the treatment of sexual dysfunction has proven to be an effective treatment modality, couples that experience severe marital or relationship distress demonstrate a poorer prognosis for treatment in a variety of forms of sex therapy. The research that supports this notion is listed in Berg & Snyder (1981) and confirms the belief that sexual dysfunctions do not occur in a vacuum, and that they must be viewed within the context of the total system of the client. This being the case,

it is obvious that a comprehensive and multi-dimensional approach to the treatment of sexual dysfunctions must include a thorough evaluation of the couple's relationship. Weeks & Hof (1987:xiii-xiv) confirm this view with the following statement: "The integration of sex therapy and couple therapy changes the way problems are understood from an individual to a systems perspective. This type of integration calls for a new breed of sex therapists. Therapists trained in individual-, sex-, couple-, and family therapy".

1.2 Motivation for the choice of subject

Sexuality is only one of the many components of a marriage or of a committed relationship. Relationship problems and sexual problems or dysfunctions are often interlinked. Woody (1992:5) states that people with sexual and intimacy problems seek help in various service settings. Those who know they are experiencing a sexual problem may seek help from a sex therapist. Clients with other forms of sexual distress might however see a marriage or relationship therapist. Woody (1992:6) states that: "...sadly, some clients never articulate their sexual concerns or dilemmas because of the practitioner's lack of knowledge and skills". Weeks & Hof (1987:viii) also state that many sex therapists still remain focused on treating the sexual dysfunction, even though they recognise on some level of consciousness that sex is but part of a particular couple's relationship.

It is often the case that a sexual problem is only a symptom of a relationship or marital problem, and this fact makes the social worker an ideal person to

deal with the problem, as he or she is well trained in the dynamics of marriage and relationship therapy. The problem however is that social workers are often not adequately trained in the field of human sexuality and sex therapy, and that they are therefore often unsure of their role within the multi-disciplinary team. Social workers are also often unaware that they have existing knowledge and skills to deal effectively with sexual problems and dysfunctions within the relationship context. "Some marital therapists may not be aware that after months of treatment, or even after termination, the couple had a sexual dysfunction. Often clients and therapists seem to have a collusive taboo against dealing with sexual problems" (Weeks & Hof, 1987:ix). Clients with sexual problems or dysfunctions are often sent from therapist to therapist without being treated effectively. This is very disturbing for clients and has an important influence on client motivation and prognosis.

This emphasises the importance of education and training of social workers in the field of human sexuality and sex therapy to develop a more positive attitude towards sexuality. It is also important to raise the comfort level of the social worker regarding sexual issues. The social worker should also be able to identify sexual problems and dysfunctions by asking the appropriate questions and then to be able to refer clients where necessary to the appropriate specialists in the field.

The World Health Organisation, Technical Report (Author unknown, 1975:50) stresses as far back as 1975, the need for education and training in human sexuality of sexual health care workers as well as of auxiliary workers such as

social workers. The report goes further in stating that in order to develop a better understanding of problems of human sexuality, it is necessary for health care workers to develop healthy attitudes toward sexuality, marriage and contraception. An understanding by the worker of his or her own sexuality and rational approach to his or her own sexual problems will help him or her to be able to deal better with the problems of others. More recently, the Promotion of Sexual Health: Recommendations for Action (Author unknown, 2000:31) states that basic sexual health education for all health professionals should be included in their basic training as well as in continued educational programmes. Health professionals include the medical fraternity, nurses, clinical psychologists, social workers and general health practitioners in their opinion. According to Promotion of Sexual Health: Recommendations for Action (Author unknown, 2000:43) this basic training should include the following:

- Basic knowledge of human sexuality.
- Awareness of personal attitudes toward one's own and other's sexuality, which should include a respectful attitude toward persons with different sexual orientations and sexual practises.
- Basic skills in identifying clients with sexual difficulties, and if necessary, referring these clients to the appropriate specialised professional.

A search done by the National Research Foundation in 1999 proved that very little research had been done in the combined field of sex therapy, marriage-

or couple therapy and social work in South Africa. Only seven related studies could be identified of which only three dealt with sexuality in the field of social work specifically. Hurwitz (1979) stressed in his study the need for the training of social workers in the field of sex therapy. Woods (1995) concluded that social workers in many countries have a history of dealing with sexuality-related issues, and that society plays an important role in determining which sexuality issue they deal with, and in what way they are dealt with. He incorporated the sexuality-related issues that occurred most consistently into a framework of social work and human sexuality. Fourie (1984) confirmed the findings of previous studies, and states that sexual dissatisfactions are one of the main reasons of marital breakdown, in his D.Ed study, entitled: "The training of sex therapists in South Africa – a multi-disciplinary approach".

1.3 Problem formulation

The nature of the research problem evolves around the proposed lack of knowledge of social workers regarding human sexuality and sex therapy. Social workers come into close contact with individuals in different communities and environments and might often be required to assist individuals with sexual problems, as relationship difficulties and sexual problems often co-exist. Sexuality and intimacy needs are connected, and therapists ought to be able to treat them holistically.

It is proposed that social workers often do not identify sexual problems because they avoid the subject of sexuality and are afraid to "open a can of

worms" which they may not be able to deal with effectively. In South Africa especially, many people and therapists are still uncomfortable with the subject of sexuality because of their conservative Victorian heritage.

Lister & Shore (1983:15) are of the opinion that it is the role of the social worker to understand the complex interplay of sexual problems and relationship difficulties and to intervene with social work skills to change or enhance both individual and social patterns that bring about sexual dysfunction. Lister & Shore (1983:16) are further of the opinion that the practice of social work has great potential for impacting the increased responsiveness of a health care system to the sexual needs of clients. In order to approach the topic of sexuality with confidence, the social worker should have accurate scientific knowledge regarding the facts of human reproduction and human sexuality. Social workers should know what are the common sexual problems experienced by clients, and how to deal with them effectively. The social worker should also know when the solution of a problem is beyond his or her ability and requires referral to a specialist. A social work perspective on sexual health can be described as the enhancement or restoration of optimal sexual functioning within a relationship context.

The problem that will be researched by means of this study can therefore be described as the proposed lack of knowledge of social workers specialising in marriage and relationship therapy (couple therapy), with regards to human sexuality and sex therapy.

1.4 Goal and objectives of study

1.4.1 Goal

The aim of this study is to explore and describe the knowledge of social workers in private practice, specialising in marriage and relationship therapy (couple therapy), with regards to human sexuality and sex therapy.

1.4.2 Objectives

To reach the above-mentioned goal, the following objectives are identified:

- To explore and describe, through a literature study, the nature, status and characteristics of human sexuality and sex therapy from a theoretical point of reference.

- To explore the role of sex therapy in couple therapy from a theoretical point of reference and within the social work context.

- To determine the level of knowledge of the social worker in private practice, specialising in couple therapy, with regards to human sexuality and sex therapy.

- To make recommendations regarding the shortcomings of social workers' knowledge regarding human sexuality and sex therapy, identified by means of this study.

1.5 Theoretical assumption

A characteristic of exploratory research is that it does not have a hypothesis and the purpose is to gain insight into a situation (Bless & Higson-Smith, 1995:42). Dane (1990:5) also states that exploratory research involves an attempt to determine whether or not a phenomenon exists. De Vos & Fouché (1998:104) also state that questions are posed about the nature of real situations, while hypotheses are statements about how things can be.

The following research question is formulated:

Do social workers in private practice who specialise in couple therapy, have a lack of knowledge regarding human sexuality and sex therapy?

1.6 Research approach

It is necessary in social work research to distinguish between the qualitative and quantitative research approaches. Both approaches aim to explain the social reality. Fouché & Delport (2002:77) state that in real life, human sciences research uses both quantitative and qualitative methodology – sometimes consciously, sometimes unconsciously. Fouché & Delport (2002:85) outline a unique perspective by highlighting certain steps that are germane to both the qualitative and the quantitative perspective. According to them the steps relevant to the qualitative and quantitative research processes are the selection of a researchable topic and formal formulations. Leedy (1993:139) states that the research methodology is dictated by the nature of

the data, as well as the research problem. De Vos, Schurink & Strydom (1998:15) also quote Leedy who identifies qualitative research methodologies as dealing with data that are principally verbal, and quantitative research methodologies as dealing with data that are principally numerical. De Vos, Schurink & Strydom (1998:15) describe the qualitative approaches as more philosophical modes of operation where in contradiction the quantitative approach to research is more formalised and explicitly controlled and is close to the physical sciences. Mouton & Marais (1990:155 –156) agree that the quantitative approach is more highly formalised and explicitly controlled. It is more exactly defined than the qualitative approach and they agree with Fouché & De Vos (1998:71) that the quantitative approach is closer to the physical sciences. Reid & Smith (1981: 87-89) add with regard to the quantitative approach that the researcher's role is that of an objective observer, and that the data collection procedures and types of measurement are constructed in advance and applied in a standardised manner. The quantitative approach also uses statistical methods to determine association or differences between variables.

It was decided to utilise the quantitative research approach and not a combination of the quantitative and qualitative research approaches in this study, because very little information regarding the subject exists. This study is only an initial study. In other words, the aim is to establish whether or not a phenomenon (lack of knowledge of human sexuality and sex therapy) exists – nothing more and nothing less. This will then provide a point of reference for further, more in-depth research studies. Fouché & Delport (2002:79) state

that the quantitative research approach is defined as an inquiry into a social or a human problem, based on testing a theory composed of variables, measured with numbers and analysed with statistical procedures in order to determine whether the predictive generalisations of the theory hold true. The quantitative study will be conducted by means of a self-constructed mailed questionnaire.

1.7 Type of research

According to Bless & Higson-Smith (1995: 41) the research problem guides the researcher in the selection of the type of research that will be suitable in resolving the research problem.

Applied research will be conducted as De Vos, Schumarink & Strydom (1998:8) state the goal of applied research as: "The development of solutions for problems and applications in practice". Arkava & Lane (1983:12) link applied research to immediate problems that the professional person experiences in practice. Thus applied research is implemented, as the topic is relevant and could contribute solutions to the problem of the proposed lack of knowledge of social workers about human sexuality and sex therapy.

1.8 Research design

According to Black & Champion (1983:75) most contemporary social scientific research is characterised by some type of study plan. This plan is labelled the

research design. Royce (1992:43) similarly refers to the research design as a blueprint that outlines the approach to be used to collect data. This view is supported by Grinnell & Williams (1990:140) who define exploratory research as: "The idea of an exploratory research study is to explore, nothing more – nothing less. We use exploratory designs when little is known in our research areas and all we want to do is make a beginning study".

The exploratory research design will thus be utilised, as there exist little information about the knowledge of social workers with regards to human sexuality and sex therapy in the social work context (Lister & Shore, 1983:1).

1.9 Research procedure and strategy

The research procedure chosen for this study has been selected keeping the aim of the study and research design in mind. A quantitative approach will be followed and thus a self-constructed mailed questionnaire will be used as method of collecting quantitative data.

The New Dictionary of Social Work (1995:51) defines a questionnaire as "...a set of questions on a form which is completed by the respondent in respect of a research project". Grinnell and Williams (1990: 216-217) define a mailed questionnaire as a questionnaire that is sent off by mail in the hope that the respondent will complete and return it. The advantages of a mailed questionnaire are according to Delport (2002:172) the fact that the costs are relatively low and that extension of the geographical area to be covered by the

researcher does not increase the cost level. Further advantages according to Snyman (1984:83) are that respondents enjoy a high degree of freedom in completing the questionnaire and information can be obtained from a large number of respondents within a brief period of time. Delport (2002:172-173) mentions the following limitations of the mailed questionnaire:

- The non-response rate may be very high
- Missing data may occur
- There is no control to determine that the right person in the household completes the questionnaire

The research population for this study consists of all the social workers who are registered with the South African Association of Social Workers in Private Practice (SAASWIPP) and who specialise in couple therapy. They amount to three hundred and forty four (344) in total. Three hundred and forty four questionnaires will thus be mailed, as it is the only feasible method to reach all the respondents countrywide.

De Vos, Fouché & Venter (2002:223) assert that data analysis in the quantitative paradigm entails the breakdown of the data into constituent parts to obtain answers to the research questions. Kerlinger (1992:125-126) states that the purpose of data analysis is to reduce data to an intelligible and interpretable form so that the relations of research problems can be studied, tested and conclusions drawn. The quantitative data collected in this study via a self-constructed, mailed questionnaires will be analysed via computer, with

the assistance of the Department of Statistics of the University of Pretoria. The research results will then be interpreted and conclusions will be drawn.

1.10 Pilot study

The pilot study may be regarded as a preliminary step in preparation of more extensive and elaborate research. It can be viewed as laying the foundation for all subsequent research steps. The pilot study is defined in the New Dictionary of Social Work (1995:45) as: "...the process whereby the research design for a prospective survey is tested".

Strydom (1998:178) quotes Singleton, Straits & McAllister who define a pilot study, as: "...the pre-testing of a measuring instrument that consists of trying it out on a small number of persons having characteristics similar to those of the target group of respondents". More recently Strydom (2002:210) refers to the pilot study as an integral part of the research process. Strydom (2002:211) states that: "Its function is the exact formulation of the research problem, and a tentative planning of the modus operandi and range of the investigation".

The pilot study can therefore be seen as a preliminary study to help orientate the researcher regarding the chosen topic of research, to determine the feasibility and extent of the study and to form a cornerstone to build on. Two respondents were chosen to complete the questionnaire as part of the pilot study. Minor alterations were made with regards to spelling, wording, and the clarity of the questions.

1.10.1 Literature study

The nature of the subject being studied required a thorough study of the relevant literature. As relevant social work literature is limited, literature from the fields of medicine, human sexuality and sex therapy were also consulted. Literature on human sexuality, sexual dysfunctions, sex therapy, couple therapy as well as the integration of sex therapy and couple therapy were consulted.

Although it was attempted to utilise as many recent references as possible, the fact remains that there are many classical works regarding sex therapy without which this study will be incomplete. This is the reason why some of the references are more than ten years old.

1.10.2 Consultation with experts

People with specialised knowledge regarding the specific field of research and research in general were consulted.

- Dr. Rina Delport and Dr. Reineth Prinsloo from the University of Pretoria were consulted as experts in the field of social work research.

- Dr. Reineth Prinsloo and Dr. Madeleine Nolte were also consulted as experts in the field of couple therapy.

- Me. Joke Nicol has been consulted as a social worker in private practice specialising in couple therapy.

- Dr. Madeleine Nolte, social worker at the student support services of the University of Pretoria and Me. Joke Nicol, a social worker in private practice, participated in the testing of the pilot questionnaire.

- Dr. Elna McIntosh, a clinical sexologist in private practice, and Mr. Eugene Viljoen, a clinical psychologist with special expertise in sex therapy with couples, were also widely consulted.

- Dr. Howard Rupel, dean of The Institute for the Advanced Study of Human Sexuality, in San Francisco, USA, was visited.

- Prof. Domeena Renshaw, Department of Psychiatry and director of the Sexual Dysfunction Clinic at the Loyola University Medical Centre in Chicago, USA, was consulted.

- Hundred and thirty-five hours of supervised clinical training in sex therapy were completed in 1997, at the Loyola University, Sexual Dysfunction Clinic, in Chicago, USA.

1.10.3 Feasibility of the study

Monette, Sullivan & De Jong (1989:92) state that the feasibility of a research study is the practical consideration of what can be accomplished within a specific time, and with limited resources.

Sufficient funds were available to carry out the research project as a bursary from the National Research Foundation, as well as a merit-bursary from the University of Pretoria, were awarded to the researcher.

Very little research has been done regarding this topic and the only current registered research project that could be found in this field relating to social work, is the study described in this dissertation.

The South African Association of Social workers in Private Practice (SAASWIPP) offered a suitable resource (database) for the execution of the research. All social workers in private practice, with their specific area of speciality, are registered with SAASWIPP. SAASWIPP published a resource book in 2000 where all the social workers in private practice, with their specific speciality are listed. This resource book offers a set sampling frame, which improves the practical feasibility of the study. Mailed questionnaires will be utilised to collect the data. It is therefore not necessary to make use of another sampling method such as cluster sampling to narrow respondents down to a certain geographical area. Six hundred and seventeen social

workers are registered as private practitioners in South Africa. Three hundred and forty four of these specialise in couple therapy.

1.10.4 Pilot test of questionnaire

A preliminary questionnaire was drawn up for completion by selected social workers and academic personnel. The results of the pilot questionnaire gave an indication of the usability and validity of the self-constructed questionnaire and whether it still needed to be refined.

Me. Joke Nicol and Dr. Madeleine Nolte completed the preliminary questionnaire. They are specialists in the field of couple therapy and are social workers with many years of experience. They were also consulted regarding the content validity of the questionnaire. The preliminary questionnaire was also handed to Dr. Ezio Baraldi, Mr. Eugene Viljoen and Me. Christa Coetzee for comments regarding content validity. They are members of the executive board of the Southern African Sexual Health Association (SASHA), and are specialists in the field of sex therapy. Minor changes were made with regards to typing errors and the clarity of questions.

Dr. Borain and Me. Rina Owen from the University of Pretoria's Statistical Department also evaluated the questionnaire.

1.11 Description of the research population, boundary of sample and sampling method

The research population is described as the total group of individuals involved in the study (Bailey, 1994:109). The research population for this study consists of all social workers who are registered with SAASWIPP and who specialise in couple therapy. A total of six hundred and seventeen social workers are registered countrywide as private practitioners. Three hundred and forty four of the registered social workers specialise in couple therapy. The study is conducted country wide to ensure validity. The population is relatively small (344) and a mailed questionnaire will be utilised. The response rate of a mailed questionnaire is between 20% and 40% (Bless & Higson-Smith, 1995:112). The whole population will therefore be used to conduct a thorough study and a sample will not be selected.

1.12 Ethical aspects

Dane (1990:58) describes the conducting of ethical research as a balancing act. Researchers must balance their general obligation to promote knowledge with the general obligation to treat others fairly. Strydom (1998:24) defines ethics as: "...a set of moral principles which is suggested by an individual or group, is subsequently widely accepted, and which offers rules and behavioural expectations about the most correct conduct towards experimental subjects and respondents, employers, sponsors, other researchers, assistants and students".

Dane (1990:39) defines the term voluntary participation as: "...the participants' rights to freely choose to subject themselves to the scrutiny inherent in research". This research project was done with the willing co-operation and informed consent of the participants without any coercion involved. The participants were also aware of the nature of the research project and of its ultimate aim and objectives. The participation of the respondents was obtained via a cover letter accompanying the questionnaire. The anonymity of participants and the confidentiality of information gathered were guaranteed. Strydom (1998:28) states in this regard that privacy implies the element of personal privacy, while confidentiality indicates the handling of information in a confidential manner. The respondents were not exposed to physical or emotional harm in any way.

1.13 Definition of key concepts

As stated previously there are some historical textbooks and resources that have to be included to make this study complete. This is especially true when key concepts are defined. The following key concepts can be defined:

1.13.1 Sex therapy

Many authors and researchers do not give a specific definition or description of sex therapy. Masters and Johnson (1970) for example do not give a definition of sex therapy. They however give a detailed outline of their therapy

strategy and the steps in their therapeutic model. Kaplan (1974:217) also spends little time on a definition of sex therapy. She does however mention: "... the primary objective of all sex therapy is to relieve the patient's sexual dysfunction. All therapeutic interventions, tasks, psychotherapy and couples therapy, are ultimately at the service of this goal".

Lopiccolo (1978:534) defines sex therapy as: "...brief (often ten to fifteen sessions) therapy, with the emphasis on directly changing the client's sexual attitudes and sexual behaviours". Ducharme (1997:20) states that sex therapists are counsellors who specialise in working with people who have sexual difficulties. The kinds of problems they deal with include a difficulty in achieving erections, premature or retarded ejaculation, and lack of sexual desire. For women, sex therapists address problems of reaching orgasm, painful intercourse, or lack of interest in sexual activity. A group of researchers who can be described as traditional sex therapists emphasises sexual functioning per se. (Compare Cole, 1985:337; Rosen & Weinstein, 1988:2 and Weeks & Hof, 1987:xii.) Cole (1985:337) describes sex therapy as: "...those therapeutic processes which are used to attempt to initiate or restore sexual function in an individual or between a couple, where it had been previously absent". Rosen & Weinstein (1988:2) state that the basic goal of sex therapy is the relief of sexual dysfunctions, resulting in the improvement of sexual functioning. These authors support the more narrow view of sex therapy that emphasises the sexual dysfunction as such without taking the relationship into account. Weeks and Hof (1987:xii) define sex therapy as an approach to therapy which is brief, problem-focused, has an

educational component, involves seeing a couple together, consists of specific treatment formats and techniques, and often involves giving clients specific homework assignments.

There is however today a shift in focus from the more narrow minded approach of sex therapy with the emphasis on sexuality as such, to a more broader perspective of which the sexual aspects are viewed from a broader conceptual framework. This statement can be confirmed by the following view held by Weeks & Hof (1987:xiv): "The traditional individual behavioural perspective of sex therapy is broadened to include the contextual and interactional dimensions of relationships". Barker (1991:213) defines sex therapy as: "Professional, clinical treatment of the psychological and physiological dysfunctions of human sexuality".

Sex therapy today is a field that includes practitioners of many different backgrounds – psychology, medicine, social work, nursing, counselling, and theology to name but a few. There are many approaches to sex therapy and therefore many definitions and perspectives. For the purpose of this study there will be focussed on sex therapy from a social work perspective, utilising the framework of sex therapy as part of marriage and relationship counselling. The relationship between the couple is taken into account. The sexual dysfunction will be viewed from the systems perspective, as the sexual dysfunction usually has a profound effect on the couple's relationship in general.

1.13.2 Human sexuality and sexual health

In the SIECUS publication, Common Ground Sexuality (Author unknown, 2001:4), it is stated that sexuality encompasses personal and social meanings as well as sexual behaviour and biology. A comprehensive view of sexuality includes social roles, personality, gender and sexual identity, biology, sexual behaviour, relationships, thoughts and feelings. This publication (Author unknown, 2001:5) states further that sexuality and sexual health are concepts that are often used interchangeably. Sexual health is however a component of sexuality.

Masters, Johnson & Kolodny (1995:21) define human sexuality as a multidimensional phenomenon having biological, psychological, behavioural, clinical, moral, and cultural aspects. They conclude further that no single dimension of sexuality is universally dominant.

Promotion of Sexual Health: Recommendations for Action (Author unknown, 2000:6) agrees with the previous statement and adds that sexuality refers to a core dimension of being human, which includes sex, gender, sexual and gender identity, sexual orientation, eroticism, emotional attachment, love and reproduction.

Sexual health is defined by the World Health Organisation (Author unknown, 1975:41) as: "The integration of the physical, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that

enhance personality, communication and love". King, Cameron & Downey (1991:268) define a sexually healthy person as someone who feels comfortable with his/her sexuality and who feels free to choose whether or not he/she wishes to try a variety of sexual behaviours.

In the SIECUS publication, Sexual Health: An Introduction (Author unknown, 1997:5) sexuality is defined as:

- **self-esteem**: the way people feel about themselves as men or women;
- **body image**: the way they feel about their bodies and the way they use them;
- **social roles**: the roles they take on and the expectations other people have of them;
- **relationships**: the way in which they relate to others.

Common Ground Sexuality (Author unknown, 2001:5) defines sexual health as: "...women's and men's ability to enjoy and express their sexuality, and to do so free from risk of sexually transmitted diseases, unwanted pregnancy, coercion, violence and discrimination. Sexual health also means being able to have an informed, enjoyable and safe sex life, based on self-esteem, a positive approach to human sexuality, and mutual respect in sexual relations. Sexual health enhances life, personal relations and the expression of one's sexual identity. It is positively enriching, includes pleasure, and enhances self-determination, communication and relationships". In The Promotion of Sexual Health: Recommendations for Action (Author unknown, 2000:6) sexual health

is defined as: "...the experience of the ongoing process of physical, psychological, and socio-cultural well being related to sexuality".

It is therefore evident that human sexuality and the term sexual health are multidimensional and interchangeable. The notion of sexual health however implies a positive approach to human sexuality, and the purpose of sexual health care should be the enhancement of life and personal relationships and not merely counselling and care related to procreation and physical problems. Sexual health is not just about sexual intercourse and reproduction. It includes such issues as self-esteem, self-expression, caring for others and cultural values. In sum, our sexuality is experienced and expressed in all that we are, what we feel, think, and do.

1.13.3 Sexual dysfunction

As in the case of the term sex therapy, Masters, Johnson & Kolodny (1995:462) only refer briefly to the term sexual dysfunction by stating that it is: "...a condition in which the ordinary physical responses of sexual function is impaired". Grazioli (1998:31) states that a sexual dysfunction is characterised by psychological and/or physiological disturbance in the four processes that characterise the sexual response cycle: desire, excitement, orgasm and resolution. Clinical judgement about the presence of a sexual dysfunction should take into account the individual's ethnic, cultural, religious and social background, which may influence sexual desire, expectations and attitude about performance.

Kaplan (1974:281) emphasises individual and physiological factors. She defines sexual dysfunction as: "...psychosomatic disorders which make it impossible for the individual to have and/or enjoy coitus". Five years later Kaplan (1979:21) goes further and describes sexual dysfunction as: "...disturbances of the desire, excitement, or orgasm phases of the sexual response cycle. All of these are psycho-physiologic disorders caused by sexually related anxiety and all are, to some degree at least, amenable to sexual therapy". Barker (1991:213) defines sexual dysfunction as: "The inability of an individual or couple to experience sexual intercourse in a satisfactory way".

The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (1994:164) groups sexual and gender identity disorders under four headings: sexual dysfunctions, paraphilias, gender identity disorders and sexual disorders not otherwise specified. Sexual dysfunctions are further grouped under sexual desire disorders, sexual arousal disorders and sexual orgasmic disorders.

It is evident that sexual dysfunction is an embracing term. The disturbance causes marked distress or interpersonal difficulty and the main complication is usually a problematic marriage and a disturbed sexual relationship.

1.13.4 Couple

The Macmillan English Dictionary (2002:318) defines a couple as two people who are married or involved in a romantic relationship with each other. For the purpose of this study a couple is defined as two people within a committed relationship. A couple may consist of a male and a female (heterosexual) or of a male and a male, or of a female and a female (homosexual). In order to simplify matters the term "couple" will be viewed from here onwards as consisting of a male and a female, but it should be noted that homosexual couples are also implied.

1.13.5 Couple therapy

Russell & Russell (1992:80) define couple therapy as a strategy of treatment that intervenes in a committed relationship. Couple therapy is an appropriate therapeutic context through which sexual dysfunction can be treated. The New Dictionary of Social Work (1995:65) describes therapy as social work assistance, which focus on the emotional and psychological needs of the client. Barker (1991:139) describes marital therapy as an intervention procedure used by social workers and other professionals to help couples resolve their relationship, communication, sexual, economical, and other family problems.

Barker (1991:139) distinguishes counselling from therapy and states that counselling is a form of therapy, which is less intense and more directive.

For the purpose of this study the terms marital therapy, relationship therapy and couples therapy will be viewed as interchangeable. The preferred term is however couple therapy as sexual dysfunctions and sexual difficulties do not occur exclusively within marital relationships. Sexual dysfunctions may also occur within committed relationships and single men or women may also experience sexual difficulties. Sexual difficulties should however be seen as a relationship problem and not as an individual problem.

Kaplan (1974:196) compares marital and relationship therapy to sex therapy. She asserts that the goal of sex therapy is to cure sexual difficulties, while the goal of marital and relationship therapy (couples therapy) is broader and includes a more extensive modification of the transactional dynamics, which lie at the root of the couple's difficulties. Kaplan (1974:217) states further that: "...the main aim of marital therapy extends beyond relief of the clients' sexual problems and includes the resolution of broader intra-psychic and interpersonal difficulties". Thus couple therapists do not treat the sexual symptoms in isolation from other problems. Sexual problems are usually the result of some or other dysfunction in the relationship and must therefore be treated by a holistic, eclectic approach, utilising basic social work marriage- and couples therapy skills as well as utilising specialised sex therapy skills.

Sex therapy has also evolved toward the integration of both couples therapy and sex therapy approaches. Through the integration of both couple and sex

therapy approaches, there is a unique opportunity for the social worker to act in a dual role with the clients.

1.13.6 Social Work

Compton & Galaway (1989:5) define social work as a profession, involving knowledge, values and skills developed by social sciences for furthering the goals of social welfare. They quote Boehm's definition (1989:6) of social work as: "Social work seeks to enhance the social functioning of individuals, singularly and in groups, by activities focused upon their social relationships which constitute interaction between individuals and environments". Hepworth & Larson (1986:12) site a similar definition of social work. They define social work as: "The professional activity of helping individuals, groups, or communities to enhance or restore their capacity for social functioning and to create societal conditions favourable to their goals". Morales & Sheafor (1989:7) agree that social workers help people to improve their interaction with various aspects of their world. "Social work is a profession committed to improving the quality of life for people through various activities directed toward social change" (Morales & Sheafor, 1989:8). Barker (1991:221) defines social work as the applied science of helping people achieve an effective level of psychosocial functioning. The New Dictionary of Social Work (1995:60) describes social work as a professional service aimed at the promotion of the social functioning of people.

Social work can thus be defined as a scientifically based profession, aimed at providing a service to clients (individual, group or community based) to improve their social functioning.

1.13.7 Social Worker

Barker (1991:222) refers to a social worker as someone who graduated from a school of social work, and who uses his or her knowledge and skills to provide social services to clients. The New Dictionary of Social Work (1995:60) refers to a social worker as a person who is registered and authorised in accordance with the Social Work Act, 1978 (Act 110 of 1978), to practice social work. The Macmillan English Dictionary (2002:1358) describes a social worker as someone who is trained to give help and advice to people who have severe social problems.

With regards to this study a social worker is defined as a person who is registered as a social worker with the South African Council for Social Service Professions (SACSSP), and who is operating through a private practice. They are therefore also registered with the South African Association of Social Workers in Private Practice (SAASWIPP).

1.13.8 Knowledge

Knowledge is defined by the Oxford Dictionary (1989:517) as a person's range of information, familiarity gained by experience and practical or

theoretical understanding of a subject. The Macmillan English Dictionary (2002:791) describes knowledge as that which someone knows about a particular subject. Morales & Sheafor (1989:181) define knowledge as the acquaintance with theoretical and practical understanding of some branch of science, art, learning or other area involving study, research, or practice, and the acquisition of skills. Barker (1991:128) refers to the social work knowledge base as: "The aggregate of accumulated information, scientific findings, values, skills and the methodology for acquiring, using, and evaluating what is known".

This study aims to assert the level of knowledge of social workers in private practice regarding human sexuality and sex therapy.

1.13.9 Comfort

The Oxford Dictionary (1989:273) describes comfort as being at ease with a subject or liking or accepting it. This study aims to assert the comfort level of social workers in private practice, specialising in couples therapy, with regards to the subject of human sexuality.

1.14 Problems encountered with this research

No major problems were encountered with this study. The only problems encountered were:

- The high non-response rate. Only 23% of respondents completed the questionnaire. This could mean that many respondents may view the topic of sexuality as threatening. According to Bless & Higson-Smith (1995:112) the response rate of a mailed questionnaire however is between 20% and 40%.

- Forty-three of the 344 questionnaires were returned undelivered because the SAASWIPP database was not up to date.

- A lot of missing data occurred, which may confirm the statement that there is a basic lack of knowledge regarding human sexuality and sex therapy among many of the respondents. Some questions may also have remained unanswered because the respondents viewed them as threatening or too personal.

- The fact that only the quantitative research approach was used, led to the fact that little data regarding respondents' perspectives and feelings, regarding human sexuality and sex therapy were obtained.

1.15 Outline of this research study

This research study consists of a number of chapters:

Chapter 1: General introduction

This chapter consists of the motivation for the choice of the study, the problem formulation and the aim and assumptions of the study. The research methodology, ethical issues and the definitions of the main concepts are also provided.

Chapter 2: Literature Overview: Part 1 – Human sexuality and sex therapy: An overview

Literature regarding human sexuality and sex therapy are explored and described. An historical overview of sex therapy as a science is provided. Key concepts are defined, and the different perspectives in human sexuality are discussed.

Chapter 3: Literature overview: Part 2 – Clinical sex therapy

Literature regarding clinical sex therapy are explored and described. The state of theory in sex therapy is discussed. The classification of sexual disorders is discussed, as well as different treatment modalities for sexual dysfunctions.

Chapter 4: Literature overview: Part 3 – The integration of couple therapy and sex therapy

The integration of couple therapy and sex therapy is discussed. The role of the social worker in sex therapy is described from a theoretical perspective and sex therapy within couple therapy is discussed from a social work perspective.

Chapter 5: Empirical results

A description of the data collected and the interpretation of the empirical research findings are given and illustrated by various tables and figures.

Chapter 6: General summary, conclusions and recommendations

This chapter ends the dissertation and includes a general summary, conclusions reached and recommendations made as a result of this study.

The **bibliography** for the study is arranged alphabetically.

1.16 Summary

This chapter consists of a general introduction to the research study. The research approach, methodology and methods of data-collection were described as well as problems encountered with the conducting of the research. Various key concepts and ethical considerations were identified and discussed.

- Sexual difficulties may well be the most important single factor resulting in marriage or relationship break-ups. There exist an interaction between sexual difficulties and relationship problems.

- Sexual dysfunctions and difficulties are not exclusive to heterosexual couples but may also occur in homosexual relationships.

- Sexual dysfunctions do not occur in a vacuum, and must be viewed within the context of the total system of the client.

- Relationship problems and sexual problems or dysfunctions are often interlinked.

- Because of this interaction between sexual difficulties and relationship problems, the social worker is the ideal person to deal effectively with these kinds of problems, as he or she is well trained in the dynamics of marriage and relationship therapy.

- There is a need for specialised education and training in human sexuality and sex therapy, of social workers.

- The problem that will be researched by means of this study can be described as the proposed lack of knowledge of social workers specialising in marriage and relationship therapy (couple therapy), with regards to human sexuality and sex therapy.

In chapter 2, literature regarding sex therapy and human sexuality will be reviewed.

CHAPTER 2

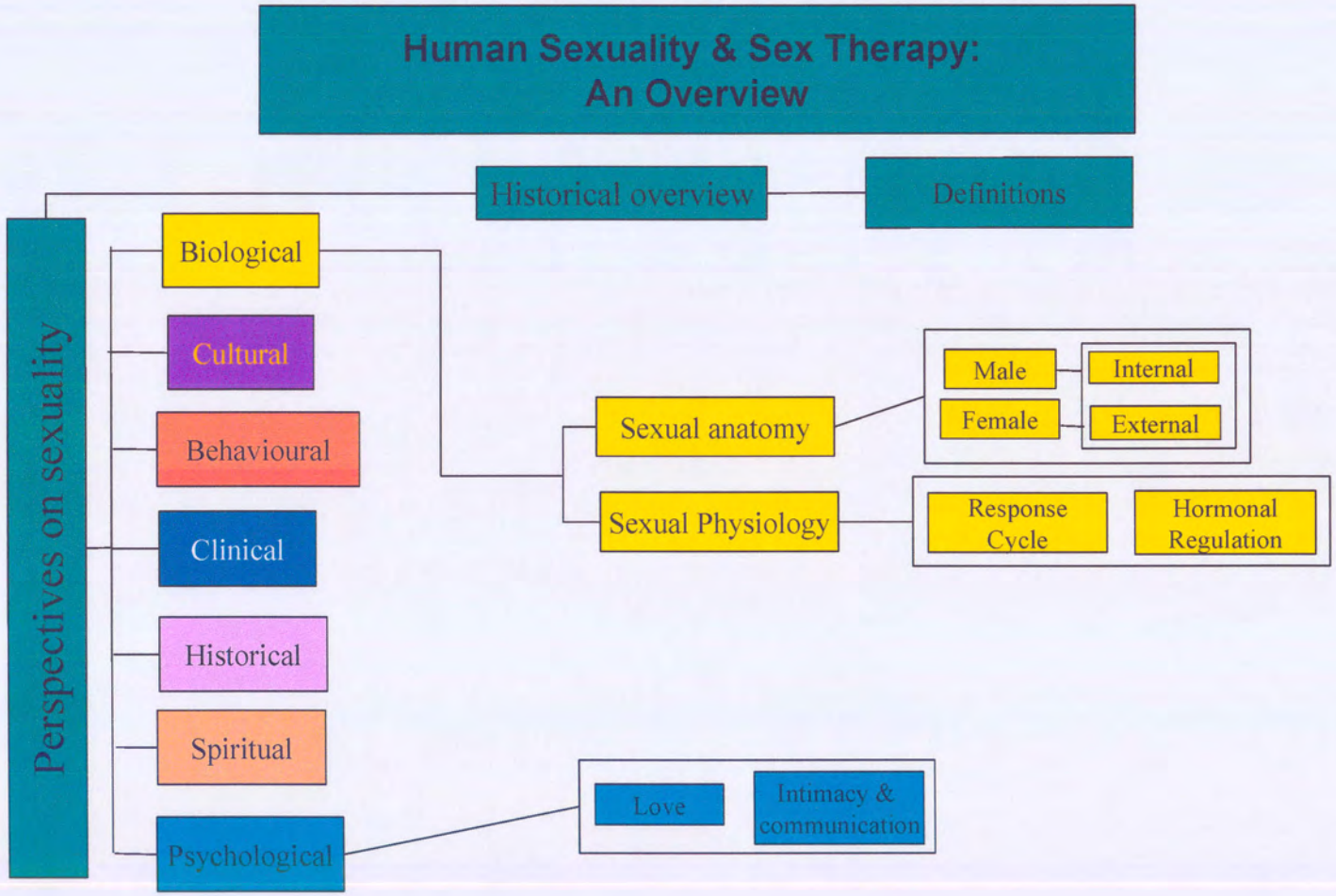
HUMAN SEXUALITY AND SEX THERAPY: AN OVERVIEW

2.1 Introduction

It is appropriate to start the theoretical overview of human sexuality and sex therapy by discussing the history and the origins of sex therapy. A short historical overview of the origins and background of sex therapy will therefore be discussed. A discussion of various definitions of human sexuality, sexual health and sex therapy follows. Various perspectives on human sexuality, namely, the biological dimension, the physiological dimension, the psychosocial dimension, the behavioural dimension, the clinical dimension, the cultural dimension and the spiritual dimension will then be discussed. The chapter concludes with a summary.

Figure 1 shows a schematic representation of the outline of this chapter.

Figure 1: Schematic representation of layout of chapter 2



2.2 Historical overview of sex therapy

Sexuality has fascinated people in all walks of life from the ancient times until the present. Masters, Johnson and Kolodny (1995:2) state that sexual themes have been common in art and literature. Religions, philosophies and legal systems, who are all concerned with shaping human behaviour, have typically tried to establish sexual values and taboos. Fourie (1984:12) states that Magnus Hirschfeld founded the first Institute of Sexual Science in Berlin, in 1919. This was followed by the establishment of a number of "Leagues of Sexual Hygiene" in Germany, Austria, Denmark and Sweden. The main emphasis of these consultation services was on sexual education and counselling. The leading figures in the field of sexology during this time were Hirshfeld, Block, Moll and Max Marcuse. Marcuse is often described as the father of sexology. Fourie (1984:13) quotes Block who defines sexology as: "... the study of the phenomena and effects of sexuality, in the relation to the physical and psychological, on the individual and emotional level".

The history of sex therapy as a discipline however, is relatively brief. Wiederman (1998:88) states that from the start of the twentieth century until the late 1960's, sexual dysfunction was typically treated within a psychoanalytic framework. From such a psychoanalytic perspective, psychological and sexual problems were viewed as originating from unresolved conflicts dating back to childhood, particularly conflicts over problematic attachments and tension in relation to one's

parents. Sexual problems were seen as symptoms of greater psychopathology. As such, treatment consisted mostly of long-term, individual psychotherapy. In contrast to this, a few clinicians like Lazarus, Obler and Wolpe also applied behavioural principles in the treatment of sexual dysfunction, but such approaches were not the norm prior to the 1970's. Barnes (1995: 351) asserts that society experienced a sexual revolution throughout the 1960s and 1970s, which allowed for increased openness toward sexual issues and a greater awareness of the importance of sexual fulfilment within intimate and significant relationships. While this increased openness about sexual issues provided the impetus for the evolution and growth of sex therapy, its practitioners focused primarily on the individual experiencing a sexual dysfunction.

King, Cameron & Downey (1991:15) and Wiederman (1998:88) agree that sex therapy as it is known today, was essentially founded by Masters and Johnson, whose report on a "new" therapeutic approach to sexual problems which was published in 1970, revolutionised what health professionals saw as the appropriate treatment for sexual difficulties. Weeks and Hof (1987:viii) quote Sager who states that: " With the publication of Masters and Johnson's research on the anatomy and physiology of sex and on the definition of sexual dysfunctions, in the late 1960's and early 1970's, an explosion took place in psychiatry, psychology and many other fields which is still reverberating...". In contrast to psychoanalytic approaches, the "new" sex therapy was relatively brief, problem focused, directive, and behavioural with regard to technique. Masters

and Johnson emphasised social and cognitive causes of sexual dysfunction. Ultimately the large majority of sexual difficulties were seen as arising from a sexually restrictive or religiously conservative background. Such a personal history appeared to result in decreased communication with sexual partners, a lack of accurate information about "normal" human sexual functioning, and subsequently anxiety and preoccupation over performance during sexual interactions. Masters and Johnson therefore used a learning model with the objectives of treatment consisting of effectively achieving alleviation of performance anxiety and re-educating clients regarding human sexuality.

Helen Kaplan followed Masters and Johnson in 1974 and introduced her version of the "new" sex therapy. Kaplan's model included an initial emphasis on immediate symptoms. If the direct approach to symptom treatment worked, the case was closed. If, however, the "new" behavioural techniques met with resistance, the therapist relied on psychodynamic theory, or consideration of "deeper" issues, to understand the possible intra-psychic and interpersonal roles the sexual dysfunction might be serving (Kaplan, 1974:264).

In the years subsequent to Masters and Johnson several changes have taken place in sex therapy. Wiederman (1998:89) states that sex therapy in the 1970's was an outgrowth of an earlier cultural shift toward greater focus on increased gratification and discussion of sexual issues. Wiederman (1989:89) concludes further that because of this focus on gratification, anorgasmia in women, and

premature ejaculation in men, were the prominent sexual dysfunctions presented to therapists in the early days of contemporary sex therapy. At the same time as the birth of contemporary sex therapy, there was a noticeable increase in mass media attention to issues of sexual enhancement. Barnes (1995: 351) agrees that society experienced a sexual revolution, which allowed for increased openness toward sexual issues and a greater awareness of the importance of sexual fulfilment within intimate and significant relationships. Renshaw (1983:33) agrees that the positive aspect of sex therapy is that much can be done with brief behavioural intervention. According to her the goal of sex therapy is symptom reversal – a direct approach.

Terapists therefore agree that the types of cases commonly seen in sex therapy clinics today have changed dramatically from the earliest days of sex therapy. Wiederman (1989:90) asserts that as the proportion of the clients who simply needed education and direction dwindled, the proportion of clients with more pervasive and chronic sexual problems increased. Accordingly, instances of erectile failure, low sexual desire and compulsive sexual behaviour have become an increasing part of sex therapists' caseloads.

Corresponding to the changing nature of the cases that sex therapists typically encounter, therapeutic approaches have changed as well. With increasing frequency, systemic approaches have been used to treat the more complex, relationship-bound sexual problems presented to sex therapists. Also, greater

attention has been paid to the role of early sexual trauma in subsequent sexual dysfunction. In general, a more complex, integrative, or post-modern approach to the conceptualisation and treatment of sexual dysfunction has emerged. With the continuing development in the field of sexual medicine as well as continuing research into human sexuality and relationships, new models and techniques for sex and marital therapy are constantly being developed. There is a movement today towards combining sex therapy and marital therapy, and also to use a more holistic approach by which the medical practitioner is more actively involved in the therapeutic process.

2.3 Definitions of human sexuality, sexual health and sex therapy

Although these definitions were already discussed in chapter 1, the importance of defining these concepts is stressed by the more detailed discussion that follows.

2.3.1 Human sexuality

Lister and Shore (1983:3) identify four spheres of human sexuality: biological and reproductive, gender identity and sex role behaviour, sex activity, as expressed privately or in interaction with other and the influence of erotic and sensual stimuli, as expressed internally by each individual. Masters, Johnson and Kolodny (1995:5) define sexuality as a broadly encompassing term that is used to refer to all aspects of being and feeling sexual. They assert further that every

person has sexual feelings, attitudes, and beliefs but everyone's experience of sexuality is unique because it is processed through an intensely personal perspective.

Masters, *et al.* (1995:21) are further of the opinion that it is impossible to understand human sexuality without recognising its multidimensional nature. Weeks and Hof (1987:24) define sexuality as a primary force in the life of every individual. It is a pervasive and integral force, involving physiological and psychological processes. Weeks and Hof (1987:25) state further that: "Sexuality is the process of being male or female, a man or a woman, masculine or feminine; it is how we think and feel about and express our gender, our sex organs, our body, our self-images, and our choices and preferences". Petitgirard (1992:5) defines sexuality as: "...self-esteem: the way people feel about themselves as men or women; body image: the way people feel about their bodies and the way they use them; social roles: the roles they take on and the expectations other people have of them; and relationships: the way in which people relate to others". Sexual Health: An Introduction (Author unknown, 1997:5) also makes use of Petitgirard's definition. Masters, *et al.* (1995:6) define human sexuality as a multidimensional phenomenon having biological, psychological, behavioural, clinical, moral and cultural aspects. They conclude further that no single dimension of sexuality is universally dominant.

In Common Ground Sexuality (Author unknown, 2001:4), it is stated that sexuality encompasses personal and social meanings as well as sexual behaviour and biology. A comprehensive view of sexuality includes social roles, personality, gender and sexual identity, biology, sexual behaviour, relationships, thoughts and feelings. The authors of this publication (2001:5) state further that sexuality and sexual health are concepts that are often used interchangeably. Sexual health is however a component of sexuality.

Promotion of Sexual Health: Recommendations for Action (Authors unknown, 2000:6), agree with the previous statement and add that sexuality refers to a core dimension of being human which includes sex, gender, sexual and gender identity, sexual orientation, eroticism, emotional attachment/love, and reproduction.

It can thus be concluded that human sexuality is multi-dimensional in nature, and no single dimension of sexuality is universally dominant. This stresses the importance of a holistic approach to therapy. Human sexuality includes biological, psychological, behavioural, clinical, moral and cultural aspects. Sexuality plays an integral part of human functioning from birth until death.

2.3.2 Sexual health

According to Wiederman (1988:90) all sex therapy approaches appear to share the underlining assumption that there is a "natural" or "healthy" state of sexual functioning that therapists aim to restore for the client. Petitgirard (1992:5) describes sexual health as the positive expression of a person's sexuality: "... sexual health is not just about sexual intercourse and reproduction. It includes such issues as self-esteem, self-expression, caring for others and cultural values". King, Cameron & Downey (1991: 268) define a sexually healthy person as someone who feels comfortable with his/her sexuality and who feels free to choose whether or not he/she wishes to try a variety of sexual behaviours. Sexual health is defined by the World Health Organisation (1975:41) as: "The integration of the physical, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love".

Common Ground Sexuality (Author unknown, 2001:5) defines sexual health as: "... women's and men's ability to enjoy and express their sexuality, and to do so free from risk of sexually transmitted diseases, unwanted pregnancy, coercion, violence and discrimination. Sexual health also means being able to have an informed, enjoyable and safe sex life, based on self-esteem, a positive approach to human sexuality, and mutual respect in sexual relations. Sexual health enhances life, personal relations and the expression of one's sexual identity. It is

positively enriching, includes pleasure, and enhances self-determination, communication and relationships". In The Promotion of Sexual Health: Recommendations for Action (Author Unknown, 2000:6), sexual health is defined as: "...the experience of the ongoing process of physical, psychological, and socio-cultural well-being related to sexuality".

It is therefore evident that human sexuality and the term sexual health are multidimensional. The notion of sexual health however implies a positive approach to human sexuality, and the purpose of sexual healthcare should be the enhancement of life and personal relationships and not merely counselling and care related to procreation and physical problems.

Sexual health is not just about sexual intercourse and reproduction. It includes such issues as self-esteem, self-expression, caring for others and cultural values. In sum, our sexuality is experienced and expressed in all that we are, what we feel, think, and do.

2.3.3 Sex Therapy

Many authors and researchers do not give a specific definition or description of sex therapy. Masters and Johnson (1970) for example do not give a definition of sex therapy. They however give a detailed outline of their therapy strategy and the steps in their therapeutic model. Kaplan (1974:217) also spends little time on

a definition of sex therapy. She does however mention: "... the primary objective of all sex therapy is to relieve the patient's sexual dysfunction. All therapeutic interventions, tasks, psychotherapy, couples therapy, etc., are ultimately at the service of this goal". Kaplan (1974:217) states further that sex therapy parts from traditional therapeutic techniques by employing a combination of prescribed sexual experiences and psychotherapy.

LoPiccolo (1978:534) defines sex therapy as: "...a brief (often ten to fifteen sessions) therapy, with the emphasis on directly changing the client's sexual attitudes and sexual behaviours". Ducharme (1997:20) states that sex therapists are counsellors who specialise in working with people who have sexual difficulties. The kinds of problems they deal with include a difficulty in achieving erections, premature or retarded ejaculation, and lack of sexual desire. For women, sex therapists address problems of reaching orgasm, painful intercourse, or lack of interest in sexual activity. Some researchers who can be described as traditional sex therapists emphasises sexual functioning per se. (Compare Cole, 1985:337; Rosen & Weinstein, 1988:2 and Wiederman, 1988:88.) Cole (1985:337) describes sex therapy as: "...those therapeutic processes which are used to attempt to initiate or restore sexual function in an individual or between a couple, where it had been previously absent". Rosen & Weinstein (1988:2) state that the basic goal of sex therapy is the relief of sexual dysfunctions, resulting in the improvement of sexual functioning. Wiederman (1988:88) defines sex therapy as any systematic attempt by a health professional

to alleviate sexual dysfunction or difficulties experienced by a specified client. These authors support the more narrow view of sex therapy that emphasises the sexual dysfunction as such without taking the relationship context into account.

Weeks and Hof (1987:xii) define sex therapy as an approach to therapy that is brief, problem-focused, has an educational component, involves seeing a couple together, consists of specific treatment formats and techniques, and often involves giving clients specific homework assignments. Renshaw (1995:120) states that sex therapy works holistically on the whole person – body, mind and feelings. She states further that sex therapy combines sex education and relationship counselling with sexual activity at home.

There is however today a shift in focus from the more narrow-minded approach of sex therapy with the emphasis on sexuality as such, to a more broader perspective of which the sexual aspects are viewed from a broader conceptual framework. This statement can be confirmed by the following view held by Weeks & Hof (1987:xiv): "The traditional individual behavioural perspective of sex therapy is broadened to include the contextual and interactional dimensions of relationships".

Woody (1992:45) refers to traditional sex therapy as the approach that evolved from Masters and Johnson's seminal work along with elaborations and refinements of the basic method. The elements of Masters and Johnson's

approach that have remained integral to sex therapy are according to Woody (1992:47):

- treatment of the dyad;
- viewing the sexual dysfunction as the problem to treat and remedy;
- assessing sexual attitudes and specific behaviours;
- providing accurate information about sexuality and eliminating myths and sex-negative attitudes;
- assigning clients behavioural/experiential tasks to be done at home.

LoPiccolo (1978) named seven basic principles of sex therapy that can be summarised as follows:

- **Mutual responsibility** emphasises the view of sexual dysfunction as a shared disorder in which both partners must participate in the solution.
- **Information and education** are provided by the therapists through discussion and recommended reading material and educational films. This education is provided to overcome client's ignorance of sexual response and function.
- **Attitude change** is indicated when clients hold negative attitudes toward sex or sexual pleasure.
- **Eliminating performance anxiety** is essential, because many clients endorse socio-cultural myths and stereotypes that emphasise the end goal

of erection, orgasm, and ejaculation as opposed to mutual sensual and sexual enjoyment.

- **Increased communication** about, and effectiveness of sexual technique, is encouraged through home assignments, as well as through therapy, discussions and advice about communication skills.
- **Changing destructive life styles and sex roles** is actively encouraged by the therapist to enable clients to reserve quality time for their sexual relationship.
- Prescribing changes in behaviour involves the therapist's assigning a **planned series of at-home experiences**, with the exact prescription depending on the specific sexual dysfunction.

It is therefore evident from these seven basic principles of LoPiccolo (1978) that the sexual dysfunction is not merely viewed as a dysfunction of one individual, but is seen in the context of the relationship between the couple.

Renshaw (1983: 32) states that sex therapy includes:

- An explicit sexual history of each partner, plus a complete medical and family history;
- Exploration of the overall and sexual relationship: tasks, roles, nurturance, interdependence, trust, problem-solving, acceptance, caring, commitment and love;

- Consideration of the context of the sexual problems;
- Excluding physical causes by a thorough physical examination;
- Suggestions for step-by-step home practise of sensual pleasuring;
- Intensive-therapy for specific problems or symptoms.

The primary goal of sex therapy is to relieve the couple's sexual dysfunction or sexual problem. Successful sex therapy however employs both acknowledged sex therapy techniques, as well as psychotherapy and couples therapy, in order to enhance the couple's physical and emotional intimacy. The sexual dysfunction is thus again viewed from the context of the relationship between the couple.

2.4 Perspectives on human sexuality

Sexuality has fascinated people since the beginning of time. Masters, Johnson & Kolodny (1995:2) state that every person has sexual feelings, attitudes, and beliefs but everyone's experience of sexuality is unique because it is processed through an intensely personal perspective. This perspective comes from both private, personal experience and public, social sources. It is impossible to understand human sexuality without recognising its multidimensional nature. Learning about sexuality, in all forms, is really learning about people and the complexities of human nature.

Masters, *et al.* (1995:3) state that Freud was of the opinion that sex is a powerful psychological and biological force, while Malinowski emphasised the sociological and cultural dimensions of sexuality. Masters, *et al.* (1995:3) state further that: "The word sexuality generally has a broader meaning than the word sex, as it refers to all aspects of being sexual. Sexuality means a dimension of personality instead of referring to a person's capacity for erotic response alone".

There are various dimensions of sexuality, namely, biological, physiological, psychological, behavioural, clinical, cultural, historical and spiritual, which will be discussed in further detail:

2.4.1 The biological dimension

According to Masters, Johnson & Kolodny (1995:6), biological factors largely control sexual development from conception until birth and our ability to reproduce after puberty. The biological side of sexuality also affects our sexual desire, our sexual functioning, and (indirectly) our sexual satisfaction. The biological dimension of sexuality encompasses both sexual anatomy and sexual physiology of the male and the female.

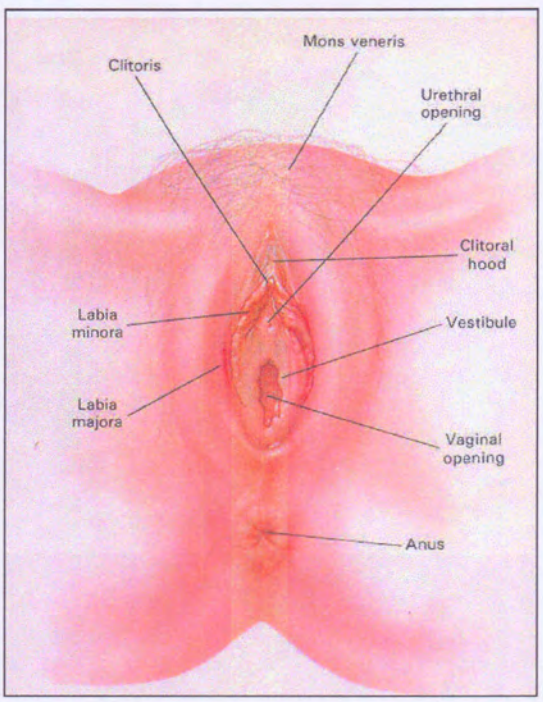
Many authors agree on the basic female and male anatomy. (Compare Masters, Johnson & Kolodny, 1995:47-69 and King, 1999:27-48.)

2.4.1.1 Female sexual anatomy

2.4.1.1.1 External female sexual anatomy

The external female anatomy (Figure 2) is collectively referred to as the vulva. It includes the mons veneris, labia majora and labia minora, clitoris, vaginal opening, and urethral opening. (Compare King, Cameron and Downey, 1991:27; King, 1999:27; Masters, Johnson & Kolodny, 1995:45 and Berman & Berman, 2001:42.)

Figure 2: External female genital anatomy in King, *et al.* (1991:23).



The vulva:

The external sex organs of the female, called the vulva (meaning "covering"), consist of the mons veneris, the labia, the clitoris, and the perineum. Although the vagina has an external opening (the introitus, or entrance), it is principally an internal organ.

The mons veneris:

The mons veneris is the area over the pubic bone that consists of a cushion of fatty tissue covered by skin and pubic hair. Since this region has numerous nerve endings, touch and or pressure here may lead to sexual arousal. Many women find that stimulation of the mons area can be as pleasurable as direct clitoral touch.

The labia:

The outer lips (labia majora) are folds of skin covering a large amount of fat tissue and a thin layer of smooth muscle. Pubic hair grows on the sides of the outer lips, and sweat glands, oil glands, and nerve endings are liberally distributed in them. The inner lips (labia minora) are like curving petals. They have a core of spongy tissue rich in small blood vessels and without fat cells. The inner lips meet just above the clitoris, forming a fold of skin, called the clitoral hood.

Bartholin's glands

These glands lie within the labia minora and are connected to small ducts that open on the inner surface of the labia next to the virginal opening. Although they produce minimal amounts of lubrication, there function is unknown.

The clitoris:

One of the most sensitive areas of a female's genitals is located just beneath the point where the top of the inner lips meet. The only directly visible part of the clitoris is the head or clitoral glans. The clitoral hood hides the clitoral shaft, the spongy tissue that branches internally like an inverted V into two longer parts or crura. The clitoris is richly endowed with nerve endings that make it highly sensitive to touch, pressure and temperature. It is unique because it is the only organ in either sex whose only known function is to focus and accumulate sexual sensations and erotic pleasure. The clitoris has no known reproductive function except to focus on sexual sensations, and many cultures around the world practice clitoral circumcision in order to minimise female sexual desires.

The perineum:

The perineum is the hairless area of skin between the bottom of the labia and the anus in women and between the scrotum and anus in the male.

The hymen:

Many sexually inexperienced females have a thin membrane called the hymen that partially covers the vaginal opening. The hymen, which has no known function, typically has perforations in it that allow menstrual flow to pass from the body. The hymen may vary in shape, size and thickness.

The breasts:

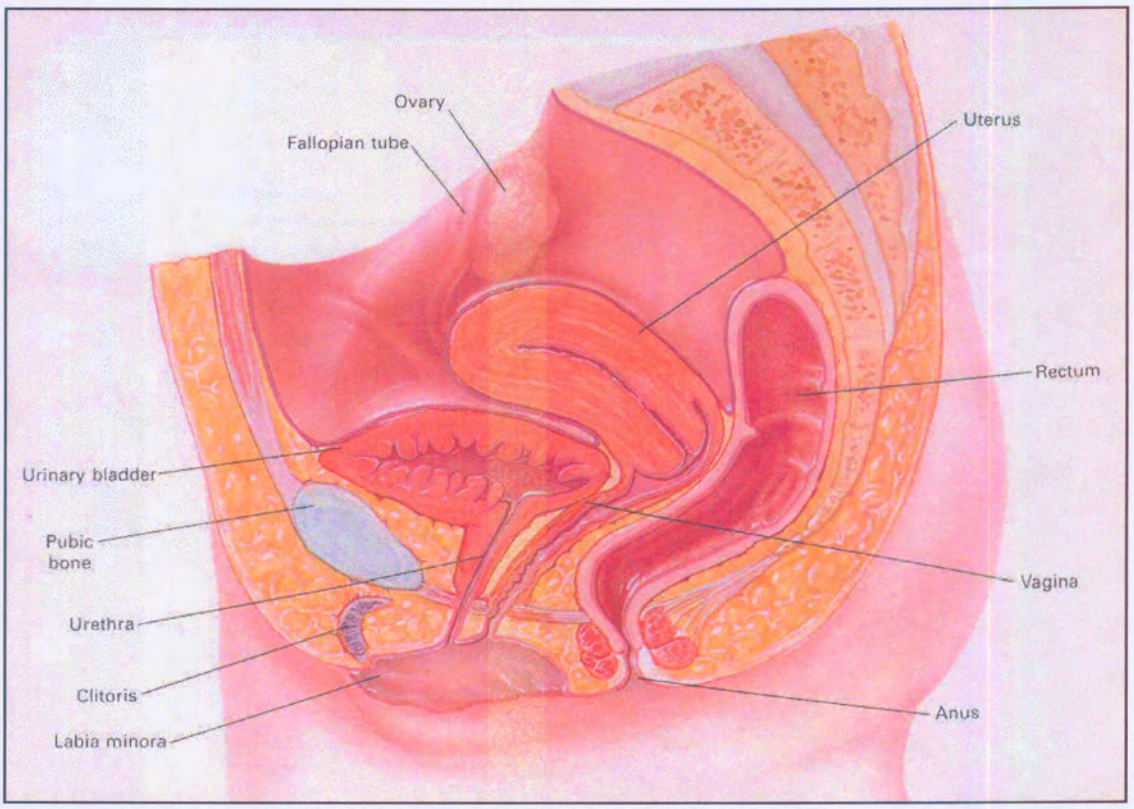
Although the breasts are not reproductive organs, they are clearly part of the sexual anatomy. There is no evidence to suggest that breast size has any relation to a woman's level of sexual interest or to her capacity for sexual response. The nipple is located at the tip of the breast and mostly consists of smooth muscle fibres and a network of nerve endings that make it highly sensitive. The dark wrinkled skin of the nipple extends onto the surface of the breast to form the areola, a circular area of dark skin with many nerve fibres and with muscle fibres that cause the nipple to stiffen and become erect. The breasts are technically not part of a woman's reproductive system, but because men in Western societies consider female breasts to be erotic, they must also be considered as part of a woman's external sexual anatomy.

2.4.1.1.2 Internal female sexual anatomy

A female's internal reproductive system includes the vagina, uterus, fallopian tubes, and ovaries (Figure 3). (Compare King, Cameron and Downey, 1991:27;

King, 1999:27; Masters, Johnson & Kolodny, 1995:45 and Berman & Berman, 2001:42.)

Figure 3: Internal female sexual anatomy in King, *et al.* (1991:24).



The vagina

The vagina is a muscular internal organ that tilts upward at a 45° angle diagonally pointed to the small of the back. The vagina functions as a potential space that, like a balloon can change shape and size. The inside of the vagina is lined with a surface similar to the lining inside the mouth. This mucosa is the source of vaginal lubrication. There are no secretory glands in the vagina but

there is a rich supply of blood vessels. The vagina has relatively few sensory nerve endings except near its opening. As a result, the inner two-thirds of the vagina are relatively insensitive to touch or pain. There have been disputed claims that a region in the front wall of the vagina midway between the pubic bone and the cervix has a special sensitivity to erotic stimulation. Called the Gräfenberg spot it has been described as a mass of tissue about the size of a small bean in the un-stimulated state.

The uterus:

The cervix is the bottom part of the uterus that protrudes into the vagina. At the mouth of the cervix, sperm cells enter the uterus and menstrual flow passes into the vagina. The cervix has no surface nerve endings, so it experiences little in the way of sexual feelings. The uterus is a hollow muscular organ. The inside lining of the uterus (the endometrium) and the muscular component of the uterus (the myometrium) have separate and distinct functions. The inner lining changes during the menstrual cycle and is where a fertilised egg implants. The muscular wall facilitates labour and delivery. Hormones regulate both aspects of uterine function. The uterus is held loosely in place in the pelvic cavity by six ligaments. The angle of the uterus in relation to the vagina varies from woman to woman.

Fallopian tubes:

The Fallopian tubes begin and extend about 10cm laterally. The far ends of the Fallopian tubes are funnel shaped and terminate in long finger-like extensions

called fimbria. The inside lining of the Fallopian tubes consists of long, thin folds of tissue covered by hair-like cilia. The Fallopian tubes pick up eggs produced and released by the nearby ovary and then serve as the meeting ground for egg and sperm.

The ovaries:

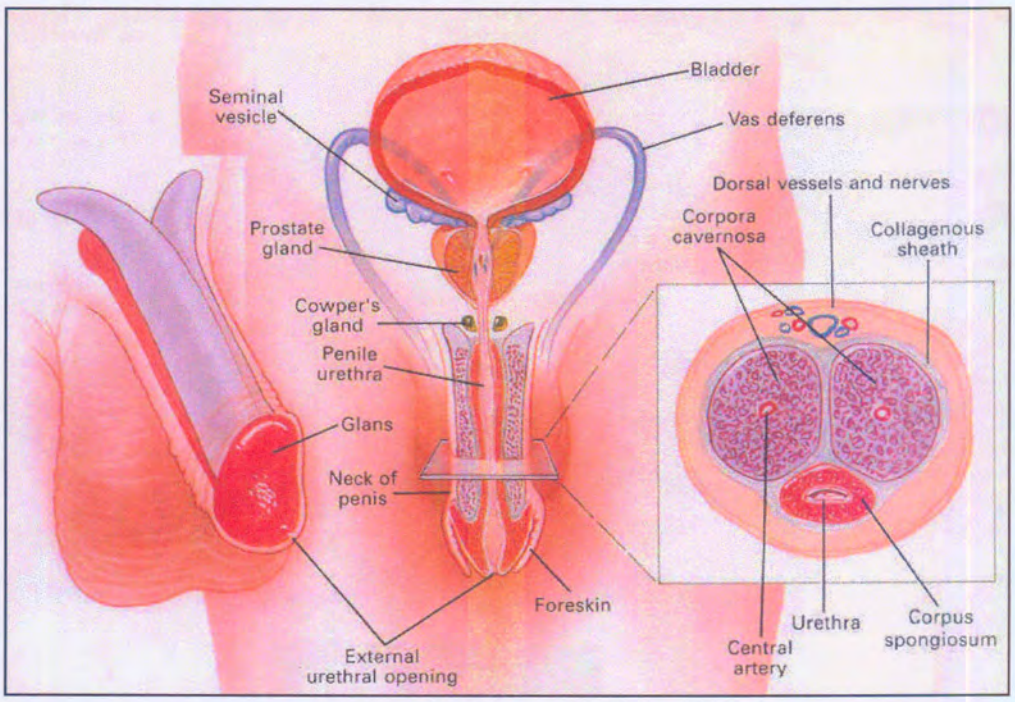
The ovaries contain the eggs (ova). When a mature egg is released from an ovary, it is picked up by a Fallopian tube and transported toward the uterus, where it normally implants if the egg is fertilised by a sperm. The vagina serves as a depository for the male's sperm. The ovaries are paired structures located on each side of the uterus. They are held in place by connective tissue that attaches to the broad ligament of the uterus. The ovaries have two separate functions: manufacturing of hormones and producing and releasing of eggs.

2.4.1.2 Male sexual anatomy

2.4.1.2.1 External male anatomy

The male's external anatomy (Figure 4) consists of the scrotum, which contains the testicles, and the penis. (Compare King, Cameron and Downey, 1991:37; King, 1999:41 and Masters, Johnson & Kolodny, 1995:60.)

Figure 4: External male genital anatomy in King, *et al.* (1991:26).



The penis:

The penis is an external organ that consists primarily of three parallel cylinders of spongy tissue with a rich network of blood vessels. There is great variation from male to male in the size of the non-erect penis but with erection, size differences tend to diminish. The glans, or head of the penis, is covered by foreskin in the uncircumcised male, but is exposed in a male who has been circumcised. Although there is considerable debate as to the merits of the procedure, many males have had their penis circumcised during infancy. Circumcision has not been proved to have any effect, positive or negative, on sexual feeling or responsivity. An erection occurs as a result of the spongy-like tissues of the penis becoming engorged with blood. Although many men worry about penis size, the

vast majority of women say that it is not important (and greatly prefer the quality of the experience). Some people take drugs to enhance sexual desire or performance (aphrodisiacs), but, except for temporarily enhancing energy or relaxation, they do not work and usually have undesirable side effects.

The scrotum:

The scrotum is a sac of skin underneath the penis that contains the testes. Muscle fibres in the scrotum move the testes closer to or farther away from the body in response to temperature changes or exercise, in order to facilitate sperm production. Sperm made in the testes are carried by a long tubing system (the epididymis and vas deferens) inside the body. Sperm are mixed with seminal fluid from the prostrate gland and seminal vesicles to make up semen.

The testes:

The testes are paired structures usually contained in the scrotum. The testes are highly sensitive to pressure or touch. They have two separate functions: hormone and sperm productions.

The breasts:

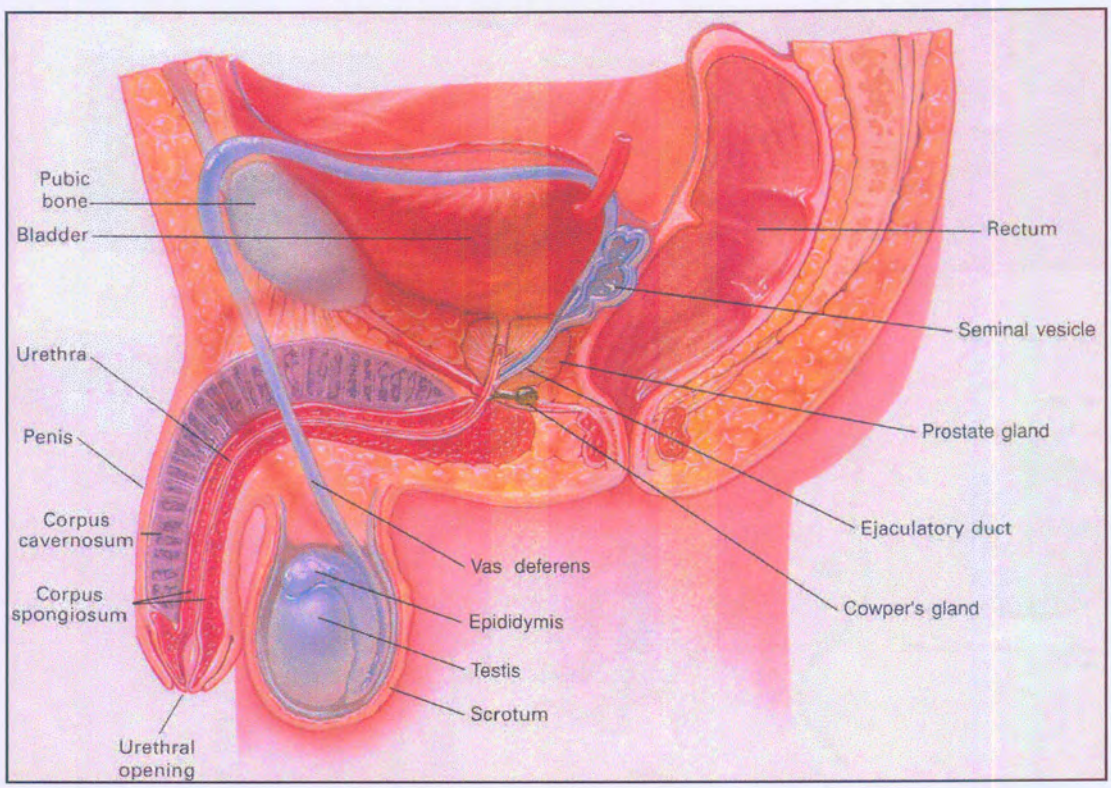
The breasts are basically modified sweat glands. The male breasts have a nipple and areola but have little underlying tissue or fatty padding. The male nipple and areola seem to be less sensitive to touch and pressure than that of the female.

The mouth, tongue, lips, thighs, buttocks, anus, and skin are other parts of the body often involved in sexual activity and can be a source of erotic arousal.

2.4.1.2.2 Internal male anatomy

The male's internal reproductive system (Figure 5) includes the testicles, which produce sperm and male hormones, and a four-part duct system (epididymis, vas deferens, ejaculatory duct, and urethra) to transport sperm out of the male's body. (Compare King, Cameron and Downey, 1991:38; King, 1999:42 and Masters, Johnson & Kolodny, 1995:61.)

Figure 5: Internal male sexual anatomy in King, *et al.* (1991:26).



During ejaculation, sperm are mixed with fluids from the prostate gland and seminal vesicles to form semen. The Cowper's glands secrete a small amount of fluid before a male reaches orgasm.

2.4.2 The physiological dimension

King (1999:72) refers to Masters and Johnson who observed and recorded physiological responses from hundreds of people engaged in sexual activity. This work led them to conclude that, contrary to previous beliefs, males and females are very similar in their responses. The physiological responses were divided into

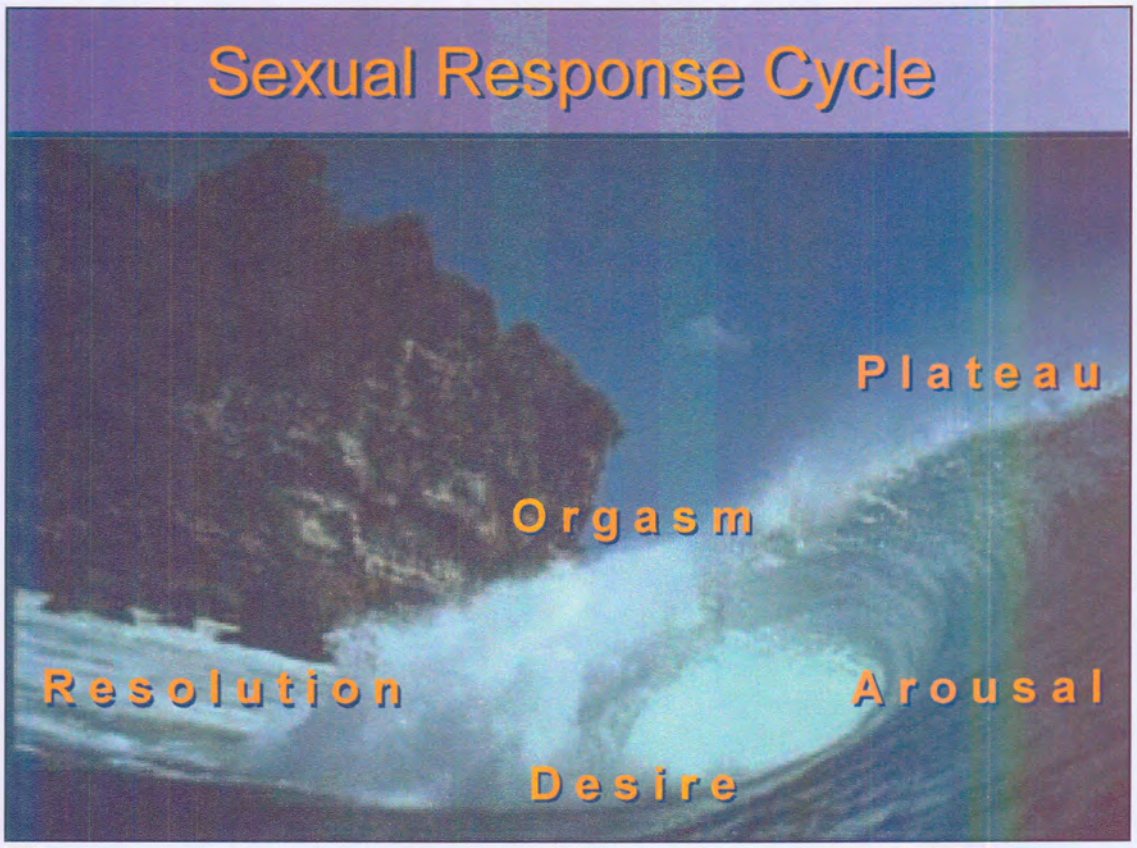
four stages: excitement (desire and arousal), plateau, orgasm, and resolution. Other researchers have organised the responses into fewer or more stages. Kaplan (1979:44) proposed a model for sexual responses that has only three phases: desire, excitement, and orgasm.

The physiological responses are the same whether a person is mechanically having sex or making love. It is the ability to include emotional and romantic feelings during sex that distinguishes humans from other species.

2.4.2.1 The sexual response cycle

The sexual response cycle (Figure 6 and 7) is a model used to illustrate physical changes the body goes through in responding to sexual stimuli.

Figure 6 - Illustration of the sexual response cycle from own personal collection, with acknowledgement to Dr. C. Hadders.



The cycle is a continuum, and can be seen as a series of stages. The body goes through the response cycle in the same way regardless of the type of activity engaged in (oral, manual, coital). A person may go through all, or part of the cycle. (Compare Masters, Johnson & Kolodny, 1995:73; King, 1999:72; Berman & Berman, 2001:54 and Masters & Johnson, 1966:3.)

The cycle, first described in modern times by Wilhelm Reich in 1930, is generally acknowledged to consist of four general phases, occurring along an unspecified timeline. Reich described these phases as mechanical tension, bioelectric charge, bioelectric discharge and mechanical relaxation (Clinical Sexology Course Material, 2000:96).

More recently, Masters and Johnson (1966:3) re-labelled these phases: excitement, plateau, orgasm and resolution. In addition, they introduced the concept of a refractory period, the fifth phase of the sexual response cycle. Only recently, researchers such as Berman & Berman (2001:55) are expanding medically and physiologically on the Masters and Johnson model, using new technologies such as photoplethysmography and Duplex Doppler ultrasound to evaluate women's genital blood flow during arousal. Although the new research has confirmed many features of the Masters and Johnson model, it has also shown that a monolithic model of sexual response is much too limited in its approach.

PHASE I: EXCITEMENT (Desire and Arousal)

A person gets turned on through his or her senses – seeing, feeling, touching, smelling, tasting and hearing as well as through thought or fantasy. An impulse is generated within the body in response to something happening outside or in the mind. The body wants to act in some manner to express this impulse.

The physiological manifestations at Phase I of the sexual response cycle are: changes in blood pressure, pulse, and respiration rate; and vasocongestion or engorgement with blood and muscle tension. Sexual arousal is first noticeable as the blood supply to the abdomen and pelvic areas increases.

Female

In the woman, sexual arousal is usually manifested by vaginal lubrication, blood engorgement, and sweating of the vaginal walls. The clitoris (made up of a glans and shaft similar to the penis) swells. The shaft of the clitoris extends about an inch under the skin and is generally not seen. The glans of the clitoris is packed with sensitive nerve endings, and is covered with a retractable hood. The hood is attached to the inner lips surrounding the vagina. In sexual arousal, swelling of the glans and an increase in the diameter of the shaft of the clitoris occurs, and some swelling of the inner lips takes place. This swelling makes the vaginal barrel somewhat longer. Excitement continues. The walls of the vaginal barrel begin to balloon out and back.

Male

In the man an erection usually occurs. The penis fills with blood. The tip, or glans, becomes extremely sensitive and red. The scrotum and testicles pull up toward the body.

Other changes may occur in either sex: nipple erection, sex flush on the abdomen and spreading upwards, increase in pulse (or heart) rate, increased breathing rate, rise in blood pressure and the muscles continue to build up tension. Psychologically, at this point a decision is made for or against engaging in some sexual action. The decision to engage in some sexual action, either alone or with someone else, is made consciously.

PHASE II: PLATEAU

The person begins active sexual movements and feels the flow of pleasurable feelings centring in the genitals and abdomen. The entire body is gradually flooded with warmth, generally increasing in intensity and reaching toward a peak. In both sexes, heart rate, breathing rate and flushing (if it occurs) continue to increase. The tension in the musculature increases (in involuntary as well as voluntary muscles).

Female

During this phase in women, formation of the "orgasmic platform" in the outer third of the vagina occurs. Contraction of the vaginal muscles can grip the penis or a finger quite firmly. The outer lips swell even more at this stage, while the inner lips become even more deeply colour (red). The clitoris usually elevates or retracts and its shaft shortens so that the clitoris may be hard to find. The uterus is pulled upward into the abdomen (a few inches) enlarging still further the total vaginal space.

Male

The penis reaches fullest erection and enlargement of the coronal ridge occurs. The testicles have increased in size by 50 percent and are pulled up tightly by further shortening of the (internal) spermatic cords. Full elevation of the testicles is a sign that the man has reaches "the point of no return" where ejaculation is imminent. A few drops of clear liquid may appear at the opening of the penis, this is a secretion from the Cowper's gland. This pre-ejaculate may contain some live sperm although the main function of the fluid is to prepare the tube for the passage of the ejaculate.

PHASE III: ORGASM

Climax occurs. The tension is discharged suddenly, with great excitement and involuntary contractions of muscles, especially in the genital area. If ejaculation is to occur, it occurs now.

Female

The "orgasmic platform" has a noticeable spasm and a series of rhythmic contractions. The entire length of the vaginal barrel may ripple with contractions that begin in the farthest end of the uterus. The subjective experience of orgasm in women coincides with the first contraction of the outer third of the vagina or orgasmic platform. Effective stimulation needs to continue up to and through orgasm.

Male

Contractions in the man are differentiated into two stages. The first, which coincides with the experience of the "point of no return", is the contraction of the seminal vesicles and prostate gland. The semen is pushed out through the urethra by the next wave of contractions. The interval between the contractions is about eight-tenths seconds in both sexes.

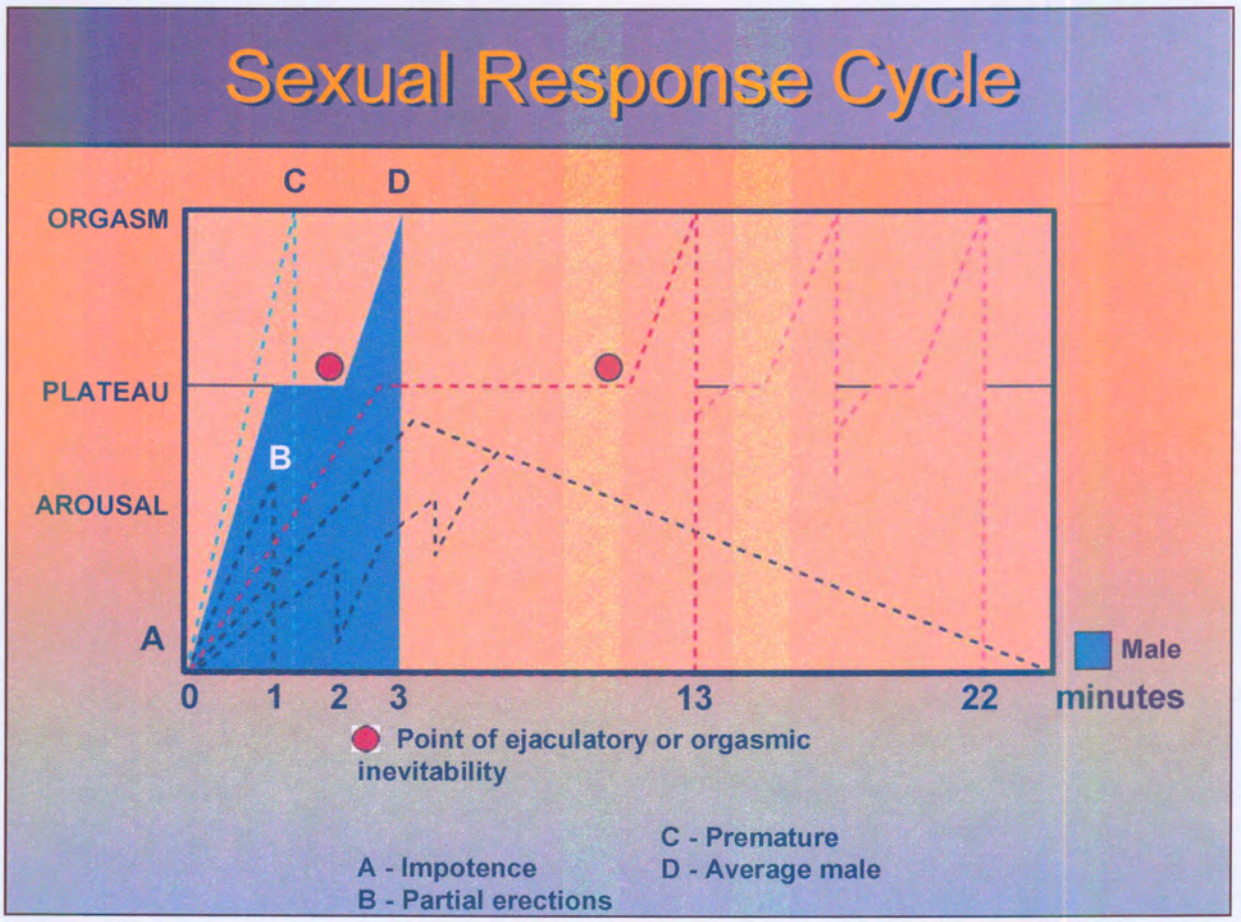
PHASE IV: RESOLUTION

The body now begins to return to its original pre-excitement state, a feeling of melting pleasure and calm. Sleep often occurs. Partners may feel especially tender and close. The expansion of orgasm is now integrated and appreciated.

PHASE V: REFRACTORY PERIOD

The time after orgasm in which little or no sexual excitement or charge is experienced, even if stimuli exist, is called the refractory period. According to the results of Masters and Johnson (1966:6) the refractory period occurs primarily in men but there is evidence that women also experience it. Some confusion results from the fact that many women are capable of experiencing multiple consecutive orgasms, while relatively few males have this experience.

Figure 7 - Graphic presentation of the sexual response cycle from own personal collection with acknowledgement to Dr. D. Renshaw.



The following is a summary of the male and female sexual response cycles in table format. (Compare Masters, Johnson & Kolodny, 1995:73; King, 1999:72; Berman & Berman, 2001:54 and Masters & Johnson, 1966:3.)

Table 1: The sexual response cycle - Males

Desire	Excitement	Plateau	Orgasm	Resolution
Specific sensations that move an individual to seek out or become receptive to sexual experiences.	Erection of the penis. Vasocongestion. Scrotum thickens and helps pull the testes toward the body Possible nipple erection.	Possible further increase in diameter of the penis. Testes become fully engorged with blood and increase in size by 50-100 percent. Cowper's glands secrete a few drops of clear fluid. Possible sex flush.	Emission-rhythmic muscular contractions in the vas deferens, prostate gland, and seminal vesicles force the sperm and fluids into the ejaculatory ducts. Contractions also in anal sphincter muscles. Expulsion-rhythmic muscular contractions in the urethra and base of the penis, force the semen from the penis (ejaculation). Subjective sensation in the glans.	Return to the unaroused state with loss of erection, decrease in testicle size and their movement away from the body. Disappearance of sex flush. A drop below the plateau level for a period of time (refractory period), before orgasm is possible again

Table 2: The Sexual Response Cycle - Females

Desire	Excitement	Plateau	Orgasm	Resolution
Specific sensations that move an individual to seek out or become receptive to sexual experiences	Vaginal lubrication due to vasocongestion; labia majora flatten and spread apart; walls of the inner two thirds of the vagina begin to balloon out; cervix and uterus begin to pull up; clitoris becomes engorged; nipples become erect.	Vaginal lubrication may slow down if plateau phase is prolonged; labia minora become engorged with blood and change colour; outer third of vagina becomes engorged and swells; engorgement of areola and breasts obscure nipple erections; Bartolin's glands secrete a few drops of fluid; sex-tension flush in 50 to 75% of women.	Single stage: rhythmic muscular contractions in the tissues of the outer third of vagina, uterus and anal sphincter muscles. Some women are capable of several successive orgasms without dropping below the plateau level of responsiveness.	After one or more orgasms return to the unaroused state with drainage of blood from the breasts, outer third of vagina, labia minora, and clitoris. Vagina shortens in length and width. Disappearance of sex flush.

2.4.2.2 Hormonal regulation of sexual function

The sex hormones, principally testosterone, estrogen and progesterone, are present in both sexes and are controlled by the hypothalamus and pituitary gland. The following description of hormonal regulation is a synthesis of literature by King (1999:52) and Masters, Johnson & Kolodny (1995:88). Testosterone has an important influence on sexual drive in males and females. Hormones are chemical substances that are released into the bloodstream by ductless endocrine glands. The ovaries and testicles are part of the endocrine gland system. In adult females, a new egg matures on a monthly basis. It is expelled from an ovary during ovulation and picked up by a Fallopian tube. If it is fertilised by a sperm, it implants in the endometrium of the uterus. If fertilisation does not occur, the endometrium is shed and discharged (menstruation), and a new egg starts to mature. The entire menstrual cycle takes an average of 28 days, but most women have cycles that vary in duration by a week or more. Some couples prefer to avoid sexual intercourse during menstruation, but this often reflects inaccurate and/or negative sexual information rather than good medical advice, for menstruation is a normal biological function.

Women sometimes suffer from menstrual-related problems, including emotional and/or physical changes in the days preceding menstruation (premenstrual syndrome or PMS) and painful cramps during menstruation (dysmenorrhea). PMS may be due to hormonal, social, and/or cultural factors. The major cause of

dysmenorrhea is an increase in prostaglandins, chemical substances that cause contractions of the uterus. In addition to these problems, some women have growth of endometrial tissue outside of the uterus (endometriosis), which can cause considerable abdominal pain.

A woman's last menstrual period (menopause) generally occurs in her late forties or early fifties. At this time, the ovaries shrivel up and there is a loss of estrogen. The loss of ovarian hormones however, usually does not affect sexual desire. Some women even show an increase in sexual desire after menopause. Evidence suggests that some minimal level of testosterone is necessary for normal sexual functioning by men and women. Sexual desire, however, is under greater control by the brain in humans than is the case for lower species.

The testicles manufacture and release testosterone, which is often referred to as the "male hormone", while the ovaries produce the "female hormones" estrogen and progesterone. However, testosterone is also produced in small amounts by the ovaries, and estrogen in small amounts by the testicles.

2.4.3 The psychological dimension

The psychological dimension of sexuality includes psychological factors such as emotions, thoughts and personalities, in combination with social elements. In other words, how people interact. According to Masters, Johnson and Kolodny

(1995:7), the psychosocial side of sexuality is important, because it sheds light not only on many sexual problems but also on how we develop as sexual beings. A person's gender identity (the personal sense of being male or female), is primarily shaped by psychosocial forces. Early sexual attitudes – which often stay with a person into adulthood – are based largely on what parents, peers, and teachers tell or show him/her about the meanings and purposes of sex. Sexuality is also social in that it is regulated by society through laws, taboos and family and peer group pressures that seek to persuade a person to follow certain paths of sexual behaviour.

2.4.4 The behavioural dimension

The behavioural perspective allows us to learn not only what people do but to understand more about how and why they do it (Masters, Johnson & Kolodny, 1995:8). According to them it is also important to avoid judging other people's sexual behaviour by our own values and experiences. Too often, people have a tendency to think about sexuality in terms of "normal" versus "abnormal". "Normal" is frequently defined as what we ourselves do and feel comfortable with, while the "abnormal" is what others do that seems different or odd to us. Trying to decide what is normal for others is a task doomed to failure because our objectivity is clouded by our own values and experiences.

2.4.5 The clinical dimension

Although sex is a natural function, many types of obstacles can lessen the pleasure or spontaneity of our sexual encounters. Physical problems such as illness, injury, or drugs can alter our sexual response patterns or knock them out completely. Feelings such as anxiety, guilt, embarrassment or depression and conflicts in our personal relationships can also hamper our sexuality. The clinical perspective of sexuality examines the solutions to these and other problems that prevent people from reaching a state of sexual health and happiness.

2.4.6 The cultural dimension

It should come as no surprise that people are different. Our own cultural attitudes toward sexuality are far from universal. Sexual topics are often controversial and value-laden, but the controversy is often relative to time, place, and circumstance. There is no comprehensive sexual value system that is right for everyone and no single moral code that is indisputably correct and universally applicable (Masters *et al.*, 1995:8). What is labelled as "moral" or "right" varies from culture to culture and from century to century. Cultures differ with regard to which part of the body they find to be erotic. People in some African tribes, for instance, carve holes in their lips, while other groups of people find it attractive to stretch their lips or necks. Many groups of people find body weight to be an important determinant of sexual attractiveness. There is a great deal of pressure

in our culture, for example, for men and women to be thin. What is considered to be sexually attractive can also change over time. Plump woman, for example, were also considered to be most attractive in Western cultures a few centuries ago.

What people consider as sexually attractive is also learned. Most heterosexual South African men find female breasts to be very sexually arousing, while there are many areas of the world where naked female breasts have no erotic significance at all.

Cultures also differ with regards to sexual behaviours and attitudes. In some societies, a man's special obligations to a guest or a friend are discharged by an invitation to have sexual relations with his wife. Ford and Bach in Masters, *et al.* (1995:7), listed eight cultural groups in which kissing were unknown. Foreplay during intercourse is entirely unheard of in some cultures. Intercourse is therefore often regarded as something positive by men, and painful and negative by women.

It is thus evident that it is very important to always consider cultural differences and culturally learned morals and values, especially when working in the field of sexuality. Sexual rights are applicable here. Sexual rights are human rights based in the inherent freedom, dignity, and equality of all human beings. The World Association for Sexology's Declaration of Sexual Rights (1999) states that

sexual health is a basic human right. The following sexual rights must be recognised, promoted and respected by all societies and especially by health care practitioners:

- The right to sexual freedom.
- The right to sexual autonomy, sexual integrity, and safety of the sexual body.
- The right to sexual privacy.
- The right to sexual equity.
- The right to sexual pleasure.
- The right to emotional sexual expression
- The right to sexually associate freely.
- The right to make free and responsible reproductive choices.
- The right to comprehensive sexuality education.
- The right to Sexual Health Care.

2.4.7 The historical dimension

Masters, Johnson & Kolodny (1995:8) state that sexual themes have been shown in art since ancient times. In certain respects, we are bound by a sexual legacy passed on from generation to generation, but in other ways, modern views of sex and sexuality differ drastically from past patterns. History teaches us that sexual attitudes and practices vary considerably over time and place. Masters *et al.*

(1995:21) state that religion has been a principal force in shaping sexual thought for more than 2000 years. In the past century, the advent of sexology as a science has also greatly influenced contemporary attitudes toward sex and sexuality.

2.4.8 The spiritual dimension

Masters, *et al.* (1995:4) and King (1999:11) agree that sexual attitudes and practises vary considerably over time and place. For more than 2000 years, religion has been a principal force in shaping sexual thought and still plays a major role in people's perceptions about sex and sexuality today.

2.5 Summary

In Chapter 2 a general overview of human sexuality and sex therapy was given. The historical development of sexology as a science was described and various definitions of key concepts were given. Different perspectives on human sexuality, namely the biological, physiological, psychological, behavioural, clinical, cultural and spiritual perspectives were also described.

The following points summarise the chapter:

- Sexuality is part of human behaviour and culture since ancient times, and is multi-dimensional in nature.

- The study of sexuality as a science started at the beginning of the twentieth century.

- The history of sex therapy as a discipline however, is relatively brief, and was essentially founded by Masters and Johnson in the late 1960's.

- Therapeutic approaches to sex therapy and sexual dysfunction have changed over the last few years.

- An integrative, holistic and post-modern approach to therapy for sexual difficulties has emerged.

- There is a movement today towards the combination of sex therapy and couple/relationship therapy. Many sexual problems are viewed as symptoms of more complex relationship issues, or problems relating to a lack of emotional intimacy.

- Sexual dysfunction is not merely viewed as a dysfunction of one individual, but it is seen in the context of the relationship between the couple.

- The purpose of sexual health care should be the enhancement of life and personal relationships and not merely counselling and care related to procreation and physical problems.

- The biological dimension of sexuality encompasses both sexual anatomy and sexual physiology of the male and the female.

- The physiological dimension of sexuality encompasses the sexual response cycle of the male and the female as well as hormonal regulation of sexual function.

- The psychological dimension of sexuality includes psychological factors such as emotions, the influence of different personality types as well as communication and conflict resolution.

- The behavioural dimension of sexuality allows for a better understanding of peoples reactions and behaviour.

- The clinical dimension of sexuality examines possible solutions to physical problems that alter sexual response, as well as possible solutions for negative feelings such as anxiety, guilt and embarrassment, which may hamper sexual functioning.

- The cultural dimension focuses on people's attitudes towards sexuality and on the influence of different culturally learned morals and values on a person's sexual behaviour and attitudes.

- The historical dimension focuses on the influence of past sexual views and attitudes on contemporary sexual attitudes.

- The spiritual dimension of sexuality takes the role that religious beliefs play in people's perceptions toward sexuality, into account.

Chapter 3 will deal with clinical sex therapy as well as with sexual dysfunctions and possible treatment options thereof.

CHAPTER 3

CLINICAL SEX THERAPY

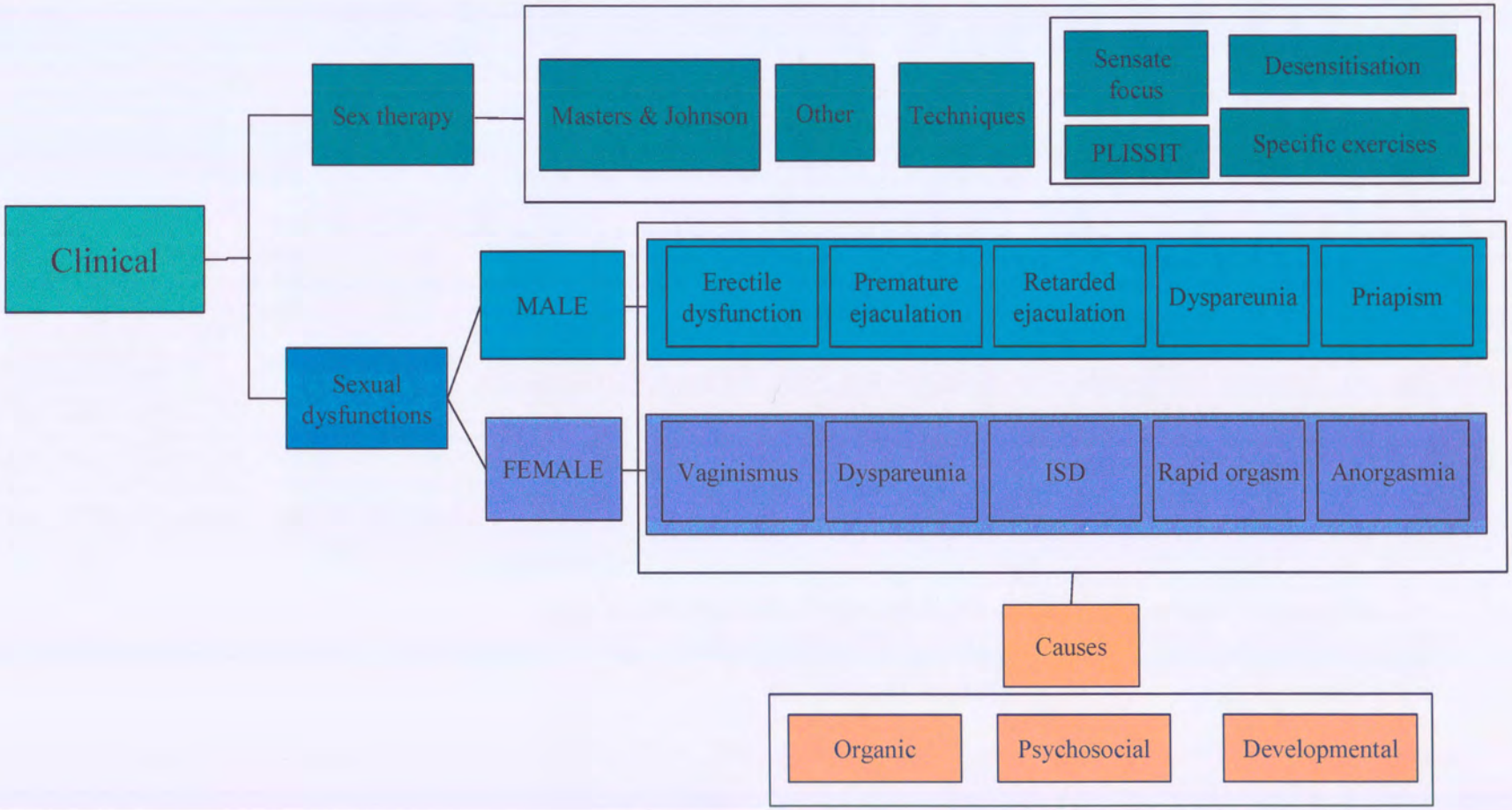
3.1 Introduction

Figure 8 contains a layout of this chapter. Shown are elements of the clinical dimension of sex therapy.

Wiederman (1998:88) asserts that studies indicate that a substantial proportion of the adult population will experience some sort of sexual dysfunction at some point in their lives. A specific field, commonly known as sex therapy, has evolved to address this growing problem of sexual difficulties, presented by clients. Wiederman (1998:88) defines sex therapy as a term that broadly refers to any systemic attempt by a health care professional to alleviate sexual dysfunction or difficulties experienced by a specified client.

Rosen & Leiblum (1995:877) are of the opinion that marked changes have however occurred in the formulation and treatment of sexual disorders since the publication of Masters and Johnson's, *Human Sexual Inadequacy* in 1970. Masters & Johnson (1970:98) proposed a treatment model based on a parallel, four-stage sequence of physiological arousal in both male and female – the so-called sexual response cycle described in chapter two. They were also of the opinion that psychogenic factors such as learning deficits and performance anxiety were part of the etiology of sexual dysfunction and they adhered to a brief, problem-focused treatment approach.

Figure 8: An outline of chapter 3 – The clinical dimension of sex therapy



Rosen & Leiblum (1995:877) state that since the 1980s however, research and practice in sex therapy have focused increasingly on the role of organic and biomedical factors. Other notable trends include a greater emphasis on sexual dysfunction in the elderly and chronically ill or disabled, as well as a focus on problems of hyper-sexuality.

Several authors have advocated an integrated approach to therapy, including elements of psychodynamic, cognitive-behavioural and systemic treatment approaches. (Compare Wiederman, 1998:96; Rosen & Leiblum, 1995: 885 and Berg & Snyder, 1981:291.)

3.2 Historical overview

The history of sex therapy as a discipline is relatively brief. From the start of the twentieth century until the late 1960's, sexual dysfunction was typically treated within a psychoanalytic framework. Wiederman (1998:88) asserts that from such a psychoanalytic perspective, psychological and sexual problems were viewed as originating from unresolved conflicts dating back to childhood, particularly conflicts over problematic attachments and tension in relation to one's parents.

Rosen & Leiblum (1995: 877) agree that sexual problems were seen as symptoms of greater "core" psychopathology. As such, treatment consisted of long-term, individual psychotherapy. In contrast to this dominant perspective, Wiederman (1998:88) mentions that a few clinicians like Lazarus, Obler and

Wolpe explicitly applied behavioural principles in the treatment of sexual dysfunction, but that such approaches were not the norm prior to the 1970's.

Sex therapy as it is known today, was essentially founded by Masters and Johnson. Their report on a "new" therapeutic approach to sexual problems that was published in 1970, revolutionised what health professionals saw as the appropriate treatment for such difficulties. In contrast to psychoanalytic approaches, the "new" sex therapy was relatively brief, problem focused, directive, and behavioural with regard to technique (Wiederman, 1998:89). Masters & Johnson (1966, 1970) emphasised social and cognitive causes of sexual dysfunction. They were of the opinion that a large majority of sexual difficulties ultimately arise from a sexually restrictive or religiously conservative background. Such a personal history appeared to result in decreased communication with sexual partners, a lack of accurate information about "normal" human sexual functioning, and subsequently anxiety and preoccupation over performance during sexual interactions. Masters & Johnson (1970:189) therefore used a learning model with the objectives of treatment consisting of effectively achieving alleviation of performance anxiety and re-educating clients regarding human sexuality.

Helen Kaplan followed Masters and Johnson in 1974 and introduced her version of the "new" sex therapy. Kaplan's model included an initial emphasis on immediate symptoms. If the direct approach to symptom treatment worked, the case was closed. If, however, the "new" behavioural techniques met with resistance, the therapist relied on psychodynamic theory, or consideration of

"deeper" issues, to understand the possible intra-psychic and interpersonal roles the sexual dysfunction might be serving. (Compare Wiederman, 1998:89; Berman & Berman, 2001:55; Kaplan, 1974:165 and Woody, 1992:35.)

Several authors (Masters & Johnson, 1970:190; Kaplan, 1974:167 and King, 1999:320) agree that the new sex therapy included short-term but intensive work with the couple as well as detailed information about relevant human anatomy and physiology. Additionally, the intervention consisted of direct behavioural exercises, including prescription of non-demand pleasuring, or "sensate focus", wherein the objective was to experience sexual pleasure in the absence of anxiety from perceptions of performance demand or excessive self-monitoring of sexual performance. Essentially, clients were aided and encouraged to discover their own and their partner's bodies. This was accomplished through a series of specific behavioural directives that resulted in pleasurable sensual and sexual experiences in the absence of anxiety. As reported by Masters and Johnson (1970:132) success rate of the new sex therapy was remarkably high. Overall, it appeared that their failure rate was only 20% for all sexual dysfunctions combined.

In the 25 years subsequent to Masters and Johnson several changes have taken place in sex therapy. Sex therapy in the 1970's was an outgrowth of an earlier cultural shift toward greater focus on increased gratification and discussion of sexual issues. Rosen & Leiblum (1995:878) state that accordingly, anorgasmia in women and premature ejaculation in men, were

the most prominent sexual dysfunctions presented to therapists in the early days of contemporary sex therapy. At the same time as the birth of contemporary sex therapy, there was a noticeable increase in mass media attention to issues of sexual enhancement.

Wiederman (1998:90) is of the opinion that the types of cases commonly seen in sex therapy clinics have changed dramatically over the last few years. As the proportion of the clients who simply needed education and direction dwindled, the proportion of clients with more pervasive and chronic sexual problems increased. Accordingly, instances of erectile failure, low sexual desire and compulsive sexual behaviour have become an increasing part of sex therapists' caseloads.

Corresponding to the changing nature of the cases that sex therapists typically encounter, therapeutic approaches have changed as well. Wiederman (1998:90) states that the systemic approaches have been used to treat the more complex, relationship-bound sexual problems presented to sex therapists, with increasing frequency. Greater attention has also been paid to the role of early sexual trauma in subsequent sexual dysfunction. In general, a more complex, integrative, or post-modern approach to the conceptualisation and treatment of sexual dysfunction has emerged.

3.3 The state of theory in sex therapy

All sex therapy approaches appear to share the underlying assumption that there is a "natural" or "healthy" state of sexual functioning that therapists aim to restore for the client. Wiederman (1998:90) state that beyond this global belief, a primary distinction among approaches to sex therapy has to do with the underlying assumptions regarding etiology of sexual dysfunction. There is a major split among therapists based on whether the sex therapist views sexual dysfunction as having primarily physical (biogenic) or social/psychological (psychogenic) causes.

Wiederman (1998:92) is further of the opinion that the primary psychogenic perspectives in sex therapy share some common assumptions about the etiology of sexual dysfunction. Psychodynamic, behavioural, cognitive, social scripting, and systems approaches are all based on the notion that the individual's past plays an important role in his or her current sexual difficulties. Psychodynamic and psychoanalytic perspectives, however, place strong emphasis on unconscious processes and unresolved conflicts from childhood. Other psychogenic approaches however share a strong social learning perspective. Sexual difficulties are thus seen as arising from current problematic thoughts and beliefs that are in some way a result of past learning experiences. The etiological assumption of the biological perspective is that some medical or physical factor is the root of the current sexual dysfunction.

Human sexuality is a multi-determined phenomenon. The need to take a multivariate approach to theorising and model building is especially important to sex therapy. Levine (1995:3) is of the opinion that there is a great need to consider the complex interplay of multiple biogenic and psychogenic factors that may underlie sexual dysfunction. Wiederman (1998:96) agrees with this statement stating: "Current sex therapy frequently consists of an integrative synthesis of the primary perspectives regarding sex therapy". This "post-modern" approach to sex therapy has evolved in response to the increasing complexity of the cases sex therapists and marriage counsellors encounter.

3.4 Classification of sexual disorders

Sexual and gender identity disorders are currently classified into four major categories, according to the Diagnostic and Statistical Manual-IV (American Psychiatric Association: 1994). These categories are: sexual dysfunctions, paraphilias, gender identity disorders and sexual disorders not otherwise specified.

Several authors discuss these categories extensively. (Compare Grazioli, 1998:31; Rosen & Leiblum, 1995:878; King, 1999:322 and Kaplan, 1997: 211.) The following is a synthesis of the classification of sexual and gender identity disorders as described in the DSM-IV (American Psychiatric Association: 1994) and as it is discussed by previously mentioned authors.

3.4.1 Sexual Dysfunctions

According to the DSM-IV (American Psychiatric Association: 1994), a sexual dysfunction is characterised by psychological and/or physiological disturbance in the four phases that characterise the sexual response cycle (Desire, Excitement, Orgasm, Resolution).

According to Grazioli (1998:31) clinical judgement about the presence of a sexual dysfunction should take into account the individual's ethnic, cultural, religious, and social background, which may influence sexual desire, expectations, and attitude about performance. The disturbance causes marked distress or interpersonal difficulty.

The disturbance is not better accounted for by another Axis I disorder (except if it is another sexual dysfunction) as described in the DSM IV, and is not due exclusively to the direct physiological effects of a substance (e.g. drug abuse, medication) or a general medical condition.

According to Renshaw, Bancroft & Mulhall (1997:25) the major female sexual problems are sexual orgasmic problems: primary (never ever had an orgasm), and secondary (could at some point have an orgasm, but not at the present). Hypoactive sexual arousal disorder is another prevalent problem.

3.4.1.1 Hypoactive sexual desire disorder

The essential feature is persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity (taking into account the effects of aging and the context of the person's life).

3.4.1.2 Sexual aversion disorder

The essential feature is the aversion to and active avoidance of all (or almost all) genital sexual contact with a sexual partner.

3.4.1.3 Female sexual arousal disorder

The essential feature is persistent or recurrent inability to attain, or maintain until completion of the sexual activity, an adequate lubrication response of sexual excitement.

3.4.1.4 Male erectile disorder

The essential feature is a persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate erection.

3.4.1.5 Female orgasmic disorder

The essential feature is persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase. Women exhibit wide variability in the type or intensity of stimulation that triggers orgasm. This diagnosis should be based on clinical judgement that the woman's orgasmic capacity is less than reasonable for her age, sexual experience, and the adequacy of sexual stimulation she receives.

3.4.1.6 Male orgasmic disorder

The essential feature is persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase during sexual activity that, taking into account the person's age, is clinically judged to be adequate in focus, intensity and duration.

3.4.1.7 Premature ejaculation

The essential feature is persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it. Factors that affect duration of the excitement phase, such as age, novelty of the sexual partner or situation, and recent frequency of sexual activity, must be taken into consideration.

3.4.1.8 Dyspareunia (not due to a general medical condition)

The essential feature is recurrent or persistent genital pain associated with sexual intercourse in either a male or a female. The condition is not caused exclusively by vaginismus or lack of lubrication.

3.4.1.9 Vaginismus (not due to a general medical condition)

The essential feature is the recurrent or persistent involuntary contraction of the perineal muscles surrounding the outer third of the vagina when vaginal penetration is attempted with penis, finger, tampon or speculum.

3.4.1.10 Sexual dysfunction not otherwise specified

This category includes sexual dysfunctions that do not meet criteria for any specific sexual dysfunction. Examples include the following:

- No (or substantially diminished) subjective erotic feelings despite otherwise normal arousal and orgasm.
- Situations where it is not clear whether a sexual dysfunction is primary, due to a general medical condition, or substance induced.

3.4.2 Paraphilias

According to Masters, *et al.* (1995:449) defining abnormal behaviour consists of several different components: social deviance, frequency and persistence, psychological dependence, and the behaviour's effect on psychosocial functioning.

The paraphilias are conditions where sexual arousal becomes dependent on an unusual type of sexual behaviour or fantasies of that behaviour. The paraphilias are much more common in men than in women and often do not cause any form of personal distress.

The focus in all paraphilias involves intense sexually arousing fantasies, sexual urges, or behaviours generally involving either nonhuman objects, the suffering or humiliation of oneself or one's partner, or children, or other non-consenting persons, that occur over a period of at least 6 months. The behaviour, sexual urges, or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. (Compare Masters *et al.,* 1995:449; Grazioli, 1997:32; DSM-IV: 1994 and King, 1999:340.)

3.4.2.1 Fetishism

The focus involves the use of nonliving objects. The fetish objects are not limited to articles of female clothing used in cross-dressing (as in transvestic

fetishism), or devices designed for the purpose of tactile genital stimulation (e.g. a vibrator).

3.4.2.2 Frotteurism

The focus involves touching and rubbing against a non-consenting person.

3.4.2.3 Paedophilia

The focus involves a pubescent child or children. The paedophile must be age 16 years or older, and at least 5 years older than the child. This does not include an individual in late adolescence involved in an ongoing sexual relationship with a 12- or 13-year old.

3.4.2.4 Sexual masochism

The focus involves the act (real, not simulated) of being humiliated, beaten, bound, or otherwise made to suffer.

3.4.2.5 Sexual sadism

The focus involves acts (real, not simulated) in which the psychological or physical suffering (including humiliation) of the victim is sexually exciting.

3.4.2.6 Transvestic fetishism

The focus involves cross-dressing. This paraphilia may or may not be associated with gender dysphoria (persistent discomfort with gender role or identity).

3.4.2.7 Voyeurism

The focus involves the act of observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity.

3.4.2.8 Paraphilias not otherwise specified

This category includes paraphilias that do not meet the criteria for any of the other specific categories, e.g.

- telephone scatologia (obscene phone calls)
- necrophilia (corpses)
- partialism (exclusive focus on part of the body)
- zoophilia (animals)
- coprophilia (faces)
- klismaphilia (enemas)
- urophilia (urine)

Masters, *et al.* (1995:450) also mention hyper sexuality (nymphomania in females, satyriasis in males). The core features seem to be an insatiable

sexual appetite, fairly impersonal sex, and low or nonexistent sexual satisfaction. Many therapists find the addiction model useful in understanding and treating compulsive sexual behaviour. (Compare Masters *et al.*, 1995:451; King, 1999:340 and Rosen & Leiblum, 1995:881.)

3.4.3 Gender identity disorders

To make the diagnosis of gender identity disorder there must be evidence of a strong and persistent cross-gender identification, which is the desire to be (Criterion A), or the insistence that one is (Criterion B), of the other sex.

This cross-gender identification must not merely be a desire for any perceived cultural advantages of being the other sex. There must also be evidence of persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex.

The diagnosis is not made if the individual has a concurrent physical intersex condition (e.g. androgen insensitivity syndrome or congenital adrenal hyperplasia).

There must be evidence of clinically significant distress or impairment in social, occupational, or other important areas of functioning

In children, Criterion A is manifested by four (or more) of the following:

- Repeatedly stated desire to be, or insistence that he or she is, the other sex.
- In boys, preference for cross-dressing or simulating female attire. In girls, insistence on wearing only stereotypical masculine clothing.
- Strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex.
- Intense desire to participate in the stereotypical games and pastimes of the other sex.
- Strong preference for playmates of the other sex.

In children, Criterion B is manifested by any of the following:

- In boys, assertion that his penis or testes are disgusting or will disappear, or assertion that it would be better not to have a penis, or aversion toward rough-and-tumble play and rejection of stereotypical toys, games and activities.
- In girls, rejection of urinating in a sitting position, assertion that she has, or will grow, a penis, or assertion that she does not want to grow breasts and menstruate, or marked aversion toward normative feminine clothing.

3.4.3.1 Gender identity disorders not otherwise specified

This category includes disorders in gender identity that are not classifiable as a specific gender identity disorder, e.g.

- Intersex conditions (e.g. androgen insensitivity syndrome or congenital adrenal hyperplasis) and accompanying gender dysphoria;
- Transient, stress-related cross-dressing behaviour;
- Persistent preoccupation with castration or penectomy, without a desire to acquire the sex characteristics of the other sex.

3.4.4 Sexual disorders not otherwise specified

This category includes disturbances that do not meet the criteria for any specific sexual disorder and is neither a sexual dysfunction nor a paraphilia, e.g.

- Marked feelings of inadequacy concerning sexual performance or other traits related to self-imposed standards of masculinity or femininity;
- Distress about a pattern of repeated sexual relationships involving a succession of lovers who are experienced by the individual only as things to be used;
- Persistent and marked distress about sexual orientation.

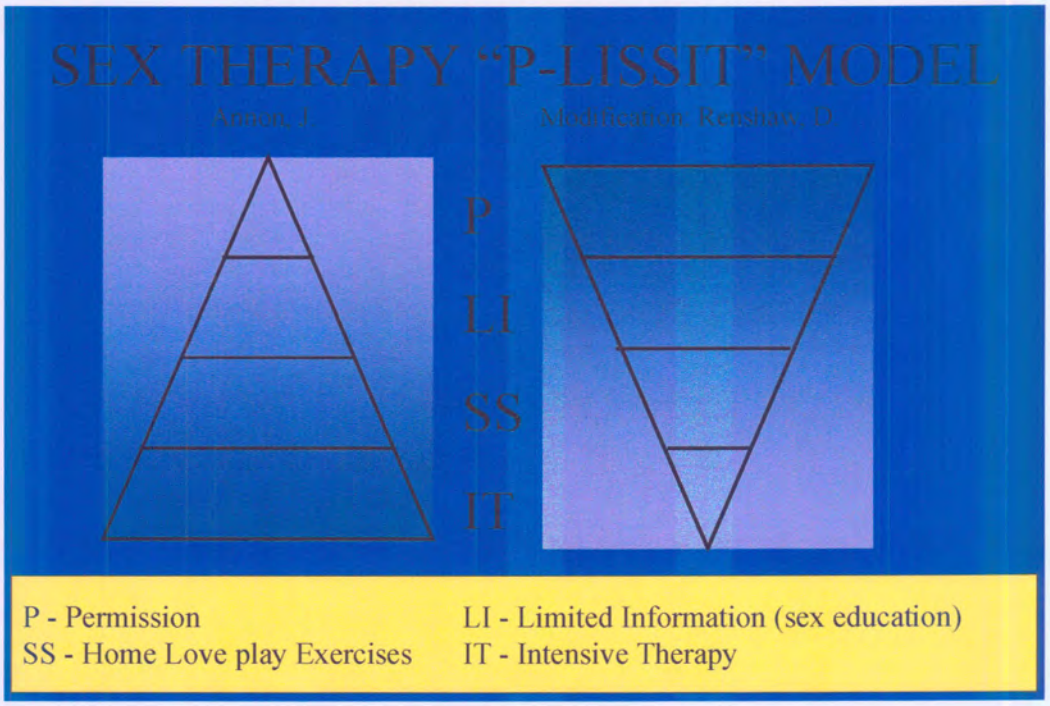
3.5 A model to treat sexual distress

Renshaw, *et al.* (1997:28) regards sexual response as a fundamentally psychosomatic phenomenon in which the interaction between psychological processes and physiological processes is absolutely basic. Remarkable

changes have been seen in the field of sexology. There have been developments in both assessment and treatment.

The PLISSIT model is widely used as a foundation for sex therapy (see Figure 8). (Compare Annon, 1976:89; Stahmann, 1997:67; Renshaw, 1995:72 and Woody, 1992:55.)

Figure 9: PLISSIT model from own personal collection with acknowledgment to Dr. D Renshaw.



Stahmann (1997:67) describes the PLISSIT model as a model for sex therapy. Annon originally developed this model in 1976. It conceptualises the different levels of intervention that is required in helping couples with sexual dysfunctions. This so-called PLISSIT model identifies four different levels of expertise and intervention. This model is very useful in sex therapy and it also

works well as a framework for providing feedback in clinical consultation and supervision.

3.5.1 Annon's model

Stahmann (1997:69) describes Annon's model as it applies to sex therapy. The four levels of expertise and intervention conceptualised are represented in the word PLISSIT. "P" represents the "Permission" level and consists of the therapist simply feeling comfortable enough to convey a sense of permission to clients so that they feel free to bring up sexual matters. The next level, which often blends with permission, is providing "LI" or "Limited Information". Many couples and individuals can be helped through providing some basic information such as an overview of the sexual response cycle. This is the sex education the client never had. The third level of intervention is giving of "SS", "Specific Suggestions," which can be viewed as the sex counselling level. Here suggestions to deal with specific sexual problems may be offered or exercises such as sensate focus are introduced. The fourth and most complex level of intervention is "IT" or "Intensive Therapy". This is the level of intensive sex therapy.

3.5.2 Stahmann's addition

Stahmann (1997:68) identified an important missing ingredient in this model, namely the expectations about therapy that the therapist and the client may

have. According to him all clients have some sort of preconceived expectation or idea about therapy as a process, or some expectation about the therapist as a person. Therapists whether they are family or sex therapists also have expectations that guide and direct their interventions. Thus with the addition of "Expectations", the model has become the EXPLISSIT or EX-P-LI-SS-IT. Stahmann consequently uses the EXPLISSIT model for conceptualising, designing and delivering marital and family therapy interventions. He first looks at the expectations of both the client and the therapist. What does the client expect about the therapy process? Why are the clients here? What might be indicators to the clients that therapy is successful? What does the therapist expect? What does the therapist expect about the therapy process with the client and what does the therapist expect about the possible outcome of therapy? In supervision and case consultation, what does the supervisor expect about the process and outcome? What are the expectations of the supervisee about the supervision process and outcome?

3.5.3 Renshaw's modification

Renshaw (1997:40) modified the model further by turning the triangle around. The permission given to the client by the social worker or therapist, to experiment with his or her own sexuality, as well as to communicate about sexual issues in a comfortable manner are seen as the most important and largest part of sex therapy. Limited information about sexuality in general and the specific sexual difficulties are then given. This phase can be described as the sex education the couple never had. Home love play exercises are then

given to the couple and the feedback on these is discussed at the beginning of the next session. The smallest part of sex therapy according to the revised PLISSIT model is then intensive therapy for specific and complicated long-term problems.

3.6 Treatment modalities for sexual dysfunctions

3.6.1 Male erectile disorder

King (1999:325) describes erectile dysfunction (ED) as a sexual problem in which a male has difficulty, or an inability to get and maintain an erection. EDs can be *primary* (i.e., a male who has never had an erection) or *secondary* (i.e., the individual has not had erectile problems in the past), and *global* (i.e., it happens in all situations) or *situational* (e.g., a man who can't get an erection with his wife, but can with other women).

Masters, *et al.* (1995: 523) describe an erection as the result from the spongy-like tissues of the corpora cavernosa and corpus spongiosum of the penis becoming engorged with blood (the penile arteries dilate and valves in the veins close). This response is under reflexive control by two centres in the spinal cord (the lower one responds to touch and the upper one responds to erotic thoughts). They normally work together, and depend on the presence of testosterone (the male hormone) and other chemicals. Any number of things

can upset the balance and impair functioning, including fatigue, stress, alcohol, and drugs.

According to Rosen & Leiblum (1995:879), the difficulty in achieving or sustaining an erection is currently the most prevalent sexual disorder in men seeking sex therapy. The frequency of ED is strongly age related. Studies have also showed a high incidence of illnesses and medication use in men with ED. Renshaw, *et al.* (1997:28) regards sexual response as a fundamentally psychosomatic phenomenon in which the interaction between psychological processes and physiological processes is absolutely basic. There have been many developments and changes in both the assessment and treatment of especially ED. In 1988 the term impotence was changed to erectile dysfunction. According to Renshaw, *et al.* (1997:29) there are several treatment possibilities for ED namely:

- penile self-injection therapy;
- oral medication;
- vacuum erection device;
- couple and sex therapy.

Rosen & Leiblum (1995:880) stress the fact that in keeping with the focus on biomedical causes of ED, medical and surgical approaches to treatment have escalated in recent years. These include surgical prostheses or penile implants, intracorporal injection or vasoactive drugs, constriction rings and vacuum pump devices and oral medication. King (1999:325) mentions that circulatory problems (e.g., arteriosclerosis, sickle-cell anaemia, or beta-

blocking medications used to treat blood pressure and heart disease), neurological disorders (e.g., accidents, pelvic surgery), and hormone imbalances (primary abnormalities or secondary complications due to diabetes) often result in ED. Eighty percent of alcoholics suffer from ED. It is important, therefore, that a client with an erectile problem have a complete medical exam before treatment begins.

Renshaw, *et al. (1997:30)* describe **intracavernosal or penile self-injection therapy** as it is sometimes referred to, as a very effective tool in the management of ED. It is a process whereby medications that are primarily vasodilators, are injected directly into the erectile chamber. Five to ten minutes later, the patient has an erection that is usable for intercourse. Many men overcome needle phobia to go along with this therapy.

The **vacuum device** is the oldest form of therapy for ED. It is a very simple mechanical device that entails a cylinder that is placed over the penis. A vacuum is created in the cylinder, drawing blood; passive congestion of the penis occurs and a constriction ring is placed over the penis that traps blood within the penis itself.

Rosen & Leiblum (1995:879) agree that psychological and interpersonal factors are also associated with ED. Renshaw, *et al.* (1997:29) stress the importance for sex therapists to indicate to the patient that even if he is unable to achieve an erection, it is still possible to enjoy sexual intimacy with one's partner. The difficulty in obtaining an erection often becomes a barrier to

sexual intimacy, and the man is very reluctant to embark on any type of affectionate interaction with a partner. This, therefore, often results in the couple becoming detached from one another and having less intimacy. Such a man can be helped to see, particularly with the partner's help, that the erection is not the only, or the most important part of lovemaking. Therefore, there is an important role for **counselling**. For many men, it is intercourse or nothing. To request that, at least for a few weeks, the couple only receive pleasure and forget about the erection can make a dramatic difference in the way the man's body performs. The client is then achieving the result of relaxation using the mind, the most important aphrodisiac, namely, fantasy, and letting the body take over naturally and have the erection.

Rosen & Leiblum (1995:880) mention that the communication between couples should also be improved during sex therapy. Effective communication is profoundly important in sexual relationships, and improving communication can often produce dramatic improvements in the relationship and the sexual dysfunction. Therapy can help clients to understand the meanings that they have attributed to their sexual lives. This can often be very important in reducing guilt and anxiety.

King (1999:325) and Masters, *et al.* (1995:581) agree that if the cause of ED is determined to be solely psychological, the success rate during therapy depends largely on whether it is a primary or secondary dysfunction. Men with primary erectile dysfunction are often found to have had a strict religious upbringing in which sex was equated with sin and guilt. They may have had

very few social experiences with females during childhood and adolescence. For men with a secondary ED due to psychological factors, the most common cause is performance anxiety. Performance anxiety is a fear of failure. Nearly all males will experience an erectile dysfunction sometime in their life, often due to stress (e.g., school, career), fatigue, drugs (e.g., prescription, antihistamines, and illicit drugs), or just too much to drink one night at a party. Having sex with a new partner can also be very anxiety producing. Although dysfunctions in these situations are normal, many men are not aware of this and begin to worry about being impotent. The next time they have sex the anxiety caused by fear of failure can result in what is called spectatoring – observing and evaluating their own responses rather than experiencing the sexual pleasures. Spectatoring is distracting (a loss of intimacy) and can lead to loss of erection, which results in even greater anxiety the next time. The behaviour becomes a vicious cycle, and what started as a normal response to fatigue, alcohol, drugs, or other factors can become a chronic psychological dysfunction.

Renshaw, *et al.* (1997:30) mention the **psychosomatic interface** as being intensely interwoven in the area of sexuality. It is important for the clinician of any discipline to see whether the ED is global or whether it is specific to the partner. If the man is having morning erections and is masturbating the therapist needs to understand what is happening between the couple.

There is also the **pharmacological approach**. The most recent development is the use of a phosphodiesterase level five inhibitor, Sildenafil, more

commonly known as Viagra. It blocks the effects of phosphodiesterase, which has a very local effect in the penile tissue. By blocking the enzyme effect, you prolong the effect of sexual stimulation. The drug has no effect without sexual stimulation. This is a very new approach to the pharmacological treatment of ED. (Compare Rosen & Leiblum, 1995:879; Renshaw, *et al.,* 1997:31 and Masters, Johnson & Kolodny, 1995:581.)

Few studies have addressed the impact of treatment in the partner relationship, and limited attempts have been made to integrate medical and psychological approaches to treatment.

As far as psychological treatment for ED goes, several authors have emphasised the importance of cognitive interventions. (Compare Masters, *et al.,* 1995:583; Renshaw, *et al.,* 1997:31 and Rosen & Leiblum, 1995:870.) Males with chronic ED typically harbour distorted cognitions about the nature of sexual arousal, sexual skills, and their partners' expectations regarding sexual satisfaction. These dysfunctional beliefs and expectations are a potentially important focus for treatment.

A number of treatment interventions for single men with chronic ED exist and have also been described by Masters, *et al.* (1995:582). Treatment strategies include sexual attitude change, masturbation exercises and social skills training.

Rosen & Leiblum (1995:881) agree that psychological and interpersonal approaches have been relatively neglected in the face of increasing medicalisation of ED. Recent studies in contrast have highlighted the importance of the integration of cognitive and interpersonal factors as well as pharmacological treatment in this highly prevalent disorder.

3.6.2 Premature ejaculation (rapid ejaculation)

Premature ejaculation is a common sexual dysfunction but is very often difficult do define. Masters, *et al.* (1995:582) define rapid ejaculation as the male who persistently ejaculates unintentionally during non-coital sexual play or while trying to enter his partner. King (1999:330) defines premature ejaculation as the recurrent and persistent absence of reasonable voluntary control of ejaculation. A man who is disturbed by his own inability to exert any control over when he ejaculates may develop performance anxiety. This, in turn, can lead to an erectile dysfunction. Many therapists believe that the early sexual experiences of some males actually teach them to rush during sex. Male masturbatory behaviour is generally orgasm-oriented anyway, but a male may hurry it even more in situations where he fears being caught.

Masters, *et al.* (1995:582) mention the fact that prevalence data suggest that approximately 25% - 40% of men in the United States of America experience difficulties with premature ejaculation (early ejaculation) at some time. A major difficulty has been the lack of a clear-cut definition or diagnostic criteria for early ejaculation. Masters & Johnson (1966:165) initially defined premature

ejaculation in terms of the male's inability to delay ejaculation until his partner had been sexually satisfied on at least 50% of intercourse attempts. Noting the lack of objectivity in this definition, other authors have emphasised the average duration of intercourse or number of thrusts following penetration. (Compare Kaplan, 1974:165; King, 1999:330 and Lopiccolo, 1978:135.) A third approach described by Renshaw (1997:30) has been to emphasise the degree of voluntary control that the man has over ejaculation.

Rosen and Leiblum (1995:883) quote the *Diagnostic and Statistical Manual of Mental Disorders, IV* who defines premature ejaculation (PE) as: "...persistent or recurrent ejaculation with minimal sexual stimulation before, upon, or shortly after penetration and before the person wishes it". The therapist must take into account factors that effect duration of the excitement phase, such as age, novelty of the sexual partner, and frequency of sexual activity. Psychological factors and early conditioning factors as causes of PE have also been emphasised.

Treatment approaches for PE include the traditional stop-start technique as well as the squeeze technique developed by Semans and Masters and Johnson (1970:165). Cognitive-behavioural interventions are also used as well as various pharmacological agents such as alpha-adrenergic antagonists or serotonin-uptake inhibitors (e.g. Prozac or Zoloft). Simply increasing the frequency of sexual stimulation may result in an increased latency to ejaculate. (Compare Masters *et al.,* 1995:582; King, 1999:331 and Renshaw, 1995:83.)

3.6.3 Male orgasmic disorder

Various authors describe male orgasmic disorder. (Compare Masters *et al.*, 1995:583; King, 1999:331 and Woody, 1992:66.) This is a relatively uncommon disorder and accounts for only about two to three percent of men who seek therapy. It refers to a difficulty (sometimes called retarded ejaculation) or a total inability (sometimes called ejaculatory incompetence) to reach orgasm and ejaculate in a woman's vagina, and it can be either primary or secondary. A few cases can be traced to organic causes (e.g., drugs, alcohol, neurological disorders). Most of these men, however, are able to reach orgasm either during masturbation or during manual or oral stimulation, which indicates that the usual cause is psychological and not physical. Masters & Johnson (1970: 165) reported that primary inhibited orgasm problems are often associated with a strict religious upbringing, a fear of getting a woman pregnant, negativity and hostility toward the partner, and/or maternal dominance. Secondary problems are often associated with some kind of previous trauma. According to King (1999:332) delayed or absent ejaculation may also be associated with a variety of medical or surgical conditions (e.g. multiple sclerosis, spinal cord injury, surgical prostatectomy), or the use of anti-adrenergic or neuroleptic medications.

Masters, *et al.* (1995:583) describe another disorder namely, retrograde ejaculation. This is a condition in which the semen spurts backward into the

bladder during orgasm because the bladder neck does not close off properly. It occurs in men with multiple scleroses and diabetes and following some types of prostate surgery.

Treatment interventions are usually aimed at reducing performance anxiety, in addition to increasing the level of genital stimulation. (Compare King, 1999:331; Masters *et al.*, 1995:583 and Renshaw, 1995:83.)

3.6.4 Priapism

King (1999:332) and Masters, *et al.* (1995:580) describe priapism as a condition in which the penis remains erect for a prolonged period of time due to damage to the valves regulating the penile blood flow. Medical attention is necessary to deal with this problem as this condition can be life threatening.

3.6.5 Female sexual arousal disorder (FSAD)

This condition refers to the lack of responsiveness to sexual stimulation in women and is defined as a "persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate lubrication response of sexual excitement" by the DSM IV as quoted in Rosen and Leiblum (1995:879). This definition emphasises the absence of physiological arousal, thereby paralleling the definition of erectile disorder. It is often difficult

to separate lack of arousal disorder in women from hypoactive sexual desire disorder or anorgasmia.

Masters and Johnson (1970:165) and Kaplan (1974:145) describe the use of biofeedback and fantasy training procedures for women with inhibited arousal and orgasmic disorders. Sexual arousal difficulties in women may also benefit from interventions to increase generalised autonomic arousal for example exercises, in addition to enhanced expectations of sexual arousal.

Psychological treatments included couples therapy, masturbation training, and sensate focus procedures as described by Masters & Johnson (1970:265).

3.6.6 Female orgasmic disorder

Female anorgasmia is generally regarded as the most prevalent sexual dysfunction in women. Some authors like Kaplan (1974:29) and King (1999:332) argue that the lack of experience with masturbation or inadequate partner stimulation frequently underlies the failure to achieve orgasm.

Inhibited Female Orgasm is defined by the DSM-IV as the difficulty or inability for a female to reach orgasm. Orgasmic dysfunction can be primary or secondary and situational or global. Many authors (King, 1999:332; Masters *et al.,* 1995:157 and Renshaw, 1997:60) agree that the key to reaching orgasm is the degree of stimulation to the clitoris. During intercourse, the penis only

indirectly stimulates the clitoris by causing the clitoral hood to rub back and forth over the clitoral glans. Fewer than half of women are therefore able to reach orgasm during intercourse without more direct stimulation of the clitoris. A healthy positive attitude about sex and pleasure is also very important. Masturbation therapy, sensate focus exercises and relaxation exercises are often used in treatment of anorgasmic women.

Masters, *et al.* (1995:586) describe the treatment of lifelong or primary anorgasmia as guided masturbation training and cognitive-behavioural sex therapy. Masturbation training procedures include manual or vibrator-assisted stimulation techniques, in addition to pubococcygeal muscle training procedures (Kegel exercises).

Secondary anorgasmia is more often associated with emotional or psychiatric disorders and with relationship conflicts.

Masters, *et al.* (1995:588) also describe a relatively rare condition called rapid orgasm. It is in essence the female counterpart of premature ejaculation, and is marked by characteristically having orgasm so quickly in a sexual encounter that it is distressful.

3.6.7 Dyspareunia

Painful intercourse does not only affect females, but may also affect males (Masters *et al.,* 1995:584). Most typically, the pain is felt in the penis, but it

can be felt in the testes or internally, where it is often associated with a problem of the prostate or seminal vesicles. King (1999:584) states that in men, the most common causes are a prostate or bladder infection, or the foreskin of the penis being too tight. In rare cases, fibrous tissue deposits can cause curvature of the penis (known as *Peyronie's disease)* and pain during erection.

Painful intercourse is a highly prevalent disorder in women, but is relatively rare in men. King (1999:325) describes etiological determinants as including a wide variety of physical factors, such as hymeneal scarring and pelvic inflammatory disease as well as psychological factors such as relationship conflicts or a history of sexual abuse. Dyspareunia may also be secondary to vaginismus or chronic lack of lubrication.

According to Masters, *et al.* (1995:588) painful sexual intercourse in women can present a major stumbling block to sexual satisfaction. This condition can occur at any age, and can appear at the start of intercourse, at the time of orgasm, or after intercourse is completed. Dyspareunia detracts from a person's sexual enjoyment and can interfere with sexual arousal and orgasm.

King (1999:325) asserts that in women, one of the most common causes of painful intercourse is vaginal dryness. If a woman is not fully lubricated when intercourse begins, the thrusting of the penis will severely irritate the dry vaginal walls. Lack of sufficient lubrication can be due to a partner who doesn't take his time, but it can also be the result of fear or anxiety, which

interferes with the vasocongestive process. Vaginal dryness can also result from hormonal changes (which occur at menopause), use of antihistamines and other medications, and even tampons. Use of a water-soluble lubricant can often substantially alleviate this problem.

Dyspareunia in women can also be caused by endometriosis (growth of the endometrium outside the uterus), pelvic inflammatory disease, vaginal infections, and urinary tract infections. Allergies to semen, feminine hygiene products (deodorants and scented douches), powders, and spermicides can also make sexual intercourse painful. Surveys generally show that about 40 percent of women have occasionally experienced painful intercourse. If the physical factors responsible for dyspareunia are not quickly taken care of, it can lead to other sexual problems. The anticipation of pain, for example, can become so great that it can lead to erectile problems in men, vaginismus in women, or loss of sexual desire in either sex.

Treatment approaches described by Masters, *et al.* (1995:588) include a variety of medical or surgical interventions in cases of specific organic pathology. In addition to medical approaches, however, most women require a course of cognitive-behavioural or sex therapy treatment. King (1999:332) mentions that for women with a long-standing history of painful intercourse the conditioned anxiety and lack of arousal associated with the disorder require additional treatment.

3.6.8 Vaginismus

Vaginismus is defined by King (1999:332) and Masters, *et al.* (1995:585) as involuntary spasms of the musculature of the outer third of the vagina and is the second major cause of penetration difficulties in women. The disorder is relatively common, occurring in 12% - 17% of women presenting to sex therapy clinics. Many authors (Rosen & Leiblum, 1995:884; King, 1999:332 and Masters *et al.,* 1995:588) distinguish between primary vaginismus, which refers to involuntary spasms in all situations, and secondary or situational vaginismus, in which some penetration is possible (e.g. insertion of a tampon).

According to King (1999:332) it is usually caused by psychological factors. Persistent and recurrent involuntary muscle spasms are often associated with the fear of injury to the internal organs or trauma like rape or abortion. It can also be due to a strict religious upbringing, hostility or fear toward men or medical reasons.

Vaginismus can also occur in association with dyspareunia, although it is more frequently caused by psychological or interpersonal factors. Masters, *et al.* (1995:585) agree that among the psychological factors most often associated with vaginismus are negative psychosexual upbringing, sexual fears and phobias and a history of sexual trauma or abuse.

Treatment usually consists of sensate focus and relaxation exercises followed by gradual dilation of the vagina. Treatment approaches described by

Masters, *et al.* (1995:585) typically consist of a combination of systematic desensitisation, pubococcygeal muscle training (Kegel exercises) and the use of vaginal dilators. The involvement of the male partner appears to be an important determinant of treatment efficacy.

Assessment and treatment approaches to sexual dysfunction have changed markedly in the more than 30 years since the publication of *Human Sexual Inadequacy* by Masters and Johnson in 1970. In particular the role of biomedical and organic factors have been emphasised increasingly.

3.7 Sex therapy techniques

3.7.1 Medical history

Sex therapists (King, 1999:320; Masters *et al.*, 1995:596 and Woody, 1992:60) agree that the vast majority of sexual problems are caused by psychological factors, but sexual dysfunctions are sometimes caused by physical or medical problems. Circulatory problems (e.g., arteriosclerosis), hormone abnormalities (e.g., low testosterone levels), or anything that causes central nervous system damage (e.g., diabetes, spinal cord injury) can cause a sexual problem. Alcohol and drugs often cause sexual impairment as well. One common cause of erectile dysfunction in men, for example, is some prescription medications used to treat hypertension and heart disease. It is important, therefore, that a therapist have a complete medical history of the

patient (and possibly have a physician do a medical exam) before beginning therapy in order to rule out any physiological basis for the presenting problem.

See Appendix A for an example of a medical history questionnaire.

3.7.2 Sexual history

Nearly all sex therapists will take a complete sexual history of the client before treatment begins. These histories are very thorough, and the length of time devoted to this will depend on how candid the client is about his or her past experiences. Some therapists like Masters, *et al.* (1995:594), prefer to work with couples because they are of the opinion that there is no such thing as an uninvolved partner. Renshaw (1995: 120) describes the goal of the taking of a complete sexual history as giving the client insight into his or her attitudes and beliefs about sex.

See Appendix B for an example of a sexual history questionnaire.

3.7.3 Systematic desensitisation

King (1999:350) states that many patients have severe anxieties about sex in certain situations. Therapists often attempt to reduce this anxiety through muscle relaxation exercises or stress reduction techniques. A series of anxiety-producing scenes is presented to the patient, and he or she is told to

try to imagine the scene. If this causes anxiety, the relaxation exercises are used until the scene can be imagined without anxiety. They then proceed to the next scene and repeat the procedure until the entire series can be completed without anxiety. Imagining a scene, of course, is not the same as a real-life situation, so a series of homework exercises are usually given as well.

3.7.4 Sensate focus

Masters, *et al.* (1995:596) and King (1999:320) agree that many people are too goal and/or performance-oriented during sexual relations (e.g., focusing on orgasm). Others have guilt or anxieties about enjoying sex. As a result, many people never really learn how to give or receive physical pleasure. Masters & Johnson (1966:176) created sensate focus exercises. The purpose is to reduce anxiety and to teach nonverbal communication skills. Most therapists, therefore, instruct couples to use non-demand pleasuring techniques when touching each other. They are instructed to go home, get undressed, and take turns touching each other without it immediately leading to the goal of having intercourse or having an orgasm. Touching of the breasts and genitals is forbidden at first, but all other areas of the body are to be explored. The receiver is instructed to focus on the sensations produced by the giver and to produce feedback as to what feels good and what does not. The giver learns what makes his or her partner feel good while simultaneously learning the pleasure of touching. The couple learns to be sensual in a non-demanding situation.

See Appendix C for an example of a sensate focus exercise handout.

3.7.5 Self awareness and masturbation

Several authors (Kaplan, 1979:231; Masters *et al.,* 1995:599; King, 1999:320 and Renshaw, 1995:42) use masturbation as a sex therapy technique. Renshaw (1995:43) states that research showed that a lack of sexual self-exploration and self-stimulation is a common feature of people seeking treatment for sexual problems. They give their clients instructions on how to masturbate because some people have never explored their own bodies. As a result, they are totally out of touch with their own physical responses. During masturbation, a person learns what kind of stimulation is pleasurable. It also helps them to learn how to relax during sex. Many therapists also consider it helpful to have a couple masturbate in each other's presence so that each can learn what the other finds most arousing and pleasurable.

3.7.6 Specific exercises

After the sensate focus exercises are successfully completed, therapists generally assign specific exercises to help with the problem for which the person came to treatment.

3.7.6.1 Erectile dysfunction

According to Masters, *et al.* (1995:597) it is important to help the man understand that he cannot will an erection to occur on demand. He can however set the stage for his own natural reflexes to take over by not trying to have erections and by moving out of his performance fears. It is also important that the therapist stresses the fact that losing an erection is not a sign of failure; it simply shows that erections come and go naturally. King (1995:325) advises that when intercourse is attempted after the man has gained considerable confidence in his erectile capacity and after he has been able to reduce his spectatoring behaviour, the women should be advised to insert the penis. This reduces pressures on the man to decide when it is time for penetration and removes the potential distraction of fumbling to "find" the vaginal opening.

3.7.6.2 The squeeze technique

Masters, *et al.* (1995:597) stress the importance of the couple approach in treating premature or rapid ejaculation since the condition may actually be more distressing to the woman than the man. In addition to discussing the physiology of ejaculation, the therapist can also introduce a specific method called the squeeze technique that helps recondition the ejaculatory reflex. Many authors describe the squeeze technique. (Compare King, 1999:330; Masters *et al.,* 1995:597 and Renshaw, 1995:197.) The woman puts her thumb on the frenulum of the penis and places her first and second finger just above or below the coronal ridge on the opposite side of the penis. A firm,

grasping pressure is applied for about fifteen seconds and then abruptly released. This technique reduces the urgency to ejaculate and usually ensures a 30% loss of the erection.

3.7.6.3 The stop-and-start technique

Renshaw (1995:83) describes this technique to utilise in the treatment of rapid ejaculation. The couple should engage in foreplay until the man almost reaches ejaculatory inevitability, then they should simply stop. They should relax, hug and hold and allow 30% loss of erection. Then loveplay continues to the same point again, and again let 30% loss of erection occur. Deliberate loss of erection can build confidence especially when loveplay returns the erection.

3.7.6.4 Kegel exercises

Several authors (King, 1999:37; Masters *et al.*, 1995:52 and McIntosh, 1997:2) advocate Kegel exercises to strengthen the pubococcygeus (P.C.) muscle. These exercises are designed to strengthen and give voluntary control over the P.C. muscle. The P.C. muscle is the support muscle for the genitals in both men and women and is the muscle that stops the flow of urine. There is a definite correlation between good tone in the P.C. muscle and orgasmic intensity. The Kegel exercises are the same exercises that physicians instruct women to do after having a baby in order to regain urinary

control. The advantages of Kegel exercises described by King (1999:37) and McIntosh (1997:1) are:

- Increasing the awareness of feeling in the genital area.
- Increasing blood circulation in the genital area.
- Increase in sexual responsiveness.
- Aid in restoring vaginal muscle tone after childbirth
- Increase control over orgasm.

See Appendix D for a program of Kegel exercises.

3.7.6.5 Vaginismus exercises

Vaginismus is treated by explaining the nature of the involuntary reflex spasm, by prescribing specific exercises and by using dilators if indicated. Masters, *et al.* (1995:599) and Renshaw (1995:85) describe specific exercises for women suffering from vaginismus.

See Appendix E for specific exercises in handout form to prescribe to clients.

3.7.6.6 Anorgasmia exercises

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Masters, *et al.* (1995:599) state that treatment strategies will vary widely depending on the cause of the anorgasmia. A woman with a poor body image may be helped to find various ways of regarding her body more positively. A woman who is distracted from high levels of arousal by disturbing fantasies might be taught thought-blocking techniques. Other common techniques

include encouraging a woman to explore her own body; dealing with performance anxieties and spectatoring; fostering sexual communications so that the woman is able to let her partner know what type of touch or stimulation she prefers and reducing inhibitions that limit her capacity for arousal or that block orgasm.

3.8 Summary

In Chapter 3 an overview of clinical sex therapy was provided. The historical background of sex therapy was followed by a description of the state of theory in sex therapy. The classification of sexual disorders followed as well as an explanation of the PLISSIT-model to treat sexual distress. Different treatment modalities for sexual dysfunctions were subsequently discussed as well as possible sex therapy techniques to utilise in treatment.

The following is a summary of the most important points:

- A substantial proportion of the adult population will experience some sort of sexual problem at some point in their lives.

- Sex therapy refers to any systemic attempt by a professional therapist to alleviate the sexual dysfunction or sexual difficulties experienced by a specific client.

- An integrated approach to therapy is needed.

- All sex therapy approaches share the underlying assumption that there is a healthy state of sexual functioning that therapists aim to restore for the client.

- Sexual and gender identity disorders are currently classified into four major categories: sexual dysfunctions, paraphilias, gender identity disorders and sexual disorders not otherwise specified.

- The PLISSIT model is widely used as a model to treat sexual distress.

- Treatment possibilities for erectile dysfunction are:
    - Penile self- injection therapy
    - Oral medication
    - Vacuum erection devices
    - Couple and sex therapy
    - Penile implants

- Treatment possibilities for premature ejaculation are:
    - The stop-start technique
    - The squeeze technique
    - Cognitive-behavioural interventions
    - Medication
    - Increasing the frequency of sexual stimulation

- Treatment possibilities for female sexual arousal disorder are:
  - Fantasy training
  - Kegel exercises
  - Masturbation training
  - Sensate focus exercises
  - Medication

- Treatment possibilities for female orgasmic disorder are:
  - Masturbation training
  - Sensate focus exercises
  - Relaxation exercises
  - Cognitive-behavioural therapy
  - Kegel exercises

- Treatment possibilities for anorgasmia include:
  - Lubricants
  - Medical and or surgical interventions to treat the physical factors contributing to anorgasmia
  - Relaxation therapy

- Treatment possibilities for vaginismus include:
  - Sensate focus exercises
  - Kegel exercises
  - Relaxation therapy
  - Specific exercises prescribed for vaginismus

- Use of vaginal dilators

- A therapist counselling clients with sexual difficulties should always take a complete medical and sexual history from the clients.

Chapter 4 will deal with the important issue of the integration of sex therapy and relationship counselling. The role of the social worker in dealing with clients with sexual difficulties will also be addressed.

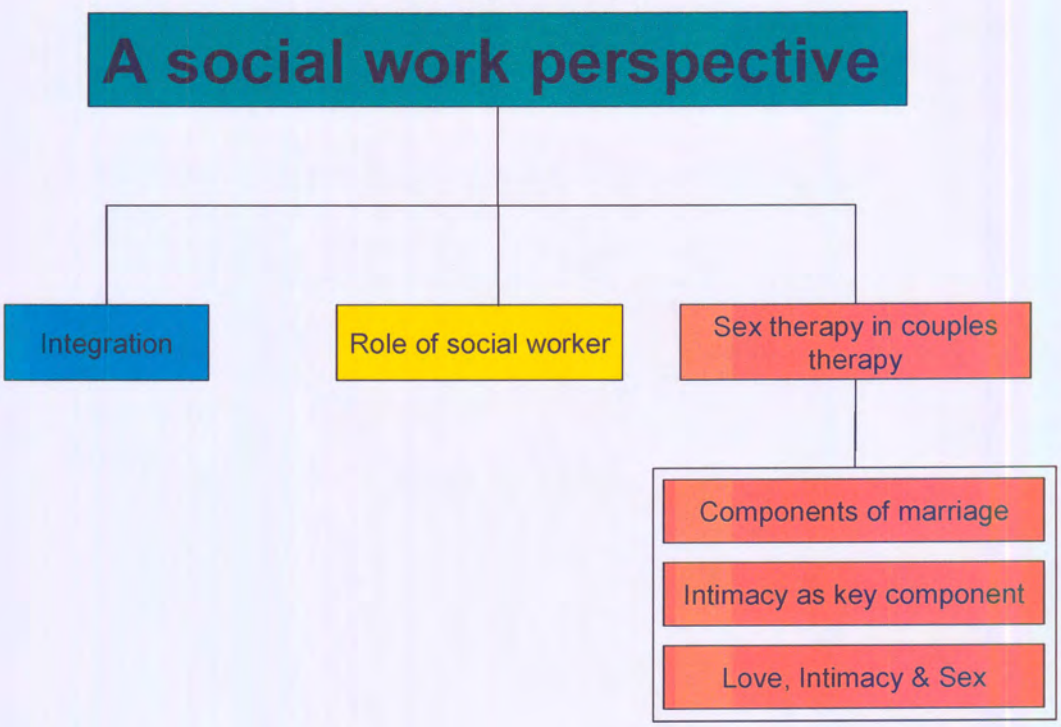
CHAPTER 4

THE INTEGRATION OF COUPLE THERAPY AND SEX THERAPY

4.1 Introduction

It will be shown in chapter 4 that there is a strong movement today to combine sex therapy and couple therapy, by integrating the basic concepts of the two. Figure 10 gives a schematic representation of the outline of chapter 4.

Figure 10: A social work perspective on the integration of sex therapy and couple therapy



Barnes (1995:351) states that the 1960s and 1970s were characterised by a sexual revolution. This sexual revolution allowed for an increased openness toward sexual issues and a greater awareness of the importance of sexual fulfilment within intimate and long-term relationships. While this increased openness about sexual issues provided the impetus for the evolution and growth of sex therapy, its practitioners focused primarily on the individual experiencing the sexual dysfunction.

With the growth of family therapy through the 1980s and 1990s, many authors began to discuss the influence of the couple system on sexual dysfunction and to propose that couple therapy is an appropriate therapeutic context through which sexual dysfunction can be understood and treated. Russell & Russell (1992:79) state that the importance of integrating sexual and marital/couple therapy is well documented. Woody (1992:3) agrees with Russell & Russell and adds that: "... a multi-theoretical integrative approach is necessary for effectively treating sexual distress in a holistic manner ".

Russell & Russell (1992:82) state that no matter what the presenting complaint is, it is essential to enhance physical and emotional intimacy by integrating sex therapy and couple therapy. Barnes (1995:355) mentions in this regard that the integration of couple and sex therapy is crucial but that many therapists avoid discussing sexual issues during therapy. Barnes (1995:356) mentions several reasons for this. One significant reason is that therapists are often uncomfortable with the discussion of sexual issues and maintain a therapeutic relationship that is isomorphic to their own "no talk"

family rules. Once the therapist is able to find his or her own comfortable language concerning sexual issues, the door is often opened for the clients to follow suit. The most frequent reason is that sexual issues are not identified in marital or family therapy as the presenting problem. Clients who experience shame and guilt about sexual issues will often enter marriage or couple therapy instead of treatment in a sex therapy clinic. Although there are a few sex therapy clinics in South Africa today, many couples still feel more comfortable seeing a marriage or couple therapist. In this context the couple will present with some other relationship issue before mentioning the sexual issues. Barnes (1995:356) asserts that while there is no guarantee that initial invitations to discuss sexual issues will result in fruitful or comprehensive interchange pertaining to the couple's concerns in this area, it is still imperative for the therapist to recognise the possibility of, and remain open to addressing sexual problems, should they emerge.

Weeks & Hof (1987:5) state that the integration of sex and marital therapy could revitalise the field of sex therapy by expanding the types of problems treated, providing new perspectives for understanding problems, and creating the opportunity for therapists to develop treatment programs for specific problems. The integration of sex and couple therapy changes the way problems are understood from an individual to a systems perspective. Not only is such integration useful for the sex therapist, but marital and couple therapists have generally had little interest or facility in doing sex therapy. These two fields can thus enhance and enrich each other.

Relationship issues, couples issues, developmental concerns, and medical concerns are presenting problems that often cover clients' serious concerns about sexual dysfunction or dissatisfaction. (Compare Russell & Russell, 1992:80; Barnes, 1995:356 and Keystone & Kaffko, 1992: 47.)

Keystone & Kaffko (1992:48) state that couple and sex therapists should be aware of the fact that when couples present with a sexual problem, their sexual functioning may in fact be symptomatic of deeper intimacy issues within the relationship. Through the integration of both couple and sex therapy approaches, there is a unique opportunity to act in a dual role with clients. The therapist can educate and instruct clients about sexual attitudes and techniques, as well as help them to become aware of the significant impact that intimacy issues have upon their relationship.

Weeks & Hof (1987:6) are of the opinion that a sexual dysfunction does not occur in a vacuum, and that it must be viewed within the context of the total system of the client. The various subsystems (e.g., marital, extended family, individual, biological and social) interact with each other and impact on one another. The marital relationship impacts on the problem, and, in turn, the sexual problem impacts on the marital relationship.

It is thus evident that a comprehensive and multidimensional approach to the treatment of sexual dysfunction should include a thorough evaluation of the marriage or relationship. If sex therapy is contra-indicated because of the presence of severe marital or relationship distress, this evaluation can

indicate what needs to be addressed in couple therapy in order to pave the way for the future treatment of the sexual problem. Weeks and Hof (1987:7) stress that the couple as a unit is always the client, and they note that a systems perspective is needed when treating sexual dysfunctions.

4.2 Sex therapy within couples therapy

Russell & Russell (1992:80) define couple therapy as a strategy of treatment that arranges to intervene in a committed relationship. Couples entering therapy are made up of two individuals with a common deficit for which they are equally responsible, and it is in the interest of both partners to change in ways that are required to correct the deficit.

Weeks & Hof (1987:7) describe the following four specific areas of focus when evaluating the marital or couple relationship within the context of sex therapy:

- Psychometric indicators of marital adjustment:

  A variety of scales are available to enable the therapist to assess sexual and marital adjustment. Weeks & Hof (1987:9) mention the **Marital Satisfaction Inventory** that was developed by Snyder in 1979. This inventory focuses on a variety of relationship issues, including effective communication, problem-solving skills and quality of leisure time together. This scale is useful in differentiating couples with generalised marital distress from those with specific sexual dysfunctions. The **Golombok Rust Inventory of Marital State**

(GRIMS) questionnaire was developed in 1986 and is a short scale for the assessment of the quality of a relationship (Davis,C.L., Yarber, Bauserman, Schreer & Davis,S.L.: 1998:468).

See Apendix F for a copy of the GRIMS inventory.

- Assessment of the current relationship style of the couple:

  The assessment of the current relationship style of the couple enables the therapist to identify positive forces and processes within their relationship that could facilitate treatment and to identify relationship-diminishing forces and processes that could disrupt or block desired growth and change in therapy. The therapist seeks information via questioning and direct observation regarding the following issues:

  - How are the control and intimacy issues handled within the relationship?
  - What is the balance between feelings, rationality, and behaviour in the relationship?
  - How effectively do the partners communicate with each other?
  - How effective is the couple's problem-solving and decision-making skills?
  - How effective do the partners manage conflict?
  - Exploration of the extended family context.

- Identification and assessment of the current marital contract:

  What are each person's desires and expectations in a variety of areas in the marriage? Open discussion regarding the current and original marital contract enables the therapist and clients to assess all the facts and to affirm where it is helpful, and to change the original contract where it blocks current desired personal or relational growth and change.

- Exploration of the extended family:

  Just as the sexual problem does not exist in a vacuum, neither does the marital relationship exist in a vacuum. The evaluation of the marital relationship must also include a look at the extended family context of the couple and the problem. A sexual genogram (a diagram of extended family relationships including at least three generations) can be utilised in this process. Family-of-origin patterns, beliefs, and loyalties affect later sexual functioning in the family of procreation. The sexual genogram is a data gathering and assessment process that enables people to explore multigenerational issues in a rapid, effective way. It may also represent the first stage of a treatment process, which involves family exploration and the family journey or may simply facilitate more traditional insight-oriented therapy.

Weeks & Hof (1987:15) state that marital or relationship evaluation, like all aspects of the total assessment process, is ongoing. It continues throughout treatment, is affected by the treatment process, and contributes to the

ongoing adjustment of the treatment process. The evaluation process is with the clients, not just by the therapist. This demystifies the therapeutic process, increases the sense of a "treatment team" approach to the sexual problem, and is likely to increase the responsible involvement of the clients in the resolution of their sexual problem. A significant part of the art of sex therapy involves assessing when relationship issues can be or need to be bypassed, and when they need to be confronted or resolved.

Weeks & Hof (1987:21) assert that if the therapist proceeds with hope, respect, and good will, moving slowly, accentuating the positive and managing anxiety along the way, actively involving the clients as therapeutic partners in all phases of the assessment and treatment process, the likelihood of the clients being able to resolve their sexual problem is greatly increased.

Barnes (1995:357) agrees with this statement and adds that once the issue of sexual dysfunction or dissatisfaction is identified, the couple and therapist should come to an agreement about a shift in clinical focus from the presenting problem, to the sexual issues. This contract to focus on sexual issues becomes an acknowledgement of the therapist's understanding of the significance that sexual issues play in the lives of the couple This contract is also a commitment by the therapist to treat these issues in a professional, supportive, and empathic manner, and becomes a point of validation of the clients' concerns about discussing this secret aspect of their relationship with a stranger. Therapists, who demonstrate belief in the clients' disclosures, are

supportive and understanding, and therapists who convey concern, care, empathy, and compassion for the client, are viewed as being most helpful.

Weeks & Hof (1987:7) and Renshaw (1983:14) agree that sexuality and therefore, sexual problems and dysfunctions, should always be seen within the context of the relationship. Renshaw (1983:14) asserts in this regard that the interaction between two people, namely the relationship, is an entity selected for treatment of a sexually troubled couple (rather than treating separate individuals), and this is the unique strength of the use of relationship or couple therapy within sex therapy.

A healthy sex life strengthens a relationship, and a loving, committed relationship, enhances the sexual relationship. Because of this, sexual problems tend to have a ripple effect by affecting the other components of marriage, such as communication and conflict. Unresolved conflict and bad communication on the other hand, can influence the sexual relationship negatively. It is therefore evident that sexual problems cannot be viewed as existing in a vacuum, and that because of the fact that relationship quality and sexual functioning are interlinked, therapy for sexual problems should also be integrated with couple therapy and with a holistic focus on the relationship as a whole.

4.3 Components of a marriage or committed relationship

Various authors agree upon the different components or ingredients of a marriage or a relationship that need to be dealt with during intensive therapy.

(Compare Alpaslan, 1994:17-23; Masters *et al.,* 1995:307-310 and Renshaw, 1995:90-94.)

4.3.1 Family of origin

The family of origin refers to the individual's background, childhood and upbringing and the individual's influence on the current relationship.

4.3.2 Motive for marriage

This component refers to the level of commitment towards the relationship. More specifically, was the initial motive for the marriage financially, status, emotionally or love driven.

4.3.3 Choice of partner

Why was this specific partner chosen? Were there any hidden agendas present?

4.3.4 Communication skills

MacNeil & Byers (1997:277) assert that both better communication in general, and disclosure of specific sexual likes and dislikes in particular, are associated with increased sexual satisfaction. Effective communication is essential to the development and maintenance of intimacy. Effective communication requires that a clear message be sent and that it is accurately received. Communication includes both verbal and nonverbal messages.

Andresen & Weinhold (1981:23) state that the main ingredient of a successful and satisfying sexual relationship is good communication. Masters, *et al.* (1995:332) agree with the previously mentioned authors and state further that communication is essential to the development and maintenance of intimacy. Ambiguity in communication commonly arises because people do not say what they mean and they often send mixed messages. Communicating in intimate relationships is best done as a form of self-expression and self-responsibility. Using I-messages can be helpful to avoid misperceptions.

Talking about sex is not inherently different from other kinds of intimate communication. Many people however have a difficult time in this area because of taboos carried over from childhood, embarrassment, or other concerns. Couples in intimate relationships should try to talk openly and honestly with each other about sexual issues. Through talking and non-verbal messages, couples can learn to enhance their sexual communications, which will often enhance their sexual intimacy (Masters *et al.,* 1995:331).

Renshaw (1995:92) agrees with this statement and adds that therapists therefore need to teach clients to dialogue about sex. There is a wide difference between the three-letter word "sex" (the mechanical deed), and the four-letter word "love" with ingredients of caring, sharing and commitment. Through talking and non-verbal messages, couples can learn to enhance their sexual communications, which will often enhance their sexual intimacy.

4.3.5 Conflict resolution skills

Clients should be educated in effective conflict resolution skills. Unresolved conflict and feelings of anger and betrayal should also be dealt with. Positive healthy conflict resolution is essential for a healthy relationship. The couple consists of unique individuals living closely together and therefore conflict is normal. Close living in harmony demands that a couple finds positive ways to deal with normal anger.

4.3.6 Self image

A person with a negative self image usually finds it very difficult to be sexually adventurous, to allow him/herself to "lose control" in the act of lovemaking, or to give love unconditionally.

4.3.7 Role division

The traditional roles of men and women have changed significantly during the past few years and the couple needs to agree on their separate roles within the relationship. Nicol (2000:6) states in this regard that the couple needs to adjust to new roles in marriage such as a more democratic style of communication and conflict resolution between the male and the female and more open and adjustable roles.

4.3.8 Career

Choice of career is related to role division. Each partner's career, and its influence on the relationship, should be discussed. Feelings of both partners regarding the role of the female as career woman or as home executive, or both, should be dealt with effectively.

4.3.9 Personal and collective growth

It is important to grow personally by having your own hobbies and interests, in order to maintain a dynamic relationship. It is however also of utmost importance to grow collectively as a couple by sharing interests and time together.

4.2.10 Parenthood

It is important for a couple to agree on the basics of child rearing and education and to the basic fact whether they both want to have children in the first place.

4.3.10 Finances

There needs to be a basic agreement on the way in which finances will be handled. Financial intimacy and emotional intimacy go hand in hand.

4.3.11 In-laws

Problems regarding in-laws may be the cause of many conflicts. The couple needs to develop certain skills or techniques in order to deal with this. It is necessary for both partners to disengage themselves from the family of origin and to redefine these relationships. They should also establish an identity as a couple that is removed from the family of origin.

4.3.13 Spiritual-growth

Spiritual growth as an individual, and together as a couple, is important for many couples. For many couples this is the foundation of a healthy and stable relationship. Religious differences should be discussed and effectively dealt with.

4.3.14 Sexuality

If there is a healthy sexual relationship, it is just another component of the relationship, but if the sexual relationship is dysfunctional, it influences the rest of the relationship. A healthy sexual relationship can be viewed as the cement keeping the other important components of the relationship healthy, and in place.

4.3.15 Love

Interpersonal love can be defined as a state in which someone else's happiness is essential to your own. It is however important to note that one

cannot feel responsible for someone else's happiness and that you, and you alone, are responsible for your own happiness. The elements of caring and respect are important aspects of love and can help one distinguish between love as a growth relationship and love as a form of addiction or dependency. Openness, sharing and desire are usually part of, but not the same as, love. Sternberg's triangular theory as described in Masters, *et al.* (1995:309) and in King (1991:295), identifies three components of love: intimacy, passion, and commitment. Sternberg contends that you can compare the involvement of two people in love by seeing how well their love triangles match; a major misfit is a sign of potential problems. In our culture, love is closely linked to sex and marriage, but either can exist without love. Sex without love isn't necessarily less good than sex with love, but love co-existing with sex is still the most comfortable and desirable for most people.

In contrast to Sternberg, Lee as described in King, *et al.* (1991:311) does not believe that there is only one type of love that should be viewed as true love. He proposes that there are many styles of loving. Erotic love is based on physical compatibility; storgic love grows from friendship; pragmatic love is rational and practical; manic love involves an intense emotional dependency; ludic love is self-centred; and, agapic love puts the interest of the loved person first. The degree of happiness an individual feels in a loving relationship depends greatly on how well his or her love-style matches that of the loved one.

Relationships that last are generally more realistic than idealistic and are often based on true companionship and real affection rather than on passion. To maintain a relationship, couples must substitute new, shared activities for old ones as their lives change, and they must also develop skills at developing and maintaining intimacy.

4.3.16 Trust and respect

Trust is the basic foundation of a healthy relationship. Without trust, intimacy on all the various levels is almost impossible. Masters, *et al.* (1995:337) state in this regard that: "I need to trust you completely to give my body and soul unconditionally and to allow myself to lose control".

4.3.17 Time

It is impossible for any relationship to grow or to stay healthy without spending quality time with each other. Relationships are hard work and couples need to agree on practical solutions to enable them to spend enough time together as a couple. It is often necessary to find creative solutions to the problem of restricted time. Sometimes a regular, diarised appointment each day and each week may resolve the problem.

4.3.18 Touch

Touching is an important and positive way of communicating. Positive appropriate touch can take away the pain of past negatives. In a relationship

one partner may want more touch, or both may want more touch but are afraid or ashamed to ask. Both partners can learn to receive and to give. Renshaw (1984:70) describes building a positive pathway from sensual (affectionate, non-sexual) touch, to sexual (heavy petting or genital) touch, as the hinge of sex therapy. The sensate focus exercises described in Chapter 3 and outlines in Annexure C can be utilised as an effective tool in assisting couples to become more sensual than sexual.

Each partner is to concentrate or focus on the feelings generated by being the one to give pleasure, while the other must focus on how it feels to be touched in each spot. This system of "touch and tell" is a way that the couple may be close and communicate openly in the first weeks of treatment without the pressure of "having to perform". It also teaches the couple to be less goal-orientated and to focus on the journey and not on the destination.

4.3.19 Commitment

Commitment to your partner and to the relationship leads to a general sense of security within the relationship. Commitment and trust go hand in hand.

4.3.20 Compromise

If a couple can learn to compromise, the relationship will grow more intimate.

4.3.21 Realistic Expectations

The general lack of sex education and the prevalence of sexuality in the media over the past few years have led to many unrealistic expectations like "... and they lived together happily ever after". These unrealistic expectations not only refer to sexuality, but to the relationship in general. If we are realistic we will admit that as we ourselves have our ups and downs, so has our relationship. The therapist should dispel general myths regarding sexuality and relationships during therapy to assure that the couple maintain realistic expectations.

4.4 Intimacy as key component of a healthy sexual and emotional relationship

Schnarch (1991:2) states that the concept of marital, romantic love is a relatively recent innovation. For most of recorded history, marriages have been arranged on the basis of social, political, and economic alliances, rather than chosen by the individuals themselves. Today however, modern society promises that intense intimacy and erotic bliss are a natural and inevitable outcome of love. Schnarch (1991:1) is of the opinion that many couples consult sex and couple therapists when they do not achieve this outcome.

Keystone & Kaffko (1992:47) state that quite often sexual intimacy seems to be the barometer of much deeper intimacy issues that exist for a couple. They are also of the opinion that redirecting therapeutic energy toward the issue of intimacy is the current challenge for today's couple and sex therapists. The

goals of sex therapy should be to recognise when and how this emotional barrier exists for a couple, to enable them to deal with self-esteem issues, teach them the skills of connectedness, and at the same time, to address the ongoing frustration they experience in wanting a satisfying physical relationship. "Enrichment beyond mere mechanics must be a standard part of sex therapy" (Keystone & Kaffko, 1992:47).

4.4.1 Defining intimacy

Intimacy and, more specifically, emotional intimacy, is the backbone of a healthy sexual relationship. Russell & Russell (1992:81) agree with this statement by asserting that intimacy is regarded as an important variable in determining the health or pathology of the marital or relationship system. Intimacy is learned in early childhood as the individual observes the level of intimacy in the parent's marriage. Renshaw (1981:3) and Russell & Russell (1992:82) agree that sexual functioning is one expression of intimacy, but there are many other dimensions determining the closeness or distance in the relationship.

There are many definitions of intimacy, but they usually refer to a special kind of closeness, sensitivity and understanding between partners. Weeks & Hof (1987:23) define intimacy as a composite of identity, expressiveness, affection, autonomy, cohesion, compatibility, conflict resolution, and sexuality. Schnarch (1991:2) states that intimacy refers to a great familiarity and disclosure of important personal information between confidants. Masters, *et al.* (1995:329) agree with the above-mentioned definitions and add that

intimacy is an ongoing process in which two caring people share as freely as possible in the exchange of their feelings, thoughts, experiences and actions, in an atmosphere of mutual acceptance, commitment, and trust. Renshaw (1981:4) defines intimacy as meaning closeness and caring, and states further that: "...intimacy is not just another word for sex". Renshaw (1981:40) elaborates on this definition of intimacy and states that intimacy entails the following:

- It is a question of quality, not quantity. Being together twenty-four hours a day does not necessarily promote intimacy.
- It includes respect for each other's person and feelings.
- Intimacy and honesty go hand in hand. Intimacy is being true to yourself and truthful to the other person.
- Intimacy involves taking risks.
- It implies mutual consent. A two-way response is needed.
- Intimacy includes each person's right to be an individual.
- It involves sharing: both taking and giving.
- It requires commitment – feeling connected to each other.
- Intimacy calls for adjustment and flexibility.
- Intimacy means sharing your values and listening to the values of your partner.
- Intimacy in a sexual relationship includes sharing your likes and dislikes and, also being open and honest about your own insecurities as a sexual person.

If intimacy has not been learned in childhood, it can be learned in therapy when the therapist is a go-between who encourages the partners to disclose their experiences as they were growing up. These experiences may explain the lack of intimacy in the current relationship. Through these self-disclosures, intimacy can be enhanced in the couple's system. Masters, *et al.* (1995:330) are of the opinion that it is easier to develop intimate relationships with others if you first have a reasonable degree of self-knowledge and self-acceptance. Renshaw (1981:3) agrees and states that intimacy starts by knowing, accepting and being comfortable with who you are. Malone & Malone in Keystone & Kaffko (1992:48) describe in this regard the role of mature self-awareness in attaining intimacy as: "...when I am close, I know you; when I am intimate, I know myself. When I am close, I know you in your presence; when I am intimate I know myself in your presence".

4.4.2 Levels of intimacy

There are many different levels of intimacy. Masters, *et al.* (1995:331) mention the personal, social, intellectual, emotional, spiritual, financial and sexual levels of intimacy. As with almost everything concerning sexuality, there is circularity involved. A lack of intimacy on one of these levels usually has an influence on the degree of intimacy on the other levels. A lack of emotional intimacy for example, may lead to difficulties in sexual intimacy. The female may then start to avoid any physical contact, as she is afraid that it may lead to a sexual encounter and this behaviour then leads to an even greater lack of emotional intimacy.

Waring, as described in Russell & Russell (1992:81) identified eight dimensions of intimacy. The first dimension involves **affection**, being the expression of a liking and loving partner. Each partner has a high personal regard for the opinions of the other, and each person receives personal pleasure from the understanding and the support he or she experiences from the other person.

A second dimension of intimacy is **cohesion.** It is the expression of commitment towards the relationship, which is considered primary by both partners. There is a sharing of interests, values and morals.

The third dimension is the easy **sharing and expression of private thoughts beliefs and attitudes, as well as feelings.** It is the capacity to communicate about the relationship and the ability to share thoughts and fantasies with trust.

Fourth, the partners are **compatible**, share similar backgrounds and have, more or less, the same attitudes about important matters. They have common goals and are able to work and have fun together.

Fifth, **conflict resolution** takes place within a reasonable period of time. There is a capacity to resolve differences of opinion without hurtful argument, criticism or the refusal to attempt to reach acceptable decisions.

A sixth dimension of intimacy is a **mutually satisfactory expression of sexuality.** There is hugging, kissing, touching and holding. The frequency of intercourse is mutually satisfying, whether it is once a day or once a month.

Seventh, the couple has **disengaged from the family of origin** and is able to get together with parents and siblings in the spirit of celebration in a conflict-free atmosphere. Autonomy has been developed in the appropriate stage of the life cycle. Relationships with friends may be close, as well as generalised, but the couple does not depend on the constant presence of friends in order to survive. Similarly, there is a positive relationship with their children and clear boundaries have been established.

Eighth, each partner has a **positive sense of identity and feelings of self-confidence**. They feel good about themselves as a couple.

4.4.3 Love, intimacy and sex

Weeks & Hof (1987:24) mention that love, intimacy, and sex are complicated, but that they are the basis of primary, intimate, committed relationships. Sex in a relationship has multiple functions. Sex as a physical act may be negotiated or exchanged for other resources. However, sex, as an act of love cannot be negotiated. It can only be given or shared.

Woody (1992:42) states that sexuality is a primary force in the life of every individual. It involves physiological and psychological processes. Sexuality is the process of being that we express through our manifestation of being male

or female. It is how we think and feel about, and express our gender, our sex organs, our body, our self-images, and our choices and preferences. Our sexual-script forms through early developing self-image, sexual experience, culture, parental role models, and peer relationships. The basic foundation of our sexual script is laid in our early development through our attachment and bonding with our primary caregivers (usually the family of origin). The quality of the attachment and the degree of intimacy in the primary years shape our ability to love, touch, give, receive and commit. The quality of attachment and affectionate care sets the tone of future intimate sexual relationships.

Weeks & Hof (1987:24-28) and Woody (1992:11-15) agree that sexual expression, especially the act of intercourse, is one of the most vulnerable interactions that a couple undertakes. The sexual expression in a committed relationship is a "physical expression" of the primary emotional bonds and is best understood in the context of the relationship that govern it, primarily the family of origin and marriage. For the marital sexual relationship to fully develop it must be bound in love, intimacy, and negotiated power.

Issues of love need to be separated from issues of power. Love is based on feelings, and feelings can be shared but not negotiated. Power is negotiable but love is not negotiable. Love in an ongoing sexual relationship requires commitment and discipline.

Weeks & Hof (1987:20) state that in addition to love, intimacy has been found increasingly to be a crucial variable in marriage and family life. The ability and

cooperation to be dependent and the ability to express, withstand, understand, and resolve the conflict and hostility that occur in intimate relationships, are critical components of intimacy. Sexual problems are often indicative of intimacy difficulties. The lack of intimate, expressed emotional feeling, affection, interdependence, and vulnerability supports the lack of sexual contact. The intimacy in the life of a couple is one of the major determining factors in a satisfactory and pleasurable sex life. The ability to negotiate is an important ingredient of a satisfactory sexual relationship. Negotiation means a process of bargaining, problem solving, and decision-making.

Woody (1992:11) states that intimacy encompasses a broad range of interactions. Intimacy problems may include: unresolved conflict, complaints about affection, lack of cohesion, sexual complaints, dysfunctions or disorders, identity problems, incompatibility of values and goals and ways of implementing these, lack of a sense of personal autonomy in the relationship, and problems in expressiveness. Intimacy problems affect the core elements involved in the deep sharing of self across several aspects of living. Intimacy disorders may also be involved in individual symptoms as depression, anxiety, phobias, eating disorders and substance abuse, that in turn have a negative effect on emotional and sexual intimacy.

One of the major dimensions of intimacy is sexuality. Sexual distress is the result of difficulties with intimacy. A multi-theoretical approach that encompasses social learning, individual development and personality, and

systems concepts, should be applicable to the simplest of sexual complaints as well as to the most complicated sexual and intimacy dysfunctions (Weeks & Hof, 1987:39).

4.5 The role of the social worker in dealing with clients with sexual difficulties

Woody (1992:13) states that most clients seeking help with relationship/marital and sexual concerns, whether hetero- or homosexual, typically expect both emotional and sexual satisfaction in the context of that committed relationship. Lister & Shore (1983:15) mention in this regard that the task of the social worker is to understand the complex interplay of sexuality and relationship issues, and to be prepared to intervene with social work skills to change or enhance, both individual and social patterns, that bring about sexual dysfunction. This may include counselling, education, policy changes, community reorganisation and advocacy. Lister & Shore (1984:15) state in this regard that: "The practice of social work has great potential for impacting the increased responsiveness of a health care system to the sexual needs of clients". The mission of social work includes both a psychosocial approach to direct service and a belief in systems intervention.

Birch (in Woody 1992:vii) states that a dysfunctional relationship is likely to be characterised by accompanying complaints of a sexual nature. He is further of the opinion that only a naïve or novice practitioner would believe that sexual distress could be treated without attention to the context of the relationship

within which it occurs, or that one could treat a relationship without also attending to the sexual concerns present.

Lister & Shore (1984:18) state that viewing the sexual problem from a purely physical perspective would be part of the medical model, and not of a social work perspective. The pure medical model limits and distorts a comprehensive view of sexual functioning within a social context.

Schnarch (1991:25) asserts that communication difficulties, lack of intimacy or trust and power struggles are frequent accompanying factors of sexual dysfunction. The role of the social worker in this regard is to enhance the communication and conflict resolution skills of the couple, as well as assessing the other basic components of the relationship.

The development of comfort in dealing with sexual issues, as well as the development of positive attitudes toward sexuality in general is integral components of the social worker's ability to deal with the sexual difficulties of clients effectively. (Compare Schnarch, 1991:59; Lister & Shore, 1984:13; and Woody, 1992:212.)

Woody (1992:48) asserts further that the major procedures and techniques associated with sex therapy merit careful review by relationship and marital therapists. Clients' sexual lives deserve to be treated respectfully and with expertise. Woody (1992:48) mentions the following in this regard: "Therapists have an ethical responsibility to assess their overall competence to deal with

sexual problems and to acquire, as needed, further training in this area". With regard to this need for training, the Education and Treatment in Human Sexuality Report (World Health Organisation: 1975) states that the need for education and training in human sexuality has become increasingly obvious. The report states further that social workers specifically, need to be trained and educated in the field of human sexuality as they come into close contact with individuals in different communities and environments, and might be asked for help with sexual problems. This historical document called upon the health sector to develop the necessary sexuality education, counselling and therapy as well as the appropriate training for health professionals to promote sexual health.

At the First African Collaboration on Sexual Health and Rights meeting (Pretoria: 2002), Thlebere mentioned the World Health Organisation (WHO) meeting in 1975, on the Educational and Treatment of Human Sexuality. She elaborated by stating that the WHO is compiling an updated report that will focus on recommendations around:

- The role of sexology in health programmes.
- The scope of sexology in various local socio-cultural contexts.
- The identification of treatment and counselling models.
- The content and methodology of teaching human sexuality to health professionals.
- The acknowledgement of human rights in delivering sexual health services

This First African Collaboration meeting also indicated that only limited training and education in human sexuality is available to social workers at a few selected professional schools or in extracurricular courses organised by some medical schools. In some cases, seminars dealing with sexuality are provided through in-service training.

Woody (1992:50) asserts further that as sex therapy evolved over the years, the understanding of individual physical and/or physiological contributors has become more sophisticated. It is therefore important that the therapist acknowledges the fact that some cases may very well require medical treatment instead or concurrent with therapy.

4.6 Summary

This chapter focussed on the importance of a holistic approach to marital and sexual dysfunctions and on the integration of sex and couple therapy.

In summary, the main points are as following:

- It is essential to enhance physical and emotional intimacy, by integrating sex therapy and couple therapy, regardless of the presenting complaint.

- This chapter also underlines the fact that human sexuality is a multi-determined phenomenon and that therapists need to have a multi-facetted approach to theorising and model building especially regarding sex therapy and couple therapy. With the multiple biogenic and psychogenic factors that may underlie sexual dysfunction, the need to consider the complex interplay of multiple factors is especially important.

- A social-work perspective on sexual health can be described as the enhancement or restoration of optimal sexual functioning within a relationship context.

- Social workers are well trained in couple therapy, and couple therapy is an appropriate therapeutic context through which sexual difficulties can be treated.

- Sexual difficulties should always be viewed as a relationship problem and not as an individual problem. Sexual problems are usually the result of some or other dysfunction in the relationship and should be treated by a holistic, eclectic approach of basic social work skills as well as couples therapy.

- Sex therapy has evolved towards the integration of both couples and sex therapy techniques, which present the social worker with a unique opportunity to act in a dual role with clients.

- Various components of a relationship were described as well as the role of the social worker in dealing with clients with sexual difficulties.

Chapter 5 will deal with the empirical results of the study.

CHAPTER 5

EMPIRICAL RESULTS

5.1 Introduction

In chapters two to four an in-depth theoretical and literature overview regarding human sexuality, sex therapy and the integration of sex therapy and couple therapy, were provided. Sexual problems or dysfunctions remain one of the prominent reasons for marital and relationship problems (Fourie, 1984:23). Relationship problems and sexual problems are often interlinked and sexual problems are often only symptoms of deeper intimacy and relationship problems. This being the case, the social worker is an ideal person to deal with sexual problems within the context of marriage or relationship therapy, as social workers are well trained in the dynamics of marriage and relationship therapy.

The nature of this research study evolves around the proposed lack of knowledge of social workers regarding human sexuality and sex therapy. A quantitative research approach was followed and applied research was conducted.

The exploratory research design was selected for the purpose of this research study. According to Collins (1990:256), exploratory research strives to acquaint the researcher with the characteristics of the phenomenon under study with the main objective of refining and developing questions and

hypotheses for further research. Data were collected by means of a mailed questionnaire.

This chapter presents the empirical research findings pertaining to the knowledge of social workers in private practice regarding human sexuality and sex therapy. The layout of this chapter will follow the same layout, and deal with the same questions and statements as pertained in the questionnaire mailed to respondents.

Findings will be reported descriptively and graphically based on frequencies, percentages and quantitative data.

5.2 Biographical information of respondents

The research population for this study consisted of all social workers who are registered with The South African Association of Social Workers in Private Practice (SAASWIPP), as social workers in private practice, who specialise in couple therapy. They amounted to a total of 344. A questionnaire was mailed to these 344 respondents. Forty-three of these questionnaires were returned because the addresses have changed. It is thus evident that SAASWIPP's database was unfortunately not up to date. Of the 301 questionnaires that were delivered, 69 were returned. The total response rate was 23%. The low response rate could be an indication that many respondents view the subject of sexuality as threatening, or that they declined to complete a questionnaire

which may indicate their possible lack of knowledge of the subject. According to Bless & Higson-Smith however (1995:112) the response rate of a mailed questionnaire is only between 20% and 40%, in which case the current response rate is not inadequate. In each case, the number of respondents (N) who answered a particular question is indicated on the figures.

5.2.1 Sex of respondents

Figure 11: Sex of respondents

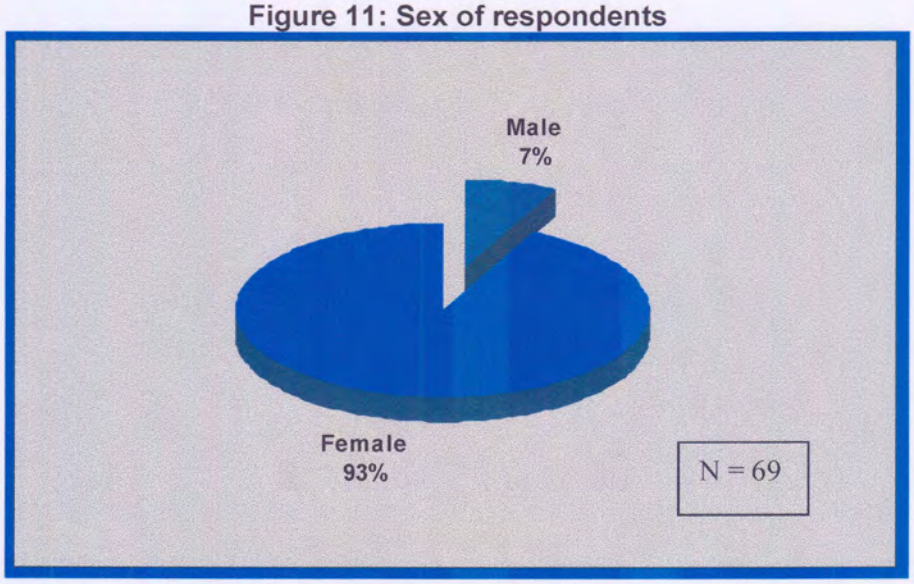
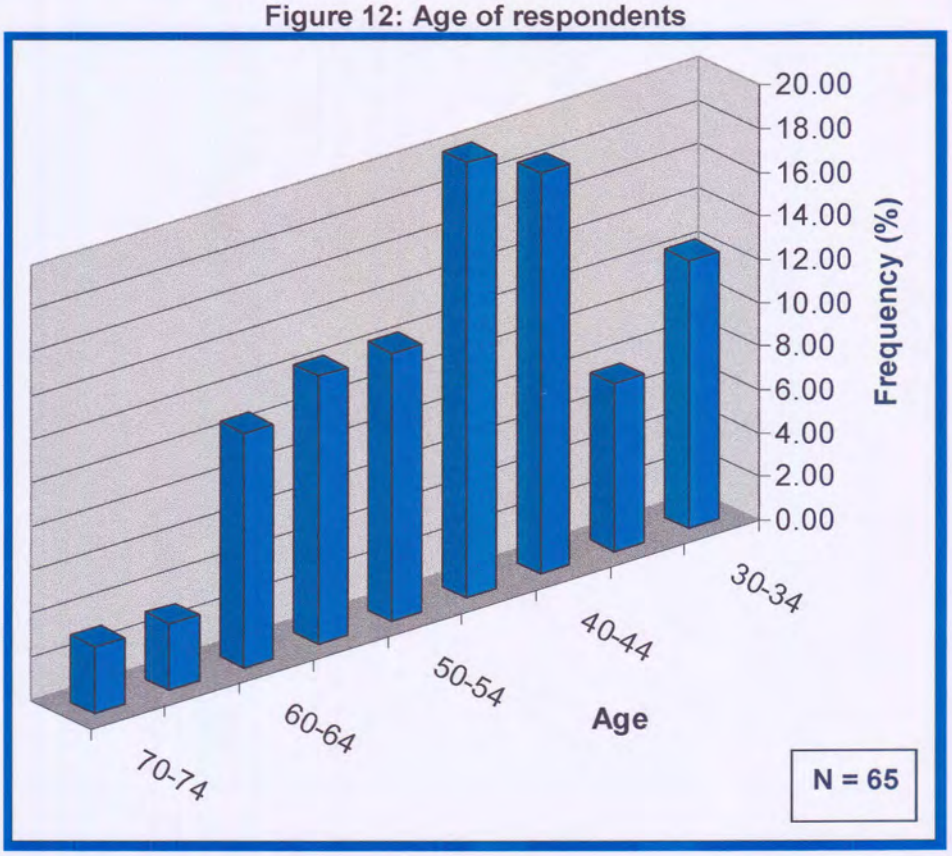


Figure 11 refers to the sex of respondents. A notably higher percentage of respondents are female, namely 93%, while only 7% of respondents are male. A similar trend is reflected in the male to female ratio of the profession as a whole. Statistics obtained from SACSSP dated 2002/06/30 states that only 1017 of a total of 9845 social workers nationwide are males. This relates to a ratio of 10.33% male to 89.67% female.

5.2.2 Age of respondents

Figure 12: Age of respondents

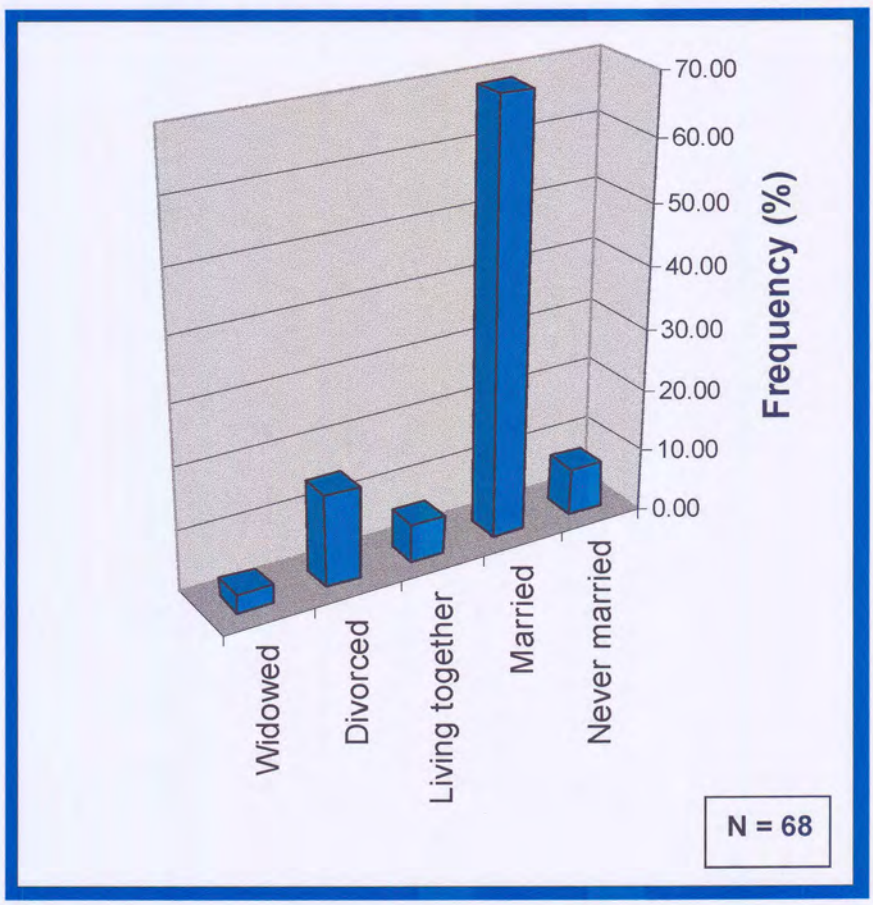


The average age of respondents was 48.32 years at the time of the survey. Eight respondents (12.31%) had ages between 30 and 34 years, 5 respondents (7.69%) were between 35 and 39 years of age, 12 respondents (18.46%) were between 40 and 44 years of age, 13 respondents (20%) were between 45 and 49 years of age, 8 respondents (12.31%) were between 50 and 54 years of age, 8 respondents (12.31%) were between 55 and 59 years of age, 7 respondents (10.77%) were between 60 and 64 years of age and 4 respondents (6.11%) were between 65 and 74 years of age. Four respondents declined to indicate their age (refer Figure 12).

The largest representation was thus between the ages of 40 and 50 years. People in this age group would normally have a lot of experience on a personal, as well as on a professional level, and would hopefully have managed to accept themselves emotionally, physically and sexually. It is important for a therapist who provides sex therapy, to be comfortable with his or her own sexuality and sexuality in general, in order to be non-judgemental and comfortable to talk about the subject.

5.2.3 Marital status of respondents

Figure 13: Marital status of respondents

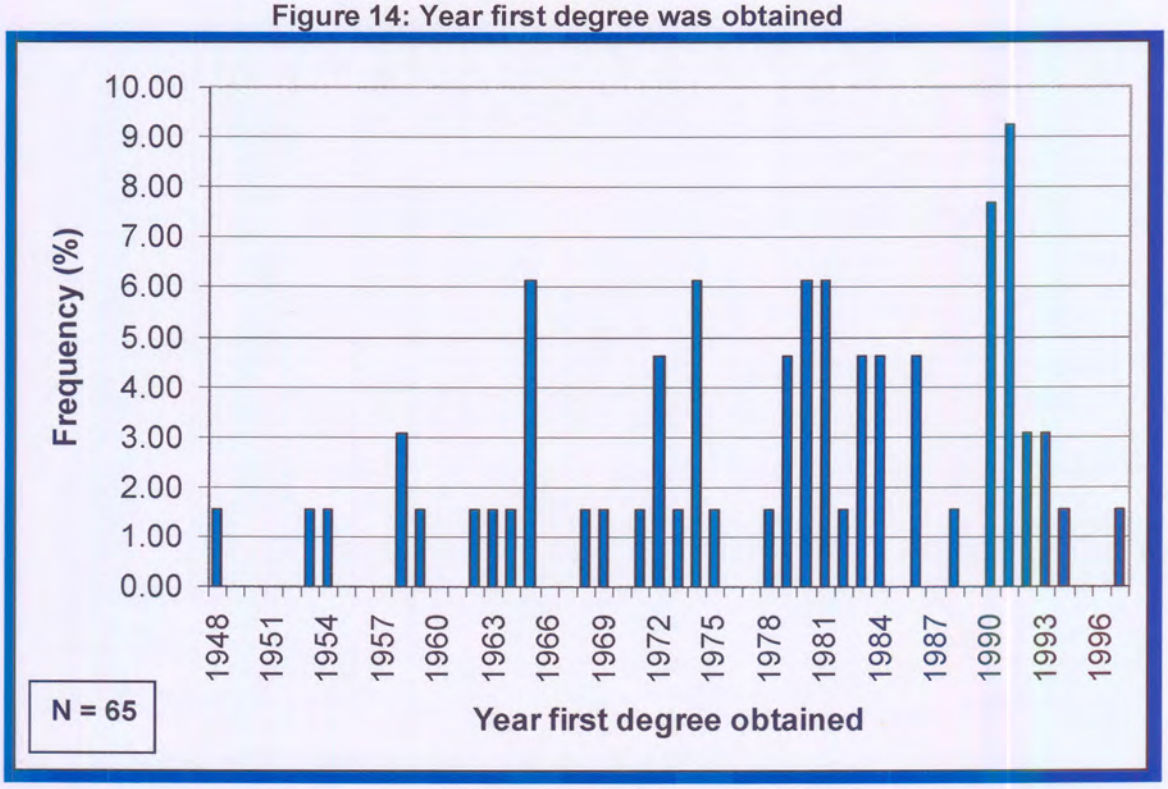


Sixty-nine percent of respondents were married at the time of the survey, while 14 % were divorced. Refer to Figure 13 for more detail. The literature does not make any distinction between the possible level of therapeutic skills and/or knowledge of therapists who are married, divorced or single. The researcher is however of the opinion that couple therapists who are happily married, or who are in a committed long-term relationship, have more credibility and a better practical understanding of the difficulties and challenges that couples have to deal with in a marriage/relationship, than

single therapists do. Therapists who are married have most probably more experience, and a higher level of knowledge regarding human sexuality and sexual practises, than single therapists do. Again, being married gives the therapist who provides sex therapy to clients, more credibility and practical experience. This being said, single therapists are also able to provide professional therapy to couples in terms of relationship or sexual difficulties, but they would probably utilise more academic knowledge and would not be able to give practical advice, or have the necessary insight into more complicated problems, while an older married therapist might do. A distinction can however be made in terms of the PLISSIT-model of sex therapy, described in chapter 3. Younger, single therapists may well be capable of providing clients with permission, to provide them with limited information, and to give them appropriate homework exercises. Couples with severe difficulties who would need intensive therapy (the last stage in the PLISSIT- model), may then be referred to more experienced colleagues.

5.2.4 Year in which first degree was obtained

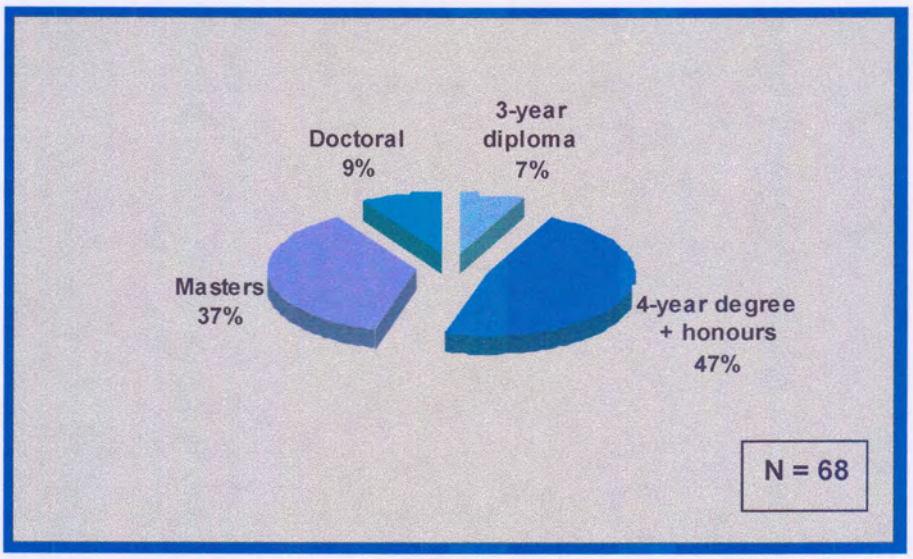
Figure 14: Year first degree was obtained



The year in which respondents obtained their first degree stretched from 1948 until 1997 (refer Figure 14). The largest percentage of respondents however obtained their first degree between 1965 and 1991 (76.92%). It is evident that the respondents' ages and the year in which they obtained their first degree, cover a large spectrum. The implication of this is that the training of these practitioners probably also vary a great deal.

5.2.5 Highest qualification obtained by respondents

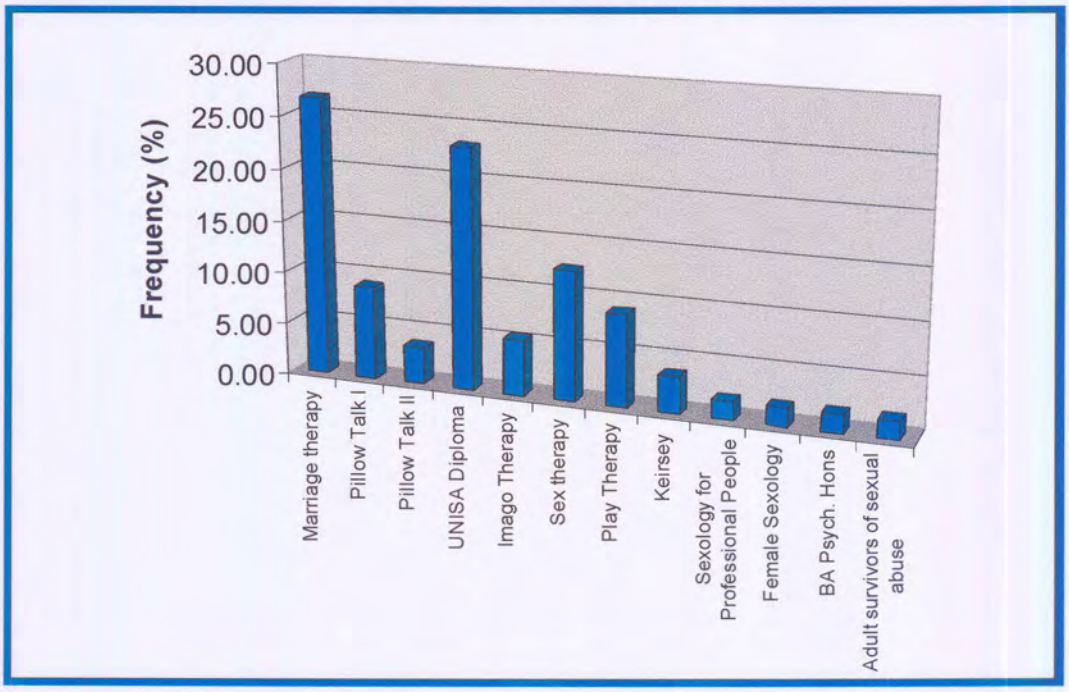
Figure 15: Highest qualification obtained by respondents



The highest percentage of respondents, namely 47%, obtained the four-year bachelors degree in social work. Thirty-seven percent of respondents also hold a Masters degree, while only 9% of respondents obtained a doctoral degree. Seven percent of respondents hold the initial 3-year degree in social work (refer Figure 15). The implication of this may be that respondents could be on different academic levels. This may influence their knowledge regarding sex therapy and relationship therapy.

5.2.6 Other education and training courses attended relating to marriage, relationship and sex therapy

Figure 16: Other courses related to marriage and relationship therapy and sex therapy, attended



As Figure 16 indicates, 23.21% of respondents completed UNISA's one-year diploma in marital guidance and therapy. Sixteen-point-oh-seven percent of respondents attended a short course at FAMSA while 12.5% of respondents attended Marlene Wassermann's Pillow Talk workshops. Forty-eight-point-two-one percent of respondents attended various other short courses relating to sex therapy. It can thus be concluded that a large percentage (76.78%) of respondents attended some or other additional training in sex therapy, although the majority of these courses are short, two to three day courses. It should however be noted that many of the respondents who attended

additional training courses in sex therapy, attended more than one course, while many of the other respondents did not attend any course at all.

Table 3: Type of course, duration and presenting institute

Type of course	Frequency (%)	Duration	Institute
Marriage therapy	35.70	Various	Various
Sex therapy I (Pillow Talk)	8.93	2-3 days	Marlene Wasserman
Sex therapy II (Pillow Talk)	3.57	2-3 days	Marlene Wasserman
Diploma: Marital Guidance and Therapy	23.21	I year	UNISA
Imago Relationship Therapy	5.36	7 days	Imago Institute
Sex therapy	12.50	2-3 days	FAMSA/Dr Renshaw/UP
Keirsey	3.57	2-3 days	Annatjie Beaton
Sexology for Professional People	1.79	2-3 days	Eugene Viljoen
Female Sexology	1.79	2-3 days	Dr Elna McIntosh
BA Psych. Hons	1.79	1 year	UP
Adult survivors of sexual abuse	1.79	1 year	RAU
Total	**100**		

Table 3 depicts the various additional courses related to couple therapy and/or sex therapy, which respondents attended. The percentage of respondents who attended the courses is also listed. The duration of the courses and the institutes or individuals presenting them are also given. Although a total of 76.78% of respondents completed additional courses in human sexuality and sex therapy or relationship therapy, there exists no standardised course. Any person who views himself/herself as a specialist in

the field is able to present a course. The level of scientific information presented as well as the level of necessary practical skills training and the raising of comfort levels of practitioners regarding human sexuality and sex therapy through effective desensitisation are difficult to measure. Some of the courses mentioned in Figure 16 may lack special focus on the role of the social worker as part of a multi-professional team, specifically.

Table 4: Number of courses attended by respondents

Number of courses	Number of respondents	Frequency (%)
One	37	53.62
Two	13	18.84
Three	4	5.80
Four	2	2.90
None	13	18.84
Total	**69**	**100**

Certain respondents attended more than one course. As indicated in Table 4, 53.62% of respondents attended at least one course. Eighteen-point-eight-four percent of respondents attended two courses, 5.8% attended three courses and only 2.9% of respondents attended four courses. Eighteen-point-eight-four percent of respondents attended no course at all. It will be shown that there is a weak correlation between the number of courses attended and the level of knowledge and comfort of therapists regarding human sexuality and sex therapy.

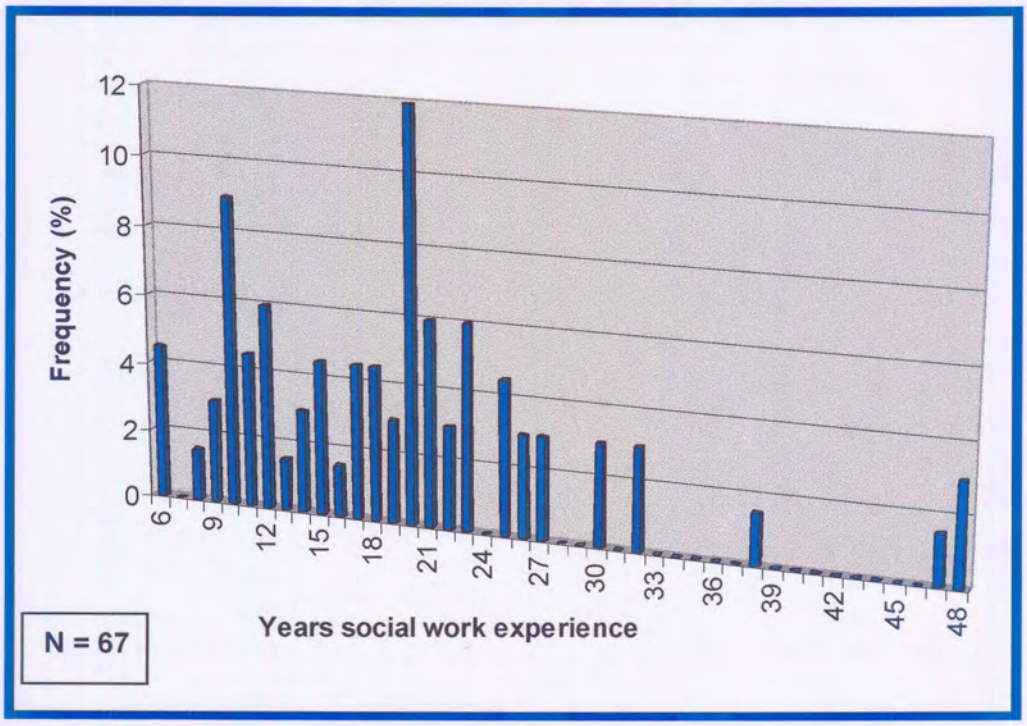
Table 5: Institutions where courses were attended

Institution	Number of respondents	Frequency (%)
University	20	35.71
Institutes/Associations/Clinics	24	42.86
Private professionals	12	21.43
Total	**56**	**100**

The spread of institutions, i.e., whether they are university-based, at other institutions, associations, or clinics, or whether they are provided by private individuals, is shown in Table 5. It is evident that the largest contingency of respondents attended additional training at private institutions and clinics (42.86%) or at private professionals (21.43%). This amounts to a total of 64.29%. Only 35.71% of respondents obtained additional training from a university. The courses provided by private professionals and institutions are mostly short, 2-3 day courses, while the university-based courses are generally longer in duration.

5.2.7 Years of social work experience

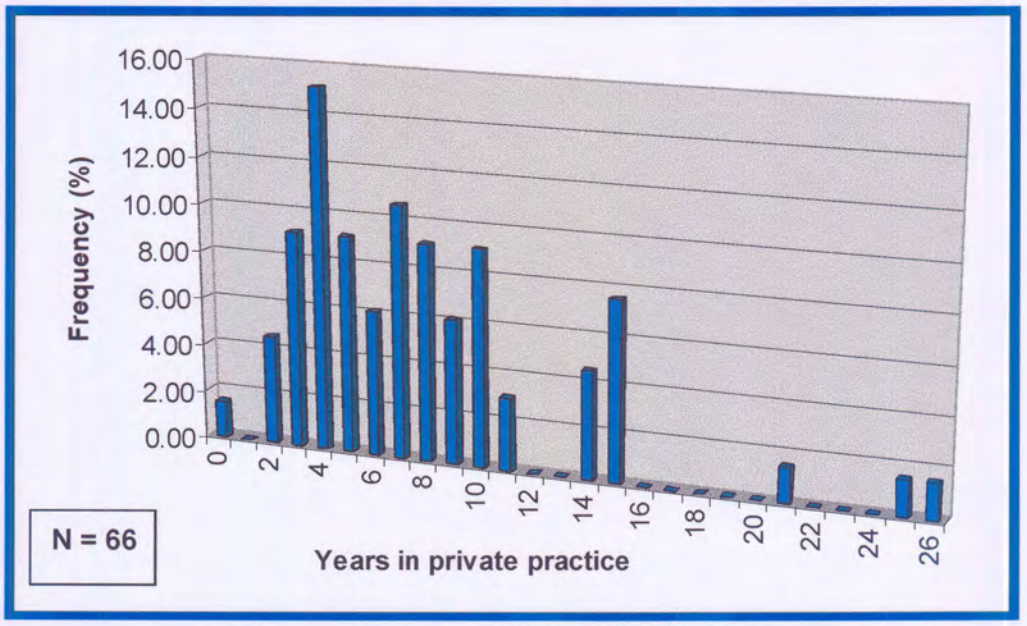
Figure 17: Years of social work experience



The number of years of social work experience of respondents stretched from 6 years to 48 years (refer Figure 17). Most respondents have between 10 and 25 years of social work experience. It will be shown that the level of knowledge of respondents correlates with the number of years social work experience they have.

5.2.8 Years of private practice experience

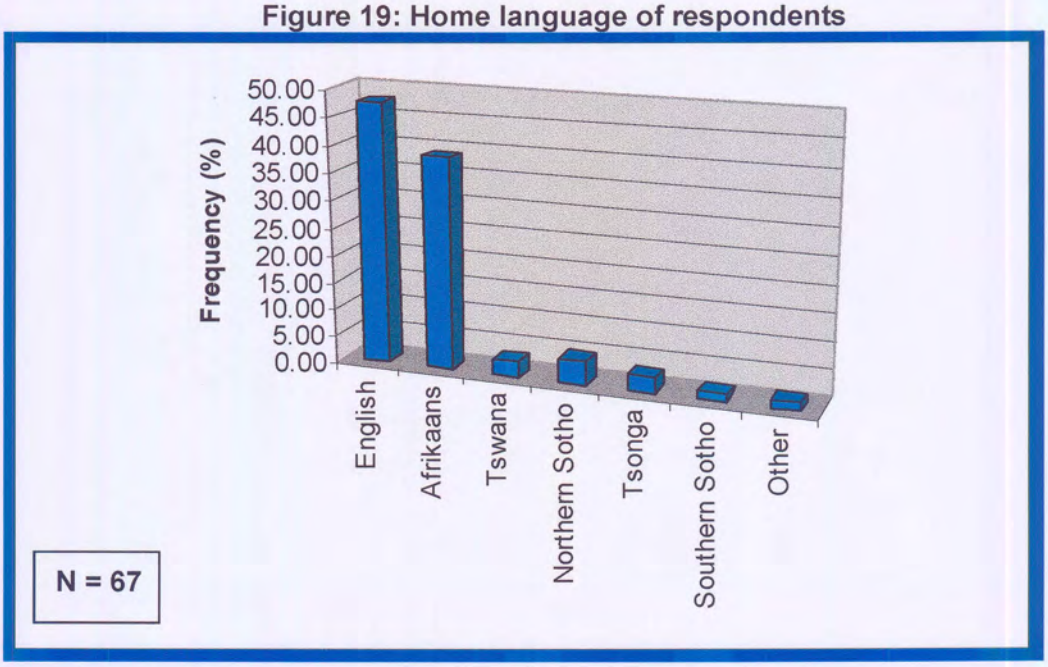
Figure 18: Years of private practice experience



Seventy-four-point-two-four percent of respondents had between 3 and 10 years experience as a social worker in private practice (refer Figure 18). It can thus be concluded that most respondents worked as a social worker for a few years before establishing a private practice. Social workers in private practice have generally more experience in the field of social work. This is because the social worker usually only gains the necessary experience and motivation to establish a private practice, after working as a social worker in the general welfare system.

5.2.9 Home language of respondents

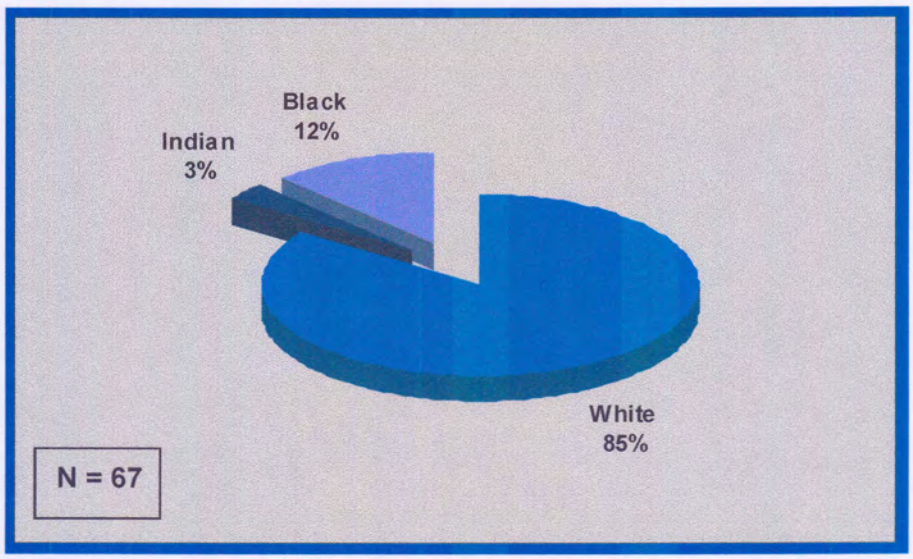
Figure 19: Home language of respondents



Thirty-two respondents (47.76%) are English-speaking while twenty-six of respondents (38.81%) speak Afrikaans. Only nine respondents (13.43%) speak another home language (refer Figure 19). These data also correlate with the data depicted in Figure 19, regarding the different racial groups represented.

5.2.10 Race

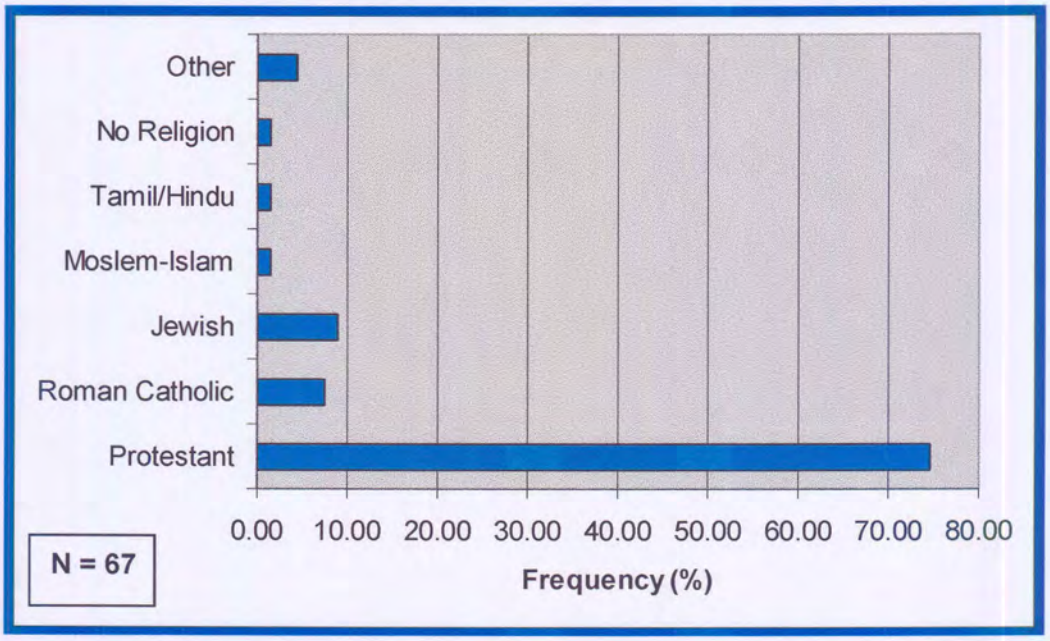
Figure 20: Race



As indicated in Figure 20, the greatest proportion of respondents (85%) is white, while 12% of respondents are black and 3% Indian. There was no coloured representation. This is significant and indicates that a white, female majority of social workers still exists in the SAASWIPP membership.

5.2.11 Religious denomination of respondents

Figure 21: Religious denomination of respondents



The largest number of respondents, namely, (74.63%) are protestant, 5 respondents (7.46%) are Roman Catholic, while 6 respondents (8.96%) are Jewish. Other religions had a negligible representation (see Figure 21). It can be derived from these data that a large number of respondents may still hold on to traditional Calvinistic beliefs regarding human sexuality, because of their protestant background. There is however currently a shift developing in the views and focus of the traditional protestant churches, towards a broader, non-judgemental view regarding sexuality. This statement can be confirmed by the view of Barnard (2000:4) and of Holtshauzen & Stander (1996:4) who are of the opinion that it is time for Christians to start thinking differently about sexuality. These authors view sexuality as an integral part of a human being's

existence, and as something that cannot and should not be ignored. Barnard (2000:4) is of the opinion that the church has an important role to play in society by uplifting moral values regarding sexuality, without being judgemental or prescribing. Holtshauzen & Stander (1996:3) state further that sex is a gift from God, and that sex should be enjoyed as such. Barnard (2000:7) states that the church has a large responsibility to dispel longstanding misunderstandings regarding sexuality. Examples of such misunderstandings are the view that of masturbation is sinful, and that homosexuality is sinful because it is a behavioural choice.

5.3 Opinions regarding sex therapy in social work practice

This section describes the opinions and perceptions of respondents regarding human sexuality and sex therapy, as well as their comfort level regarding the subject.

5.3.1 Ability of respondents to refer clients for sex therapy

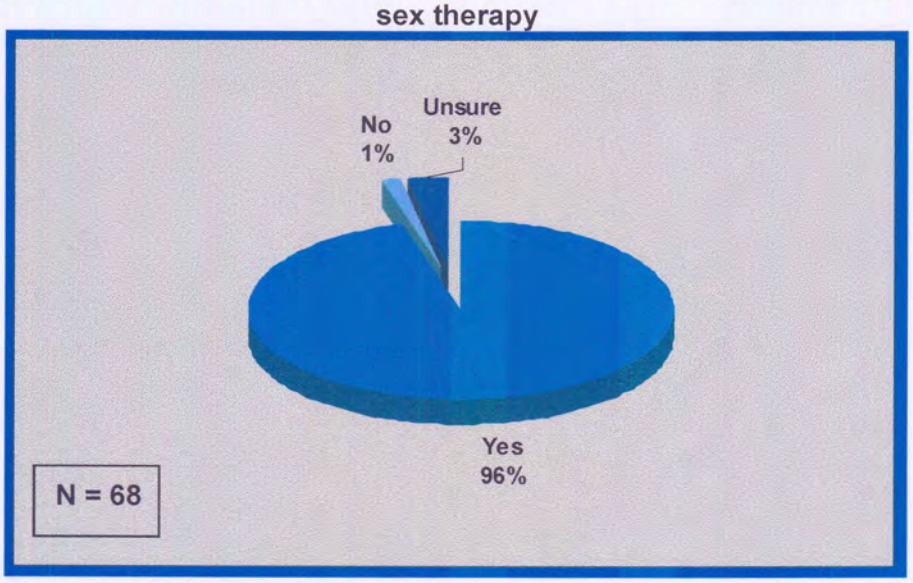
Table 6: Ability to refer clients for sex therapy

	Frequency	Percentage
Yes	55	80.88
No	8	11.76
Unsure	5	7.36
Total	**68**	**100**

As indicated in Table 6, the majority of respondents, namely 80.88%, is of the opinion that they are able to refer clients with specific sexual difficulties, to specialists in the field of sex therapy. Eight respondents (11.76%) felt that they are not able to refer clients for sex therapy while 5 respondents (7.36%) were unsure what the answer to this question should be. It should however be noted that Weeks & Hof (1987:iv) as referred to in chapter 1, are of the opinion that some marital or relationship therapists may not be aware, even after months of treatment, that the couple experience sexual difficulties. It may then be easy to indicate that you are able to refer clients for sex therapy, but this does not necessarily mean that you are able to ask the right questions in order to assess or identify sexual problems effectively.

5.3.2 The need for social workers to be trained in human sexuality and sex therapy according to respondents

Figure 22: Need for social workers to be trained in human sexuality and sex therapy



An overwhelming majority of respondents, namely 65 (96%), is of the opinion that there exists a need for social workers to be trained in the field of human sexuality and sex therapy. Only 1 respondent (1%) disagreed and stated that social workers are able to refer clients with sexual difficulties if necessary. Two respondents (3%) were unsure about this (refer Figure 22).

5.3.3 Suggested level of additional sexology education

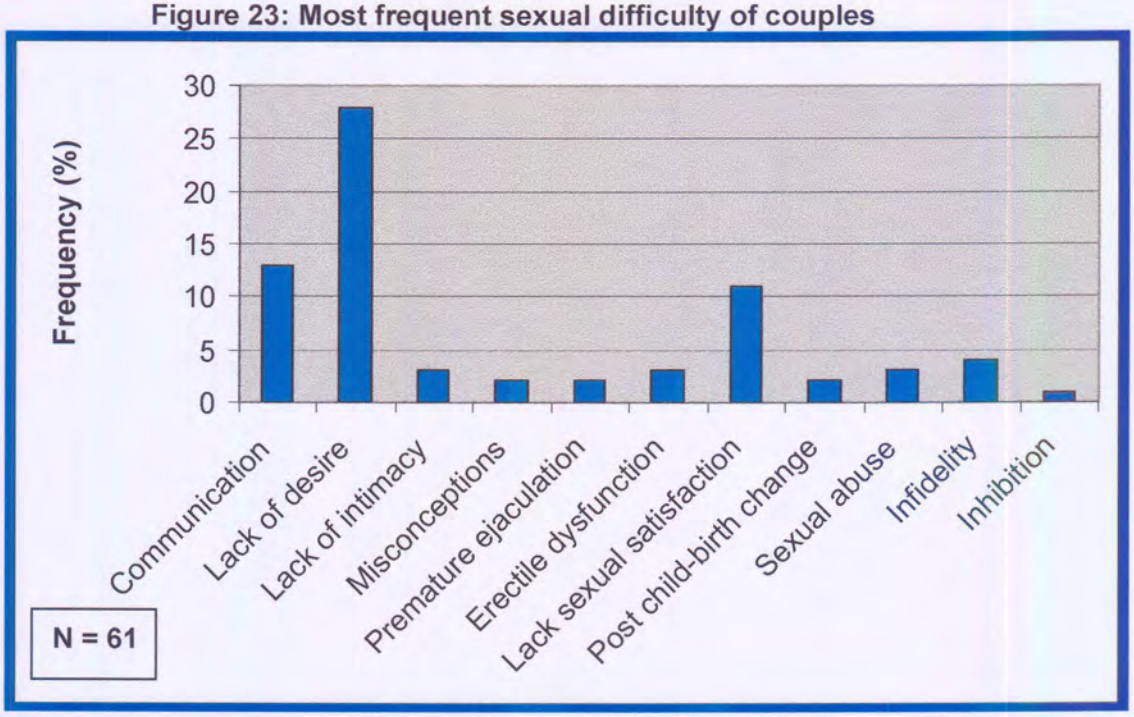
Table 7: Suggested level of additional sexology education

Level of education	Number of replies	Frequency (%)
Undergraduate	31	25.62
Post-graduate	42	34.71
Short course/seminar	48	39.67
Total	**121**	**100**

As indicated in Table 7, thirty-one respondents (25.62%) are of the opinion that additional training in human sexuality and sex therapy should occur on the undergraduate level, while 42 respondents (34.71%) agree that additional sexology training should occur at the Masters level. Forty-eight respondents (39.67%) suggest that short courses on the post-graduate level should also be provided. It is evident that many of the respondents are of the opinion that training in human sexuality and sex therapy should be included on the undergraduate, as well as on the post-graduate level.

5.3.4 Most frequent sexual difficulty of couples seen by respondents

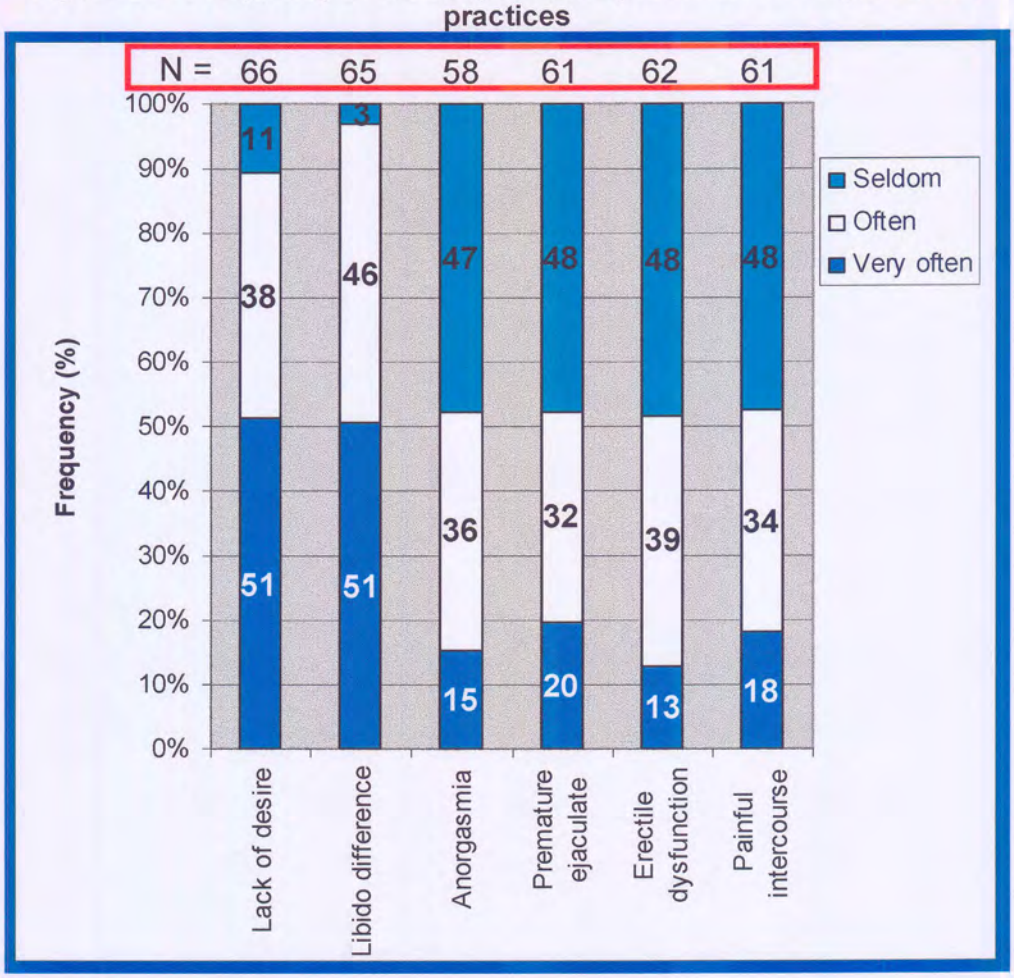
Figure 23: Most frequent sexual difficulty of couples



Twenty-eight respondents (45.90%) identified lack of desire as the most frequent sexual problem they have to deal with in their practices. Thirteen respondents (21.31%) identified the lack of effective communication skills as the most frequent problem affecting sexual functioning of clients. Eleven respondents (18.03%) also identified lack of sexual satisfaction in a relationship as a common problem (refer Figure 23). These data correlate with the researcher's experience in practice as well as with literature, which state that lack of desire disorder is the most prevalent sexual difficulty. (Compare Renshaw, Bancroft & Mulhall, 1997:25; King, 1999:322 & Masters *et al.*, 1995:593.)

5.3.5 Frequency of sexual problems presenting in respondent's practices

Figure 24 - Frequency of sexual problems presented in respondent's practices

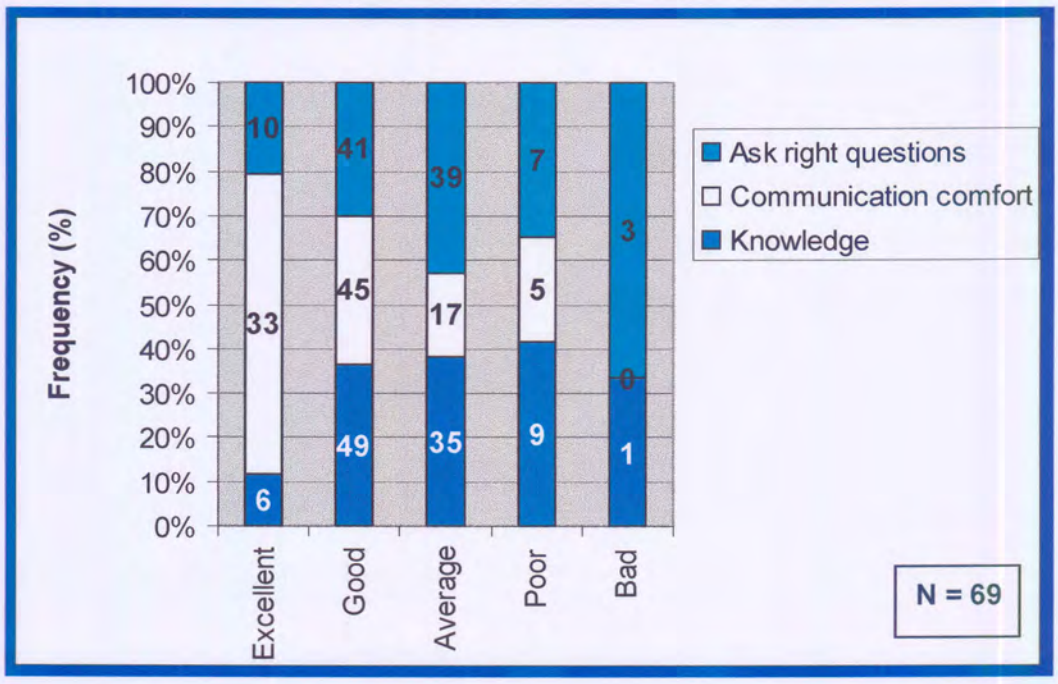


According to the survey, the most frequent sexual problems presented by clients are lack of desire disorder (51%) and libido difference (51%). Anorgasmia also seems to be prevalent with a combined score of very often and often, of 51%. Premature ejaculation (20%), erectile dysfunction (13%) and painful intercourse (18%) seem to be less prevalent. Figure 24 shows the relative frequency of occurrence, e.g., very often, often or seldom for each of

these problems, along with the number of respondents for each problem (N). These data correlates with the literature. Masters, *et al.* (1995:582) state that premature ejaculation and erectile dysfunction are the most prevalent sexual dysfunctions experienced by men, while anorgasmia is the most prevalent sexual dysfunction experienced by women. Although 51% of respondents indicated that they seldom see clients with lack of desire disorder or libido differences, literature in this regard indicates that a lack of desire disorder and libido differences are common and especially prevalent amongst women. (Compare Masters *et al.*, 1995:593 & King, 1999:317.)

5.3.6 Interaction with clients with sexual difficulties

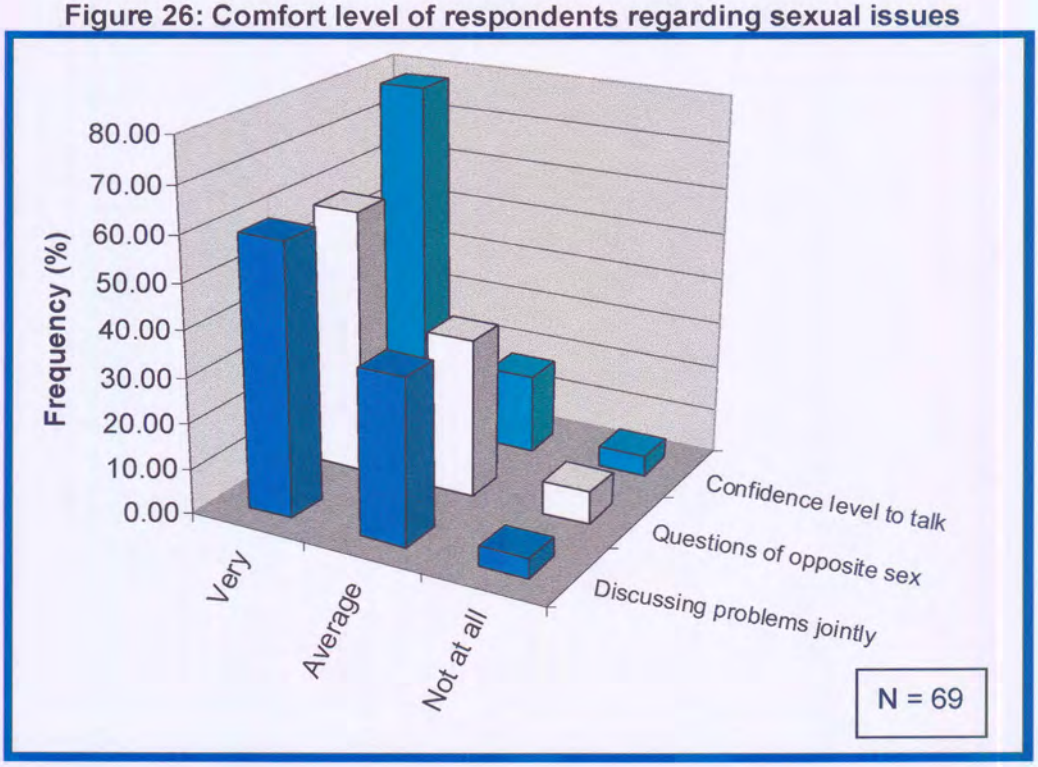
Figure 25: Interaction with clients with sexual difficulties



The ability of respondents to interact with clients with sexual difficulties is depicted in Figure 25. The numbers on the bars are percentages that add up to 100% horizontally. As can be seen, most respondents felt that they had an average to good ability to ask the right questions, communicate sexual issues with comfort, and that they had sufficient knowledge to breach the subject. This professed knowledge should be seen against the backdrop of their actual sexual knowledge as discussed in Section 5.4 below.

5.3.7 Comfort level of respondents regarding sexual issues

Figure 26: Comfort level of respondents regarding sexual issues



Most of the respondents regard themselves as being very comfortable or at least comfortable in discussing sexual problems jointly with a couple, that they

have confidence to discuss sexual problems with clients openly, and that they are comfortable to ask intimate sexual questions to a person of the opposite sex (refer Figure 26).

This professed comfort level should be seen against the information of their actual comfort level as discussed in Section 5.4 below.

5.3.8 Source of primary sex education

Figure 27: Source of primary sex education

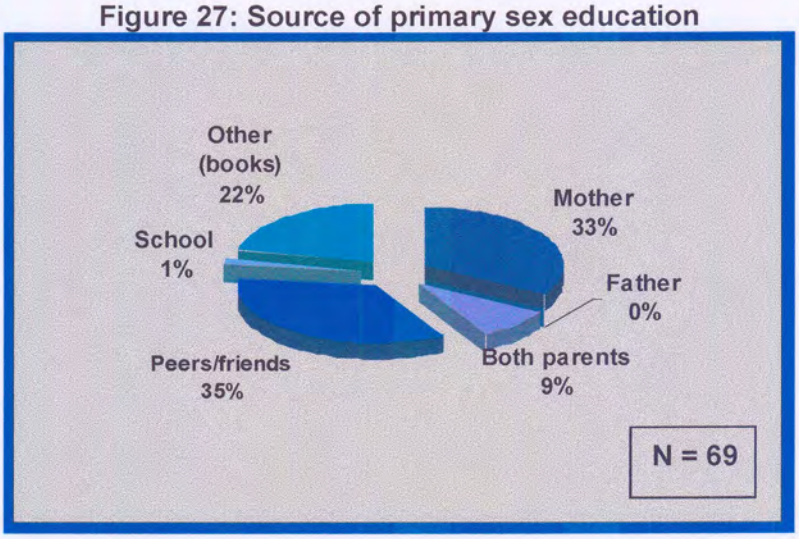


Figure 27 indicates that the majority of respondents, namely 24 (35%) received their primary sex education from peers, while 23 respondents (33%) received their primary sex education from their mother. Literature and books are also prevalent as sources of information, with 22% of respondents indicating these as their primary source of sex education. A combined effort by both parents and the involvement of the father seems lacking, with a combined percentage of 9. The data also show that some social workers who

experience a lack of knowledge regarding human sexuality because of inadequate sex education, utilise literature and books on the subject to further their education.

5.3.9 Need for sex therapy

Five respondents (7.94%) were of the opinion that they never see clients that are in need of sex therapy. Eleven respondents (17.46%) felt they rarely see couples in need of sex therapy. The majority of respondents, namely 33 (52.38%), were of the opinion that they occasionally see couples that are in need of sex therapy. Only fourteen respondents (22.22%) were of the opinion that they frequently see couples in need of sex therapy. These percentages should be viewed against the fact that 72.61% (56.52 + 26.09) (refer 5.3.10) of respondents only occasionally, or never take a sexual history from clients. It could therefore be possible that many more clients are in need of sex therapy, but that because of the fact that the respondent did not ask the right questions, or that a comfortable atmosphere was not created in which these issues could be raised, the client did not discuss his or her sexual issues.

5.3.10 Taking of a complete sexual history

Fifty-six-point-five-two percent of respondents occasionally take a complete sexual history from clients. Twenty-six-point-oh-nine percent never or rarely take a sexual history, while 17.4% of respondents always or frequently take a sexual history from clients. It is thus evident that a small percentage (17.4%)

of respondents frequently take a complete sexual history from clients. This may explain the respondent's answers indicated in section 5.3.9, in that 25.40% of respondents felt that they never or rarely see couples in need of sex therapy. Renshaw (1983:32) and Woody (1992:47) indicate that the taking of a complete sexual history from clients sets the stage for clients to discuss their sexual problems. They also experience permission-giving by the therapist in terms of discussing sexual issues. The comfort level of the therapist determines the comfort level of clients when discussing sexual issues openly. If the therapist is comfortable, open and non-judgemental, while taking the sexual history, the clients will experience an accommodating environment in which to discuss sexual issues openly.

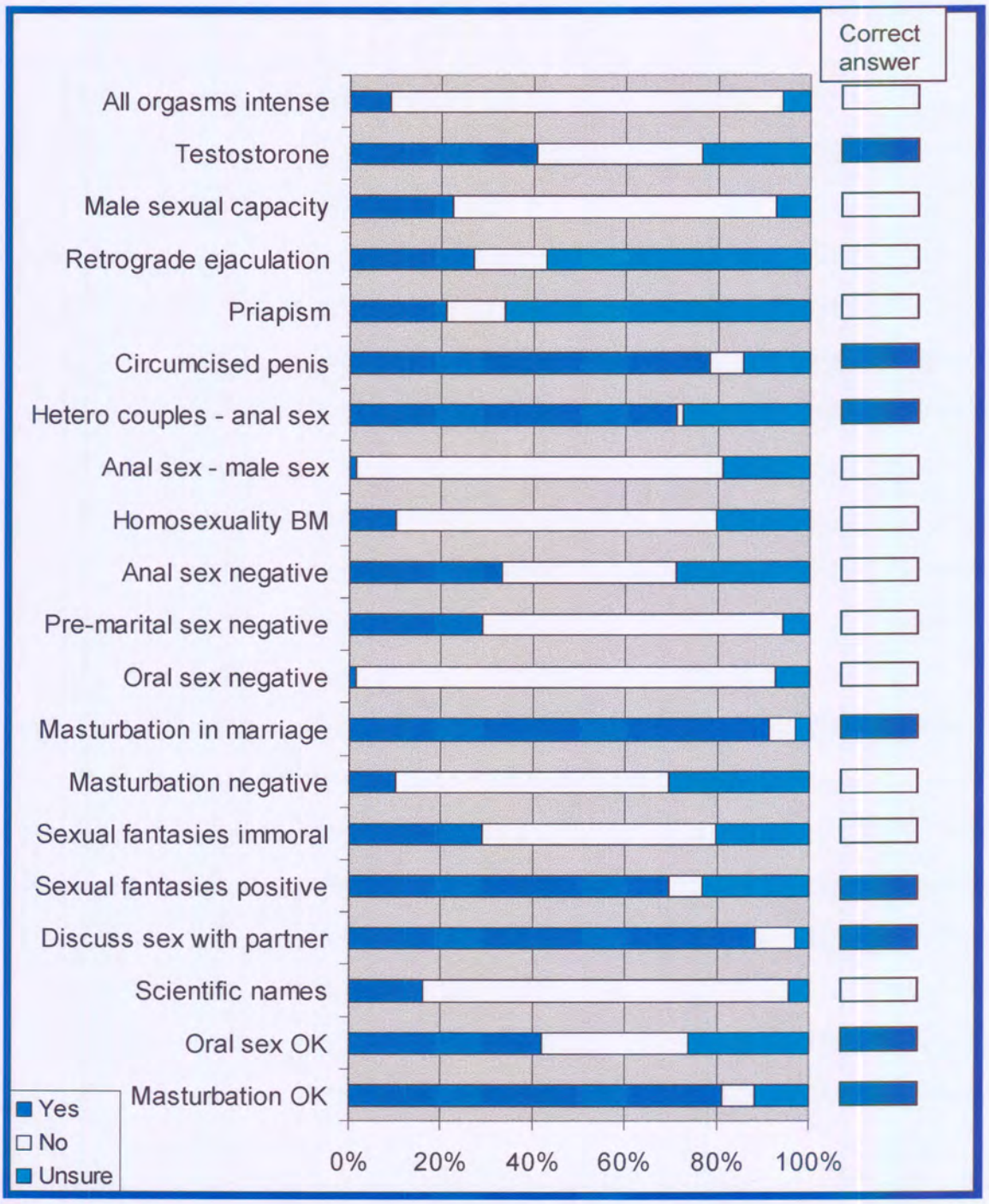
5.4 Knowledge regarding human sexuality and sex therapy

The aim of this section of the questionnaire was to test each respondent's clinical knowledge about human sexuality and sex therapy. This aim was reached by providing questions related to general knowledge and information pertaining to human sexuality and sex therapy. The content of these questions as being valid and reliable were tested against the researcher's experience with couples with sexual dysfunctions. Additional validity was ensured by obtaining feedback from other specialists in the field of sexology and sex therapy.

Although many of the questions may appear to be clinical and focussed on terminology, it is important for the social worker to have this clinical knowledge, as many social workers avoid the subject of sexuality because

they often do not know what the correct terminology to use is. This may lead to social workers avoiding sexually related questions. Refer to Figure 28 for the dissemination and correlation of information gathered from the first section of knowledge-based questions. The correct answer is indicated in the figure with icons to the right. The number of respondents who declined to answer the questions should also be noted. The derivation can be made that these respondents did not know the correct answer to the question, or that they felt uncomfortable answering the question. The responses to the knowledge-based questions are discussed separately in sections 5.4.1 to 5.4.34.

Figure 28: Statistics of number of correct, incorrect and unsure answers to described knowledge questions



5.4.1 Masturbation offers a satisfactory outlet at all ages for the release of sexual tension

Fifty-six respondents (81.16%) answered this question correctly. Masturbation does offer a satisfactory outlet for the release of sexual tension, at all ages. Historically, masturbation was often viewed as being sinful or physically harmful. The fact that only 18.84% of respondents view masturbation as being negative supports the notion that negative perceptions and myths about masturbation are being successfully countered by the availability of correct information and education, as well as by the new tendency of religious organisations to view masturbation as a normal and healthy component of one's sexual functioning.

5.4.2 Oral sex is something that the majority of sexually active people engage in

Only 42.03% of respondents view oral sex as a normal sexual activity that the majority of sexual active couples engage in. A large percentage (31.88%) of respondents view oral sex as being negative or not being a normal, prevalent sexual activity amongst couples. This may indicate that many respondents still have a few negative or unrealistic perceptions regarding oral sex and that they may transfer these negative attitudes to clients, if they do not take care to be non-judgemental. This question may also indicate something of the lack of respondent's comfort levels regarding human sexuality in general.

5.4.3 It is difficult to refer to the various parts of the genitals by their scientific names when discussing sexually-related issues with clients

Seventy-nine-point-seven-one percent of respondents indicated that they are able to refer to the various parts of the genitals by their scientific names. This high percentage is positive because knowledge of accurate scientific names and terminology is important in order to provide a comfortable framework for both the client and the therapist to communicate about sexuality.

5.4.4 It is possible to discuss sexually-related matters with my partner

Sixty-one respondents (88.41%) can discuss sexually related matters with their own partners. This may indicate that the respondents have a certain comfort level discussing sexually related matters in a known, trusting and secure environment.

5.4.5 Sexual fantasies are powerful aphrodisiacs because they offer people a chance to enjoy sexual activities they might not normally – or necessarily ever – want to experience

Forty-eight respondents (69.56%) answered correctly that sexual fantasies are powerful aphrodisiacs that enable people to enjoy sexual activities they might not otherwise experience. Five respondents (7.25%) indicated this statement as being untrue, while 16 respondents (23.19%) were unsure whether this statement was true or false. The fact that the largest proportion

(69.56%) of respondents was of the opinion that sexual fantasies are positive and powerful aphrodisiacs, is positive in that it shows an open-mindedness and is also an indication of a certain level of knowledge. This is confirmed by the fact that the brain is regarded as the most important sexual organ involved in the sexual arousal of both the male and the female.

5.4.6 Sexual fantasies can lead to immoral behaviour

Twenty respondents (28.99%) believe sexual fantasies can lead to immoral behaviour. Thirty-five respondents (50.72%) believe that sexual fantasies do not lead to immoral behaviour, while 14 respondents (20.29%) were unsure what to answer to this question.

Sexual fantasies do not lead to immoral behaviour, but are in fact essential for effective sexual functioning as the brain is the most important organ in sexual desire.

The fact that 49.28% (28.99 + 20.29) of respondents indicated sexual fantasies as having a possible negative effect, or being unsure about this, does however not correlate with the respondents' answers as shown in section in 5.4.5. In section 5.4.5, 69.56% of respondents indicated sexual fantasies as being powerful aphrodisiacs in which people can experience sexual activities in a protected environment, fantasies they would not necessarily want to experience in real life.

5.4.7 Masturbation practised too frequently causes fatigue and physical debilitation

The majority of respondents (59.42%) indicated this statement as being false. Frequent masturbation does not cause fatigue or physical debilitation. Ten-point-one-five percent of respondents however do view masturbation as being physically harmful, while 30.43% of respondents were unsure about this. The fact that 40.58% (10.15 + 30.43) of respondents answered this question incorrectly is very disturbing, because this myth that masturbation may have a negative physical impact on a person should have been dispelled by now. This should be even of more concern where social workers who deal with individuals and couples are concerned. Even though a negative perception regarding masturbation is in some way understandable given the majority of respondents' religious backgrounds, there is no excuse for not knowing the basic, medically and scientifically acknowledged facts regarding the physical effects of masturbation. It is impossible to dispel these myths for clients if the social worker does not have the basic knowledge to provide clients with. It is even more appalling because masturbation can be a powerful and positive alternative that can be offered to clients with various sexual difficulties as described in chapters two and three.

5.4.8 Masturbation is sometimes an effective alternative to penetrative sex within a marriage

The majority of respondents (91.30%) indicated correctly that masturbation is sometimes an effective alternative to sex penetration within a marriage. Only

8.7% of respondents disagreed with this statement. Again this does not correlate with the respondents' previous responses regarding masturbation, and may indicate ambivalence and a lack of scientific knowledge regarding the subject of masturbation.

5.4.9 Oral sex is dangerous and should be avoided

A total of 91.30% of respondents answered this question correctly by indicating that oral sex is not dangerous, and that oral sex does not have to be avoided. One-point-four-five percent of respondents viewed oral sex as being dangerous, while 7.25% of respondents were unsure. It is interesting that the majority of respondents (91.30%) regarded oral sex as being less dangerous and more acceptable than the 59.42% of respondents who saw masturbation as being positive in 5.4.7. The same percentage, namely, 91.30% of respondents also viewed masturbation as being a positive alternative to sex penetration in marriage.

5.4.10 Pre-marital sex is harmful and should be avoided

A total of 65.22% of respondents were of the opinion that pre-marital sex is not necessarily harmful. Twenty-eight-point-nine-nine percent of respondents view pre-marital sex as being harmful, while 5.80% of respondents were unsure about this. Although pre-marital sex may be viewed as being harmful from a spiritual point of view, it is an acknowledged fact that pre-marital sex is very much prevalent in today's society where people tend to be much older

when they get married. Practical experience of the researcher also indicates that many couples who abstain from pre-marital sex, experience sexual difficulties once they do get married. This may be caused by the fact that the normal development of their sexual relationship had to be repressed. Many women especially, may later on suffer from a lack of desire disorder or anorgasmia, or even in extreme cases from vaginismus because they repressed their sexual feelings so deeply. Once they do have a marriage certificate in hand, and are "allowed" to have sex, many women are unable to open up sexually and to view themselves as sexual beings that are allowed to enjoy sexual fulfilment, without extreme feelings of guilt and shame.

It is acknowledged that the view of pre-marital sex as being harmful or not, is a very personal issue, but the fact remains that the social worker dealing with couples, should remain neutral and non-judgemental.

5.4.11 Anal sex is painful and leads to HIV infection

Only 37.68% of respondents answered this question correctly. Anal sex should not be painful and should not lead to HIV infection. A total of 62.32% of respondents answered this question incorrectly, which supports the general myth in society that anal sex is painful and that it is the primary cause of HIV infection. Morin (1998:3) states that the widespread belief that anal pleasure and anal health are not compatible, is untrue. Morin (1998:3) goes further in stating that anal wellness and maximum anal enjoyment require:

- Deepening awareness of the anal area and its functioning

- Total elimination of anal pain
- Reduction of muscular tension
- Replacing negative feelings and attitudes toward the anus and rectum with positive ones.

These data again indicate the lack of scientific knowledge of respondents.

5.4.12 Homosexuality can effectively be reversed by behavioural modification

The majority of respondents (69.57%) answered correctly that homosexuality cannot be successfully reversed by behavioural modification. Ten-point-one-four percent of respondents however are of the opinion that homosexuality can be reversed by behavioural modification, while 20.29% of respondents were unsure about this. Masters, *et al.* (1995:370) state that new research findings suggest a genetic predisposition to homosexuality, making the idea that sexual orientation is primarily a matter of choice, scientifically unsupportable. King (1991:244) agrees with this statement and is of the opinion that many therapists today believe that sexual orientation cannot be changed. This conclusion has gained strength with recent findings of a possible biological role in sexual orientation.

5.4.13 Anal sex is only practised during male sex

Seventy-nine-point-seven-one percent of respondents answered correctly that anal sex is not only practised during male sex. One-point-four-five percent of

respondents were however of the opinion that anal sex is only practised during male sex, while 18.84% of respondents were unsure. Literature and the researcher's experience in practice show that anal sex is becoming an acceptable sexual activity for many couples. This statement is confirmed by Morin (1998:9) who states that anal pleasure – with or without intercourse – can be a comfortable part of the sensual and sexual experience of any man or women who wants it, regardless of sexual orientation. The term anal sex is preferred to the term anal intercourse because the term anal sex refers to any anal play and is much broader, than the term anal intercourse, which only implies actual intercourse.

5.4.14 There are some heterosexual couples who enjoy anal sex

Seventy-one-point-oh-one percent of respondents answered correctly that some heterosexual couples enjoy the practise of anal sex, while 27.54% of respondents were unsure what the correct answer should be. One-point-four-five percent of respondents were of the opinion that heterosexual couples do not enjoy anal sex. King (1991:291) states that one in ten heterosexual couples engage in anal intercourse somewhat regularly. Morin (1998:11) agrees with King's statement and asserts that many people are surprised when they hear about the prevalence of anal experimentation among heterosexuals. The subject of anal intercourse is still somewhat controversial and it is thus interesting that 71.01% of respondents responded correctly that anal sex is an activity that some heterosexual couples engage in. Again there

seems to be no general trend in respondents' responses regarding issues of masturbation, oral sex and anal intercourse.

5.4.15 Functionally speaking the circumcised penis does not have a foreskin to retract during coitus or masturbation as the uncircumcised penis has

Fifty-four respondents (78.26%) answered correctly that the circumcised penis does not have a foreskin to retract during coitus or during masturbation, as the uncircumcised penis has. Seven-point-two-five percent of respondents answered incorrectly, while 14.49% of respondents were unsure. Twenty-one-point-seven-four percent of respondents thus lack knowledge regarding the basic physiological working of the genitals.

5.4.16 Priapism is an ability of some men to attain erections frequently and with minimum stimulation

Only 8 respondents (12.90%) answered correctly. Priapism is a condition of prolonged erection, which can be life threatening. Sixty-six-point-one-three percent of respondents were unsure as to what the correct answer is, while 20.97% answered incorrectly. Although the term priapism may sound technical, it is a well-documented condition. It is important for social workers dealing with couples to be aware of this condition, especially in the new age of pharmaceuticals such as Viagra. These medications have various positive effects, but may also have negative side effects of which priapism is one, and

of which the social worker should take note in order to provide clients with sufficient and correct information.

5.4.17 Retrograde ejaculation means delayed ejaculation

Only 10 respondents (15.87%) answered this question correctly. Retrograde ejaculation is a condition in which the semen spurts backward into the bladder during orgasm or ejaculation, because the bladder neck does not close off properly. The majority of respondents (84.13%) answered incorrectly. These data again indicate the lack of scientific knowledge of social workers regarding human sexuality. Retrograde ejaculation is not an uncommon condition, and is especially prevalent in males who had surgery for prostate cancer. As many social workers provide services to cancer patients and their families, this is a condition they should know about. Social workers should be able to provide male cancer patients with the correct knowledge regarding their future sexual functioning after surgery, as well as be able to provide them with possible alternatives to sex penetration if they experience erectile dysfunction. The sexual component of the patient's relationship with his partner should thus not be simply ignored.

5.4.18 Males have a greater sexual capacity than females

Seventy-four respondents (70.15%) answered correctly that males do not have a greater sexual capacity than females. Twenty-nine-point-eight-five percent of respondents interestingly enough indicated that males do have a greater sexual capacity than females do. Seven-point-four-six percent of

respondents were unsure about this. Twenty-nine-point-eight-five percent of respondents thus still believe the myth that males have greater sexual capacity than females. Masters, *et al.* (1995:86) state that it is a commonly held belief, that males have a greater sexual capacity than females do. They state that the reverse is actually true. From the viewpoint of physical capability, females have an almost unlimited orgasmic potential, while men, because of the refractory period, are unable to have a rapid series of ejaculations. These data support the notion that social workers lack knowledge regarding human sexuality.

5.4.19 The most important hormone in sexual motivation in males and females is testosterone

Only 40.63% of respondents answered correctly that testosterone is the most important hormone in the sexual motivation of males and females. Masters, *et al.* (1995:87) state that testosterone is the principle biologic determinant of the sex drive in both men and women. Thirty-five-point-nine-four percent of respondents indicated the wrong answer, while 23.44% of respondents were unsure. This again supports the statement that social workers lack knowledge regarding human sexuality, as the importance of testosterone in sexual functioning is a basic fact that should be common knowledge. It is unproductive and in a sense unethical to intervene with couple therapy regarding sexual difficulties if the cause of the problem is organic or hormonal, and medical intervention is indicated.

5.4.20 All orgasms are intense, explosive events

Eighty-five-point-nine percent of respondents answered correctly that all orgasms are not intense, explosive events. Masters, *et al.* (1995:80) state that orgasms do not only differ from one individual to another, but also for each individual. Different intensities of orgasms arise from physical factors such as fatigue and the time since the last orgasm as well as from a wide range of psychological factors, including mood, relation to partner, activity, expectations, and feelings about the experience. Eight-point-two-nine percent of respondents however indicated that all orgasms are intense, explosive events, while 5.88% of respondents were unsure.

5.4.21 The term paraphilia

Only 36.54% of respondents answered this question correctly, and stated that paraphilia is the term used to describe a condition in which a person's sexual gratification is dependant on an unusual sexual experience. It is also a neutral term for sexual alternatives that previously have been called deviant. The majority of respondents (48.02%) confused the term paraphilia with the term fetishism. A large percentage (25%) of respondents also declined to answer this question, which could indicate that they simply did not know the correct answer. These data are also indicative of the lack of knowledge of social workers as the term paraphilia is described in detail in the Diagnostic and Statistical Manual for Psychiatric Disorders, and is a collective term for sexual

variant behaviour such as fetishism, paedophilia, voyeurism and others that social workers may come in contact with.

5.4.22 PLISSIT model as basis for sex therapy

The majority of respondents, namely 81.48%, answered incorrectly and stated that Masters and Johnson was the correct answer. The basis for sex therapy today however, is the PLISSIT model, which describes permission-giving, basic information giving, home love-play exercises and intensive therapy as the last resort. A large percentage (22%) of respondents declined to answer this question. These data support the notion that social workers lack knowledge regarding basic sex therapy techniques.

5.4.23 Average time longer for a woman to reach orgasm, than for a man

Only 26.67% of respondents answered correctly, that it takes a women on average four times longer to reach orgasm than it takes a man. The majority of respondents (66.67%) were of the opinion that it takes twice as long for a woman to reach orgasm than it takes for a man. Thirteen percent of respondents declined to answer this question. These data indicate the lack of knowledge of respondents. The fact that women on average take four times longer to reach orgasm than men emphasises the importance of foreplay. The social worker should also be able to generalise clients' difficulties in this regard by stating this physiological fact, and by setting the woman's mind at

ease that this is perfectly normal and that there is not something inherently wrong with her, especially if she thought that her inability to reach orgasm in the time her partner had, was abnormal.

5.4.24 Percentage of women able to reach orgasm with penetration only

Fifty-two-point-five-four percent of respondents indicated the correct answer that only 20-30% of women are able to achieve orgasm through penetration. Although this seems to be a high percentage, almost half (47.46%) of respondents answered incorrectly, and 14% of respondents declined to answer the question. This basic knowledge regarding sexual physiology is important because many women believe that they are at fault for not being able to achieve orgasm through penetration. When the social worker is able to present the couple with accurate information in stating that the majority (70-80%) of women are not able to achieve orgasm through penetration only, but needs manual stimulation of the clitoris, many couples may be reassured.

5.4.25 Possibility of women to be multi-orgasmic

The majority of respondents, namely 95.45%, answered correctly that it is possible for women to be multi-orgasmic. King (1999:78) states that some women are capable of having multiple orgasms the amount of which are only limited by the point of physical exhaustion. Multiple-orgasms imply two or more orgasms without dropping below the plateau phase.

5.4.26 The term fetishism

The majority of respondents (72.41%) answered this question correctly, stating that the term fetishism refers to a sexual variation in which objects are endowed with erotic properties. Sixteen percent of respondents declined to answer this question. Examples of typical objects include feet and shoes.

5.4.27 The Kinsey scale

Only 9.52% of respondents answered this question correctly. The majority of respondents (69.05%) answered that the Kinsey scale refers to libido differences between men and women, instead of the frequency of hetero- and homosexual experiences per year. A large percentage (39%) of respondents declined to answer this question, which possibly indicates that they did not know the answer. These data are also indicative of a lack of knowledge.

5.4.28 Cause of menopause

Sixty-eight respondents (99.99%) answered this question correctly by indicating that the decrease of estrogen causes the onset of menopause. Only one respondent declined to answer this question. These data indicate that respondents do have knowledge regarding menopause. This may be the result of the large representation of females in the sample and of the subject of menopause being a non-sensitive and a more openly discussed subject.

5.4.29 Penis size

A majority of 91.04% of respondents answered this question correctly by indicating that penis size determines little, if anything, physiologically to the male or female's sexual functioning. These data indicate that the myth surrounding penis size has been successfully eradicated.

5.4.30 Sexual performance in older men

Only 55.36% of respondents answered this question correctly by indicating that the refractory period of the sexual response cycle becomes longer in older men. This means that the waiting period before a male can obtain another erection becomes longer. Eighteen-point-eight-four percent of respondents declined to answer this question. This information should also be basic knowledge for social workers dealing with couples' issues as clients should be informed that the refractory period of men over 50 years of age becomes longer, and that more direct, on the penis stimulation is needed for erection to occur satisfactorily.

5.4.31 The phases of the sexual response cycle in proper sequence

Only 48.15% of respondents answered this question correctly by indicting the proper phases of the sexual response cycle as: excitement, plateau, orgasm and resolution. A total of 51.85% of respondents did not know the correct answer to this question and 15 respondents declined to answer the question.

The sexual response cycle and its phases are basic knowledge elements regarding human sexuality, and should be part of the knowledge base of social workers who do couple therapy.

5.4.32 The term coitus interruptus

A total of 60.61% of respondents answered correctly that the removal of the penis before ejaculation is referred to as coitus interruptus. Twenty-six (39.39%) of respondents answered incorrectly, while 3 respondents declined to answer the question. When providing sex education as it is expected from many social workers, it is important to have knowledge about correct terminology as it assists both the social worker and the client in providing the necessary "language" to discuss sexually related matters.

5.4.33 The term vaginismus

Forty-three respondents (81.13%) answered correctly by indicating that the condition of involuntary spasms of the muscles in the outer third of the vagina, is referred to as vaginismus. Twenty-three percent of respondents did not answer this question, which may indicate that they did not know the answer. It can be derived from this that of the 46 respondents who did answer, 81.13% were correct, but that a total of 52.2% of respondents did not know the answer.

5.4.34 Techniques to treat premature ejaculation

Seventy-five-point-eight-six percent of respondents indicated correctly that the stop-start technique, medication and the squeeze technique are suitable treatments for premature ejaculation. Eleven respondents (16%), declined to answer this question, which indicate that a total of 40.14% of respondents did not know the correct answer.

5.4.35 The term sensate focus

A total of 76.55% of respondents indicated all the correct answers that sensate focus can involve non-genital touching, prolonged touching of one's partner's genitals, the giving and receiving of pleasure, as well as focusing on the journey and not on the destination. This could be indicative of the fact that Masters and Johnson and their technique of sensate focus are relatively well known.

5.5 Correlations

Figure 29: Correlation between years of social work experience and knowledge as determined by number of correct answers

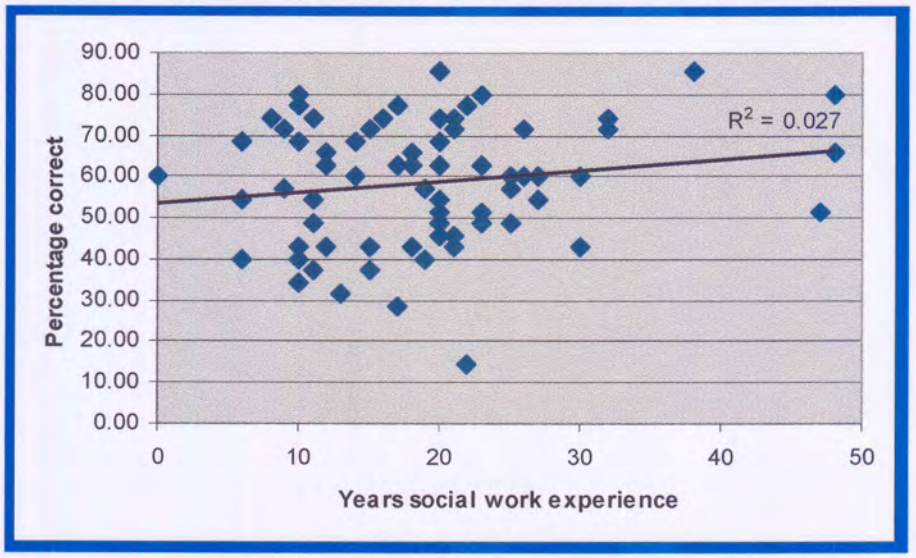


Figure 30: Correlation between years of in private practice and knowledge as determined by number of correct answers

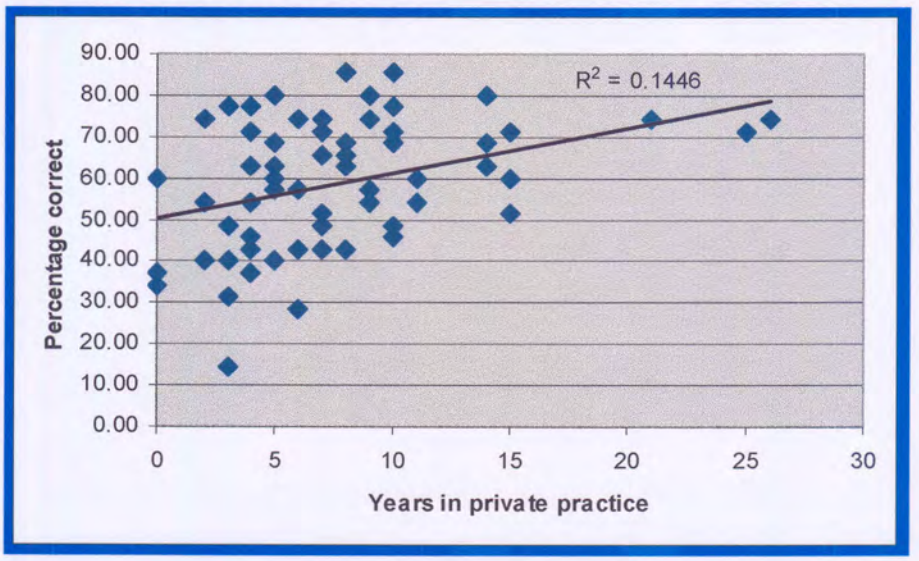


Figure 31: Correlation between qualification level and knowledge as determined by number of correct answers

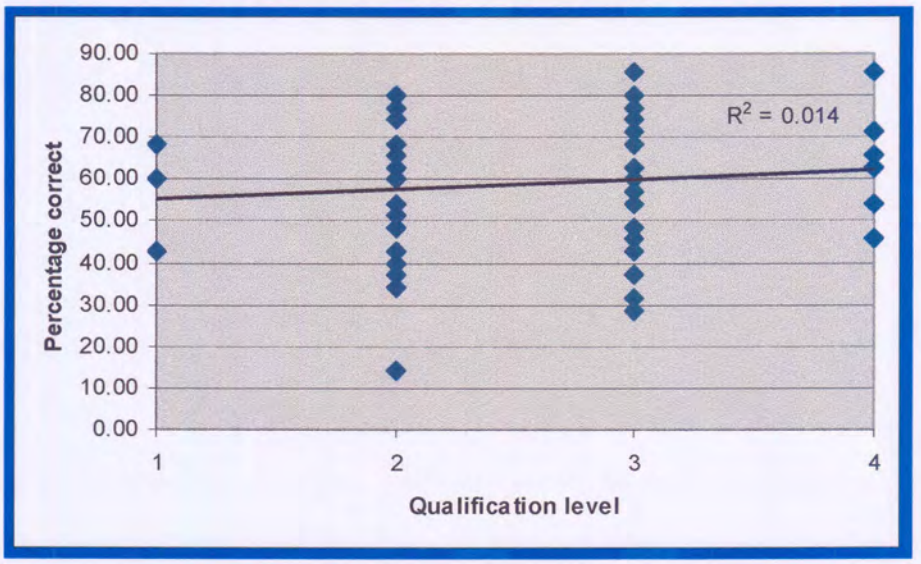


Figure 32: Correlation between number of days of additional courses attended and knowledge as determined by number of correct answers

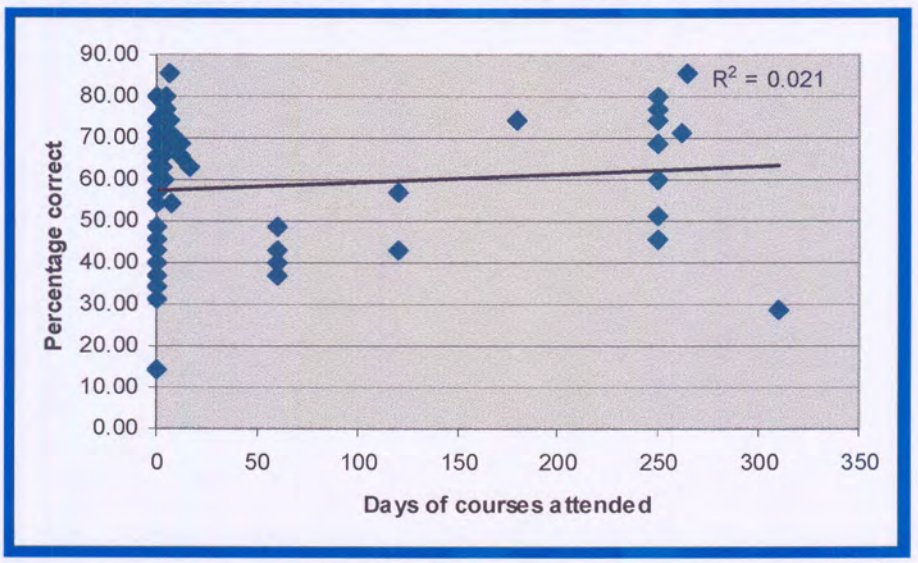
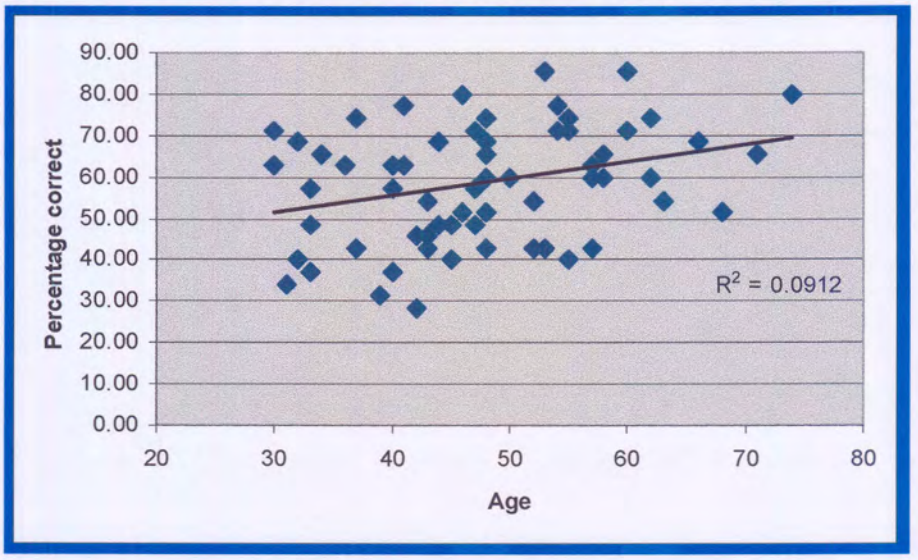
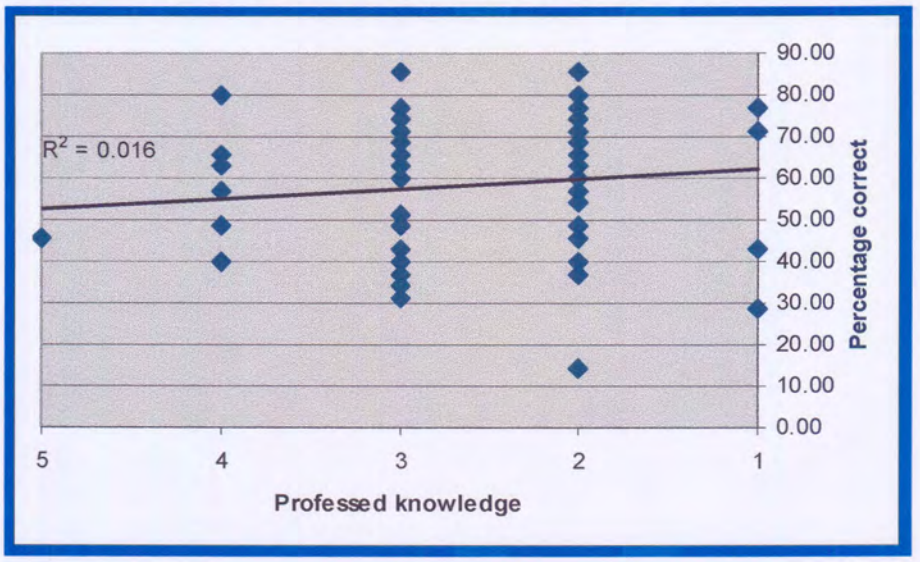


Figure 33: Correlation between age of respondents and knowledge as determined by number of correct answers



As can be seen from Figures 29 through 33, there is little correlation between the years of social work experience, years in private practice, qualification level, days of additional sexuality-related courses attended, and the age of respondents, and their knowledge as determined by the number of correct answers in the relevant section of the questionnaire. The strongest trends, as indicated by the respective trend line and correlation coefficient, R^2 shown, exist for private practice experience and age.

Figure 34: Correlation between professed knowledge and knowledge as determined by number of correct answers



As can be seen from Figure 34, there is little correlation between the professed knowledge regarding human sexuality and sex therapy of respondents on the one hand, and the actual number of correct answers to the sexuality-knowledge questions in the questionnaire. Of interest especially, is the below average score obtained by respondents who thought that they had an excellent knowledge in this field (1 on the horizontal axis in Figure 34).

5.6 Summary

In chapter 5, the empirical data of the research study were described and statistically presented by the utilisation of various tables and figures.

5.6.1 Bibliographical information

The largest proportion of respondents (93%) are female, and the average age of respondents was 48 years at the time of the survey. The largest representation of age was between 40 and 50 years. The majority of respondents (69%) were married, while 14% were divorced. The majority of respondents (47.76%) are English-speaking, while 38.81% of respondents speak Afrikaans as home language. The largest proportion of respondents originate from a protestant background.

The year in which respondents obtained their first degree, stretches over a large spectrum, from 1948 to 1997. The majority of respondents (47%) holds a bachelors degree, 37% a Masters degree and 9% a doctoral degree.

A large percentage (76.78%) of respondents obtained additional training in relationship therapy and/or sex therapy. These courses wee however mostly short 2-3 day courses that were presented by private institutions or private professionals.

The largest percentage of respondents had between 10 and 25 years social work experience, while 74.24% of respondents had between 3 and 10 years experience in private practice at the time of the survey.

5.6.2 Opinions regarding sex therapy in social work practice

A large percentage (80.88%) of respondents are of the opinion that they are able to refer clients with sexual difficulties that require specialised therapy, to the appropriate professionals. An overwhelming majority of respondents (95.59%) emphasised the need for additional education and training of social workers in the specialised field of human sexuality and sex therapy. The majority of respondents suggested that this training should occur on the undergraduate as well as on the post-graduate level of study.

The most frequent sexual difficulties that respondents are confronted with in their practices are a lack of desire disorder, a lack of effective communication skills regarding sexuality and a lack of sexual satisfaction.

5.6.3 Comfort level of respondents regarding sexual issues

The majority of respondents rated themselves as being very comfortable or at least averagely comfortable discussing sexual issues with their partner and with clients.

5.6.4 Knowledge-base of respondents regarding human sexuality and sex therapy

An average of 58.53% of respondents answered the knowledge-based questions correctly. A large percentage of respondents however declined to answer some of the questions.

The final summary, conclusions and recommendations of this study will follow in chapter 6.

CHAPTER 6

GENERAL SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

Practical experience and the lack of recent research findings regarding the integration of scientifically based sex therapy techniques and traditional couple therapy, within the social work context sparked interest in this field of study.

The content of the research report is structured as follows: Chapter 1 focused on a general introduction and outline of the research study. The motivation for the choice of the subject, the problem formulation, the goal and objectives of the study, the theoretical assumption, the research approach, the type of research conducted, the research design, the research procedures and strategy, the feasibility of the study, the research population and boundary of the sample and sampling method, possible ethical considerations, as well as the definition of key concepts and problems encountered in the study, were provided and described in detail.

In chapter 2 a literature overview of human sexuality and sex therapy was provided. The historical background of the origin of sex therapy was described, various definitions were provided, and the different perspectives on human sexuality were discussed.

In chapter 3 a literature overview of clinical sex therapy was provided. The state of theory in sex therapy was discussed, the classification of sexual disorders was provided and different models and treatment modalities pertaining to sexual dysfunctions were presented.

Chapter 4 described the integration of couple therapy and sex therapy and focused on the different components of a committed relationship or marriage. Intimacy, as key component of a healthy sexual and emotional relationship was described in detail, and the role of the social worker in dealing with clients with sexual difficulties were discussed.

Chapter 5 was devoted to the empirical research results, and the quantitative data collected were discussed and presented visually.

The current Chapter 6 consists of a general summary, conclusions drawn, and recommendations made regarding all the previous chapters of the research report. The research goal, objectives and the research question are also tested and discussed.

6.2 Chapter 1: General introduction and outline of study

6.2.1 Summary

The important negative impact of sexual dysfunctions or difficulties on a committed relationship or on a marital relationship was discussed. The facts

that sex therapy is multi-dimensional in nature, and that sex therapists originate from various professional fields, were stressed.

The importance of the integration of sex therapy and couple therapy in order to treat clients with sexual difficulties effectively was discussed. Furthermore, the notion that sexual dysfunctions do not occur in a vacuum and that it should be treated within the total context of the client system, was emphasised.

The research problem was formulated in terms of the fact that relationship problems and sexual dysfunctions are often interlinked. A previous research finding, i.e., that a need exists for additional training of social workers in the field of sex therapy, was confirmed. Because of the nature of social work services, many social workers are confronted with couples that experience sexual difficulties. It was however proposed that many social workers avoid the subject of sexuality because of a lack of knowledge and comfort regarding the subject.

The research problem was thus described as the proposed lack of knowledge of social workers, specialising in marriage and relationship therapy (couple therapy), with regards to human sexuality and sex therapy.

The goal of the study was to explore and to describe the knowledge of social workers in private practice, specialising in marriage and relationship therapy (couple therapy), with regards to human sexuality and sex therapy.

The objectives of the study were:

- To explore and describe, through a literature study, the nature, status and characteristics of human sexuality and sex therapy from a theoretical point of reference.

- To explore the role of sex therapy in couple therapy from a theoretical point of reference and within the social work context.

- To determine the level of knowledge of the social worker in private practice, specialising in couple therapy, with regards to human sexuality and sex therapy.

- To make recommendations regarding the shortcomings of social worker's knowledge regarding human sexuality and sex therapy, identified by means of this study.

The following research question was formulated:

Do social workers in private practice who specialise in couple therapy, have a lack of knowledge regarding human sexuality and sex therapy?

A quantitative research approach was utilised for this study, and applied research was conducted, as this study wants to contribute possible solutions for the proposed lack of knowledge of social workers regarding sexuality issues.

The exploratory research design utilised was only implemented after a comprehensive literature study was undertaken, and after a pilot study was implemented. The research population for this study consisted of all the social workers who are registered with the South African Association of Social Workers in Private Practice (SAASWIPP), and who specialise in couple therapy. A total of three-hundred-and-forty-four questionnaires were mailed, as no sample was selected and the whole population was used, to ensure validity.

6.2.2 Conclusions

From this general introduction to the study the following conclusions can be drawn:

- There exist an interaction between sexual difficulties and relationship problems.

- Sexual dysfunctions and difficulties are not exclusive to heterosexual couples, but may also occur in homosexual relationships.

- Sexual dysfunctions do not occur in a vacuum, and must be viewed within the context of the total system of the client.

- Relationship problems and sexual problems or dysfunctions are often interlinked.

- Social workers should be non-judgemental in dealing with clients who are homosexual, or who participate in deviant behaviour.

- Because of the interaction between relationship problems and sexual problems, the social worker is the ideal person to deal with sexual difficulties, as he or she is well trained in the dynamics of marriage and relationship therapy.

- There is a need for specialised education and training of social workers in the field of human sexuality and sex therapy.

- Social workers or therapists treating couples with sexual distress, should always evaluate themselves and their motives, in terms of their own comfort level, as well as their knowledge base, regarding sexuality.

- Social workers treating sexual difficulties should have a network of other related professionals (like the general physician, the gynaecologist and the urologist) to enable them to consult these professionals where necessary. This will also simplify the therapeutic process and it would enable a following researcher to utilise the multi-professional approach to sexual difficulties, where appropriate.

- The problem that was researched by means of this study, namely, the proposed lack of knowledge of social workers specialising in marriage and relationship therapy (couple therapy), with regards to human sexuality and sex

therapy, is current and valuable to ensure that the social work profession keeps up to date with the worldwide movement to combine sex therapy with couple therapy.

- The quantitative research approach that was utilised in this study seems to have been appropriate, as it enabled the researcher to evaluate the knowledge of social workers, regarding human sexuality and sex therapy, statistically. These data also enabled the researcher to define the level of knowledge of respondents more definitely.

- The applied research that was implemented contributed to the effective development of possible solutions to the problem of the lack of knowledge of social workers, regarding human sexuality and sex therapy.

- The fact that no sample was taken and that the total population of social workers in private practice, specialising in couple therapy was selected as the research population, improved the validity and the reliability of the study, because the research was conducted country wide, and without any race, sex or other restrictions.

- The SAASWIPP database was not up to date. This resulted in many of the questionnaires being returned unopened.

6.2.3 Recommendations

- Even though the quantitative research approach was found to be effective in this applied research study, future research studies in this field could successfully utilise the qualitative research approach to gain more insight into the respondents' perceptions and feelings regarding sexuality.

- A combination of quantitative and qualitative research approaches can also be utilised successfully, as it will provide even more in-depth information.

- Future research can focus more specifically on the comfort level of respondents regarding specific sexually-related issues, as well as on general myths regarding sexuality that are still widely accepted as facts.

- Future research studies could also focus more on homosexual couples, and on the exploration of their specific needs that may exist, relating to relationship and sex therapy.

- Future studies can be extended to all registered social workers. It would also then be possible to draw interesting and insightful correlations between the knowledge of social workers within a structured career environment, and between social workers in private practice.

- Future research studies can thus utilise the database of the South African Council for Social Service Professions (SACSSP), provided that it is up to date.

- Social workers should be empowered by the knowledge and skills that they already have, as being well trained in the field of relationship therapy. The social worker's therapeutic skills to deal with sexual difficulties effectively within the context of relationship therapy can thus be enhanced by proving additional and specialised training and education regarding human sexuality and sex therapy.

- Future research could aid in the development of a course in human sexuality and sex therapy, specifically aimed at social workers.

- An interdisciplinary approach is necessary to cover all the aspects of sexual problems, as human sexuality and sex therapy are multi-dimensional in nature. The social worker should thus utilise the skills and knowledge of the family physician, the gynaecologist, the urologist, the psychiatrist and the psychologist to assist him or her in the assessment and intervention processes.

6.3 Chapter 2: Human sexuality and sex therapy: An overview

6.3.1 Summary

A short historical overview of human sexuality and sex therapy was given in Chapter 2. Sexuality has been part of human life and existence since ancient

times. The study of human sexuality as a science started as early as 1919. The history of sex therapy as a specialised discipline however, is relatively brief. Sexual problems and dysfunctions were originally treated from a psychoanalytical framework. Since the sexual revolution of the 1960's and 1970's an increased openness toward sexual issues occurred. A greater awareness of the importance of sexual fulfilment provided the impetus for the evolution and growth of sex therapy as a specialised field.

Masters and Johnson (1966) founded sex therapy as it is known today. They revolutionised what health professionals saw as the appropriate treatment for sexual difficulties. A new approach to sex therapy surfaced. The "new" sex therapy was relatively brief, problem focused, directive, and behavioural with regards to technique. In the years subsequent to Masters and Johnson, several changes have taken place in the approach to sex therapy. Corresponding to the changing nature of cases commonly seen by therapists, systemic approaches have been used to treat more complex, relationship-bound sexual problems. A more complex, integrative, or post-modern approach to the conceptualisation and treatment of sexual dysfunction has emerged. New models and techniques for sex and marital or relationship therapy are constantly being developed. Development in the field of sexual medicine and continuing research into human sexuality and relationship dynamics make this a dynamic field of research. There is a worldwide movement today towards combining sex therapy and relationship therapy. A holistic and multi-professional approach is being advocated, as no single dimension of human sexuality is universally dominant.

Various key components and terms, such as human sexuality, sexual health and sex therapy were defined. Different perspectives on human sexuality were also discussed. The biological dimension of sexuality encompasses both the sexual anatomy and sexual physiology of the male and the female. The physiological dimension includes the male and the female's sexual response cycle, as well as hormonal regulation of sexual function. The psychosocial dimension of sexuality includes psychosocial factors such as emotions, thoughts and personalities, in combination with social elements. The behavioural dimension of sexuality, focus on the understanding of people's sexual behaviour. The non-judgemental attitude of the therapist in dealing with clients with variant sexual behaviours is also stressed. The clinical dimension focus on physical problems such as illness, injury or the use of drugs and medication that interfere with sexual response, and possible solutions to these problems.

The cultural dimension focuses on the different cultural beliefs and their influence on the perceptions of people with regards to human sexuality and sexual functioning. The historical dimension states that we are to a certain extent bound by a sexual legacy that is passed on from generation to generation. The spiritual dimension asserts that religion has been a principal force in shaping sexual thought over the years, and still plays a major role in perceptions about sex and sexuality today.

6.3.2 Conclusions

From this overview of human sexuality and sex therapy the following conclusions can be drawn:

- Sexuality is part of human behaviour and culture since ancient times, and is multi-dimensional in nature.

- The study of sexuality as a science started at the beginning of the twentieth century.

- The history of sex therapy as a discipline however, is relatively brief, and was essentially founded by Masters and Johnson in the late 1960's.

- Therapeutic approaches to sex therapy and sexual dysfunction have changed over the last few years.

- A more complex, integrative, holistic and post-modern approach to therapy for sexual difficulties has emerged.

- There is a movement today towards the combination of sex therapy and couple/relationship therapy. Many sexual problems are viewed as symptoms of more complex relationship issues, or problems relating to a lack of emotional intimacy.

- Sexual dysfunction is not merely viewed as a dysfunction of one individual, but it is seen in the context of the relationship between the couple.

- The purpose of sexual health care should be the enhancement of life and personal relationships and not merely counselling and care related to procreation and physical problems.

- The biological dimension of sexuality encompasses both sexual anatomy and sexual physiology of the male and the female.

- The physiological dimension of sexuality encompasses the sexual response cycle of the male and the female as well as the hormonal regulation of sexual function.

- The psychological dimension of sexuality includes psychological factors such as emotions, the influence of different personality types, as well as communication and conflict resolution.

- The behavioural dimension of sexuality allows for a better understanding of people's reactions and behaviour.

- The clinical dimension of sexuality examines possible solutions to physical problems that alter sexual response, as well as possible solutions for negative feelings such as anxiety, guilt and embarrassment, which may hamper sexual functioning.

- The cultural dimension focuses on people's attitudes towards sexuality and on the influence of different culturally-learned morals and values on a person's sexual behaviour and attitudes.

- The historical dimension focuses on the influence of past views on and attitudes to contemporary sexual issues.

- The spiritual dimension of sexuality considers the role that religious beliefs play in people's perceptions toward sexuality.

6.3.3 Recommendations

The following recommendations are made keeping the before-mentioned conclusions in mind:

- Social workers should be educated to apply the worldwide trend of integrating sex therapy and relationship therapy, in their work with couples with relationship and/or sexual difficulties.

- Social workers should adopt a holistic approach to therapy.

- Social workers have an obligation to educate the community in which they work regarding sexual health. This education should not only deal with sexual

intercourse and reproduction, but also include such issues as self-esteem, self-expression and caring for one's own and other's bodies. Respect for others' cultural values should also be included.

- Future studies could focus more on the different cultural norms and values regarding human sexuality within the South African context.

- Social workers are already armed with various therapeutic skills that enable them to play a major role in the psychological dimension of sexuality education. They have expert skills and knowledge to educate and treat couples regarding effective communication skills, effective conflict resolution and the positive integration of different personality types within a relationship.

- The social worker should keep the spiritual dimension of sexuality in mind. This is especially true in the South African context where religion still plays a major and decisive role in people's attitudes and beliefs regarding sexuality and sexual behaviour.

6.4 Chapter 3: Clinical sex therapy

6.4.1 Summary

Research findings indicate that a substantial proportion of the adult population will experience some sort of sexual dysfunction at some point in their life. The

field of sex therapy has evolved to address this growing problem of sexual difficulties presented by clients. Sex therapy is a term that broadly refers to any systemic attempt by a healthcare professional to alleviate sexual dysfunction or difficulties experienced by clients.

Several authors advocate an integrated approach to therapy, including elements of psychodynamic, cognitive-behavioural and systemic treatment approaches. (Compare Weeks & Hof, 1987:5; Russell & Russell, 1992:82 & Woody, 1992:3.) All sex therapy approaches share the underlying assumption that there is a "natural" or "healthy" state of sexual functioning that therapists aim to restore for the client. The need to take a multivariate approach to theorising and model building is especially important to sex therapy.

Sexual and gender identity disorders were subsequently discussed. The various classifications of these disorders according to the Diagnostic and Statistical Manual of Psychiatric Disorders- IV were also elaborated upon.

Different models to treat sexual distress were described. The PLISSIT model and different variations of it, as foundation for sex therapy, was described. Different treatment modalities for sexual dysfunctions of the male and the female were subsequently discussed.

6.4.2 Conclusions

The following conclusions can be drawn:

- A substantial proportion of the adult population will experience some sort of sexual problem at some point in their lives.

- Sex therapy refers to any systemic attempt by a professional therapist to alleviate the sexual dysfunction or sexual difficulties experienced by a specific client.

- An integrated approach to therapy is needed.

- All sex therapy approaches share the underlying assumption that there is a healthy state of sexual functioning that therapists aim to restore for the client.

- Sexual and gender identity disorders are currently classified into four major categories: sexual dysfunctions, paraphilias, gender identity disorders and sexual disorders not otherwise specified.

- The PLISSIT model is widely used as a model to treat sexual distress.

- Treatment possibilities for erectile dysfunction are:
    - Penile self- injection therapy
    - Oral medication
    - Vacuum erection devices
    - Couple and sex therapy
    - Penile implants

- Treatment possibilities for premature ejaculation are:
    - The stop-start technique
    - The squeeze technique
    - Cognitive-behavioural interventions
    - Medication
    - Increasing the frequency of sexual stimulation

- Treatment possibilities for female sexual arousal disorder are:
    - Fantasy training
    - Kegel exercises
    - Masturbation training
    - Sensate focus exercises
    - Medication

- Treatment possibilities for female orgasmic disorder are:
    - Masturbation training
    - Sensate focus exercises
    - Relaxation exercises
    - Cognitive-behavioural therapy
    - Kegel exercises

- Treatment possibilities for anorgasmia include:
    - Lubricants

- Medical and or surgical interventions to treat the physical factors contributing to anorgasmia
- Relaxation therapy

- Treatment possibilities for vaginismus include:
  - Sensate focus exercises
  - Kegel exercises
  - Relaxation therapy
  - Specific exercises prescribed for vaginismus
  - Use of vaginal dilators

6.4.3 Recommendations

- A therapist counselling clients with sexual difficulties should always take a complete medical and sexual history from the client.

- It is important for social workers to have sufficient knowledge regarding human sexuality and sex therapy because of the high incidence of sexual dysfunctions and difficulties in society.

- Sex therapy should be a systemic, well-planned and integrated therapeutic approach.

- Social workers should have appropriate knowledge of the proposed healthy state of sexual functioning, in order to provide professional and ethical treatment.

- Social workers should have appropriate knowledge regarding the different classifications of sexual disorders in order to provide professional and effective treatment to clients.

- Social workers should be educated and skilled in the use of the PLISSIT model to treat sexual difficulties effectively.

- Social workers should also be educated and skilled in the different treatment modalities for the different sexual dysfunctions.

- Knowledge and skills breed comfort. A positive and comfortable approach to human sexuality is of utmost importance to provide a secure and comfortable environment in which clients can discuss possible sexual difficulties. The more knowledge social workers thus have, the better their comfort level would be to openly and non-judgementally discuss sexually-related issues with clients.

6.5 Chapter 4: The integration of couple therapy and sex therapy

6.5.1 Summary

With the growth of family therapy in the 1980s and 1990's, many authors began to discuss the influence of the couple system on sexual dysfunction. (Compare Russell & Russell, 1992:82; Woody, 1992:3 & Barnes, 1995:355.) They also proposed that couple therapy is an appropriate therapeutic context through which sexual dysfunction can be understood and treated. The importance of integrating sexual and marital/couple therapy is well documented.

Four specific areas of focus when evaluating the couple relationship within the context of sex therapy were described. These areas are:

- Psychometric indicators of marital adjustment
- Assessment of the current relationship style of the couple
- Identification and assessment of the current marital contract
- Exploration of the extended family

In chapter 4 the importance of a healthy sex life to strengthen the relationship was stressed, as well as the fact that a loving, committed relationship enhances the sexual relationship in turn. Sexual problems tend to have a ripple and snowball effect on the other components of the relationship, such as communication and conflict. These components should therefore also be

attended to in therapy. Relationship quality and sexual functioning are thus interlinked.

Various components of a relationship were discussed, namely, family of origin, motive for marriage, choice of partner, communications skills, conflict resolution skills, self image, role division, career, personal and collective growth, parenthood, finances, in-laws, spiritual growth, sexuality, love, trust and respect, time, touch, commitment, compromise and realistic expectations.

Intimacy as key component of a healthy sexual and emotional relationship was subsequently discussed. It transpired that redirecting therapy toward the issue of intimacy is a challenge for the effective therapist. Emotional intimacy is seen as the backbone of a healthy sexual relationship. Various levels and dimensions of intimacy were subsequently discussed.

The terms love, intimacy and sex and their relation to each other were also described. Love, intimacy and sex are the basis of primary, intimate and committed relationships.

The role of the social worker in dealing with clients with sexual difficulties was also discussed. The practice of social work has great potential for impacting on the sexual needs of clients. A dysfunctional relationship is likely to be characterised by accompanying complaints of a sexual nature. It transpired that it is impossible to treat relationship difficulties without also attending to the sexual concerns present. The role of the social worker is to enhance the

communication and conflict resolution skills of the couple, as well as assessing the other key components of the relationship. The improvement of the therapist's comfort level in dealing with sexual issues, as well as the development of positive attitudes toward sexuality, were stressed.

6.5.2 Conclusions

The following conclusions can be drawn:

- It is essential to enhance physical and emotional intimacy, by integrating sex therapy and couples therapy, regardless of the presenting complaint.

- Human sexuality is a multi-determined phenomenon and therapists need to have a multi-facetted approach to theorising and model building especially regarding sex therapy and couple therapy. With the multiple biogenic and psychogenic factors that may underlie sexual dysfunction, the need to consider the complex interplay of multiple factors is especially important.

- A social-work perspective on sexual health can be described as the enhancement or restoration of optimal sexual functioning within a relationship context.

- Social workers are well trained in couple therapy, and couple therapy is an appropriate therapeutic context through which sexual difficulties can be treated.

- Sexual difficulties should always be viewed as a relationship problem and not as an individual problem. Sexual problems are usually the result of some or other dysfunction in the relationship and should be treated by a holistic, eclectic approach of basic social work skills as well as couples therapy.

- Sex therapy has evolved towards the integration of both couples and sex therapy techniques. This presents the social worker with a unique opportunity to act in a dual role with clients.

6.5.3 Recommendations

The following recommendations can be made:

- Social workers should be educated to treat clients with sexual difficulties with a holistic and multi-professional approach.

- Social workers should be trained to integrate sex therapy and couple therapy.

- Social workers should network in order to establish a support system in his/her immediate community in order to utilise the skills and knowledge of the family physician, the gynaecologist, the urologist and other related professionals. This network will support the multi-professional approach that needs to be taken in the treatment of sexual difficulties.

6.6 Chapter 5: Empirical results

6.6.1 Summary

Chapter 5 reported the empirical results obtained from the quantitative data that were obtained by means of a self-constructed mailed questionnaire.

The research population consisted of all social workers who are registered with SAASWIPP as social workers in private practice, and who specialise in couple therapy. There were a total of 344 respondents and the response rate was 23%.

Ninety-three percent of respondents were female, while only 7% were male. The age of respondents varied between 30 and 74 years and the average age of respondents was 48.32 years at the time of the survey.

The majority (69%) of respondents were married at the time of the study, while 14% were divorced.

The year in which respondents obtained their first degree stretched from 1948 to 1997 of which the largest percentage (76.9%) was between 1965 and 1991.

The highest percentage (47%) of respondents obtained a four-year bachelors degree in social work, while 37% hold a masters degree and 9% a doctoral

degree. Only 7% of respondents hold a 3-year social work degree. A large percentage (76.78%) of respondents completed other educational or training courses related to marriage/relationship and sex therapy. Most of these additional training courses were however short 2-3 day courses.

The number of years of social work experience of respondents stretched from 6 years to 48 years. The majority (73.13%) of respondents have between 10 and 25 years social work experience. Seventy-four-point-two-four percent of respondents had between 3 and 10 years experience as a social worker in private practice.

The majority of respondents (47.76%) were English speaking, while 38.81% of respondents were Afrikaans speaking and 13.43% spoke other languages.

Eighty-five percent of respondents were white, 12% black and 3% Indian. The largest number (74.63%) of respondents were protestant, 7.46% Roman Catholic and 8.96% Jewish.

The majority of respondents (80.88%) indicated that they are able to refer clients to specialists in the field of sex therapy. Ninety-six percent of respondents indicated a need for social workers to be trained in human sexuality and sex therapy. Many respondents were of the opinion that this training should be included on the undergraduate, as well as on the post-graduate level.

The most frequent sexual problem presented by clients was lack of desire disorder (51%) and libido differences (51%). Most of the respondents regarded themselves as being comfortable in discussing sexual problems with clients openly.

The majority of respondents (35%) received their primary sex education from peers, while 33% received it from their mother. Literature and books were also prevalent with 22% listing these sources.

The majority of respondents (52.38%) were of the opinion that they occasionally see clients that are in need of sex therapy, while 22.22% were of the opinion that they frequently see clients in need of sex therapy.

Fifty-six-point-five-two percent of respondents occasionally take a complete sexual history from clients, while 26.09% of respondents never or rarely ever take a sexual history. Only 17.4% of respondents frequently take a sexual history from clients.

An average of 58.53% of respondents answered the knowledge-based questions correctly. A large percentage of respondents however declined to answer some of the questions.

6.6.2 Conclusions

Conclusions from the empirical research findings, which were to a large extent supported by findings of the literature study, were the following:

- The male to female ratio indicated in this study correlates with the male to female ratio of social workers countrywide.

- Social workers in private practice, specialising in couple therapy, are mainly white, Afrikaans or English speaking and from a protestant background.

- A largest percentage of social workers in private practice are of middle age (between 40 and 50 years). This could indicate more life experience as well as more professional experience.

- The majority of social workers in private practice as indicated in this study are married, which may aid in their credibility as therapists in providing effective sex therapy.

- The large percentage (76.78%) of respondents indicated that they obtained additional training. This may lead to the conclusion that there does exist a need for additional training of social workers in the field of human sexuality and sex therapy, and that social workers are open to continuing professional development.

- The majority of these additional training courses were short courses. It is however possible to provide extensive information in a short 2 to 3 day course. It should however be stressed that practical implementation and the development of skills related to sex therapy should also be included in training.

- The level of knowledge of respondents correlates with the number of years social work experience they have.

- Social workers in private practise specialising in couple therapy do lack knowledge regarding human sexuality and sex therapy. The respondents in this study answered only 58.53% of the knowledge-based questions correctly.

6.6.3 Recommendations

The following recommendations can be made:

- Training in human sexuality and sex therapy should be included in the undergraduate, post-graduate and continuing education levels of social work training.

- This training should include desensitisation, the improvement of comfort levels regarding the subject of sexuality, as well as intensive practical and skills training.

- Future research studies can aid in the development of a course in human sexuality and sex therapy aimed at social workers specifically, as no such course exists presently.

- The field of social work can gain much in providing a commonly accepted, standardised and peer-reviewed course in human sexuality and sex therapy.

- Such a course should be accredited with the South African Qualifications Authority (SAQA), and should ideally be recognised internationally to optimise the value of such a course.

6.7 Testing of the research goal

6.7.1 Goal

The aim of this study is to explore and describe the knowledge of social workers in private practice, specialising in marriage and relationship therapy (couple therapy), with regards to human sexuality and sex therapy.

In order to achieve this goal a thorough literature study and pilot study were conducted. Experts in the field of marriage and relationship therapy as well as experts in the field of sex therapy were consulted.

A broad perspective and historical background to clinical sex therapy as well as to couple therapy were described. The importance of the integration of sex therapy and couple therapy was also discussed in detail. The role of the social worker in providing sex therapy, as couple therapist with specialised knowledge, was also described.

The level of knowledge of social workers in private practice, specialising in marriage and relationship therapy (couple therapy), was explored by the utilisation of a self-constructed mailed questionnaire.

The goal of this study was successfully reached as the knowledge of social workers in private practice, specialising in marriage and relationship (couple therapy) with regards to human sexuality and sex therapy, was successfully explored. The findings of the research data also enabled the researcher to describe the level of knowledge of respondents successfully.

6.8 Testing of the research objectives

6.8.1 To explore and describe, through a literature study, the nature, status and characteristics of human sexuality and sex therapy from a theoretical point of reference.

To achieve this objective a literature study was conducted in which the nature, status and characteristics of human sexuality and sex therapy were explored and described in detail. This was done from a theoretical point of reference.

6.8.2 To explore the role of sex therapy in couple therapy from a theoretical point of reference and within the social work context.

This objective was successfully reached by exploring the role of sex therapy in couple therapy from a theoretical point of reference, by means of a literature study. It was concluded that couple therapy and sex therapy can be and should be successfully integrated by social workers specialising in couple therapy.

6.8.3 To determine the level of knowledge of the social worker in private practice, specialising in couple therapy, with regards to human sexuality and sex therapy.

This objective was successfully reached by determining the level of knowledge of social workers in private practice, specialising in couple therapy, with regards to human sexuality and sex therapy, by means of a self-constructed mailed questionnaire obtaining certain knowledge-based questions. It was determined that social workers do lack knowledge regarding human sexuality and sex therapy as only 58.53% of these questions were answered correctly.

6.8.4 To make recommendations regarding the shortcomings of social workers' knowledge regarding human sexuality and sex therapy, identified by means of this study.

This goal was successfully reached by the fact that the research outcomes aided the researcher in making certain recommendations regarding the shortcomings of social workers' knowledge regarding human sexuality and sex therapy, as indicated in chapter 6.

6.9 Testing of the research question

A characteristic of exploratory research is that it does not have a hypothesis and the purpose is to gain insight into a situation (Bless & Higson-Smith, 1995:42). Dane (1990:5) also states that exploratory research involves an attempt to determine whether or not a phenomenon exists. The following research question was thus formulated:

Do social workers in private practice that specialise in couple therapy have a lack of knowledge regarding human sexuality and sex therapy?

The research findings indicted that there exists a lack of knowledge among social workers in private practice, specialising in couple therapy, with regards to human sexuality and sex therapy and that they should improve their knowledge regarding the subject. This statement was confirmed by the research findings that only 58.53% of the knowledge-based questions in the questionnaire were answered correctly. Many respondents did not even

answer many of the questions, which led the researcher to conclude that they also did not know the correct answer.

6.10 Formulating of hypotheses

Fouché (2002:97) states that researchers frequently have to investigate phenomena for which few established models exist. This is also true for this study. Fouché (2002:97) states further that in this type of situation, researchers have to attempt to generate new hypotheses by using exploratory studies.

Based on the research findings, the following hypotheses can be formulated to be used as a point of departure in subsequent research.

- If social workers have a broad knowledge base regarding human sexuality and sex therapy, meaningful and successful treatment and service will be provided to clients who experience sexual difficulties.

- If education and training regarding human sexuality and sex therapy are provided on the undergraduate level of social work training, the student will be empowered with comfort and knowledge to deal effectively with the sexual problems of clients, from the start of his/her career as a social worker.

- If social workers regularly attend courses on human sexuality and sex therapy, on a continuing educational level, the level of service and

treatment to clients with sexual problems and relationship difficulties, will be improved.

- If social workers are trained to integrate relationship therapy and sex therapy the success rate of relationship therapy will be improved.

6.11 Value of this study

This study was of great value to the researcher personally. Being a specialist in the field of sex therapy, a need was identified to provide social workers with scientific knowledge regarding the subject of human sexuality and sex therapy, and it is with great pleasure and sense of accomplishment that this study is completed. The researcher's knowledge base and skills in the integration of couple therapy and sex therapy were also extended to a great amount.

This research study can also be of great value for the profession of social work as it provides a basis for further research and confirms the need for specialised training courses for social workers in human sexuality and sex therapy.

Finally, the research can also be of value for the study field of sexology and sex therapy as it provides information on the integration of couple therapy and sex therapy.

6.12 Concluding remarks

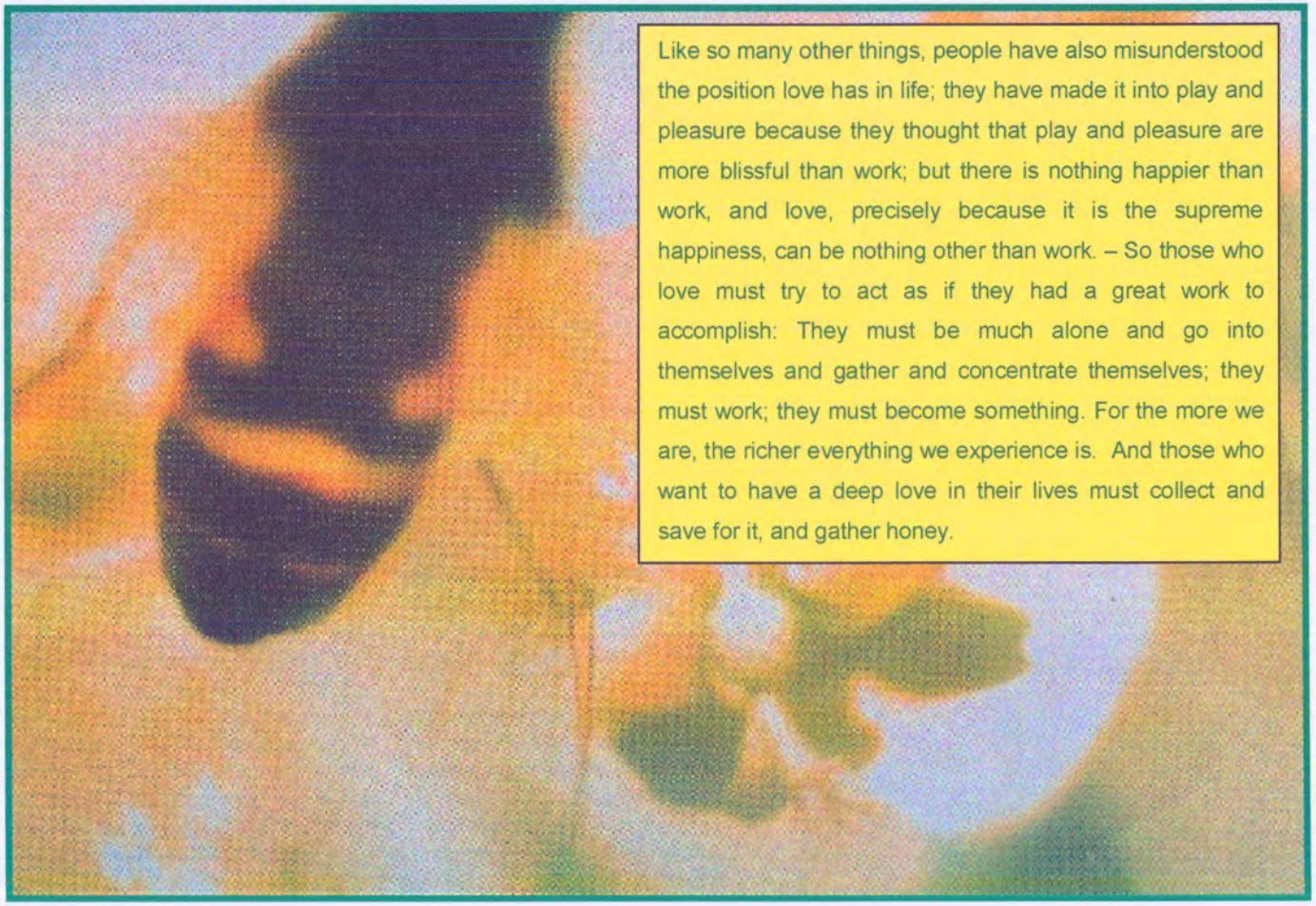
This study confirmed the need for additional training of social workers in the field of human sexuality and sex therapy. It also confirmed the importance of a multi-theoretical integrative and multi-professional approach for the effective treatment of sexual distress in a holistic manner.

The researcher agrees with the following remarks as stated in The Oprah Magazine (October, 2001:40-41):

" A marriage where not only esteem, but passion is kept awake, is, I am convinced, the most perfect state of sublunary happiness..." – Francis Brooke, playwright.

" The married are those who have taken the terrible risk of intimacy and, having taken it, know life without intimacy to be impossible." – Corolyn Heilbrun, author and educator.

This dissertation concludes with the following poem by Rilke (2002:45):



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APPENDICES

APPENDIX A - MEDICAL HISTORY QUESTIONNAIRE

Medical History Questionnaire

Personal Data

Date Name

Home Address

City State Zip

Home Phone Work Phone Cell/Pager

Date of Birth Occupation

Referring Physician

Name Phone

Address

City State Zip

Do you wish a report sent to this physician? Yes No

Present Symptoms

Please briefly describe your symptoms, giving their date of onset, treatments prescribed, and the physicians you have consulted.

Have you had or do you have now any of the following conditions?

	Yes	No	Don't Know
1. Diabetes			
2. Tuberculosis			
3. Anemia			
4. Bleeding tendency or easy bruising			
5. Other tumors or cancer			
6. Mumps			
7. Rheumatic fever			
8. Scarlet fever			
9. Nervous disorder			
10. Gallbladder disease			
11. Venereal disease			
12. Hepatitis			
13. Cirrhosis			
14. Epilepsy			
15. Headaches			
16. Dizziness or fainting spells			
17. Eye injuries			
18. Double vision			
19. Blurring vision			
20. Eye Pain			
21. Cataracts			
22. Glaucoma			
23. Earaches			
24. Ringing or buzzing in the ear			
25. Loss of hearing			
26. Sensation of spinning			
27. Sinus trouble			
28. Nose bleeds			
29. Skin disease			
30. Bleeding gums			
31. Skin tumors or moles removed			
32. Chronic or frequent colds			
33. Thyroid problems			
Diagnosed with hypothyroid			
Diagnosed with hyperthyroid			
Medication & dosage (please list overleaf)			
Surgery			
Radiation			
34. Frequent laryngitis			
35. Hoarseness			
36. Lumps in breast			
37. Pain in breast			
38. Nipple discharge			
39. Heart disease			
40. High blood pressure			
41. Pain or pressure in chest			

	Yes	No	Don't Know
42. Shortness of breath			
43. Ankle swelling			
44. Pain in legs while walking			
45. Fast or irregular heartbeat			
46. Heart murmurs			
47. Heart attack			
48. Chronic cough, coughed up blood			
49. When was your last chest X-ray?			
50. Soaking Sweats			
51. Asthma			
52. Stomach, liver intestinal trouble			
53. Recent gain or loss of weight			
54. Decreased appetite			
55. Difficulty with swallowing			
56. Nausea, vomiting			
57. Diarrhea			
58. Constipation			
59. Change in bowel movements			
60. Black bowel movements			
61. Blood in stool			
62. Jaundice			
63. Kidney trouble			
64. Painful urination			
65. Kidney stones or blood in urine			
66. Sugar or albumin in urine			
67. Passing urine at night			
68. Slow starting of urine stream			
69. Arthritis			
70. Back or bone pain			
71. Clumsiness of hands or feet 72. Numbness of hands or feet			
73. Muscle pain or weakness			
74. Memory loss			
75. Reaction to drugs or medication			
76. Swollen glands			
77. Unusual fatigue			
78. Excessive depression			
79. Sexual impotence			
80. Smoking			
81. Daily alcohol intake			
82. Hepatitis (A, B, C)			
83. STD's			
HIV/AIDS			
HPV (genital warts)			
Herpes			
Gonorrhea			
Chlamydia			
Syphilis			

Illnesses, Accidents, and Hospitalizations

Please list in chronological order.

Year	Type	Hospital	Physician's Name

Past Surgeries

Please list in chronological order.

Year	Type of Operation	Reason	Hospital

Past Radiation Therapy Treatment

Please list in chronological order.

Please note dates treatment started and ended.

Started		Stopped		Area of Body Treated	Hospital	Physician's Name
Mo	Yr	Mo	Yr			

Medications

Please list any medications you are now taking:

Pain Pills

_____ _____
_____ _____
_____ _____
_____ _____

Tranquilizers

_____ _____
_____ _____
_____ _____

Sleeping Pills

_____ _____
_____ _____
_____ _____

Other

_____ _____
_____ _____
_____ _____

Please list any medications to which you have had an allergic reaction:

_____ _____
_____ _____
_____ _____

Family History

Have any of your blood relatives, husband, or children had the following conditions? Please check each item.

Yes	No	Condition	Relation
		Tuberculosis	
		Diabetes	
		Cancer	
		Leukemia	
		Anemia	
		Bleeding tendency	
		Heart disease	
		High blood pressure	
		Kidney disease	
		Asthma, hay fever, other disorder	
		Chronic arthritis	
		Nervous or mental disorder	
		Goiter	
		Emphysema	
		Any other illness	

Current Health Status

Relation	Age	State of Health	If Deceased, Cause	Age at Death
Mother				
Father				
Spouse				
Brothers				
Sisters				
Children				

Urologic and Gynecologic History

Please circle "Yes" or "No", check the appropriate blank, or write your answer in the blanks. Feel free to add any other comments in the margins, on the back of the page, or on a separate sheet of paper.

I. Incontinence

Do you ever have difficulty controlling your urine, or lose urine accidentally? Yes No
If no, please go to Part II on the next page.
If yes, please answer the questions below.

How long have you had trouble controlling your urine? months _____ years_____

How often does it happen that you lose urine accidentally?

_____ More than once a day
_____ Approximately once a day
_____ Not daily, but at least once a week
_____ 1 to 4 times a month
_____ Less than once a month

Do you wear pads or devices to protect yourself against accidental urine loss? Yes No
If yes, how many pads do you need each day?_____

Do you leak urine during certain activities? Yes No
If yes, which activities?

_____ Coughing
_____ Sneezing
_____ Sports
_____ Exercise
_____ Lifting
_____ Other_____

Do you ever accidentally leak urine while you are sitting still? Yes No

If yes, do you feel the urge to urinate before the accident occurs? Yes No

Do you accidentally leak urine while you are lying flat (but not sleeping)? Yes No

If no: If your bladder is full, what happens when you rise to a standing position?

Do you accidentally leak urine while you are sleeping? Yes No

Have you tried any medication(s) to keep you from losing urine accidentally? Yes No

If yes, which medication(s)?

Have you had any operation(s) to keep you from losing urine accidentally? Yes No

If yes, what type of operation(s) and dates?

If yes, what happened after the operation(s)?

II. Frequency and Urgency

How often do you urinate during the daytime?

_____ Every 3 hrs or longer
_____ Every 2 to 3 hrs
_____ Every 1 to 2 hrs
_____ Every 30 minutes or less

If this varies, please tell about your best days and your worst days.

How many times do you have to urinate at night?

_____ None
_____ 1 time
_____ 2 times
_____ 3 times
_____ 4 times
_____ 5 to 8 times
_____ more than 8 times

If this varies, please tell about your best nights and your worst nights.

When you feel the urge to urinate, can you wait a few minutes or do you have to rush to the bathroom?

_____ Have to rush
_____ Can wait

III. Pain

Do you now have pain or burning when you urinate? Yes No

Have you ever had pain or burning during urination? Yes No
If yes, please describe the situation(s) in which pain occurred.

Have you tried any medication(s) or treatments for pain? Yes No
If yes, how did they affect you?

Do you have pain or discomfort with a full bladder, which is relieved by urinating? Yes No
If yes, please describe any factors (diet, activity, time in menstrual cycle, etc.) that make the discomfort either better or worse.

Have you tried any medication(s) or treatment for the pain? Yes No
If so, how did they affect you?

Do you experience vaginal pain? Yes No

IV. Urinary Infection

Have you ever had an infection of the urinary tract? Yes No
If no, please go to Part V.
If yes, please answer the following questions:

What symptoms did you have when you had the infection(s)?

Did the symptoms improve quickly with antibiotics? Yes No

How old were you when you had the first infection?

When was your most recent infection?

Has any other doctor ever sent your urine to the laboratory for culture? Yes No
If yes, what were the results?

V. Gynecology

When was your most recent Pap smear?

How old were you when you had your first menstrual period?

Are you presently using any method of birth control? Yes No
If yes, what method?

How many babies have you had by vaginal delivery?

How many babies have you had by cesarean section?

Have you had twins, triplets or other multiple births?

Were any of your deliveries especially prolonged or difficult? Yes No
If yes, please describe what happened.

Are you still having menstrual periods? Yes No
If yes: What was the date of your last period?

Please describe any problems you are having with your periods –
such as pain, excessive bleeding, irregularity, etc

If you are no longer having menstrual periods:
How old were you when your periods stopped?

Did they stop because of menopause, or did you have a hysterectomy?

If you had a hysterectomy, please answer the following:

What was the reason for surgery?

Was the hysterectomy done through the abdomen or the vagina?

Were the ovaries removed at the same time? Yes No Don't know

Were any other surgical procedures done at the same time? Yes No Don't know
If yes, what were the other procedures?

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PHYSICAL EXAMINATION -9-

Date: _____ Pt. Name: _____

L.U.M.C. S.D.C.

Use the following codes to indicate findings for those categories reviewed during this examina
☑WNL = All category items are within normal limits POS = An item with positive findin
X = Mark X across names of categories not examined

GENERAL ☐WNL
a. Posture ____
b. Gait ____
c. Speech ____
d. Appearance ____
e. Emotion ____

HEAD ☐WNL
a. Hair ____
b. Masses ____
c. Shape ____
d. Bruits ____
e. Tenderness ____
f. Sinus ____

EYES ☐WNL
a. Lids R__L__
b. Sclera R__L__
c. Conjunctiva R__L__
d. Muscles R__L__
e. Cornea R__L__
f. Pupils R__L__
g. Fundi R__L__
h. Light R__L__
i. Bruit R__L__
j. Accommodation R__L__

EARS ☐WNL
a. Pinna R____L____
b. Canal R____L____
c. Drum R____L____
d. Weber ____
e. Rinne ____

NOSE ☐WNL
a. Septum ____
b. Mucosa R__L__
c. Obstruction ____

MOUTH/THROAT ☐WNL
a. Lips ____
b. Breath ____
c. Tongue ____
d. Pharynx ____
e. Tonsils ____
f. Teeth ____
g. Dentures ____
h. Caries ____
i. Larynx ____
j. Floor ____
k. Mucosa ____

NECK ☐WNL
a. Thyroid ____
b. Trachea ____
c. Veins ____
d. Spine ____
e. Nodes R__L__
f. Bruit R__L__
g. Carotid R__L__
h. Motion ____

LUNGS ☐WNL
a. Chest ____
b. Symmetry ____
c. Diaphragm ____
d. Rubs ____
e. Bruit ____
f. Sounds ____
g. Fremitus ____

HEART ☐WNL
B.P. ✓
Pulse: ____
a. PMI ____
b. Rate ____
c. Rhythm ____
d. Thrill ____
e. Tones ____
f. Rub ____
g. Murmurs ____

BREASTS ☐WNL
a. Nodes R__L__
b. Discharge R__L__
c. Nipple R__L__
d. Areolar R__L__
e. Symmetry R__L__
f. Consistency R__L__
g. Scars R__L__

ABDOMEN ☐WNL
a. Contour ____
b. Tenderness ____
c. Organs ____
d. Masses ____
e. Hernia R__L__
f. Bruit R__L__
g. Sounds R__L__
h. Femoral pulse R__L__
i. Ing nodes R__L__

BACK ☐WNL
a. Curvation ____
b. Mobility ____
c. Tenderness ____
CVA Renal ____
Bone ____

FEMALE GENITALS ☐WNL
a. Labia ____
b. Bartholin's gland ____
c. Urethra ____
d. Vagina ____
e. Cervix ____
f. Uterus ____
g. Adnexa R__L__
h. Pap smear done ____
i. Discharge ____

MALE GENITALS ☐WNL
a. Penis ____
b. Scrotum ____
c. Testicles ____
d. Discharge ____
e. Scars ____
f. Meatus ____
g. Epididymis ____
h. Varicocele ____

RECTAL ☐WNL
a. Pilonidal ____
b. Anus ____
c. Sphincter ____
d. Fissure ____
e. Prostate ____
f. Masses ____
g. Hemorrhoids ____
h. Sigmoid ____
____cm.
i. Mucosa ____
j. Other ____

SKIN ☐WNL
a. Scars ____
b. Birthmarks ____
c. Other marks ____
d. Texture ____
e. Sweat ____
f. Color ____
g. Ulcers ____

NEUROLOGIC ☐WNL

	Strength*	Reflex**
a. Biceps	R____L____	R____L____
b. Triceps	R____L____	R____L____
c. Knee	R____L____	R____L____
d. Ankle	R____L____	R____L____
e. Romberg	____	
f. Babinski	____	
g. Cranial N	____	
h. Sensory	____	
i. Coordination		____
j. Tremor		____
k. Vibratory		____

EXTREMITIES ☐WNL

a. Shoulder	R____L____	i. Hip	R____L____
b. Arm	R____L____	j. Leg	R____L____
c. Elbow	R____L____	k. Knee	R____L____
d Radial pulse	R____L____	l. Ankle	R____L____
e. Wrist	R____L____	m. Foot	R____L____
f. Hand	R____L____	n. Pedal pulse	R____L____
g. Fingers	R____L____	o. Toes	R____L____
h. Nails	R____L____	p. Nails	R____L____

Comments: Δ:

*When testing strength use grades: Weak (W); Normal (N); Strong (S)
**When testing reflexes use Absent (A); Present (P); Brisk (B)

M.D/LUMS
Signature

PROGRESS NOTES: WEEK THREE:

WEEK FOUR:

WEEK FIVE:

WEEK SIX:

WEEK SEVEN: CLOSING SUMMARY:

APPENDIX B - SEXUAL HISTORY QUESTIONNAIRE

LOYOLA UNIVERSITY SEXUAL DYSFUNCTION CLINIC
2160 South First Avenue, Maywood, Illinois, 60153

Domeena C. Renshaw, M.D., Director
5/1/91

SEXUAL HISTORY

DATE: _____

NAME: _____ SPOUSE: _____

ADDRESS: _____

Phone: Home: _____ Work: _____

Age: _____ Age of Spouse: _____

Occupation: _____ Of Spouse: _____

Education: _____ Of Spouse: _____

Religion: _____ Of Spouse: _____

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

_____

How did your spouse feel about coming here? _____

_____

Which of you suggested it? _____

Who made the first call? _____

Did you or your partner feel any pressure from the other to come? _____

What discussion did you have in the car coming here? _____

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

_____

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

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

Are you committed to this marriage? _____

Is your spouse? _____

MEDICAL HISTORY

Present state of health: _____
Last check-up: _____
Serious medical illnesses: _____
Surgery: _____
Medications: _____
Over-the-counter medicines: _____
Cigarettes (daily): _____
Alcohol (daily intake): _____
Problem due to alcohol (self or spouse): _____
Psychiatric illness: Self: _____ Describe: _____
Hospitalization: _____
Spouse: _____ Describe: _____
Child: _____ Describe: _____
Family member: _____ Describe: _____
Suicide sttempt: Self: _____ Describe: _____
Spouse: _____ Describe: _____
Child: _____ Describe: _____
Family member: _____ Describe: _____
Violent episode: Self: _____ Describe: _____
Spouse: _____ Describe: _____

FAMILY HISTORY:

Duration of this marriage:_____ Children:_____

Names and ages of children: Problems with child/ren:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

No. of previous marriage/s:_____ Duration:_____

No. of children:_____ Name/s & Age/s:_____

Custody:_____ Visits:_____ Conflicts:_____

Description (including sexual adjustment):_____

financial adjustment:_____

Ex. spouse's name:_____

Who left/filed for divorce?_____

Why ended:_____

Effect on this marriage:_____

Spouse's previous marriage/s:_____ Duration:_____

No. of children:_____ Name/s & Age/s:_____

Name of ex. spouse:_____

Sexual problem: Self:_____ Spouse:_____

What do you see as your own greatest problem?_____

How long has it existed?_____

Why are you now seeking help?_____

_____

Previous help:_____ From:_____

Are you committed to this marriage?_____

Is your spouse committed to this marriage?_____

In this marriage, how are these handled?

	Self	Spouse
Communication		
Finances		
In-laws		
Orderliness		
Arguments		
Affection		
Suspicions		
Control		
Trust		
Faithfulness		
Love		
Religion		
Cooking		
Health		
Humor		
Fun/play		
Time		
Transport		
Stepfamily issues		
Children		
Decisions		
Leadership		

What attracted you to this partner?_____
How did you meet your partner?_____
What did you like best?_____
What do you now like least?_____
Courtship:_____ Duration:_____ Petting:_____
Premaritally any sex?_____ Love;_____ Communication:_____
First sexual encounter: (with spouse):_____

First sexual encounter: (with other):_____

Honeymoon: Duration:_____ Description:_____

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

How do you account for this?_____

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

ORIGINAL FAMILY OF BIRTH:

Father: Age:_____ Occupation:_____
Background (educational and cultural):_____

Type of relationship with his wife:_____

Attitude toward sex:_____

Type of relationship with you as a child:_____
Now:_____

Mother: Age:_____ Occupation:_____
Background (educational and cultural):_____

Type of relationship with her husband:_____

Attitude toward sex:_____

Type of relationship with you as a child:_____
Now:_____
Parents' sex life:_____

Home sex education:_____

Brothers and sisters: type of relationship with you and their adjustment to marri and life:

Name	Age	Marital Status	Positives/Negatives

Who was most important to you as a child?_____
Did you feel part of your family?_____

What kind of a family were you?_____
How was discipline handled?_____
Did anything about your family trouble you as a child or teenager?_____
_____
_____
_____

Childhood sex exploration and sex play (age and outcome - pleasure/trauma):_____
_____
_____

First menstruation: age:_____ feelings:_____
Parental attitude:_____
Instructions at onset:_____
Prior education/preparation:_____
_____
Was contraception discussed?_____
Specific fears regarding menses/pregnancy:_____
_____

PRESENT NUCLEAR FAMILY:

Own children and how you relate to them:_____
_____
_____
_____
What kind of family life do you have now?_____
_____
What kind of parent are you?_____
How do you handle discipline?_____
What kind of parent is your spouse?_____
How does he/she handle discipline?_____
How do you handle sex education for your children?_____
Has family/child counseling been used?_____
In-laws: (positives/negatives):_____

PERSONAL:

Own Education: Level:_____
Learning Problems:_____
Grades:_____
Sports:_____
Social activities:_____
Problems:_____
Civic activities:_____
Problems:_____
Hobbies:_____
Problems:_____
Job: Description:_____
Satisfaction:_____
Problems: holding:_____ Changing:_____ Coping:_____
Supervisors:_____ Co-workers:_____ Supervisees:_____
Money/Bills/Bankruptcy:_____
Other:_____

Military Service: Yes/No_____ Date:_____ Details:_____
_____

EMOTIONAL:

What kind of a person are you?_____
Feelings of inferiority:_____
Sensitivity:_____

EMOTIONAL:

Anxiety
Depression
Appetite
Weight loss
Insomnia (duration and details):

Self-confidence
Influence of religion on your marriage

Influence of religion on yourself (seminary, convent, etc.)

Influence of religion on your sexuality

Influence of religion on your partner's sexuality

How would you describe your marriage?

What would you change about your marriage?

What would you change about your partner?

Do you think your partner loves you?
Do you love your partner?
Did you, in the past, fear/wish the loss of your partner? and now?
Did your partner, in the past, fear/wish the loss of you? and now?
Miscarriages: Details: What year/s:
Extramarital activity:
Does spouse know?
Details:

SEXUAL HISTORY:

Have you, in the past, ever thought of/threatened/attempted separation or divor

If yes, how did you resolve the conflict?

Did you have sexual problems before?
How does this affect your spouse's sexual function?

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

Own remedies: alcohol? other partners? etc.
Reading: sex manuals, magazines, etc.
What is your concept of the optimum sexual function for a woman?

Should she approach him for sex?
For a man?
Should he always make sex advances?
What is your concept of marital roles for a wife?
in bed Conflict?
socially Conflict?
financially Conflict?
with children Conflict?
other Conflict?

What is your concept of marital roles for a husband?
in bed _____ Conflict? _____
socially _____ Conflict? _____
financially _____ Conflict? _____
with children _____ Conflict? _____
other _____ Conflict? _____
Own sexual satisfaction: Yes____ No____ Comment: _____
Frequency of affectionate expression per week: _____
Frequency of intercourse per week: _____
Difficulties: irregular climax: _____ no climax: _____
Repulsion: _____ Why? _____
Pain? _____ Where? _____
Erection difficulty: _____ What? _____
Morning erections? _____ Frequency per week: _____
With masturbation? _____ With specific partner? _____
Describe in detail first episode of erection problem: (alcohol/anxiety/anger): ___
_____
_____
Ejaculation: premature: _____ delayed _____
KISSING: yes/no____ Who initiates?____ Preference:____ Aversion:____ Conflict:__
FOREPLAY: yes/no____ Who initiates?____ Preference:____ Aversion:____ Conflict:__
MASTURBATION: Religious attitude: _____ Feared consequences: _____
Guilt: _____ Aversion: _____ Attempts to control: _____
Age first masturbation: _____ Frequency pre-marriage: _____
Frequency per week now: _____ Does partner know? _____
Feelings: _____ Masturbatory fantasies: _____
Discovery/Trauma: _____

ORAL SEX: Fellatio: Yes/No____ Who initiates?____ Preference____ Aversion____
Conflict _____
Cunnilingus: Yes/No____ Who initiates?____ Preference____ Aversion___
Conflict _____
Anal intercourse: Yes/No____ Who initiates?____ Preference____ Aversi
Conflict _____
Age first intercourse: ____ Details (pleasure/trauma): _____
Preferred I/C position: _____
First childhood sex play: Age:____ Details (pleasure/trauma): _____
Sex fantasy: frequency _____
questions _____
concerns _____
content _____
Reading sexual material: Yes/No____ Who initiates____ Preference____ Aversion___
Conflict _____
Vibrator: Yes/No____ Comment: _____
Venereal Disease: Yes_____ No_____ Type: _____
Method of Contraception:
B.C. pill _____ Duration _____ Feelings _____
Brand _____ Symptoms _____
Intrauterine Device _____ Diaphragm _____ Vasectomy _____
Foam _____ Jelly _____ Rhythm _____ Condom _____
Conflict in this area: _____
Rape (real): _____ Age:____ Details: _____
Rape (fantasies): _____
Specific fears about sex? _____
_____
Specific guilts about sex: _____
_____
Specific hang-ups about sex: _____
_____

Child molestation: _____

Incest: (Details - touch/full coitus. How much alcohol involved?) Trauma/pleasur

_____

Name relative: _____

Fertility problems: Details: _____

Fertility issues: Duration: _____ Cost: _____ Details: _____

Reactions: Self: _____ Partner: _____

Sex during pregnancy: _____

Sex feelings during delivery of babies: Yes/No/Maybe & afterwards? _____

Labor anesthetic: Yes/No _____

Breast feeding: Yes: _____ No: _____

Sexual feelings while breast feeding: No: _____ Yes: _____

Homosexual fears: _____

_____

Homosexual episode/s: pleasure/trauma: _____

_____

Specific sexual enjoyment today: _____

_____

Summary: (end of visit one)

a.)	nudity in bed	never/sometimes/often
b.)	lights on during sexplay	never/sometimes/often
c.)	touching own genitals	never/sometimes/often
d.)	touching partner's genitals	never/sometimes/often
e.)	foreplay in bed (over 3 min.)	never/sometimes/often
f.)	new sexual positions	never/sometimes/often
g.)	sexual discussion with partner	never/sometimes/often
h.)	guilt around sex act	never/sometimes/often
i.)	anxiety around sex act	never/sometimes/often
j.)	shame about sex activity	never/sometimes/often
k.)	enjoyment of sexplay	never/sometimes/often
l.)	enjoyment of sex act	never/sometimes/often
m.)	frequency of masturbation	per month
n.)	frequency of intercourse	per month

Any special comments? _____

_____

_____

_____

_____

MENTAL STATUS: _____

_____

Judgement: _____

Orientation: _____

Intellect: _____

Memory: _____

Affect: _____

_____

_____

_____

_____

_____

DIAGNOSIS: _____

_____

_____

_____

IMPRESSION: _____

_____

_____

_____ Signature: _____

_____

_____ Signature: _____

_____

_____

WEEK TWO: Date: _____

Home loveplay: _____

Frequency: _____

Details: _____

Arousal/Erections with loveplay: _____

Arousal/Erections with masturbation: _____

Sexual fantasy: _____

Other: _____

Surprise: _____

I-Language: _____

_____

Conflicts: _____

_____

Questions: _____

_____

_____

_____

Important issues to discuss: _____

_____

_____

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_____

APPENDIX C - SENSATE FOCUS EDUCATION

SENSATE FOCUS EDUCATION

Sensate Focus is a phrase for "petting", massaging, intimate touch, foreplay both sensual and sexual. Note the differences between sexual and sensual in yourself (many have not learned to differentiate them, especially men). Feelings of affection and sex are a natural, normal, healthy part of each of us.

These 30 minute daily suggestions are for you at home. Bathe, undress totally. Lock your door, take the phone off the hook. Soft lights & music. Sensual first rather than sexual, i.e., sound, sight, smells, thoughts, taste, and touch that are pleasing to each. Freely tell your partner. Become self aware. Relax and enjoy. This is a "joy" break to refresh you. Avoid the pressure of time and performance. Each be acutely SELF-AWARE of feelings, both as a giver and a receiver. Express in sound, smile or words your reactions. It is a wonderful gift to your partner to know that you are enjoying. Many women do not realize this. If you are solo, use lots of fantasy and do the same touch pleasuring. A warm soaping and a hot soak, a top-to-toe lotion, a towel massage, a cottonbud tickle are some ways to have fun end experiment with your skin responses.

STEP 1

A: Face exploration, with fingertips and lips, eyes open and closed. Also, ears and neck. Light, firm, brush, feather etc. Be creative.

B: Explore body; stroke lightly and firmly, massage, caress, kiss areas of pleasurable sensation on entire back, arms, chest, abdomen, legs, etc. Take turns. Guide with words, own hand, sounds. Say how it feels. RELAX. Breathe in and out slowly. Use Fantasy.

C: Avoid the breast and genital areas. No intercourse. If arousal or erections occur, simply stop, hug, let the erections subside deliberately. Tell your partner of the arousal, embrace awhile. Then start to play again. This connects your sensual end sexual self and build confidence. Think of this special fun during the day, tomorrow. It's yours free to repeat. Add surprises and laughter.

APPENDIX D - KEGEL EXERCISES

KEGEL EXERCISES

SLOW KEGELS

Tighten the P.C. muscle and hold it as you did when you stopped the flow of urine for a slow count to 3. Then relax the muscle.

QUICK KEGELS

Tighten and relax the P.C. muscle as rapidly as you can. At first it will feel like a flutter. You will gradually gain more control.

PULL IN / PUSH OUT

Pull up the entire pelvic area as though trying to suck up water into your genitals. Then push out or bear down as if trying to push the imaginary water out. (This exercise will use a number of "stomach" or "abdominal" muscles as well as the P.C. muscle).

REPETITIONS

At first do ten of these exercises (pone set), 3 times a day.
(3 exercises X 10 X 3 times a day = 90 total exercises to start).

Each week add 5 more times to each exercise.
Example: Week 2 – 3 sets X 15 times X 3 times a day
Week 3 – 3 sets X 20 times X 3 times a day
Week 4 – 3 sets X 25 times X 3 times a day.
Keep doing 3 sets a day.

You can help yourself remember to do the exercises by associating them with some activity you do every day: talking on the phone, watching television, waiting in line, or lying on the bed. Think of activities which don't require much moving around.

Don't worry if your muscles seem to get tired easily at first, that's normal for exercising any new muscle group. Rest between sets for a few seconds and start again. Remember to keep breathing naturally.

You can place one or two fingers into the vagina in order to feel the movement and strength of the muscle. You may watch the movement by looking at your genitals in a hand mirror. Doing these things with your Kegels will help you learn more rapidly.

Optional exercise for men with too much time on their hands: when the penis is erect, sit or stand with you legs apart and try wagging your penis up and down or sideways by squeezing the muscles in the groin.

APPENDIX E - VAGINISMUS SPECIFIC EXERCISES

VAGINISMUS - SPECIFIC EXERCISES

- Lock the door, disconnect the phone, and lie down in a comfortable spot. Breathe very slowly and open your mouth when you exhale.
- Insert a well-lubricated finger, into your vagina and continue to breathe deeply.
- Relax. Explore your vagina. Breathe slowly and deeply.
- Deliberately contract the muscles in the lower third of the vagina very tightly around your finger. Relax and repeat.
- Repeat these exercises for five minutes twice daily. On the first two days use one finger. For the next two days, insert two fingers, while breathing slowly in and out with your mouth open. Contract and relax the muscles surrounding the opening of the vagina.
- On the next two days ask your partner to insert one lubricated finger into your vagina while you continue your slow, open-mouthed breathing. Guide his finger into your vagina. Use plenty of sexual fantasy to keep your mind focussed on your sexuality.
- On the following two days, after an extended period of foreplay, let your partner lie passively, straddle him, and stuff his non-erect penis into your vagina. Contract and relax your vaginal muscles around his soft penis.
- The important thing is to remember that you are in control.
- Do not be concerned if you need more time for any of these stages.

APPENDIX F - THE GOLOMBOK RUST INVENTORY OF MARITAL STATE (GRIMS) QUESTIONNAIRE

The Golombok Rust Inventory of Marital State (GRIMS) Questionnaire

Before beginning the questionnaire, please complete this section in block capitals.

NAME: ..... SEX: .....

DATE: ..... AGE: ..... LENGTH OF RELATIONSHIP: .....Years ..... Months

Instructions

Each statement is followed by a series of possible responses: strongly disagree (SD), disagree (D), agree (A), strongly agree (SA). Read each statement carefully and decide which response best describes how you feel about your relationship with your partner, then circle the corresponding response.

Please respond to every statement: if none of the responses seem completely accurate, circle the one which you feel is most appropriate. Do not spend too long on each question.

Please answer this questionnaire without discussing any of the statements with your partner. In order for us to obtain valid information, it is important for you to be as honest and as accurate as possible.

All information will be treated in the strictest confidence.

1. My partner is usually sensitive to and aware of my needs.	SD	D	A	SA
2. I really appreciate my partner's sense of humor.	SD	D	A	SA
3. My partner doesn't seem to listen to me any more.	SD	D	A	SA
4. My partner has never been disloyal to me.	SD	D	A	SA
5. I would be willing to give up my friends if it meant saving our relationship.	SD	D	A	SA
6. I am dissatisfied with our relationship.	SD	D	A	SA
7. I wish my partner was not so lazy and didn't keep putting things off.	SD	D	A	SA
8. I sometimes feel lonely even when I am with my partner.	SD	D	A	SA
9. If my partner left me, life would not be worth living.	SD	D	A	SA
10. We can "agree to disagree" with each other.	SD	D	A	SA
11. It is useless carrying on with a marriage beyond a certain point.	SD	D	A	SA
12. We both seem to like the same things.	SD	D	A	SA
13. I find it difficult to show my partner that I am feeling affectionate.	SD	D	A	SA
14. I never have second thoughts about our relationship.	SD	D	A	SA
15. I enjoy just sitting and talking with my partner.	SD	D	A	SA
16. I find the idea of spending the rest of my life with my partner rather boring.	SD	D	A	SA
17. There is always plenty of "give and take" in our relationship.	SD	D	A	SA
18. We become competitive when we have to make decisions.	SD	D	A	SA
19. I no longer feel I can really trust my partner.	SD	D	A	SA
20. Our relationship is still full of joy and excitement.	SD	D	A	SA
21. One of us is continually talking and the other is usually silent.	SD	D	A	SA
22. Our relationship is continually evolving.	SD	D	A	SA
23. Marriage is really more about security and money than about love.	SD	D	A	SA
24. I wish there were more warmth and affection between us.	SD	D	A	SA
25. I am totally committed to my relationship with my partner.	SD	D	A	SA
26. Our relationship is sometimes strained because my partner is always correcting me.	SD	D	A	SA
27. I suspect we may be on the brink of separation.	SD	D	A	SA
28. We can always make up quickly after an argument.	SD	D	A	SA

APPENDIX G - QUESTIONNAIRE: "THE KNOWLEDGE OF SOCIAL WORKERS IN PRIVATE PRACTICE REGARDING HUMAN SEXUALITY AND SEX THERAPY"

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Dear Colleague,

Many marriages in South Africa today end in divorce, as you may well be aware off. According to literature sexual problems and dysfunctions remain some of the most prominent reasons for marital problems. During the last few years sex therapy shifted from being considered to be an individual problem, to being a couple's problem and even a family problem, thereby becoming part of marital and couple therapy.

I am currently conducting research about the knowledge of social workers in private practise regarding human sexuality and sex therapy. This research is conducted with the goal of obtaining a Masters Degree in Social Work from the Department of Social Work at the University of Pretoria, and to develop a curriculum for sex therapy training within the social work discipline in future. Applied research will be conducted and it would be exploratory in nature.

I would appreciate it if you could spare 20 minutes of your time to complete the attached questionnaire. It is important to establich the current knowledge of social workers regarding human sexuality and sex therapy. A pre-paid envelope is included to minimise cost and effort on your part.

This is an anonymous questionnaire and no identifying particulars are being required. All information will be treated confidentially and will be analysed via computer.

Feel free to contact Elmari Craig at 082 783 6633 or (012) 997-4633 for any further information or enquiries.

Your co-operation in this regard is highly appreciated.

Regards.

Elmari Craig
MASTERS CANDIDATE

Prof. M.S.E. (Rita) du Preez
STUDY LEADER

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Questionnaire

"The knowledge of social workers in private practice regarding human sexuality and sex therapy"

Respondent Number:

For office use

V1 [ ][ ][ ] 1-3

Please supply your response to the following questions by indicating the correct answer with an X.

SECTION I

1. Sex:

Male	1	
Female	2	

V2 [ ] 4

2. Age:

[ ] Years

V3 [ ][ ] 5-6

3. Marital status:

Never married	1	
Married	2	
Living together	3	
Divorced	4	
Widowed	5	

V4 [ ] 7

4. Which year did you obtain your first degree/diploma:

[ ]

V5 [ ][ ][ ][ ] 8-11

5. Highest qualification:

3-year diploma	1	
4-year degree	2	
Honours	3	
Masters	4	
Doctoral	5	

V6 [ ] 12

6. Name any other educational or training courses you attended related to marriage counselling and sex therapy.

Course	Duration	Institution

V7 [ ][ ][ ] 13-15
V8 [ ][ ][ ] 16-18
V9 [ ][ ][ ] 19-21
V10 [ ][ ][ ] 22-24

7. Years social work experience:

	V11 25-26

8. Years practising as a social worker in private practice?

	V12 27-28

9. Home language:

English	1		V13 29-30
Afrikaans	2		
Zulu	3		
Venda	4		
Tswana	5		
Xhosa	6		
Northern Sotho	7		
Tshonga	8		
Swazi	9		
Ndebele	10		
Southern Sotho	11		
Other	12		

Specify:.....

10. Race:

White	1		V14 31
Coloured	2		
Indian	3		
Black	4		

11. Religious denomination:

Protestant	1		V15 32
Roman Catholic	2		
Jewish	3		
Moslem/Islam	4		
Tamil/Hindu	5		
No Religion	6		
Other	7		

Specify:.....

SECTION II

1. Are you aware of specialists in the field of sexology/sex therapy to refer clients to?

Yes	1		V16 ☐33
No	2		
Unsure	3		

2. Is there in your opinion a need for social workers to be trained in the field of human sexuality and sex therapy?

Yes	1		V17 ☐34
No	2		
Unsure	3		

2.1 If no, why not? V18 ☐35

2.2 If yes ...

	1 Yes	2 No	3 Unsure		
Pre-graduate				V19	☐36
Post-graduate as a specialty (e.g. Masters)				V20	☐37
Post-graduate as short course/seminar				V21	☐38

3. What is the most frequent sexual difficulty of married couples according to your experience? V22 ☐39

4. Rate the following sexual problems in order of the frequency that clients present with it in your practice:

	1 very often	2 often	3 seldom		
Lack of desire				V23	☐40
Libido differences between male and female				V24	☐41
Anorgasmia				V25	☐42
Premature ejaculation				V26	☐43
Erectile dysfunction				V27	☐44
Painful intercourse				V28	☐45
Other Specify:.....				V29	☐46

2. Do you take a complete sexual history from your clients?

Never	1		V37 ☐54
Rarely	2		
Occasionally/when necessary	3		
Frequently	4		
Always	5		

3. Please indicate whether you agree with the following statements:

	1 Yes	2 No	3 Unsure		
Masturbation offers a satisfactory outlet at all ages for the release of sexual tension				V38	☐55
Oral sex is something that the majority of sexually active people engage in				V39	☐56
It is difficult to refer to the various parts of the genitals by their scientific names when discussing sexually-related issues with clients				V40	☐57
It is possible to discuss sexual related matters with my partner				V41	☐58
Sexual fantasies are a powerful aphrodisiac because they offer people a chance to enjoy sexual activities they might not normally - or necessarily ever - want to experience				V42	☐59
Sexual fantasies can lead to immoral behaviour				V43	☐60
Masturbation practised too frequently causes fatigue and physical debilitation				V44	☐61
Masturbation is sometimes an effective alternative to penetrative sex within a marriage				V45	☐62
Oral sex is dangerous and should be avoided				V46	☐63
Pre-marital sex is harmful and should be avoided				V47	☐64
It is normally a comfortable situation counselling clients with sexually related problems				V48	☐65
Anal sex is painful and leads to HIV infection				V49	☐66
Homosexuality can effectively be reversed by behavioural modification				V50	☐67
Anal sex is only practised during male sex				V51	☐68
There are some heterosexual couples who enjoy the practise of anal sex				V52	☐69
Functionally speaking the circumcised penis does not have a foreskin to retract during coitus or masturbation as the uncircumcised penis has				V53	☐70

	Yes	No	Unsure		
Priapism is an ability of some men to attain erections frequently and with minimum stimulation				V54	71
Retrograde ejaculation means delayed ejaculation				V55	72
Males have a greater sexual capacity than females				V56	73
The most important hormone in sexual motivation in males and females is testostorone				V57	74
All orgasms are intense, explosive events				V58	75

SECTION IV

1. Would you describe the following as sexual dysfunctions?

	1 Yes	2 No	3 Unsure		
Sexual aversion				V59	76
Hypo-active sexual arousal				V60	77
Anorgasmia				V61	78
Vaginismus				V62	79
Dyspareunia				V63	80
Retarded ejaculation				V64	81
Pedophilia				V65	82
Voyeurism				V66	83

2. The following is a term used to describe a condition in which a person's sexual gratification is dependant on an unusual sexual experience. A neutral term for sexual alternatives that have been called deviant.

Fetishisms	1	V67	84
Paraphilias	2		
Gender Identity Disorders	3		
Sexual dysfunctions	4		

3. Which one of the following models is the basis for sex therapy and describes permission-giving, basic information giving, home loveplay exercises and intensive therapy as the last resort?

Masters and Johnson	1	V68	85
Plissit	2		
Freudian	3		
Kinsey	4		

4. How much longer does women on average take to reach orgasm than a man?

Twice as long	1		V69 ☐86
Four times as long	2		
Six times as long	3		
Ten times as long	4		

5. How many women are able to reach orgasm with penetration only?

80-100%	1		V70 ☐87
60-80%	2		
40-60%	3		
20-30%	4		

6. Is it possible for women to be multi-orgasmic?

Yes	1		V71 ☐88
No	2		
Unsure	3		

7. Endowing inanimate objects with erotic properties is most closely related to a sexual variation known as:

Voyeurism	1		V72 ☐89
Exhibitionism	2		
Fetishism	3		
Zoophilia	4		

8. With his 0-6 scale, Kinsey measures the:

libido differences between men and women	1		V73 ☐90
balance of hetero- and homosexual feelings	2		
frequency of hetero- and homosexual experiences per year	3		

9. Menopause is caused by:

	1 Yes	2 No	3 Unsure		
atrophy of the uterus				V74	☐91
shrinkage of the vagina				V75	☐92
cessation of sexual drive				V76	☐93
poor diet				V77	☐94
decreased production of estrogen				V78	☐95

10. Penis size usually determines ...

	1 Yes	2 No	3 Unsure		
the male's ability to impregnate a female.				V79	☐96
the degree of male pleasuring during coitus.				V80	☐97
the female's sexual satisfaction.				V81	☐98
little, if anything, physiologically.				V82	☐99

11. In older men ...

	1 Yes	2 No	3 Unsure		
the refractory period becomes longer.				V83	100
the excitement phase becomes shorter.				V84	101
the plateau phase becomes shorter.				V85	102

12. Which of the following are the phases of the sexual response cycle in proper sequence according to Masters and Johnson?

plateau, orgasm, excitement, resolution	1		V86 103
excitement, orgasm, resolution, plateau	2		
refractory period, orgasm, resolution, plateau	3		
excitement, plateau, orgasm, resolution	4		

13. Removal of the penis before ejaculation, is ...

ejaculatory control.	1		V87 104
the rhythm method.	2		
coitus interruptus.	3		
expulsion.	4		

14. An involuntary muscular spasm that closes the vaginal entrance is called ...

vaginitus	1		V88 105
vaginismus	2		
hymenitis	3		
dyspareunia	4		

15. Medication, the stop-start technique and the squeeze technique, are suitable treatments for ...

erectile dysfunction	1		V89 106
premature ejaculation	2		
hypo-sexual desire disorder	3		

16. Sensate focus can involve ...

	1 Yes	2 No	3 Unsure		
non-genital touching of one partner by the other.				V90	107
prolonged touching of one's partner's genitals.				V91	108
giving and receiving pleasure.				V92	109
focusing on the journey and not on the destination				V93	110

Any other comments:

.....

.....

Thank you for your co-operation!

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APPENDICES

APPENDIX A - MEDICAL HISTORY QUESTIONNAIRE

Medical History Questionnaire

Personal Data

Date Name

Home Address

City State Zip

Home Phone Work Phone Cell/Pager

Date of Birth Occupation

Referring Physician

Name Phone

Address

City State Zip

Do you wish a report sent to this physician? Yes No

Present Symptoms

Please briefly describe your symptoms, giving their date of onset, treatments prescribed, and the physicians you have consulted.

Have you had or do you have now any of the following conditions?

	Yes	No	Don't Know
1. Diabetes			
2. Tuberculosis			
3. Anemia			
4. Bleeding tendency or easy bruising			
5. Other tumors or cancer			
6. Mumps			
7. Rheumatic fever			
8. Scarlet fever			
9. Nervous disorder			
10. Gallbladder disease			
11. Venereal disease			
12. Hepatitis			
13. Cirrhosis			
14. Epilepsy			
15. Headaches			
16. Dizziness or fainting spells			
17. Eye injuries			
18. Double vision			
19. Blurring vision			
20. Eye Pain			
21. Cataracts			
22. Glaucoma			
23. Earaches			
24. Ringing or buzzing in the ear			
25. Loss of hearing			
26. Sensation of spinning			
27. Sinus trouble			
28. Nose bleeds			
29. Skin disease			
30. Bleeding gums			
31. Skin tumors or moles removed			
32. Chronic or frequent colds			
33. Thyroid problems			
Diagnosed with hypothyroid			
Diagnosed with hyperthyroid			
Medication & dosage (please list overleaf)			
Surgery			
Radiation			
34. Frequent laryngitis			
35. Hoarseness			
36. Lumps in breast			
37. Pain in breast			
38. Nipple discharge			
39. Heart disease			
40. High blood pressure			
41. Pain or pressure in chest			

	Yes	No	Don't Know
42. Shortness of breath			
43. Ankle swelling			
44. Pain in legs while walking			
45. Fast or irregular heartbeat			
46. Heart murmurs			
47. Heart attack			
48. Chronic cough, coughed up blood			
49. When was your last chest X-ray?			
50. Soaking Sweats			
51. Asthma			
52. Stomach, liver intestinal trouble			
53. Recent gain or loss of weight			
54. Decreased appetite			
55. Difficulty with swallowing			
56. Nausea, vomiting			
57. Diarrhea			
58. Constipation			
59. Change in bowel movements			
60. Black bowel movements			
61. Blood in stool			
62. Jaundice			
63. Kidney trouble			
64. Painful urination			
65. Kidney stones or blood in urine			
66. Sugar or albumin in urine			
67. Passing urine at night			
68. Slow starting of urine stream			
69. Arthritis			
70. Back or bone pain			
71. Clumsiness of hands or feet 72. Numbness of hands or feet			
73. Muscle pain or weakness			
74. Memory loss			
75. Reaction to drugs or medication			
76. Swollen glands			
77. Unusual fatigue			
78. Excessive depression			
79. Sexual impotence			
80. Smoking			
81. Daily alcohol intake			
82. Hepatitis (A, B, C)			
83. STD's			
HIV/AIDS			
HPV (genital warts)			
Herpes			
Gonorrhea			
Chlamydia			
Syphilis			

Illnesses, Accidents, and Hospitalizations

Please list in chronological order.

Year	Type	Hospital	Physician's Name

Past Surgeries

Please list in chronological order.

Year	Type of Operation	Reason	Hospital

Past Radiation Therapy Treatment

Please list in chronological order.

Please note dates treatment started and ended.

Started		Stopped		Area of Body Treated	Hospital	Physician's Name
Mo	Yr	Mo	Yr			

Medications

Please list any medications you are now taking:

Pain Pills

_____ _____
_____ _____
_____ _____
_____ _____

Tranquilizers

_____ _____
_____ _____
_____ _____

Sleeping Pills

_____ _____
_____ _____
_____ _____

Other

_____ _____
_____ _____
_____ _____

Please list any medications to which you have had an allergic reaction:

_____ _____
_____ _____
_____ _____

Family History

Have any of your blood relatives, husband, or children had the following conditions? Please check each item.

Yes	No	Condition	Relation
		Tuberculosis	
		Diabetes	
		Cancer	
		Leukemia	
		Anemia	
		Bleeding tendency	
		Heart disease	
		High blood pressure	
		Kidney disease	
		Asthma, hay fever, other disorder	
		Chronic arthritis	
		Nervous or mental disorder	
		Goiter	
		Emphysema	
		Any other illness	

Current Health Status

Relation	Age	State of Health	If Deceased, Cause	Age at Death
Mother				
Father				
Spouse				
Brothers				
Sisters				
Children				

Urologic and Gynecologic History

Please circle "Yes" or "No", check the appropriate blank, or write your answer in the blanks. Feel free to add any other comments in the margins, on the back of the page, or on a separate sheet of paper.

I. Incontinence

Do you ever have difficulty controlling your urine, or lose urine accidentally? Yes No
If no, please go to Part II on the next page.
If yes, please answer the questions below.

How long have you had trouble controlling your urine? months _____ years_____

How often does it happen that you lose urine accidentally?

_____ More than once a day
_____ Approximately once a day
_____ Not daily, but at least once a week
_____ 1 to 4 times a month
_____ Less than once a month

Do you wear pads or devices to protect yourself against accidental urine loss? Yes No
If yes, how many pads do you need each day?_____

Do you leak urine during certain activities? Yes No
If yes, which activities?

_____ Coughing
_____ Sneezing
_____ Sports
_____ Exercise
_____ Lifting
_____ Other_____

Do you ever accidentally leak urine while you are sitting still? Yes No

If yes, do you feel the urge to urinate before the accident occurs? Yes No

Do you accidentally leak urine while you are lying flat (but not sleeping)? Yes No

If no: If your bladder is full, what happens when you rise to a standing position?

Do you accidentally leak urine while you are sleeping? Yes No

Have you tried any medication(s) to keep you from losing urine accidentally? Yes No

If yes, which medication(s)?

Have you had any operation(s) to keep you from losing urine accidentally? Yes No

If yes, what type of operation(s) and dates?

If yes, what happened after the operation(s)?

II. Frequency and Urgency

How often do you urinate during the daytime?

_____ Every 3 hrs or longer
_____ Every 2 to 3 hrs
_____ Every 1 to 2 hrs
_____ Every 30 minutes or less

If this varies, please tell about your best days and your worst days.

How many times do you have to urinate at night?

_____ None
_____ 1 time
_____ 2 times
_____ 3 times
_____ 4 times
_____ 5 to 8 times
_____ more than 8 times

If this varies, please tell about your best nights and your worst nights.

When you feel the urge to urinate, can you wait a few minutes or do you have to rush to the bathroom?

_____ Have to rush
_____ Can wait

III. Pain

Do you now have pain or burning when you urinate? Yes No

Have you ever had pain or burning during urination? Yes No
If yes, please describe the situation(s) in which pain occurred.

Have you tried any medication(s) or treatments for pain? Yes No
If yes, how did they affect you?

Do you have pain or discomfort with a full bladder, which is relieved by urinating? Yes No
If yes, please describe any factors (diet, activity, time in menstrual cycle, etc.) that make the discomfort either better or worse.

Have you tried any medication(s) or treatment for the pain? Yes No
If so, how did they affect you?

Do you experience vaginal pain? Yes No

IV. Urinary Infection

Have you ever had an infection of the urinary tract? Yes No
If no, please go to Part V.
If yes, please answer the following questions:

What symptoms did you have when you had the infection(s)?

Did the symptoms improve quickly with antibiotics? Yes No

How old were you when you had the first infection?

When was your most recent infection?

Has any other doctor ever sent your urine to the laboratory for culture? Yes No
If yes, what were the results?

V. Gynecology

When was your most recent Pap smear?

How old were you when you had your first menstrual period?

Are you presently using any method of birth control? Yes No
If yes, what method?

How many babies have you had by vaginal delivery?

How many babies have you had by cesarean section?

Have you had twins, triplets or other multiple births?

Were any of your deliveries especially prolonged or difficult? Yes No
If yes, please describe what happened.

Are you still having menstrual periods? Yes No
If yes: What was the date of your last period?

Please describe any problems you are having with your periods –
such as pain, excessive bleeding, irregularity, etc

If you are no longer having menstrual periods:
How old were you when your periods stopped?

Did they stop because of menopause, or did you have a hysterectomy?

If you had a hysterectomy, please answer the following:

What was the reason for surgery?

Was the hysterectomy done through the abdomen or the vagina?

Were the ovaries removed at the same time? Yes No Don't know

Were any other surgical procedures done at the same time? Yes No Don't know
If yes, what were the other procedures?

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PHYSICAL EXAMINATION -9-

Date: _____ Pt. Name: _____

L.U.M.C. S.D.C.

Use the following codes to indicate findings for those categories reviewed during this examina
☑WNL = All category items are within normal limits POS = An item with positive findin
X = Mark X across names of categories not examined

GENERAL ☐WNL
a. Posture ____
b. Gait ____
c. Speech ____
d. Appearance ____
e. Emotion ____

HEAD ☐WNL
a. Hair ____
b. Masses ____
c. Shape ____
d. Bruits ____
e. Tenderness ____
f. Sinus ____

EYES ☐WNL
a. Lids R__L__
b. Sclera R__L__
c. Conjunctiva R__L__
d. Muscles R__L__
e. Cornea R__L__
f. Pupils R__L__
g. Fundi R__L__
h. Light R__L__
i. Bruit R__L__
j. Accommodation R__L__

EARS ☐WNL
a. Pinna R____L____
b. Canal R____L____
c. Drum R____L____
d. Weber ____
e. Rinne ____

NOSE ☐WNL
a. Septum ____
b. Mucosa R__L__
c. Obstruction ____

MOUTH/THROAT ☐WNL
a. Lips ____
b. Breath ____
c. Tongue ____
d. Pharynx ____
e. Tonsils ____
f. Teeth ____
g. Dentures ____
h. Caries ____
i. Larynx ____
j. Floor ____
k. Mucosa ____

NECK ☐WNL
a. Thyroid ____
b. Trachea ____
c. Veins ____
d. Spine ____
e. Nodes R__L__
f. Bruit R__L__
g. Carotid R__L__
h. Motion ____

LUNGS ☐WNL
a. Chest ____
b. Symmetry ____
c. Diaphragm ____
d. Rubs ____
e. Bruit ____
f. Sounds ____
g. Fremitus ____

HEART ☐WNL
B.P. ✓
Pulse: ____
a. PMI ____
b. Rate ____
c. Rhythm ____
d. Thrill ____
e. Tones ____
f. Rub ____
g. Murmurs ____

BREASTS ☐WNL
a. Nodes R__L__
b. Discharge R__L__
c. Nipple R__L__
d. Areolar R__L__
e. Symmetry R__L__
f. Consistency R__L__
g. Scars R__L__

ABDOMEN ☐WNL
a. Contour ____
b. Tenderness ____
c. Organs ____
d. Masses ____
e. Hernia R__L__
f. Bruit R__L__
g. Sounds R__L__
h. Femoral pulse R__L__
i. Ing nodes R__L__

BACK ☐WNL
a. Curvation ____
b. Mobility ____
c. Tenderness ____
CVA Renal ____
Bone ____

FEMALE GENITALS ☐WNL
a. Labia ____
b. Bartholin's gland ____
c. Urethra ____
d. Vagina ____
e. Cervix ____
f. Uterus ____
g. Adnexa R__L__
h. Pap smear done ____
i. Discharge ____

MALE GENITALS ☐WNL
a. Penis ____
b. Scrotum ____
c. Testicles ____
d. Discharge ____
e. Scars ____
f. Meatus ____
g. Epididymis ____
h. Varicocele ____

RECTAL ☐WNL
a. Pilonidal ____
b. Anus ____
c. Sphincter ____
d. Fissure ____
e. Prostate ____
f. Masses ____
g. Hemorrhoids ____
h. Sigmoid ____
____cm.
i. Mucosa ____
j. Other ____

SKIN ☐WNL
a. Scars ____
b. Birthmarks ____
c. Other marks ____
d. Texture ____
e. Sweat ____
f. Color ____
g. Ulcers ____

NEUROLOGIC ☐WNL

	Strength*	Reflex**
a. Biceps	R____L____	R____L____
b. Triceps	R____L____	R____L____
c. Knee	R____L____	R____L____
d. Ankle	R____L____	R____L____
e. Romberg	____	
f. Babinski	____	
g. Cranial N	____	
h. Sensory	____	
i. Coordination		____
j. Tremor		____
k. Vibratory		____

EXTREMITIES ☐WNL

a. Shoulder	R____L____	i. Hip	R____L____
b. Arm	R____L____	j. Leg	R____L____
c. Elbow	R____L____	k. Knee	R____L____
d Radial pulse	R____L____	l. Ankle	R____L____
e. Wrist	R____L____	m. Foot	R____L____
f. Hand	R____L____	n. Pedal pulse	R____L____
g. Fingers	R____L____	o. Toes	R____L____
h. Nails	R____L____	p. Nails	R____L____

Comments: Δ:

*When testing strength use grades: Weak (W); Normal (N); Strong (S)
**When testing reflexes use Absent (A); Present (P); Brisk (B)

M.D/LUMS
Signature

PROGRESS NOTES: WEEK THREE:

WEEK FOUR:

WEEK FIVE:

WEEK SIX:

WEEK SEVEN: CLOSING SUMMARY:

APPENDIX B - SEXUAL HISTORY QUESTIONNAIRE

LOYOLA UNIVERSITY SEXUAL DYSFUNCTION CLINIC
2160 South First Avenue, Maywood, Illinois, 60153

Domeena C. Renshaw, M.D., Director
5/1/91

SEXUAL HISTORY

DATE: _____

NAME: _____ SPOUSE: _____

ADDRESS: _____

Phone: Home: _____ Work: _____

Age: _____ Age of Spouse: _____

Occupation: _____ Of Spouse: _____

Education: _____ Of Spouse: _____

Religion: _____ Of Spouse: _____

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

_____

How did your spouse feel about coming here? _____

_____

Which of you suggested it? _____

Who made the first call? _____

Did you or your partner feel any pressure from the other to come? _____

What discussion did you have in the car coming here? _____

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

_____

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

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

Are you committed to this marriage? _____

Is your spouse? _____

MEDICAL HISTORY

Present state of health: _____
Last check-up: _____
Serious medical illnesses: _____
Surgery: _____
Medications: _____
Over-the-counter medicines: _____
Cigarettes (daily): _____
Alcohol (daily intake): _____
Problem due to alcohol (self or spouse): _____
Psychiatric illness: Self: _____ Describe: _____
Hospitalization: _____
Spouse: _____ Describe: _____
Child: _____ Describe: _____
Family member: _____ Describe: _____
Suicide sttempt: Self: _____ Describe: _____
Spouse: _____ Describe: _____
Child: _____ Describe: _____
Family member: _____ Describe: _____
Violent episode: Self: _____ Describe: _____
Spouse: _____ Describe: _____

FAMILY HISTORY:

Duration of this marriage:_____ Children:_____

Names and ages of children: Problems with child/ren:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

No. of previous marriage/s:_____ Duration:_____

No. of children:_____ Name/s & Age/s:_____

Custody:_____ Visits:_____ Conflicts:_____

Description (including sexual adjustment):_____

financial adjustment:_____

Ex. spouse's name:_____

Who left/filed for divorce?_____

Why ended:_____

Effect on this marriage:_____

Spouse's previous marriage/s:_____ Duration:_____

No. of children:_____ Name/s & Age/s:_____

Name of ex. spouse:_____

Sexual problem: Self:_____ Spouse:_____

What do you see as your own greatest problem?_____

How long has it existed?_____

Why are you now seeking help?_____

_____

Previous help:_____ From:_____

Are you committed to this marriage?_____

Is your spouse committed to this marriage?_____

In this marriage, how are these handled?

	Self	Spouse
Communication		
Finances		
In-laws		
Orderliness		
Arguments		
Affection		
Suspicions		
Control		
Trust		
Faithfulness		
Love		
Religion		
Cooking		
Health		
Humor		
Fun/play		
Time		
Transport		
Stepfamily issues		
Children		
Decisions		
Leadership		

What attracted you to this partner?_____
How did you meet your partner?_____
What did you like best?_____
What do you now like least?_____
Courtship:_____ Duration:_____ Petting:_____
Premaritally any sex?_____ Love;_____ Communication:_____
First sexual encounter: (with spouse):_____

First sexual encounter: (with other):_____

Honeymoon: Duration:_____ Description:_____

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

How do you account for this?_____

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

ORIGINAL FAMILY OF BIRTH:

Father: Age:_____ Occupation:_____
Background (educational and cultural):_____

Type of relationship with his wife:_____

Attitude toward sex:_____

Type of relationship with you as a child:_____
Now:_____

Mother: Age:_____ Occupation:_____
Background (educational and cultural):_____

Type of relationship with her husband:_____

Attitude toward sex:_____

Type of relationship with you as a child:_____
Now:_____
Parents' sex life:_____

Home sex education:_____

Brothers and sisters: type of relationship with you and their adjustment to marri and life:

Name	Age	Marital Status	Positives/Negatives

Who was most important to you as a child?_____
Did you feel part of your family?_____

What kind of a family were you?_____
How was discipline handled?_____
Did anything about your family trouble you as a child or teenager?_____
_____
_____
_____

Childhood sex exploration and sex play (age and outcome - pleasure/trauma):_____
_____
_____

First menstruation: age:_____ feelings:_____
Parental attitude:_____
Instructions at onset:_____
Prior education/preparation:_____
_____
Was contraception discussed?_____
Specific fears regarding menses/pregnancy:_____
_____

PRESENT NUCLEAR FAMILY:

Own children and how you relate to them:_____
_____
_____
_____
What kind of family life do you have now?_____
_____
What kind of parent are you?_____
How do you handle discipline?_____
What kind of parent is your spouse?_____
How does he/she handle discipline?_____
How do you handle sex education for your children?_____
Has family/child counseling been used?_____
In-laws: (positives/negatives):_____

PERSONAL:

Own Education: Level:_____
Learning Problems:_____
Grades:_____
Sports:_____
Social activities:_____
Problems:_____
Civic activities:_____
Problems:_____
Hobbies:_____
Problems:_____
Job: Description:_____
Satisfaction:_____
Problems: holding:_____ Changing:_____ Coping:_____
Supervisors:_____ Co-workers:_____ Supervisees:_____
Money/Bills/Bankruptcy:_____
Other:_____

Military Service: Yes/No_____ Date:_____ Details:_____
_____

EMOTIONAL:

What kind of a person are you?_____
Feelings of inferiority:_____
Sensitivity:_____

EMOTIONAL:

Anxiety
Depression
Appetite
Weight loss
Insomnia (duration and details):

Self-confidence
Influence of religion on your marriage

Influence of religion on yourself (seminary, convent, etc.)

Influence of religion on your sexuality

Influence of religion on your partner's sexuality

How would you describe your marriage?

What would you change about your marriage?

What would you change about your partner?

Do you think your partner loves you?
Do you love your partner?
Did you, in the past, fear/wish the loss of your partner? and now?
Did your partner, in the past, fear/wish the loss of you? and now?
Miscarriages: Details: What year/s:
Extramarital activity:
Does spouse know?
Details:

SEXUAL HISTORY:

Have you, in the past, ever thought of/threatened/attempted separation or divor

If yes, how did you resolve the conflict?

Did you have sexual problems before?
How does this affect your spouse's sexual function?

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

Own remedies: alcohol? other partners? etc.
Reading: sex manuals, magazines, etc.
What is your concept of the optimum sexual function for a woman?

Should she approach him for sex?
For a man?
Should he always make sex advances?
What is your concept of marital roles for a wife?
in bed Conflict?
socially Conflict?
financially Conflict?
with children Conflict?
other Conflict?

What is your concept of marital roles for a husband?
in bed _____ Conflict? _____
socially _____ Conflict? _____
financially _____ Conflict? _____
with children _____ Conflict? _____
other _____ Conflict? _____
Own sexual satisfaction: Yes____ No____ Comment: _____
Frequency of affectionate expression per week: _____
Frequency of intercourse per week: _____
Difficulties: irregular climax: _____ no climax: _____
Repulsion: _____ Why? _____
Pain? _____ Where? _____
Erection difficulty: _____ What? _____
Morning erections? _____ Frequency per week: _____
With masturbation? _____ With specific partner? _____
Describe in detail first episode of erection problem: (alcohol/anxiety/anger): ___
_____
_____
Ejaculation: premature: _____ delayed _____
KISSING: yes/no____ Who initiates?____ Preference:____ Aversion:____ Conflict:__
FOREPLAY: yes/no____ Who initiates?____ Preference:____ Aversion:____ Conflict:__
MASTURBATION: Religious attitude: _____ Feared consequences: _____
Guilt: _____ Aversion: _____ Attempts to control: _____
Age first masturbation: _____ Frequency pre-marriage: _____
Frequency per week now: _____ Does partner know? _____
Feelings: _____ Masturbatory fantasies: _____
Discovery/Trauma: _____

ORAL SEX: Fellatio: Yes/No____ Who initiates?____ Preference____ Aversion____
Conflict _____
Cunnilingus: Yes/No____ Who initiates?____ Preference____ Aversion___
Conflict _____
Anal intercourse: Yes/No____ Who initiates?____ Preference____ Aversi
Conflict _____
Age first intercourse: ____ Details (pleasure/trauma): _____
Preferred I/C position: _____
First childhood sex play: Age:____ Details (pleasure/trauma): _____
Sex fantasy: frequency _____
questions _____
concerns _____
content _____
Reading sexual material: Yes/No____ Who initiates____ Preference____ Aversion___
Conflict _____
Vibrator: Yes/No____ Comment: _____
Venereal Disease: Yes_____ No_____ Type: _____
Method of Contraception:
B.C. pill _____ Duration _____ Feelings _____
Brand _____ Symptoms _____
Intrauterine Device _____ Diaphragm _____ Vasectomy _____
Foam _____ Jelly _____ Rhythm _____ Condom _____
Conflict in this area: _____
Rape (real): _____ Age:____ Details: _____
Rape (fantasies): _____
Specific fears about sex? _____
_____
Specific guilts about sex: _____
_____
Specific hang-ups about sex: _____
_____

Child molestation: _____

Incest: (Details - touch/full coitus. How much alcohol involved?) Trauma/pleasur

_____

Name relative: _____

Fertility problems: Details: _____

Fertility issues: Duration: _____ Cost: _____ Details: _____

Reactions: Self: _____ Partner: _____

Sex during pregnancy: _____

Sex feelings during delivery of babies: Yes/No/Maybe & afterwards? _____

Labor anesthetic: Yes/No _____

Breast feeding: Yes: _____ No: _____

Sexual feelings while breast feeding: No: _____ Yes: _____

Homosexual fears: _____

_____

Homosexual episode/s: pleasure/trauma: _____

_____

Specific sexual enjoyment today: _____

_____

Summary: (end of visit one)

a.)	nudity in bed	never/sometimes/often
b.)	lights on during sexplay	never/sometimes/often
c.)	touching own genitals	never/sometimes/often
d.)	touching partner's genitals	never/sometimes/often
e.)	foreplay in bed (over 3 min.)	never/sometimes/often
f.)	new sexual positions	never/sometimes/often
g.)	sexual discussion with partner	never/sometimes/often
h.)	guilt around sex act	never/sometimes/often
i.)	anxiety around sex act	never/sometimes/often
j.)	shame about sex activity	never/sometimes/often
k.)	enjoyment of sexplay	never/sometimes/often
l.)	enjoyment of sex act	never/sometimes/often
m.)	frequency of masturbation	per month
n.)	frequency of intercourse	per month

Any special comments? _____

_____

_____

_____

_____

MENTAL STATUS: _____

_____

Judgement: _____

Orientation: _____

Intellect: _____

Memory: _____

Affect: _____

_____

_____

_____

_____

_____

DIAGNOSIS: _____

_____

_____

_____

IMPRESSION: _____

_____

_____

_____ Signature: _____

_____

_____ Signature: _____

_____

_____

WEEK TWO: Date: _____

Home loveplay: _____

Frequency: _____

Details: _____

Arousal/Erections with loveplay: _____

Arousal/Erections with masturbation: _____

Sexual fantasy: _____

Other: _____

Surprise: _____

I-Language: _____

_____

Conflicts: _____

_____

Questions: _____

_____

_____

_____

Important issues to discuss: _____

_____

_____

_____

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_____

_____

APPENDIX C - SENSATE FOCUS EDUCATION

SENSATE FOCUS EDUCATION

Sensate Focus is a phrase for "petting", massaging, intimate touch, foreplay both sensual and sexual. Note the differences between sexual and sensual in yourself (many have not learned to differentiate them, especially men). Feelings of affection and sex are a natural, normal, healthy part of each of us.

These 30 minute daily suggestions are for you at home. Bathe, undress totally. Lock your door, take the phone off the hook. Soft lights & music. Sensual first rather than sexual, i.e., sound, sight, smells, thoughts, taste, and touch that are pleasing to each. Freely tell your partner. Become self aware. Relax and enjoy. This is a "joy" break to refresh you. Avoid the pressure of time and performance. Each be acutely SELF-AWARE of feelings, both as a giver and a receiver. Express in sound, smile or words your reactions. It is a wonderful gift to your partner to know that you are enjoying. Many women do not realize this. If you are solo, use lots of fantasy and do the same touch pleasuring. A warm soaping and a hot soak, a top-to-toe lotion, a towel massage, a cottonbud tickle are some ways to have fun end experiment with your skin responses.

STEP 1

A: Face exploration, with fingertips and lips, eyes open and closed. Also, ears and neck. Light, firm, brush, feather etc. Be creative.

B: Explore body; stroke lightly and firmly, massage, caress, kiss areas of pleasurable sensation on entire back, arms, chest, abdomen, legs, etc. Take turns. Guide with words, own hand, sounds. Say how it feels. RELAX. Breathe in and out slowly. Use Fantasy.

C: Avoid the breast and genital areas. No intercourse. If arousal or erections occur, simply stop, hug, let the erections subside deliberately. Tell your partner of the arousal, embrace awhile. Then start to play again. This connects your sensual end sexual self and build confidence. Think of this special fun during the day, tomorrow. It's yours free to repeat. Add surprises and laughter.

APPENDIX D - KEGEL EXERCISES

KEGEL EXERCISES

SLOW KEGELS

Tighten the P.C. muscle and hold it as you did when you stopped the flow of urine for a slow count to 3. Then relax the muscle.

QUICK KEGELS

Tighten and relax the P.C. muscle as rapidly as you can. At first it will feel like a flutter. You will gradually gain more control.

PULL IN / PUSH OUT

Pull up the entire pelvic area as though trying to suck up water into your genitals. Then push out or bear down as if trying to push the imaginary water out. (This exercise will use a number of "stomach" or "abdominal" muscles as well as the P.C. muscle).

REPETITIONS

At first do ten of these exercises (pone set), 3 times a day.
(3 exercises X 10 X 3 times a day = 90 total exercises to start).

Each week add 5 more times to each exercise.
Example: Week 2 – 3 sets X 15 times X 3 times a day
Week 3 – 3 sets X 20 times X 3 times a day
Week 4 – 3 sets X 25 times X 3 times a day.
Keep doing 3 sets a day.

You can help yourself remember to do the exercises by associating them with some activity you do every day: talking on the phone, watching television, waiting in line, or lying on the bed. Think of activities which don't require much moving around.

Don't worry if your muscles seem to get tired easily at first, that's normal for exercising any new muscle group. Rest between sets for a few seconds and start again. Remember to keep breathing naturally.

You can place one or two fingers into the vagina in order to feel the movement and strength of the muscle. You may watch the movement by looking at your genitals in a hand mirror. Doing these things with your Kegels will help you learn more rapidly.

Optional exercise for men with too much time on their hands: when the penis is erect, sit or stand with you legs apart and try wagging your penis up and down or sideways by squeezing the muscles in the groin.

APPENDIX E - VAGINISMUS SPECIFIC EXERCISES

VAGINISMUS - SPECIFIC EXERCISES

- Lock the door, disconnect the phone, and lie down in a comfortable spot. Breathe very slowly and open your mouth when you exhale.
- Insert a well-lubricated finger, into your vagina and continue to breathe deeply.
- Relax. Explore your vagina. Breathe slowly and deeply.
- Deliberately contract the muscles in the lower third of the vagina very tightly around your finger. Relax and repeat.
- Repeat these exercises for five minutes twice daily. On the first two days use one finger. For the next two days, insert two fingers, while breathing slowly in and out with your mouth open. Contract and relax the muscles surrounding the opening of the vagina.
- On the next two days ask your partner to insert one lubricated finger into your vagina while you continue your slow, open-mouthed breathing. Guide his finger into your vagina. Use plenty of sexual fantasy to keep your mind focussed on your sexuality.
- On the following two days, after an extended period of foreplay, let your partner lie passively, straddle him, and stuff his non-erect penis into your vagina. Contract and relax your vaginal muscles around his soft penis.
- The important thing is to remember that you are in control.
- Do not be concerned if you need more time for any of these stages.

APPENDIX F - THE GOLOMBOK RUST INVENTORY OF MARITAL STATE (GRIMS) QUESTIONNAIRE

The Golombok Rust Inventory of Marital State (GRIMS) Questionnaire

Before beginning the questionnaire, please complete this section in block capitals.

NAME: ..... SEX: .....

DATE: ..... AGE: ..... LENGTH OF RELATIONSHIP: .....Years ..... Months

Instructions

Each statement is followed by a series of possible responses: strongly disagree (SD), disagree (D), agree (A), strongly agree (SA). Read each statement carefully and decide which response best describes how you feel about your relationship with your partner, then circle the corresponding response.

Please respond to every statement: if none of the responses seem completely accurate, circle the one which you feel is most appropriate. Do not spend too long on each question.

Please answer this questionnaire without discussing any of the statements with your partner. In order for us to obtain valid information, it is important for you to be as honest and as accurate as possible.

All information will be treated in the strictest confidence.

1. My partner is usually sensitive to and aware of my needs.	SD	D	A	SA
2. I really appreciate my partner's sense of humor.	SD	D	A	SA
3. My partner doesn't seem to listen to me any more.	SD	D	A	SA
4. My partner has never been disloyal to me.	SD	D	A	SA
5. I would be willing to give up my friends if it meant saving our relationship.	SD	D	A	SA
6. I am dissatisfied with our relationship.	SD	D	A	SA
7. I wish my partner was not so lazy and didn't keep putting things off.	SD	D	A	SA
8. I sometimes feel lonely even when I am with my partner.	SD	D	A	SA
9. If my partner left me, life would not be worth living.	SD	D	A	SA
10. We can "agree to disagree" with each other.	SD	D	A	SA
11. It is useless carrying on with a marriage beyond a certain point.	SD	D	A	SA
12. We both seem to like the same things.	SD	D	A	SA
13. I find it difficult to show my partner that I am feeling affectionate.	SD	D	A	SA
14. I never have second thoughts about our relationship.	SD	D	A	SA
15. I enjoy just sitting and talking with my partner.	SD	D	A	SA
16. I find the idea of spending the rest of my life with my partner rather boring.	SD	D	A	SA
17. There is always plenty of "give and take" in our relationship.	SD	D	A	SA
18. We become competitive when we have to make decisions.	SD	D	A	SA
19. I no longer feel I can really trust my partner.	SD	D	A	SA
20. Our relationship is still full of joy and excitement.	SD	D	A	SA
21. One of us is continually talking and the other is usually silent.	SD	D	A	SA
22. Our relationship is continually evolving.	SD	D	A	SA
23. Marriage is really more about security and money than about love.	SD	D	A	SA
24. I wish there were more warmth and affection between us.	SD	D	A	SA
25. I am totally committed to my relationship with my partner.	SD	D	A	SA
26. Our relationship is sometimes strained because my partner is always correcting me.	SD	D	A	SA
27. I suspect we may be on the brink of separation.	SD	D	A	SA
28. We can always make up quickly after an argument.	SD	D	A	SA

APPENDIX G - QUESTIONNAIRE: "THE KNOWLEDGE OF SOCIAL WORKERS IN PRIVATE PRACTICE REGARDING HUMAN SEXUALITY AND SEX THERAPY"

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My ref. Elmari Craig 2002-07-23
Masters Candidate
Prof M S E du Preez
Tel. (012) 420-2325 E-mail: mdupreez@postino.up.ac.za

Dear Colleague,

Many marriages in South Africa today end in divorce, as you may well be aware off. According to literature sexual problems and dysfunctions remain some of the most prominent reasons for marital problems. During the last few years sex therapy shifted from being considered to be an individual problem, to being a couple's problem and even a family problem, thereby becoming part of marital and couple therapy.

I am currently conducting research about the knowledge of social workers in private practise regarding human sexuality and sex therapy. This research is conducted with the goal of obtaining a Masters Degree in Social Work from the Department of Social Work at the University of Pretoria, and to develop a curriculum for sex therapy training within the social work discipline in future. Applied research will be conducted and it would be exploratory in nature.

I would appreciate it if you could spare 20 minutes of your time to complete the attached questionnaire. It is important to establich the current knowledge of social workers regarding human sexuality and sex therapy. A pre-paid envelope is included to minimise cost and effort on your part.

This is an anonymous questionnaire and no identifying particulars are being required. All information will be treated confidentially and will be analysed via computer.

Feel free to contact Elmari Craig at 082 783 6633 or (012) 997-4633 for any further information or enquiries.

Your co-operation in this regard is highly appreciated.

Regards.

Elmari Craig
MASTERS CANDIDATE

Prof. M.S.E. (Rita) du Preez
STUDY LEADER

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Questionnaire

"The knowledge of social workers in private practice regarding human sexuality and sex therapy"

Respondent Number:

For office use

V1 [ ][ ][ ] 1-3

Please supply your response to the following questions by indicating the correct answer with an X.

SECTION I

1. Sex:

Male	1	
Female	2	

V2 [ ] 4

2. Age:

[ ] Years

V3 [ ][ ] 5-6

3. Marital status:

Never married	1	
Married	2	
Living together	3	
Divorced	4	
Widowed	5	

V4 [ ] 7

4. Which year did you obtain your first degree/diploma:

[ ]

V5 [ ][ ][ ][ ] 8-11

5. Highest qualification:

3-year diploma	1	
4-year degree	2	
Honours	3	
Masters	4	
Doctoral	5	

V6 [ ] 12

6. Name any other educational or training courses you attended related to marriage counselling and sex therapy.

Course	Duration	Institution

V7 [ ][ ][ ] 13-15
V8 [ ][ ][ ] 16-18
V9 [ ][ ][ ] 19-21
V10 [ ][ ][ ] 22-24

7. Years social work experience:

	V11 25-26

8. Years practising as a social worker in private practice?

	V12 27-28

9. Home language:

English	1		V13 29-30
Afrikaans	2		
Zulu	3		
Venda	4		
Tswana	5		
Xhosa	6		
Northern Sotho	7		
Tshonga	8		
Swazi	9		
Ndebele	10		
Southern Sotho	11		
Other	12		

Specify:.....

10. Race:

White	1		V14 31
Coloured	2		
Indian	3		
Black	4		

11. Religious denomination:

Protestant	1		V15 32
Roman Catholic	2		
Jewish	3		
Moslem/Islam	4		
Tamil/Hindu	5		
No Religion	6		
Other	7		

Specify:.....

SECTION II

1. Are you aware of specialists in the field of sexology/sex therapy to refer clients to?

Yes	1		V16 ☐33
No	2		
Unsure	3		

2. Is there in your opinion a need for social workers to be trained in the field of human sexuality and sex therapy?

Yes	1		V17 ☐34
No	2		
Unsure	3		

2.1 If no, why not? V18 ☐35

2.2 If yes ...

	1 Yes	2 No	3 Unsure		
Pre-graduate				V19	☐36
Post-graduate as a specialty (e.g. Masters)				V20	☐37
Post-graduate as short course/seminar				V21	☐38

3. What is the most frequent sexual difficulty of married couples according to your experience? V22 ☐39

4. Rate the following sexual problems in order of the frequency that clients present with it in your practice:

	1 very often	2 often	3 seldom		
Lack of desire				V23	☐40
Libido differences between male and female				V24	☐41
Anorgasmia				V25	☐42
Premature ejaculation				V26	☐43
Erectile dysfunction				V27	☐44
Painful intercourse				V28	☐45
Other Specify:.....				V29	☐46

2. Do you take a complete sexual history from your clients?

Never	1		V37 ☐54
Rarely	2		
Occasionally/when necessary	3		
Frequently	4		
Always	5		

3. Please indicate whether you agree with the following statements:

	1 Yes	2 No	3 Unsure		
Masturbation offers a satisfactory outlet at all ages for the release of sexual tension				V38	☐55
Oral sex is something that the majority of sexually active people engage in				V39	☐56
It is difficult to refer to the various parts of the genitals by their scientific names when discussing sexually-related issues with clients				V40	☐57
It is possible to discuss sexual related matters with my partner				V41	☐58
Sexual fantasies are a powerful aphrodisiac because they offer people a chance to enjoy sexual activities they might not normally - or necessarily ever - want to experience				V42	☐59
Sexual fantasies can lead to immoral behaviour				V43	☐60
Masturbation practised too frequently causes fatigue and physical debilitation				V44	☐61
Masturbation is sometimes an effective alternative to penetrative sex within a marriage				V45	☐62
Oral sex is dangerous and should be avoided				V46	☐63
Pre-marital sex is harmful and should be avoided				V47	☐64
It is normally a comfortable situation counselling clients with sexually related problems				V48	☐65
Anal sex is painful and leads to HIV infection				V49	☐66
Homosexuality can effectively be reversed by behavioural modification				V50	☐67
Anal sex is only practised during male sex				V51	☐68
There are some heterosexual couples who enjoy the practise of anal sex				V52	☐69
Functionally speaking the circumcised penis does not have a foreskin to retract during coitus or masturbation as the uncircumcised penis has				V53	☐70

	Yes	No	Unsure		
Priapism is an ability of some men to attain erections frequently and with minimum stimulation				V54	71
Retrograde ejaculation means delayed ejaculation				V55	72
Males have a greater sexual capacity than females				V56	73
The most important hormone in sexual motivation in males and females is testostorone				V57	74
All orgasms are intense, explosive events				V58	75

SECTION IV

1. Would you describe the following as sexual dysfunctions?

	1 Yes	2 No	3 Unsure		
Sexual aversion				V59	76
Hypo-active sexual arousal				V60	77
Anorgasmia				V61	78
Vaginismus				V62	79
Dyspareunia				V63	80
Retarded ejaculation				V64	81
Pedophilia				V65	82
Voyeurism				V66	83

2. The following is a term used to describe a condition in which a person's sexual gratification is dependant on an unusual sexual experience. A neutral term for sexual alternatives that have been called deviant.

Fetishisms	1	V67	84
Paraphilias	2		
Gender Identity Disorders	3		
Sexual dysfunctions	4		

3. Which one of the following models is the basis for sex therapy and describes permission-giving, basic information giving, home loveplay exercises and intensive therapy as the last resort?

Masters and Johnson	1	V68	85
Plissit	2		
Freudian	3		
Kinsey	4		

4. How much longer does women on average take to reach orgasm than a man?

Twice as long	1		V69 ☐86
Four times as long	2		
Six times as long	3		
Ten times as long	4		

5. How many women are able to reach orgasm with penetration only?

80-100%	1		V70 ☐87
60-80%	2		
40-60%	3		
20-30%	4		

6. Is it possible for women to be multi-orgasmic?

Yes	1		V71 ☐88
No	2		
Unsure	3		

7. Endowing inanimate objects with erotic properties is most closely related to a sexual variation known as:

Voyeurism	1		V72 ☐89
Exhibitionism	2		
Fetishism	3		
Zoophilia	4		

8. With his 0-6 scale, Kinsey measures the:

libido differences between men and women	1		V73 ☐90
balance of hetero- and homosexual feelings	2		
frequency of hetero- and homosexual experiences per year	3		

9. Menopause is caused by:

	1 Yes	2 No	3 Unsure		
atrophy of the uterus				V74	☐91
shrinkage of the vagina				V75	☐92
cessation of sexual drive				V76	☐93
poor diet				V77	☐94
decreased production of estrogen				V78	☐95

10. Penis size usually determines ...

	1 Yes	2 No	3 Unsure		
the male's ability to impregnate a female.				V79	☐96
the degree of male pleasuring during coitus.				V80	☐97
the female's sexual satisfaction.				V81	☐98
little, if anything, physiologically.				V82	☐99

11. In older men ...

	1 Yes	2 No	3 Unsure		
the refractory period becomes longer.				V83	100
the excitement phase becomes shorter.				V84	101
the plateau phase becomes shorter.				V85	102

12. Which of the following are the phases of the sexual response cycle in proper sequence according to Masters and Johnson?

plateau, orgasm, excitement, resolution	1		V86 103
excitement, orgasm, resolution, plateau	2		
refractory period, orgasm, resolution, plateau	3		
excitement, plateau, orgasm, resolution	4		

13. Removal of the penis before ejaculation, is ...

ejaculatory control.	1		V87 104
the rhythm method.	2		
coitus interruptus.	3		
expulsion.	4		

14. An involuntary muscular spasm that closes the vaginal entrance is called ...

vaginitus	1		V88 105
vaginismus	2		
hymenitis	3		
dyspareunia	4		

15. Medication, the stop-start technique and the squeeze technique, are suitable treatments for ...

erectile dysfunction	1		V89 106
premature ejaculation	2		
hypo-sexual desire disorder	3		

16. Sensate focus can involve ...

	1 Yes	2 No	3 Unsure		
non-genital touching of one partner by the other.				V90	107
prolonged touching of one's partner's genitals.				V91	108
giving and receiving pleasure.				V92	109
focusing on the journey and not on the destination				V93	110

Any other comments:

.....

.....

Thank you for your co-operation!