THE TREATMENT OF SEXUAL DYSFUNCTION IN MARRIAGE:

STRENGTHS AND LIMITATIONS OF KAPLAN'S MODIFICATION

OF THE MASTERS AND JOHNSON MODEL.

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Thesis submitted as the final requirement for the degree of
M.A. in Applied Psychology (Clinical),
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DECLARATION OF AUTHORSHIP

This is to certify, in accordance with University regulations, that this study is my own work, and all sources used have been acknowledged.

(John Doenau).
NOTE ON CONFIDENTIALITY

In accordance with the requirements of the course, this study was undertaken in order to demonstrate the writer's ability to integrate theory and practice in a chosen clinical field. It was drawn up for the attention of the examiners only. As is customary in such work, care has been taken to remove identifying details from the clinical material. Nonetheless, in its present form, the study should be regarded as a confidential document.
ACKNOWLEDGEMENTS

This study was written in extremely difficult circumstances. Throughout the period of its formulation, my chief preoccupation and concern was to provide adequate nursing care for my mother in her own home. In addition to increasing frailty due to advancing age, she was also contending with a painful and incapacitating physical handicap tragically incurred when she fell and fractured her hip two years ago. I would like to thank all those who made it possible for me to complete this study under such conditions, and in particular the following:

Father Patrick O'Sullivan, S.J., Father Paul Duffy, S.J., Father Peter Steele, S.J., Father Brendan Byrne, S.J., Mr. Michael Sutton, S.J., and the community of Campion College, Kew, for their interest, encouragement and material support throughout; Miss Avis Ware, Miss Terry Barker, Miss Rita Martin, and Mrs Elise Reynolds for their assistance and kindness shown in the care of my mother; Ms Peggy Kerr of Indiana University, and Ms Joan Scherer Brewer of the Institute of Sex Research, Indiana University, for their assistance in researching the literature of the field; my brother Mr. Stan Doenau of the Department of Education, Macquarie University, Sydney, for his help in arranging the Selected Bibliography; and Miss Maureen Miller and Mrs Helen Hole for typing the manuscript. Finally, I would like to thank my mother for responding so graciously to the additional stresses which the attempt to complete this study by the due date entailed for her.

J.D.
ABSTRACT

The aim of this study is to evaluate the strengths and limitations of Kaplan's model for the treatment of sexual dysfunction (Kaplan 1974, 1975) as applied to a small number of cases within the setting of a marriage and family counselling agency. The pivotal idea of the study is that Kaplan's model is a modification and development of that of Masters and Johnson (Masters and Johnson, 1970, 1972, 1976). Hence it was proposed that the Kaplan model could be usefully evaluated by comparing and contrasting it with the strengths and limitations of the Masters and Johnson prototype as applied within the same clinical setting.

The principal clinical data on which the study is based consists of two series of cases culled from the writer's own clinical files. The 13 consecutive cases of Series 1 (begun before 1975) provide the basis for a systematic qualitative and quantitative analysis of the strengths and limitations of the Masters and Johnson model. While the 13 consecutive cases of Series II (begun after 1975) are used for the comparative assessment of the Kaplan model as applied within the same clinical setting.

The study falls into two parts. Part I is an analysis of the strengths and limitations of the Masters and Johnson model. This is used as a base-line or bench-mark against which Kaplan's contribution is assessed in Part II.

The major findings can be summarized under 3 headings:

1. The Kaplan model incorporates the main contributions of the Masters and Johnson prototype which were found to be viable and effective in the clinical setting.

2. In addition, the Kaplan model goes a long way towards meeting some of the major limitations of the Masters and Johnson paradigm as they became evident in that setting.

3. Nonetheless, there are important remaining deficiencies—particularly Kaplan's failure to capitalise fully on the contribution of the behavioural tradition of sex therapy which has developed independently of the Masters and Johnson paradigm.

Hence, when compared with the Masters and Johnson prototype the Kaplan model is a notable advance. But when compared with the contribution of the behavioural tradition of sex therapy which arose independently of the Masters and Johnson paradigm, it falls considerably short.
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*FOR BRIEF REVIEW OF THE STUDY*

Each of these case reports has been prepared with special care. A brief review of the salient features of the study could be made by reading in sequence the series of case reports and the commentary which follows each.
INTRODUCTION.

1. Masters and Johnson's model and Kaplan's modification.

Although practised in restricted circles for considerably longer, it has only been in the last 10 years that the methodology for the direct treatment of sexual dysfunction has been generally available to clinicians (LoPiccolo and LoPiccolo, 1978). The most revolutionary and influential contribution to this advance was the comprehensive treatment paradigm proposed by Masters and Johnson in their Human Sexual Inadequacy (1970). Apart from this work, the most widely known single contribution has been that of Helen Singer Kaplan (Kaplan 1974, 1974a, 1974b, 1975; Sollard and Kaplan, 1976). This writer offers an eclectic model incorporating elements borrowed from Freudian psychoanalysis, psychodynamic marital therapy, and behaviour therapy. Her basic building block however, is a modified and amplified version of the classical Masters and Johnson prototype, adapted to the restraints imposed by the more usual conditions of clinical practice in which the "dual-sex therapy team" and the intensive 14 days live-in programme of Masters and Johnson are impractical ideals.

This present study is an attempt to evaluate Kaplan's contribution (particularly as compared to that of Masters and Johnson) from the experience of the writer's own clinical practice in the setting of a marriage and family counselling agency (cf. Appendix A, pp 105-6; Appendix B, pp 107-115; and Appendix C, pp 116-121).

2. Some important preliminary definitions.

a) Sexual dysfunctions.

Sexual dysfunctions have been defined by Hogan (1978) as "cognitive, effective and/or behavioural problems that prevent an individual or couple from engaging in and/or enjoying satisfactory intercourse and orgasm."
Such dysfunctions may occur inside or outside the context of the marriage relationship. But because of the nature of the writer's clinical experience they will be considered only as they appear within the marriage relationship.

b) Therapeutic model.

The term "therapeutic model" (or simply "model") as employed in this study refers to a set of concepts and procedures integrated into a unifying theoretic framework which is used as a guide to facilitate behavioural change. The emphasis in this study will be on the evaluation of how far the two models in question measure up to the exigencies of actual clinical practice.

The great number of therapeutic models which have appeared in the expanding literature of sex therapy could usefully be divided into 2 major classes:

1) Specific treatment models are those which are proposed as a guide for the treatment of one specific sexual dysfunction of one sex, such as premature ejaculation (e.g. Razani, 1972), male impotence (e.g. Garfield, McBrearty and Dichter, 1969), and female orgasmic difficulty (e.g. Kohlenberg, 1974). In the literature of sex therapy, such specific treatment models preponderate.

2) Comprehensive treatment models are those which offer general principles which are common to the treatment of the range of commonly occurring male and female dysfunctions. Relatively few comprehensive treatment models have appeared in the literature, and among the most outstanding are those of Masters and Johnson
This present study deals with the comparative evaluation of two comprehensive treatment models viz. those of Masters and Johnson and Kaplan. The emphasis throughout is on those features of the models which are common to the treatment of the range of commonly occurring male and female sexual dysfunctions. The clinical samples used as the basis of the study contain an assorted mixture of various male and female dysfunctions rather than just one specific syndrome affecting one sex only.

3. The Clinical Data.

The key clinical data on which the study is based consists of 26 cases culled from the writer's own clinical files in which the direct treatment of sexual dysfunction was undertaken. For the purpose of subsequent reference these have been divided and labelled as follows:

**Series 1**: a series of 13 consecutive cases begun before 1975, for which the main therapeutic model available to the writer was that of Masters and Johnson (1970). This series can be subdivided as follows:

- **Series A**: one case only, in which concepts derived from conjoint marital therapy provided the principle treatment guidelines. This case has been included because the treatment methodology was partly influenced by the Masters and Johnson model.

- **Series B**: ("The Masters and Johnson Series") 12 cases for which the Masters and Johnson model (1970) provided the principle treatment guidelines.
Series II: a series of 13 consecutive cases begun after 1975 i.e. after the writer had gained detailed knowledge of the models of Kaplan (1974, 1975), Annon (1974, 1975) and other approaches described in the current behavioural literature. This series can be subdivided as follows:

**Series C** ("The Kaplan Series"): 10 cases for which the model of Helen Singer Kaplan (Kaplan 1974, 1974a, 1974b, 1975) proved the principle treatment concepts.

**Series D** ("The PLISSIT Series"): 3 cases for which Annon's "PLISSIT" model (Annon, 1974, 1975) provided the principle treatment concepts.

Detailed written records were kept of each interview of all these cases. The basic primary data for the study therefore is a rich clinical deposit comprising the detailed records of 394 interviews (241 for Series 1 and 253 for Series II) of which 166 were cotherapy sessions.

4. The basic idea of the study.

The study hinges on the fact that the Kaplan model is a modification and development of that of Masters and Johnson. This is clear from the comparative study of the 2 models and from the statements of Kaplan herself (e.g. Kaplan 1974 pp 195; Kaplan and Kohl, 1972 pp 186). Given this, some crucial questions are:

a) Is the Kaplan model an improvement over that of Masters and Johnson or not?

b) If so, in what respects is it an improvement?

c) What are its remaining deficiencies?
To answer these questions it was proposed that a retrospective analysis of the Series B cases ("The Masters and Johnson Series") would starkly highlight the strengths and limitations of the Masters and Johnson model as they appeared in the writer's clinical practice. These findings would then be used to provide a baseline or bench-mark against which the specific contribution of the Kaplan model (derived principally from an analysis of the Series C cases) could be evaluated. The additional cases of Series A and Series D would provide supplementary material, and in particular point to some of the remaining deficiencies of the Kaplan model.

5. Research methodology.

Over a period of time the writer gradually elaborated a method of retrospective research embodying both quantitative and qualitative analysis which was appropriate to the goals of the enquiry and the nature of the clinical data in hand (i.e. the detailed written case records).

a) Qualitative Analysis.

The goal of the qualitative analysis was to discover and delineate the strengths and limitations of each model as they were evident in the case work.

"Strengths" were defined as those features of the model which in clinical practice appeared to contribute to the reversal or alleviation of the target sexual dysfunction.

"Limitations" were defined as those features of the model which were impossible or difficult to implement in clinical practice, or which appeared not to contribute effectively or efficiently to the reversal or alleviation of the target sexual dysfunction.
Such limitations were frequently made clear from a study of the divergences from the models, and the modifications or additions to them which were found necessary in practice.

The qualitative analysis proceeded through the following three stages:

Stage I was a close study and comparison of the features of the two models as they were described by their original authors. Summaries of these are reported below in Part I, Section 1, and Part II, Section (pp 9-15, 51-66)

Stage II The case files were arranged in chronological order determined by the commencement date, and were then carefully reviewed for material bearing on:

1) the strengths of the relevant model;

2) the limitations of the relevant model;

3) divergences from the relevant model, and modifications or additions which were found necessary in practice.

Each item of the analysis was placed on a separate card and given an appropriate heading. The chronological ordering of the cases brought out the successive modifications to the model which were found necessary as experience accumulated, thereby throwing the advantages and disadvantages of each model into clearer relief.

Stage III The cards derived from Stage II were now rearranged in a logical order according to the themes and topics relevant to each model that had emerged. The structure of Part I, Sections 4, 5 and 6 and Part II Sections 4, 5 and 6 of this study were derived directly from Stage III of the qualitative analysis.
The present study therefore was principally compiled from two sets of systematically ordered working papers comprising:

1) the chronologically ordered data of Stage I1, emphasizing the strengths and deficiencies of each model as they were made evident with accumulating clinical experience;

and 2) the thematically ordered data of Stage III emphasizing common themes appropriate to each model which recurred throughout the casework.

The structure of the present study reflects the features of the qualitative analysis described above.

b) Quantitative Analysis.

In addition, an attempt was made to quantify relevant dimensions of the clinical population, and of the process and outcome of therapy. The various categories of information required for this purpose were itemized in the Treatment Data Schedule (Appendix D, pp 122-3), and the data relevant to each case was entered on a separate form of this schedule. A summary of the findings may be found in Table 15: Client Population: Summary of Data (Appendix E, pp 125-6) and in Table 16: Therapy Process: Summary of Data (Appendix F, pp 127-8). This data was used to delineate the profiles of the clinical population of each model, and to provide the statistics for the various aspects of therapy which are tabulated throughout the study.

6. Tentative viewpoint only.

Throughout the period of the conduct of this retrospective study the writer was preoccupied with increasing responsibilities arising from protracted family illness which severely curtailed his time, attention, energy, and mobility. Hence the specifications of the study are far less ambitious than those originally planned. What follows is presented as
a position-paper expressing a tentative personal viewpoint. The writer is well aware of the limitations of the study due to such factors as:

1) the use of small, unmatched clinical samples containing a mixed assortment of presenting male and female dysfunctions;
2) absence of clinical control groups;
3) experimenter bias.

Nonetheless, a study of the kind presented here appeared to be the best way to exploit the rich deposit of clinical material already in hand within the restrictions of the writer's personal situation.

7. Divisions of the study.

Part I of the study gathers together all the material relevant to the Masters and Johnson model: the profile of the clinical population, therapy results, strengths, limitations and necessary modifications. This review of the Masters and Johnson model provides a base-line or bench-mark against which the Kaplan model can be evaluated.

Part II of the study gathers together the parallel material relevant to the Kaplan model. However in Part II the Kaplan model is evaluated by reference to the Masters and Johnson model, and particularly in Section 5, by reference to the current literature of sex therapy.

The Analytical Index, pp vi above, has been compiled to provide a brief overview of the whole study and of its components.
PART 1 THE MASTERS AND JOHNSON MODEL.

Section 1: Outline of the Masters and Johnson Model.

The most important single influence in recent years on methods for the treatment of sexual problems has been the work of Masters and Johnson. Leaning on the findings of their pioneering research into the physiology of the human sexual response (Masters and Johnson, 1966) they described a revolutionary model for the treatment of several categories of sexual dysfunction viz.: premature ejaculation, ejaculatory incompetence and impotence in the male, and orgasmic dysfunction in the female, along with dyspareunia (painful intercourse) in both sexes (Masters and Johnson 1965, 1970, 1972, 1976). The following are the salient features of their approach:


In the Masters and Johnson programme the focus of treatment is not on the dysfunctional partner, but on the marital couple considered as a unit. The authors insist that "although both husband and wife in a sexually dysfunctional marriage are treated, the marital relationship is considered as the patient" (Masters and Johnson 1970, pp 3).

2. The mixed gender co-therapy team.

The use of a "dual-sex therapy team" is a cardinal principle in the treatment of sexual dysfunction according to Masters and Johnson. The basic reason for this insistence is that "no man will ever fully understand woman's sexual function or dysfunction because he can never experience orgasm as a woman. The exact converse applies to any woman". (Masters and Johnson, 1970, pp 4). Elsewhere they explain that "the primary purpose of the use of a male-female team is to provide full and fair clinical representation for both members of the marital unit undergoing treatment". (Masters and Johnson, 1972, pp 554-5). Each member of the dysfunctional unit is provided with "a friend
in court as well as an interpreter" (Masters and Johnson, 1970, pp 4).

3. **Brief, intensive, full-time therapy.**

The Masters and Johnson programme requires that the marital partners isolate themselves from the demands of everyday responsibilities throughout the 2-3 weeks treatment period, during which they are interviewed on a daily basis. The authors advance several reasons for this:

a) The partners have the opportunity to develop a closeness and unity difficult to achieve amidst the pressures and demands of everyday life. (Masters and Johnson, 1970, pp 18).

b) Sexual interest tends to be heightened (Masters and Johnson, 1970, pp 18).

c) Unsettling mistakes which could re-awaken old "performance fears" (see 5(b) below) can be reviewed with the therapists within 24 hours (ibid. pp 19).

"Partners in sexually distressed marriages who cannot or do not isolate themselves from the social or professional concerns of the moment react more slowly, absorb less, and communicate at a much lower degree of efficiency than those advantaged by social retreat."

4. **Physiological sexual processes are linked with the individual's psychosexual system.**

Masters and Johnson's approach to therapy is based on the idea that sexual function is a "natural process". They point out that like respiration, bladder function and bowel function, sexual responsivity, given adequate stimulation, will occur naturally and spontaneously without conscious control. However, unlike these other bodily functions, sexual response alone can be inhibited indefinitely by conscious factors without physical impairment. This underlines the unique sensitivity of the sexual response to impairment by psychological factors. Treatment therefore is based not on the idea of trying to teach people how
to respond sexually, but on the employment of techniques designed to progressively remove the psychosocial blocks inhibiting sexual responsivity. (Masters and Johnson, 1972, pp 556.)

5. Some key psycho-social blocks to sexual functioning.

   a) Role of ignorance and faulty attitudes rather than psychopathology.

   Prior to the publication of the work of Masters and Johnson, the insights of Sigmund Freud provided the main guidelines to the understanding and treatment of sexual problems. From this perspective, sexual inadequacy was regarded as the surface symptom of deep-seated psychopathology, which would require lengthy and costly treatment based on the psychoanalytic model. The most fundamental contribution of Masters and Johnson was the denial of this traditional view with the contention that faulty attitudes and ignorance play the major role in sexual dysfunction:

   "Sociocultural deprivation and ignorance of sexual physiology rather than psychiatric or medical illness constitute the etiologic background for most sexual dysfunction." (Masters and Johnson, 1970, pp 21.)

   The corollary of this view is that sexual problems should yield to brief therapy focussed on the presenting symptoms and their immediate causes, rather than lengthy "deep" therapy.

   b) Fears of inadequate sexual performance.

   The most pervasive inhibitory force in sexually dysfunctional individuals, according to Masters and Johnson, is fear of failing sexually (performance fear). Such fears impede the individual from abandoning himself to the enjoyment of sexual pleasure:

   "It should be restated that fear of inadequacy is the greatest known deterrent to effective sexual functioning, simply because it so completely distracts the fearful individual from his or her natural responsivity by blocking reception of sexual stimuli either created by or reflected from the sexual partner" (ibid. pp 12. Italics mine).
c) The Spectator Role.

According to Masters and Johnson, the psyche of the dysfunctional individual is frequently divided: part of him is involved in the reception and appreciation of sexual stimuli; but another part of him is observing and assessing the performance. The authors dramatically label this anxious condition "the Spectator Role" (ibid. pp 65).

d) Ineffective sexual communication (faulty "sexual signal systems").

An important determinant of sexual dysfunction for Masters and Johnson is an ineffective "sexual signal system" for the communication of sexual needs. Men and women, they stress, have no inborn faculty of intuition whereby they divine each other's sexual requirements without being told. Each person's sexual needs can only be met if the partners have developed an adequate "signal system" (consisting of verbal and non-verbal cues) to guide their partner to provide the kind of input which they require at any moment. This is most dramatically illustrated in the case of female dysfunction, but applies equally to males:

"The most unfortunate misconception our culture has assigned to sexual functioning is the assumption by both men and women that men by divine guidance and infallible instinct are able to discern exactly what a woman wants and when she wants it. Probably this fallacy has interfered with sexual interaction as much as any other single factor." (ibid. pp 87).


Masters and Johnson conceive of their treatment programme as an educational process designed to help the couple learn how to allow sexual response to occur spontaneously without being inhibited by "psychosocial" factors, especially those referred to above. The educational process consists of a counterpoint between two elements:
a) [structured erotic experiences. In the privacy of their room, the couple "tries on" ideas and modes of physical interaction designed to help them discover how to give each other pleasure in a way which will allow the sexual response to emerge spontaneously. They may subsequently either accept or reject these ideas according as they are found to be rewarding or not. (Masters and Johnson, 1972, pp 555.)

b) daily office interviews. In the daily office interviews which interleave with the couple's structured sexual encounters, they are helped to explore the impact of the physical experiences, and to evaluate the kind of sexual and non-sexual, verbal and non-verbal communication required to produce the feelings and attitudes which they desire. On the basis of this review, a further experience is designed to take them one more step towards their goal. (ibid. pp 555.)

7. The structured erotic experiences. Masters and Johnson have elaborated a graded series of pleasuring experiences ranging from simple body caressing through to intercourse, which are designed to help the couple discover:

   a) the kind and patterning of tactile stimulation to which they are responsive;

   b) the conditions under which adequate sexual response will spontaneously emerge, particularly in the dysfunctional partner, given adequate stimulation.

8. The interleaving office interviews. Meantime, daily interviews in the office are conducted in counterpoint with the couple's graded sexual encounters in the bedroom. These form the other arm of the educational battery, and have several functions:

   1) In the interview the co-therapists assist the couple to review their preceding sexual encounters.
2) Related feelings and attitudes which impinge on the couple’s sexual interaction are discussed.

3) The therapists may present new relevant information or correct the couple's misinformation.

4) They may suggest ways of altering patterns of behaviour which the husband or wife may have found unsatisfactory.

5) On the basis of all the data in hand up to this point, they plan the next encounter with the couple.

6) The therapists’ most important role is to assist the couple to communicate effectively about:

a) their sexual needs and requirements;

b) other relevant areas of their life which impinge on the quality of their sexual relationship.

It is hoped that the increased facility in communication will improve the couple's sexual interaction, the warmth and understanding between them, and the quality of their marital relationship in general:

"The cotherapists are fully aware that their most important role in the reversal of sexual dysfunction is that of catalyst to communication. Along with the opportunity to educate concomitantly exists the opportunity to encourage discussion between the marital partners wherein they can share and understand each other's needs." (Masters and Johnson, 1970, pp 14. Italics mine.)

After Masters and Johnson's study appeared in 1970, many other workers attempted to adapt their basic ideas to the limitations of other settings. (See pp 84-5 below for a list of some of the main versions that have appeared.) In these adaptations the 2-week intensive programme was frequently abandoned in favour of weekly interviews, and the use of the dual-sex co-therapy team was frequently found to be impracticable.
In the early phase of his own use of the paradigm, the present writer attempted to employ the model expounded by Masters and Johnson as an ideal to be implemented as fully as possible within the constraints of the agency in which he worked (a Marriage and Family Counselling agency). In practice this meant that:

1) No set fee was charged, but the clients were free to offer a donation.

2) A co-therapy team was used where possible, although the requirement that one co-therapist should be a physician could not be fulfilled.

3) A period of "intensive" therapy was used where practicable, which included the elements of social isolation of the couple with frequent, and if possible, daily interviews.

4) The rigorous medical evaluation of each partner stipulated by Masters and Johnson (Masters and Johnson 1970, pp 57-60) could not be included. Instead, one or other partner was referred to a specialist at another centre when this seemed to be required.

5) A number of difficulties and obstructions were encountered in the treatment process which were not fully described in the model. In order to deal with these the writer found it necessary to make supplementary use of a variety of therapeutic concepts and procedures not included in the original version.

However, in other respects the writer attempted to follow as closely as possible the methodology expounded by Masters and Johnson. The details of these adaptations are described more fully below in Part I, Section 6, pp47-8 and in Appendix B, pp107. Various inadequacies of the Masters and Johnson model soon became evident in the casework.
Section 2: Profile of Clinical Population, Masters and Johnson Series.

Twelve cases for which the Masters and Johnson paradigm provided the principle therapeutic concepts were subjected to detailed qualitative and quantitative analysis along parameters suggested by current writing and research in the field (cf. Munjack and Kanno, 1976; Wright et al. 1977; Hogan, 1978). For details, see Treatment Data Schedule (Appendix D, pp 122-4); Client Population: Summary of Data (Appendix E, pp 125-6); and Therapy Process, Summary of Data (Appendix F, pp 127-8). The target sexual problems encountered in the sample are set out in Table 1. (N.B. some partners had more than one target problem).

**TABLE 1.** TARGET SEXUAL PROBLEMS IN MASTERS AND JOHNSON SAMPLE.

<table>
<thead>
<tr>
<th>Sex</th>
<th>Target Sexual Problem</th>
<th>Instances in M. &amp; J. Sample (N=12 couples)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>erectile difficulty</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>premature ejaculation</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>retarded ejaculation</td>
<td>2</td>
</tr>
<tr>
<td>Female</td>
<td>arousal difficulty</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>climax difficulty</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>vaginismus</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>dyspareunia</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>behavioural inhibition</td>
<td>2</td>
</tr>
</tbody>
</table>

In 9 out of the 12 cases the symptomatic patient was female, and the preponderating complaint was difficulty in arousal (rather than the "orgasmic dysfunctions" implied by the Masters and Johnson paradigm) (Cf. Masters and Johnson, 1970, pp 214-9, 295 315). The
average duration of the problem was 3 years (range: 6 months to 7 years). The mean age of the husbands was 34 years, and of the wives 31 years. On average the couples had been married for 7 years, and typically had 2 children of primary school age. In 11 of the 12 marriages both partners were Australian born. Both partners were Catholic in all but one instance. Most couples were using the Ovulation Method of family planning.

Educational and occupational indices placed most of the sample in the lower middle-class bracket of the socio-economic scale. The average years of formal education enjoyed by both male and female members of the client-population was 12.8 years (with a range of 8-16 years). More than half the sample (54%) had only primary or some secondary education, while less than half (42%) had a university degree or other tertiary qualification. Thus the higher socio-economic strata which predominated in the clinical population treated by Masters and Johnson were notably absent from this one (cf. Masters and Johnson, 1970, pp 356).

The bearing of the quality of the marital relationship on the outcome of sex therapy has not been the subject of a great deal of research scrutiny, possibly because a satisfactory method of analysis has not yet been devised. However the clinical experience of this writer has suggested that this factor is crucial. On the basis of clinical judgment, the marital relationships of the sample were graded on a 5-point scale from "very satisfactory" (+2), through "ambivalent" (0) to "very unsatisfactory" (-2) (Cf. Bancroft et al. 1976, pp 430; Gelder and Marks, 1966; Edwards and Booth 1976). The mean rating for the 12 couples in the sample was 0.92 and the distribution was as follows:

<table>
<thead>
<tr>
<th>Rating</th>
<th>Marital Functioning</th>
<th>Number of Couples</th>
</tr>
</thead>
<tbody>
<tr>
<td>+2</td>
<td>Very Satisfactory</td>
<td>4</td>
</tr>
<tr>
<td>+1</td>
<td>Satisfactory</td>
<td>5</td>
</tr>
<tr>
<td>0</td>
<td>Ambivalent</td>
<td>2</td>
</tr>
<tr>
<td>-1</td>
<td>Unsatisfactory</td>
<td>0</td>
</tr>
<tr>
<td>-2</td>
<td>Very Unsatisfactory</td>
<td>1</td>
</tr>
</tbody>
</table>

TABLE 2: DISTRIBUTION OF MARITAL FUNCTIONING RATINGS
MASTERS AND JOHNSON SERIES (N = 12).
Hence harmonious marriages predominated in the sample. Despite this, in 6 out of the 9 satisfactory marriages (rating: +2 or +1) the sexual dysfunction was linked with a variety of marital conflicts which required recourse to therapeutic concepts outside the framework provided by Masters and Johnson.

In addition, there were marked intra-psychic problems of the individual spouse complicating the sexual dysfunction in 3 out of the 12 cases, which also required therapeutic intervention of a kind not included in the Masters and Johnson model.

Section 3: Results: Masters and Johnson Series.

Table 3 represents the outcome of the application of the Masters and Johnson model, as indicated at follow-up of 3 months or more after termination of treatment. Each couple was assessed as a unit according to categories adapted from Meyer et al., 1975. "Marked improvement" indicates that the primary target sexual dysfunction of both partners was completely reversed. "Improved" indicates that the sexual relationship of the couple was significantly improved even though the target dysfunction(s) were not completely reversed (cf. Meyer et al., 1975, pp 173).

**TABLE 3: MASTERS AND JOHNSON SERIES: OUTCOME STATISTICS.**

<table>
<thead>
<tr>
<th>Clinical Population</th>
<th>Marked Improvement</th>
<th>Improved</th>
<th>Not Improved</th>
</tr>
</thead>
<tbody>
<tr>
<td>M.&amp; J. Series (N = 12 couples)</td>
<td>3 (25%)</td>
<td>5 (42%)</td>
<td>4 (33%)</td>
</tr>
</tbody>
</table>

In order to assess the cost-effectiveness of the treatment, the therapy process was analysed according to the categories set out in Table 4. "Assessment sessions" refers to single and joint interviews primarily devoted to assessment, inclusive of the "round-table" session (Masters and Johnson 1970, pp 60-84). "Treatment sessions" refers to interviews subsequent to the
"round-table session". "Therapist-hours" involved double time when co-therapy was used, as occurred extensively in 7 of the 12 cases.

TABLE 4: MASTERS AND JOHNSON SERIES: COST-EFFECTIVENESS SUMMARY.
(All figures represent mean number per case.)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>M. &amp; J. Series</td>
<td>9.3</td>
<td>10.6</td>
<td>19.7</td>
<td>28.3</td>
<td>$283</td>
</tr>
<tr>
<td>(N=12 couples)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section 4: Strengths of the Masters and Johnson Model.

In order to assess the contribution of Masters and Johnson to the treatment of sexual dysfunction, two types of appraisal are necessary:

a) consideration of the separate elements of which the model is composed;

and b) consideration of the way in which these elements have been orchestrated to form a unified, multiple-impact treatment method.

This review can be brief because the contribution of Masters and Johnson is by now well attested in the literature.

A. Elements of the Model Considered Separately.

A close review of the case material of Series I and Series II suggested that many elements of the Masters and Johnson model could be powerful contributory factors in the dissolution of various types of sexual dysfunction when suitably orchestrated. Among the most outstanding were found to be the following:

1. Emphasis on the couple as the patient rather than the dysfunctional individual.

Prior to the publication of Masters and Johnson's work, the first main treatment option available was to regard the sexual dysfunction as a manifestation of problems within the individual system, and to focus intervention there. Since sexual dysfunction entails clearly defined physical manifestations, prima facie this would appear to be the most obvious course to take. Masters and Johnson effected a Copernican Revolution in placing the emphasis on the couple rather than on the dysfunctional partner throughout all phases of assessment and treatment. Almost every interview of almost every case of Series I and Series II provides support for the efficacy of this principle.
The case experience elucidated two main virtues of this principle. In the assessment phase, the focus on the couple reliably brings to light factors associated with effective or ineffective sexual functioning that would otherwise be difficult to pinpoint - particularly the role of the non-dysfunctional partner. While in the treatment phase, the application of this principle allows the use of types of intervention that require the co-operation of both marital partners e.g. training in more effective sexual and marital communication (both verbal and non-verbal) and the use of structured erotic experiences by which more effective patterns of sexual interaction are carefully built up step by step.

2. Emphasis in assessment on the ongoing sexual interaction of the couple in the here-and-now.

Apart from individually focussed treatment, prior to the publication of the work of Masters and Johnson (1966, 1970) the second main option in the treatment of sexual dysfunction was the conjoint marital therapy which was developing throughout the 1960's (cf. Olson, 1970). Like the Masters and Johnson model this orientation focussed on the couple as a system rather than on the individual. But it differed from the latter in placing primary emphasis on the marital relationship rather than on the details of the couple's sexual interaction. The conceptual technology to deal with this did not then exist. The contribution of Masters and Johnson was to focus prime attention on the couple's specifically sexual relationship within the format of conjoint couple therapy, while the background marital relationship received subsidiary attention.

This new emphasis required the formulation of a set of concepts which could accurately describe the various relevant aspects of the ongoing sexual relationship, particularly those features which commonly constitute blockages to optimal functioning. Masters and Johnson drew attention to such phenomena as "the spectator role", "performance fears", "goal oriented sexual behaviour", the part played by the possession or absence of relevant sexual information, and by effective and ineffective patterns of sexual communication.
Again the case records of Series I and Series II amply illustrate the efficacy of this general strategy of assessment, and the utility of the battery of concepts provided by Masters and Johnson for the analysis of the ongoing sexual interaction of the couple.

3. The combination of therapeutic interviews and structured erotic experiences.

Stated in its most general form the major over-riding intervention strategy of the Masters and Johnson model is the combination of regular office interviews and a series of graded erotic experiences carried out by the couple at home. Only a few couples did not respond positively to this strategy. Most cases of Series I and Series II, even those in which the presenting dysfunction was not definitively reversed, provided evidence that this strategy can be a means of moving the couple in the direction of more adequate sexual functioning.


The experiential element of the Masters and Johnson model is designed to assist the couple to discover patterns of sexual interaction (including verbal and non-verbal communication), that result in positive pleasurable return.

With an initial embargo on intercourse, the couple is led from the enjoyment of simple body-caressing to more adequate sexual interaction by a series of carefully-graded steps. Their sexual repertoire is thus built up, step by step, from the simplest skills in which it is very difficult to fail, to more complex ones which may have proved to be stumbling blocks in the past. After the couple have mastered the simpler skills involved in "sensate focus" they are provided with a further set of experiences designed to counter the specific dysfunction with which they are troubled.

Again the cases in Series I and Series II confirmed the utility of this general strategy, even though it was found necessary
in practice to deviate considerably from the exact details of the graded series of experiences which were laid down by Masters and Johnson.

5. "Non-demand pleasuring."

The casework strongly suggested that the most important common element involved throughout all phases of the experiential component of the model is the attitudes and skills involved in "non-demand pleasuring" in which the emphasis is on the giving and receiving of pleasure rather than on producing a sexual response in oneself or one's partner. The "sensate focus" experiences along with the embargo on intercourse appeared to provide a particularly apt vehicle for this basic learning. As will be seen, however, the exercises as described by Masters and Johnson proved to be too advanced to provide a satisfactory starting-point for some couples.

6. Components of the therapeutic office interview.

The office treatment interview as described by Masters and Johnson involves the provision of relevant information, the review of the immediately preceding structured erotic experiences, the planning of the succeeding experiences, and the facilitation of open sexual and marital communication between the partners. Masters and Johnson regarded this latter as one of the most important skills of the sex therapist (see pp 14 above).

Treatment interviews of most cases of Series I and Series II included these elements, and suggested that they are in fact important factors in moving the couple in the direction of more adequate sexual functioning. Frequently the sexual and marital communication skills of the couple improved as treatment progressed, in the way predicted by Masters and Johnson (Masters and Johnson, 1970, pp 14). In the retrospective review of their treatment experiences conducted at termination of treatment, several couples of Series II spontaneously expressed the view that improvement in communication had been the main element in their cure.
B. Elements of the Model Considered as a Total System.

The contribution of the Masters and Johnson model is not exhausted by the enumeration of its separate elements. Its unique feature is the welding of all the elements into a finely articulated system, in which the impact of each is intensified.

The operation of the model as a whole can be compared to the functioning of a symphony orchestra in which each instrument corresponds to a separate element of the model. It is not sufficient that each instrument in the orchestra plays however well the melody assigned to it. The melodic parts played by each must be correctly phased and attenuated to accord with those of all the other instruments. It is only the orchestra as a whole that can make the optimum impact. So it is with the separate elements of the Masters and Johnson model: the therapeutic impact of the model comes from the correct orchestration of all the separate elements. Even if it is true that some of the elements had been discovered and utilized by other workers before them (e.g. Wolpe 1958, 1966; Wolpe and Lazarus, 1966) the total orchestration is unique, and constitutes the major contribution of Masters and Johnson.

The power of the multiple-impact therapy devised by Masters and Johnson was seen at its best in the four cases of Series I and one case in Series II in which the couple were seen very frequently (as close as possible to daily) during a holiday from their ordinary occupations. When these elements were introduced the couples were preoccupied much more fully with their sexual interaction, communication was at a deeper level, therapeutic interviews were almost wholly focussed on reviewing sexual interaction rather than on other problems in the marital relationship, the structured erotic experiences were scarcely ever avoided, and change was more rapid. When the couple resumed the routine patterns of daily living, the therapeutic process became notably slower, less intense, less absorbing to the spouses, and was complicated by individual, marital and family problems triggered by the hazards of normal life.
The following case illustrates many of the strengths of the Masters and Johnson model.


Mr. A. aged 26 was a recently graduated engineer, while Mrs. A. had trained as a welfare officer. They had been married for 18 months and had one child now aged 5 months. They had a close marital relationship free from marked conflict. Mrs. A. was referred by her gynecologist for treatment of vaginismus which had set in after the birth of the baby. In addition, she complained that since the beginning of her marriage she had lost interest and arousal before penetration by her husband, had been inhibited in sexual experimentation, and had never reached climax. The husband was free of sexual difficulties.

The physical side of the marriage had been beset with difficulties from the beginning. The first attempts at penetration on the honeymoon resulted in intense pain for Mrs. A. due to a resistant hymen. An inept and clumsy hymenectomy performed by a General Practitioner during the honeymoon resulted in a local infection which made intercourse impossible for the first 2 or 3 months of marriage. Finally, a gynecologist recommended that the best way to heal the infection completely was for Mrs. A. to become pregnant - advice which the couple promptly put into practice. A caesarian section was required at the delivery of the baby, and after the birth a further vaginal infection ensued. When this had been pronounced cured, further attempts at penetration were prevented by vaginismus.

Mrs. A.'s attitudes towards sexuality were influenced by the rigid and restrictive value-system of her parents, particularly her mother. At the age of 5 she was severely punished for engaging in sex play with her younger brother. There were severe restrictions on nudity in the home, and complete parental silence on the subject of sex. Mrs. A. said that the painful physical traumas and infections which she had experienced had been super-imposed as the culmination of pre-existing layers of guilt, conflict, and tension. Had they not occurred, she said, the rigid, restrictive and guilty attitudes towards sexuality transmitted by her mother would have "closed me up".

The three-year courtship of the couple was characterized by a prolonged conflict over sexual values. Mr. A. had far more liberal and accepting attitudes towards sexuality than his fiancée. He believed that he was struggling against the "conservative" values of her parents, which he saw as embodied in her. Throughout the courtship he persisted in making physical advances to her short of intercourse. But all attempts to arouse her sexually met with firm resistance on her part and caused her great internal conflict because they were a violation of the strict values of her parents.

It appeared that this pattern of resisting sexual arousal, established in the courtship, persisted into the marriage,
and prevented Mrs. A. from being able to abandon herself to
erotic feelings. Fear of a further pregnancy also contributed
to her difficulties - an element which was intensified by the
fact that the couple were practicing the Ovulation Method of
family planning without full internal commitment to it. In
their sexual encounters they were focussed on the end-point
of intercourse: they had no idea of exploiting other sources
of sensual pleasure. Both were locked into the "spectator
role". Mr. A. tried to arouse his wife rather than simply to
give her enjoyment, while she tried desperately to respond.
It also appeared that fear of losing control and of "going
unconscious" prevented her from being able to reach climax.

Treatment. The concepts and strategies of the Masters and
Johnson model provided the principle guidelines for
the treatment of this couple, though considerable divergence
from the paradigm occurred in practice. Cotherapy was used
throughout, and the focus was on the marital and sexual
relationship rather than on the individual. The methodology
of Masters and Johnson (Masters and Johnson, 1970, pp 1-67)
was used in the assessment phase, which consisted of 4 inter­
views with each partner and 2 joint interviews spread out over
2 months. Mrs. A.'s internal struggle to emancipate herself
from the restrictive attitudes of her mother towards sexual
enjoyment (a process actively promoted and encouraged by her
husband) was the dominant theme of assessment and treatment.

Crucial interventions not envisaged in the Masters and Johnson
model occurred during the single interviews of the assessment
phase. In the first and second interviews Mrs. A. began to
explore in detail with the female cotherapist her conflicts
concerning sexual enjoyment, and particularly her struggle to
free herself from the restrictive attitudes of her mother.
Between interviews which covered similar phases of the
backgrounds of each partner, the couple found the freedom to
discuss this and other aspects of their sexual life in long
sessions at home. They were given joint reading assignments
in order to catalyse this process still further. In her
third interview (three weeks after the second) Mrs. A.
reported that the vaginal pain was abating, and that she and
her husband had been having intercourse regularly over the
past fortnight with little discomfort. By the joint "round-
table" sessions vaginismus was no longer a problem and this
was confirmed by the referring gynecologist. It appeared
that the exploration of the wife's inner conflicts, the
permission and encouragement of the female cotherapist to
reject her mother's negative attitudes towards sexual
enjoyment, the approval of her husband, and the communication
between the couple established at home had enabled her
gradually to relax.

However, the problem of losing arousal and interest before
penetration, and failure to climax remained. Mrs. A. noted
that the last time she had intercourse she "stopped herself"
as she began to enjoy herself. She expressed resentment that
she could not give herself up uninhibitedly to enjoyment as her
husband could. This was clearly what she now wanted to be
able to do.
In the second joint interview (the "round-table" session) the simple "sensate focus" exercise of Masters and Johnson was prescribed (Masters and Johnson, 1970, pp 67-75) with an embargo on intercourse and contact with the genitals and female breasts. The object was to give Mrs. A. the opportunity to enjoy simple non-genital body caressing. She responded positively, and found far greater pleasure in caressing her husband than she had anticipated. In the next session the couple were advised to include gentle "non-demand" genital caressing. This experience likewise proved positive. Hence in the third joint interview they were advised to proceed to vaginal containment of the penis in the female-superior position should they so desire, and to experiment with gentle non-demand thrusting under the wife's control (Masters and Johnson, 1970, pp 306-310). At first this was somewhat awkward and a little painful for Mrs. A. (due to inadequate vaginal lubrication), but by the fifth joint interview she reported positive enjoyment. She had been given opportunity to explore at leisure a range of sensation that was completely new to her.

However she still complained that she was not able to relax and "let herself go completely". She was still in conflict: part of her wanted to "relax completely and let it happen", but part of her "will not let me do it". A combination of techniques derived from Gestalt Therapy and Transactional Analysis were used to clarify and deal with this conflict in the interview (James and Jongeward, 1971). Using 2 chairs, Mrs. A. was helped to act out a dialogue between these 2 conflicting parts of herself i.e. her "Parent" and her "Child".

She concluded with her "Child" saying forcibly to her "Parent": "From now on I will not let you hold me back!" The co-therapist and her husband supported her in this decision.

In the sixth joint interview the couple reported two failures but one very successful sexual encounter. However at home they had been able to frankly discuss the reasons for the failures and to apply their own remedy. Mrs. A. had really not been in the mood for sex, but had complied for fear of disappointing her husband. In the event, she had not been able to respond. However at the third attempt Mrs. A. discovered more enjoyment than ever before in the female-superior position, and was becoming much more uninhibited in her movements.

From this point on the couple's sexual relationship improved steadily until Mrs. A. began to wean the baby. Since the assessment of fertility was difficult at this time, for a period of 3 months intercourse was virtually impossible. Several interviews with the couple during this phase focussed on assisting them to cope with the sexual tensions and frustrations necessitated by this long abstinence, and with their commitment to the Ovulation Method. Finally it was agreed that therapy would be interrupted, and that the couple would return when the wife's menstrual periods had settled down into a regular pattern.
Seven months later the couple returned to report that Mrs. A. was again pregnant (freeing them from the frustrations of the Ovulation Method) and that their sexual relationship was now excellent. During a recent holiday at the seaside they had intercourse almost every day. In their sexual encounters Mrs. A. now felt no pain, and she was able to abandon herself freely to erotic enjoyment without "switching off" before penetration as she had done before. During the holiday she had felt free to experiment with a number of new positions for intercourse, though not quite so enthusiastically as her husband. She was still not reaching climax, but did not now regard this as a problem. Further counselling was offered to deal with this remaining difficulty, but the couple declined to accept it. Both had heavy time commitments elsewhere, and felt that they could now resolve the remaining issues by themselves.

A letter received from Mrs. A. 18 months after this confirmed that improvement had been maintained. She wrote that although she still had not reached climax this was now not of great concern because "we are enjoying our sex relationship more and more as time develops out taste for each other".

Comment on Case Report No. 1.

This case represents one of the first attempts by the present writer to apply the Masters and Johnson paradigm in his clinical practice. It illustrates many features of the model that have already been outlined: (1) the use of cotherapy, (2) focus on the couple rather than on the dysfunctional individual, (3) focus on the specifics of the sexual relationship in the here-and-now, (4) the methodology of assessment, (5) joint use of therapeutic interviews and structured erotic experiences, and (6) the key role of marital and sexual communication in behavioural change.

However it should also be noted that it was necessary to diverge from the model in several important respects. The most remarkable feature of the case is that contrary to the prediction of the model and the expectation of the therapists a definitive remission of the principle target symptom (vaginismus) occurred during the assessment phase, before the specific treatment interventions described by Masters and Johnson had been applied (pp 26 above). This forcibly suggested to the writer that insight methods derived from psychodynamic theory could play an important role in the treatment of some aspects of sexual dysfunction.
The case also points up the inadequacy of the Masters and Johnson model to deal with some specific features of sexual conflict. In order to assist Mrs. A. to free herself from the restrictive attitudes of her mother, the cotherapists had to supplement the interventions described by Masters and Johnson with elements derived from Gestalt Therapy and Transactional Analysis (pp 27 above).

Thus, in his early use of the Masters and Johnson model the present writer was moving, albeit in an ad hoc fashion, in the direction later to be developed systematically by Kaplan (1974). Subsequent attempts to apply the model forced him further in this direction (see Part I, Section 6, pp 47 below; see also Appendix B, pp 107 below).
Section 5: Limitations of the Masters and Johnson Model.

Source of the Limitations of the Model. The major source of the limitations of the Masters and Johnson model as they were encountered in the Series B cases was that a highly complex paradigm was being applied in a setting for which it was not designed. The original model can be regarded as a highly articulated formula answering exceptionally well to the particular problems and needs encountered in a particular setting: the clinic of the Reproductive Biology Research Foundation at St. Louis. With its specific goals, resources and constraints, this agency caters to the needs of a highly selected and highly motivated client population. Considerable modification was required to adapt the model to the goals, resources and constraints of a different setting ministering to a different client population. The main differences between the specifications and constraints of the two settings are set out schematically in Table 5, pp 31 below.

Furthermore, in their presentation of the model the original authors gave no assistance whatsoever to those who would attempt to adapt their work to another setting. Since no control groups were employed, it is impossible to tell from the work of Masters and Johnson which elements are essential and which are unnecessary (Prochaska and Marzelli, 1973). Verbally, the authors insist in dogmatic fashion on the importance of the finest details of each element in the package, while the research data, though impressive is related only to the effectiveness of the package as a whole. The clinician attempting to adapt the model to another setting therefore has no guidelines as to which elements can be modified or omitted without diminishing or crippling its overall effectiveness.
<table>
<thead>
<tr>
<th>Differential Feature</th>
<th>Reproductive Biology Research Foundation</th>
<th>Marriage and Family Counselling Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Type of agency.</td>
<td>a) medically oriented clinic.</td>
<td>a) not medically oriented clinic.</td>
</tr>
<tr>
<td></td>
<td>b) devoted entirely to treatment of sexual problems.</td>
<td>b) sexual problems only part of broad range of marital and family problems.</td>
</tr>
<tr>
<td>2. Goals of agency.</td>
<td>a) to provide a predesigned programme.</td>
<td>a) not a predesigned programme.</td>
</tr>
<tr>
<td></td>
<td>b) to deal with specified range of male and female sexual dysfunctions.</td>
<td>b) attempted resolution of wide range of presenting problems by most appropriate means adapted to individuals or couples.</td>
</tr>
<tr>
<td>3. Type of programme.</td>
<td>Primarily a research programme.</td>
<td>Not a research programme.</td>
</tr>
<tr>
<td>4. Client population.</td>
<td>Affluent professional class predominate.</td>
<td>Affluent professional class do not predominate.</td>
</tr>
<tr>
<td>5. Fee.</td>
<td>Set fee of 2,500 dollars.</td>
<td>No fee charged. Donation may be accepted.</td>
</tr>
<tr>
<td>6. Residence.</td>
<td>Most couples not local residents of city.</td>
<td>Most couples are local residents.</td>
</tr>
<tr>
<td>8. Therapy context.</td>
<td>Most couples socially isolated in honeymoon conditions.</td>
<td>Most couples not socially isolated. Honeymoon conditions not possible.</td>
</tr>
</tbody>
</table>
The present writer discovered from experience that radical alterations were necessary in order to adapt the model to the setting in which he worked.

1. Medical examinations. The routine medical examinations of both marital partners prescribed by Masters and Johnson (Masters and Johnson, 1970, pp 60) had to be omitted from the assessment process. Medical examinations were arranged as considered necessary, and generally were not prescribed for the non-dysfunctional partner.

2. Intensive time-limited therapy. In the Masters and Johnson model therapy takes place in a brief time-limited period which involves: (a) the social isolation of the couple, and (b) daily interviews. Although several cases in Series I and Series II provided convincing evidence that both these elements can make an effective contribution towards rapid behavioural change, their implementation was generally not feasible in the setting in which the writer worked. Table 6 illustrates how the implementation of "intensive therapy" involving social isolation and daily interviews fell short of planning in 7 cases of Series B (i.e. "The Masters and Johnson" series).

**TABLE 6: PLANNING VERSUS IMPLEMENTATION OF INTENSIVE THERAPY.**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>M. &amp; J. Series (Series B)</td>
<td>12</td>
<td>7 cases</td>
<td>4 cases</td>
<td>57%</td>
</tr>
</tbody>
</table>

According to Masters and Johnson the 2-week programme for clients from other cities was not adequate for local residents of St. Louis. These required a programme of 21 days during which they were given 17 interviews (Masters and Johnson, 1970, pp 19-20). Even when it was possible to incorporate the elements of social isolation and
frequent interviewing within the setting of the marriage and family agency the degree of implementation fell far short of the ideal proposed by Masters and Johnson for local residents. Table 7 indicates how these two conditions were fulfilled in the 4 cases of Series B in which an attempt was made to implement this aspect of the Masters and Johnson model.

Table 7: Degree of Implementation of Intensive Therapy for 4 Couples in Masters and Johnson Series.

<table>
<thead>
<tr>
<th>Identification Code</th>
<th>Period of Intensive Therapy</th>
<th>Number of Interviews in Period</th>
<th>Average Interval between Interviews</th>
<th>Social Isolation Implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Couple 1</td>
<td>6 days</td>
<td>4</td>
<td>1.5 days</td>
<td>Yes</td>
</tr>
<tr>
<td>Couple II</td>
<td>14 days</td>
<td>10</td>
<td>1.4 days</td>
<td>No</td>
</tr>
<tr>
<td>Couple III</td>
<td>15 days</td>
<td>11</td>
<td>1.4 days</td>
<td>Yes</td>
</tr>
<tr>
<td>Couple IV</td>
<td>17 days</td>
<td>11</td>
<td>1.5 days</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Means: 13 days \[\bar{x} = 9\] Average Interval between Interviews; Yes: 75%

3. Dual-sex therapy team. Masters and Johnson insisted for various reasons that are outlined above (pp 9) that the use of the dual-sex therapy team is an essential component in the therapy of sexual dysfunction. However their experiments were not factorially designed to demonstrate the efficacy of this precise element (Prochaska and Marzilli, 1973). Recent reviews of the literature indicate that the superiority of cotherapy in sex therapy has not yet been definitively proved (cf. Hogan, 1978; Roman and Meltzer, 1977). The present writer gradually abandoned the use of cotherapy in his practice for two reasons:

a) In the first place the approach proved to be far too cumbersome for extensive use within the agency. A cotherapy interview in which the couple is seen jointly requires the co-ordination of the schedules of 4 busy people. When a cotherapy team is not exclusively devoted to sex therapy the difficulty
involved becomes insuperable. A serious attempt to implement the cotherapy element was made in 9 cases in Series B and 4 cases in Series C. The data summarized in Table 8 (derived from Table 17, Appendix G pp 129-30) indicates the level of difficulty actually encountered:

**TABLE 8: ACHIEVED PROPORTION OF COTHERAPY IN 13 ATTEMPTED CASES.**

<table>
<thead>
<tr>
<th>Phase of Therapy Process</th>
<th>Series B (N = 9)</th>
<th>Series C (N = 4)</th>
<th>Series B &amp; C (N = 13)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment Phase.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total interviews per case</td>
<td>10.7</td>
<td>4.5</td>
<td>8.8</td>
</tr>
<tr>
<td>Cotherapy interviews per case</td>
<td>7.8</td>
<td>4.0</td>
<td>6.7</td>
</tr>
<tr>
<td>Percentage cotherapy per case</td>
<td>73.9%</td>
<td>88.9%</td>
<td>76.3%</td>
</tr>
<tr>
<td><strong>Treatment Phase.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total interviews per case</td>
<td>13.0</td>
<td>11.5</td>
<td>12.5</td>
</tr>
<tr>
<td>Cotherapy interviews per case</td>
<td>8.0</td>
<td>1.8</td>
<td>6.1</td>
</tr>
<tr>
<td>Percentage cotherapy per case</td>
<td>61.5%</td>
<td>15.2%</td>
<td>48.4%</td>
</tr>
<tr>
<td><strong>Total Therapy Process.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total interviews per case</td>
<td>24.0</td>
<td>16.0</td>
<td>21.5</td>
</tr>
<tr>
<td>Cotherapy interviews per case</td>
<td>15.8</td>
<td>5.8</td>
<td>12.7</td>
</tr>
<tr>
<td>Percentage cotherapy per case</td>
<td>66.2%</td>
<td>35.9%</td>
<td>59.2%</td>
</tr>
</tbody>
</table>

It was easier to sustain the cotherapy programme in the assessment phase because most of the interviews here are one-to-one, and hence the scheduling problem is at a minimum. However the percentage of achieved cotherapy falls in the treatment phase because when 4 people involved are required to meet together the scheduling problem becomes more acute. Similar practical difficulties in implementing the cotherapy element of the Masters and Johnson model were noted by Clarke (1974) and Bancroft (1974).
b) A fully implemented cotherapy programme doubles the cost of treatment. Yet the outcome results to hand did not seem to warrant the additional expense. Sifting of the total data resulted in a list of 18 comparable cases in which either the Masters and Johnson model or the Kaplan model were used. Cases in which the focus was on the individual partner rather than the couple or which utilized the model of J.S. Annon (1974, 1975) were omitted from the list. Cases were classified as "cotherapy" only if 50% or more of the interviews were conducted by the dual-sex therapy team. Sorting of the data resulted in the following contingency table:

**TABLE 9: COTHERAPY VERSUS SINGLE THERAPIST TREATMENT FOR 18 COUPLES.**

<table>
<thead>
<tr>
<th></th>
<th>Success</th>
<th>Failure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cotherapy</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Single therapist</td>
<td>7</td>
<td>3</td>
</tr>
</tbody>
</table>

N = 18

Although there is no claim to statistical significance, the trend of the data so far to hand harmonizes with the conclusion reached by Hogan (1978) after a review of the research literature available to this date:

"Thus, the evidence does not support Masters and Johnson's assertion that cotherapy teams are a vital component in the treatment package." (Hogan, 1978, pp 78).

4. **Insufficient flexibility of experiential component of the Masters and Johnson model.**

The experiential element of the Masters and Johnson model consists of relatively standard hierarchies which in some cases the authors consider represent basic irreducible components of sexual interaction:

"Cotherapists must constantly bear in mind during the rapid-treatment programme that the authoritative introduction of specific exercises represents a deliberate breakdown of woman's sexual responsivity into its natural components." (Masters and Johnson, 1970, pp 305.)
However the graded series of erotic experiences as originally described by these authors were found to be far too limited and stereotyped. Considerable alteration and improvisation was necessary in order to provide experiential hierarchies tailored to the specific requirements of individuals. Thus in the Masters and Johnson programme the "sensate focus" experiences constitute the starting point for all couples regardless of the presenting dysfunction (Masters and Johnson, 1970, pp 69). However for some couples these proved to be far too advanced. Simpler preliminary steps had to be devised such as face-caressing and body-caressing while clothed, showering and bathing together, sleeping together nude, and massage - in order to bring the couple to the point where the "sensate focus" experiences could be profitable. Masters and Johnson's insistence on nudity for the "sensate focus" exercises sometimes produced too much anxiety (Masters and Johnson, 1970, pp 72). In one case, female sexual arousal difficulty was quite successfully treated while the wife retained her severe inhibition against being seen nude, and while most caressing took place under the covers. Similarly the technique of "guiding of hands" suggested by Masters and Johnson to enhance non-verbal sexual communication (Masters and Johnson, 1970, pp 86) was sometimes more of a distraction than a help.

The procedures prescribed for the treatment of specific dysfunctions likewise required considerable modification. Thus the method of non-demand genital caressing of the female as described by Masters and Johnson (Masters and Johnson, 1970, pp 300) was not always acceptable to the woman. Similarly the female-superior coital position used in the treatment of both male and female dysfunction was sometimes distasteful to the wife. The same could be said of the "squeeze technique", the one and only treatment method described for the treatment of premature ejaculation (Masters and Johnson, 1970, pp 102-105).

In some cases the treatment programme as described by Masters and Johnson was found to be far too elaborate. In three cases of Series A marked relief of the presenting sexual dysfunction (vaginismus, retarded ejaculation, and female dyspareunia respectively) took place during the lengthy assessment phase of treatment, rendering the specific intervention procedures described by Masters and Johnson...
unnecessary (see Case Report No. 1 pp 26 above). In three cases, difficulty in sexual arousal was relieved through the simple "sensate focus" experiences alone, so that it was not necessary to proceed through the other specific treatment exercises in the hierarchy.

5. Inadequate guidelines for difficulties and obstructions to treatment.

The Masters and Johnson model provides no guidelines for handling the many individual, marital and family problems which complicate the extended treatment of sexual dysfunction (cf. article by "A Melbourne Psychiatrist", 1977, pp 11-15).

The original Masters and Johnson model was designed to meet the requirements of couples who place an extremely high priority on sexual harmony, who are highly motivated, and who are in an artificial honeymoon situation isolated from the routine cares of everyday life. Frequently the brief treatment of sexual dysfunction in the St. Louis clinic is simply the "acute phase" of more extended treatment undertaken elsewhere, in which other problems are dealt with by other therapeutic modalities (Masters and Johnson, 1970, pp 297). It is probably this context which explains why the original model can focus almost exclusively on sexual problems in isolation from others. However when the model is transposed to another setting in which couples are treated over a 12-16 week period while they continue their normal pattern of living, a range of individual, marital and family problems are encountered which must be dealt with concurrently in sex therapy, but for which the original model provides no guidelines. The dampening effect of the routines of normal daily living with its super­vening problems was seen most clearly in the case of 6 couples who returned to their normal occupations while sex-therapy was still in progress after a period of social isolation (see above pp 33).

The following were the major difficulties and obstacles for which the Masters and Johnson model was found to be inadequate.

a) Difficulties in the experiential element of therapy.

The prescribed erotic experiences were avoided entirely by some couples on occasions, or if carried out, resulted in a negative or neutral response from one or both partners.
b) Marital conflict. Various types of marital conflict commonly interfered with the treatment process. It was necessary to borrow a range of interventions from the literature of marital therapy to deal with such problems as:

1) conflict concerning the fundamental commitment of the partners to each other;
2) extra-marital affairs;
3) conflicts over careers;
4) the amount of time spent together;
5) responsibility in disciplining and managing the children;
6) the husband's over-involvement in his work.

(cf. Jacobs, 1974; Racy, 1974; Mead, 1974.)

c) Problems of the individual partner. A number of problems affecting one of the individual partners were also encountered which required intervention outside the Masters and Johnson framework. For example the treatment of several individuals was blocked by inhibitions stemming from the inability of the person concerned to detach himself/herself from restrictive parental attitudes (see "Case Report No. 1", p. 25 above). In one instance the treatment of the sexual problem was delayed for many weeks by the general social anxiety of the wife, resulting in chronic debility and fatigue. In another, the treatment of the sexual problem had to be postponed until the wife's depression had been alleviated by extensive supportive therapy.

d) Family problems. Family problems also had to receive appropriate treatment on occasion before the sexual problem could be dealt with. Thus before Mr. and Mrs. H. could address themselves to the problem of the wife's loss of sexual desire, Mrs. H. had to be given help to deal more effectively with her teenage daughters, since problems in their management contributed significantly to her depression, which in turn was linked with her lack of sexual response (Kaplan, 1974, pp 75-77).

Masters and Johnson not only provide no guidelines for dealing with such problems. In addition they have not shown how their ideosyncratic theory can be related to the other established bodies of theory required to deal with them. The practitioner who attempts
to adapt the Masters and Johnson model to another setting is therefore obliged to amalgamate it with other disparate bodies of theory with which he is familiar on an *ad hoc* basis. The result is an eclectic patchwork lacking in theoretic unity. Helen Kaplan attempted to deal with this problem by providing an eclectic theoretic framework within which the Masters and Johnson model could be integrated with several other established bodies of theory required to deal with the actual issues which commonly occur in clinical practice.

The following case report illustrates how the Masters and Johnson model fails to answer all aspects of sexual problems as they are encountered in clinical practice.

**Case Report No. 2 Difficulties in the application of the Masters and Johnson Model.**

Mr B., a teacher aged 29 and Mrs B., a physiotherapist aged 26, had been married for 4 years and had one child 6 months old. They were referred by a marriage counsellor for treatment of the wife's vaginismus which had persisted for 3 years.

Mrs B. was an independent, articulate and self-aware young woman. To be able to function sexually as a woman appeared to be one of the dominating aspects of her personality. Yet due to prior family experiences, beneath her surface poise there was a distrust of men and fear that she would be hurt by them in her close inter-personal relationships. This fear was a factor in the vaginismus, and caused her to be insecure at the prospect of examination by a male doctor.

Mr. B. was also articulate but was not as much in touch with his feelings as his wife, and was far less self-assured than she. He had reached puberty late, and the main formative experience of his adolescence had been his struggle to assert his competence and masculinity in the face of some derision from his peers. For him also the assertion of his sexual competence was one of the cardinal aspects of his personality.

A brief and intense courtship convinced the couple that they were extremely sexually compatible, but gave them little opportunity to explore their suitability as marriage partners. Both looked forward to sexual fulfillment as the most important aspect of marriage but they were quite unprepared for the demands that would be made on them. For the first year of marriage they did in fact enjoy a satisfying marital and sexual relationship until Mrs B. developed a persistent infection which made attempts at intercourse extremely painful. This fulfilled her fears that she would only be hurt in a close relationship with a man. Although by the end of the second year of marriage the infection was
pronounced cured, the couple were confused and dismayed to find that intercourse still remained painful. Finally the condition was diagnosed by a gynecologist as vaginismus, and treatment by insertion of a graduated series of glass dilators were prescribed. This was ineffective, since by this time intense marital conflict had supervened to threaten the couple's commitment to each other. Furthermore Mr. B. considered that the vaginismus was his wife's problem, not his, and that it was up to her to solve it.

By now Mrs. B. was pregnant with a baby she did not want because it would interfere with her career, and she blamed her husband for placing her in the predicament. She became far more dependent on him during pregnancy than she had been before, but when she turned to him for emotional support he was unable to give it: the long frustration caused by her sexual avoidance, and abortive attempts at intercourse ending with her painful withdrawal had threatened his sense of identity, and made him waver in his commitment to her. Finally, Mrs. B. was outraged to learn that he was considering embarking on an extra-marital relationship with a joint acquaintance in order to prove to himself that he was still capable of satisfying a woman.

The birth proved to be difficult, requiring extensive vaginal repair. Afterwards painful scar tissue further compounded the sexual difficulty, making intercourse doubly impossible. Further, Mrs. B. began to be haunted by fears that she may not have been "sewn up properly", or that she may have vaginal cancer. For his part Mr. B. found these further frustrations intolerable, and blamed his wife for using pain as an excuse for preventing his access to her. In fact there was now some truth in this belief for indeed Mrs. B.'s vaginismus carried the secondary gain of punishing her husband in the most effective way possible for the wounds he had inflicted on her. As the conflict between the couple intensified, Mrs. B. sought marriage counselling in a frantic attempt to save the marriage before it was too late. Since the sexual problem was the central core of the marital difficulty, the couple was referred for sex therapy when the baby was 6 months old.

Treatment At intake the couple were seen briefly together and then were given three separate assessment interviews over a three week period, using the format provided by Masters and Johnson (Masters and Johnson, 1970 pp 24 - 56). Cotherapy was not possible so a single therapist conducted all the interviews. Meantime a male gynecologist conducted a physical examination and concluded that painful scar tissue from the vaginal repair contributed to the vaginismus. This could remain tender for a further 3 - 4 months. Hence, it would not be possible to undertake the deconditioning procedure recommended by Masters and Johnson until then (Masters and Johnson, 1970 pp 263). Although the couple both wanted the sexual problem solved, the assessment interviews confirmed that Mr. B. was still wavering in his commitment to his wife. The couple were offered marital therapy to sustain them and to deal with their outstanding problems until the deconditioning process could be undertaken with some hope of success.

The first phase of therapy focussed on the husband, and was directed towards helping him resolve his conflict over his commitment to his wife. The methodology used here was principally Rogerian (Rogers 1942, 1951, 1961). After
several separate interviews over two months he finally reached the decision that his future lay with Mrs B., and he definitively renounced further extra-marital interest.

By the time he had reached this conclusion however, Mrs B. in her turn had begun to waver in her commitment to him. She had concluded from his behaviour that he was no longer attracted to or interested in her, and bitterly she considered separation.

The couple were next seen jointly to help them explore whether they wished to remain together. From the beginning the husband was definite that he saw his future with his wife, but at first she was non-committal. She began to feel more positively about the relationship when she learned that he still did care about her, that he looked forward to coming home to her and the baby in the evening, and that over the last 2 months he had tried desperately to make a contribution to the family by assisting in the domestic chores of cleaning the house, feeding the baby etc. She was still more gratified to learn that he still found her sexually attractive. In the atmosphere of intense frustration and resentment engendered by the sexual difficulty all these points had been misconstrued by her. Their deep common interest in the baby was a further bond. Gradually, over 4 interviews the couple's communication and positive feeling towards each other improved to a point where they both were committed to remain together and to work at improving their relationship still further.

For the first time the couple seemed to have the minimal level of harmony required to give the deconditioning of the vaginismus some hope of success.

Mr and Mrs B. were dismayed to learn that a further medical examination would be necessary to ascertain whether the scar tissue was still tender, and whether the vaginismus still existed. The prospect threw Mrs B. into intense conflict, and her fear of being hurt by a male doctor now emerged into full consciousness. But principally she was paralysed by fear of failure: if she went ahead with the treatment now and if it failed, she thought, the vaginismus would never be cured. Her whole identity as a sexually functioning woman was threatened. After these issues were explored with Mrs B. in 2 more joint interviews the couple were ready to accept a referral for a further vaginal examination, this time to a female gynecologist. This time the gynecologist reported that no physical anomaly could be detected, and that only a moderate degree of vaginismus now existed on examination. Six months of irregularly spaced interview had now elapsed since the intake interview.

Having reached this point there was now little difficulty in implementing the Masters and Johnson approach to the treatment of vaginismus. Pending the medical examination the couple had been advised to experiment with massage as a means of sharing the experience of physical contact without the expectation of sexual involvement (Downing 1972; Inkeles and Todris, 1972). This experience proved to be enjoyable to both and brought them physically closer. On reception of the favorable medical report, the sensate focus exercises and the non-demand genital caressing of the female (Masters and Johnson, 1970 pp 300) were prescribed for the following week. In addition, the couple were instructed in the method of vaginal deconditioning by insertion of a graduated series of glass dilators as described by Masters.
and Johnson, 1970, pp 263). Although intercourse was expressly forbidden at this stage, the couple in fact attempted it, and jubilantly discovered that it was accompanied by only a moderate and quite tolerable level of pain, which gradually lessened with each subsequent attempt. By the end of 3 weeks, Mrs B. was enjoying frequent intercourse with no pain. The couple's new-found and long-awaited sexual success further enhanced their previously tottering relationship, and strengthened their commitment to each other. For some time at least they enjoyed a honeymoon atmosphere.

Not long after the sexual difficulty had been resolved, a series of conflicts and crises requiring further protracted marital counselling again supervened, as this couple struggled to reach an adjustment together. However, follow-up enquiries made 3 months and 12 months after termination of sex therapy confirmed that despite this, the relief of the vaginismus had been sustained.

Comment on Case Report No. 2.

This case illustrates that the treatment as described by Masters and Johnson is applicable only when certain conditions prevail in the marital relationship, and in the individual spouses. Most of the time and therapeutic effort in this case was expended in attempting to bring about these preconditions rather than in implementing the specific treatment methodology of the Masters and Johnson model. This latter provided only one strand of a total therapeutic approach which borrowed heavily from the literature of individual psychotherapy and of marital therapy. Since Masters and Johnson do not describe how their conceptual system relates to other contemporary bodies of psychotherapeutic theory, the different elements required were used on an ad hoc basis without an over-arching integrating theoretic framework. The methodology however is moving in the direction later to be systematized by Kaplan (1974).

6. Categories of Sexual Dysfunction Inadequate.

The Masters and Johnson model provides guidelines for the treatment of 8 classes of sexual dysfunction: 4 male and 4 female, each defined in terms of observable physical phenomena affecting the genital system. These categories were too narrow to deal with the range of sexual problems submitted by the 25 couples in Series I and Series II. The most notable of deficiency was the inadequacy of the category of female "orgasmic dysfunction."
Prior to the publication of Masters and Johnson (1970), there was great conceptual confusion over the nature and classification of the common female sexual difficulties. The term "frigidity" was used to cover a variety of conditions ranging from complete lack of sexual response or absence of sexual interest, to minor difficulties of orgasmic attainment (Kaplan, 1974 pp 339-40). In addition the term bore the perjorative implication that a woman suffering from such difficulties was cold and hostile towards men.

Masters and Johnson sought to clarify the prevailing terminology by substituting the neutral descriptive term "orgasmic dysfunction" for frigidity. This new denomination had the advantage that it lacked the pejorative implication of the older category, and referred to definite physiological events i.e. failure to attain the orgasmic phase of the sexual response cycle as it had been clinically described in Masters and Johnson (1966). It could further be refined into three categories "absolute", "random", or "situational", each of which could be primary or secondary.

Masters and Johnson employ the single category "orgasmic dysfunction" as an umbrella-term to describe major difficulties of sexual congress in women. They provide only two alternative categories of female sexual difficulty: "vaginismus" and female "dyspareunia." In their chapter on the treatment of orgasmic dysfunction (Masters and Johnson, 1970, ch. 11, page 295-315) they describe one basic treatment strategy for all forms of this difficulty: i.e. graduated structured erotic experience carried out by the couple together, which begin with "sensate focus" and culminate apparently with orgasm intercourse. The object of the treatment appears to be to set the required conditions and remove the obstacles which would prevent the woman from passing through all four stages of the sexual response cycle (Masters and Johnson, 1966 pp 3-8), finally culminating in orgasm. The implication is that the major and essential female coital difficulty is failure to attain orgasm, and that the bulk of female difficulties (apart from vaginismus and dyspareunia) can appropriately be named "orgasmic dysfunction." After Masters and Johnson much of the current literature adopted this category to replace the older term "frigidity." (e.g. Clarke, 1974 pp 408,409; Maurice and Guze, 1970;

However, an examination of the actual complaints of women in the 2 samples suggested that Masters and Johnson's term "orgasmic dysfunction" confuses two clinically relevant categories: failure to be sexually aroused (or achieve sexual enjoyment) and failure to reach orgasm (or reach it in a specified way). It was clear that a number of women had achieved their goal when they were able to be sexually aroused and respond to their husbands even though they had not reached orgasm (as for example Mrs A. in Case Report No. 1, pp 28 above). Table 10 sets out the major female complaints in the two samples:

**TABLE 10 MAJOR FEMALE SEXUAL COMPLAINTS IN SERIES I & II**

<table>
<thead>
<tr>
<th>Specific Complaint of Wife</th>
<th>Series I (N = 13)</th>
<th>Series II (N = 12)</th>
<th>Total (N=25)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to be sexually aroused (or achieve sexual enjoyment)</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Failure to reach orgasm</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Failure to reach orgasm in a specified way</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Inhibition in a specific sexual activity</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>10</strong></td>
<td><strong>7</strong></td>
<td><strong>17</strong></td>
</tr>
</tbody>
</table>

The Masters and Johnson categories also fall short because of their operational definition in terms of observable physical phenomena affecting the genital system. They do not take account of non-observable emotional and cognitive components of sexual problems which for some clients constitute the preponderating element.

Thus, an important element in the complaints of 3 wives and 1 husband was that they were "not interested in sex." One male was not interested in sex even though he was quite capable of arousal.
and orgasm (Kaplan 1977). Another male fitted the Masters and Johnson category of "Ejaculatory Incompetence". Yet his crucial concern was that he wanted to be able to express warmth, tenderness and affection to his wife in their sexual encounters. Even when he was enabled to ejaculate successfully through the treatment prescribed by the Masters and Johnson model, it did not satisfy him: he felt "lonely, in foreign territory, and scared."

7. Model not equipped to deal with unaccompanied marital partner.

Since the focus of therapy for the Masters and Johnson model is not the dysfunctional individual partner but the marital unit, its application requires that both partners enter therapy together and cooperate wholeheartedly in the process. This requirement constitutes a serious constraint in those cases where the other partner will not or cannot take part in the therapy process. Although the Masters and Johnson model was applied in the 12 cases of Series B, it was judged as not applicable in a further 7 instances because the non-dysfunctional partner either refused or was unable to enter therapy. In a further 2 instances treatment for the sexual problem had to be abandoned after the assessment stage because the husbands withdrew from therapy. The failure of at least 2 of the Series B cases (both involving secondary female arousal difficulty) appears to have been due to the fact that the women concerned had been pressured into therapy by their husbands, and though they were present at the interviews, at heart they were reluctant to involve themselves fully in the therapy process.

There was one notable exception to the absolute rule of conjoint treatment in the Masters and Johnson series - the case of Mrs C.

Case Report No. 3 Masters and Johnson model adapted to the unaccompanied spouse.

Mrs C. was 37 years old and had 4 children; her husband aged 39 was a factory foreman. She requested help to deal with her repugnance against engaging in intercourse in the female-superior position which her husband very much desired on some occasions. The couple otherwise had a good marital and sexual relationship, though there was no verbal
communication about sex, because for Mrs. C. this was taboo.

Mr. C. declined to participate in the therapy interviews since he said he had no problem. It was decided to apply the principles and philosophy of the Masters and Johnson model (1970) consistent with this constraint.

Transactional Analysis (Berne 1961; James and Jongeward, 1971) was used to explore the origins of Mrs. C.'s sexual value system. It appeared that most of the "parental messages" about sexual activity and sexual enjoyment received by Mrs. C. were negative. When her husband wanted intercourse in the forbidden position Mrs. C. was inhibited by the idea: "No, that's not right", an internal verbalization that expressed prohibitions which Mrs. C. had received from her mother in childhood and adolescence. The therapist gave Mrs. C. authoritative permission to disobey these parental injunctions. In addition, Mrs. C. never talked about sex with her husband or anyone else since the maternal injunction: "Don't talk about it - but it's O.K. to listen" was also operating. Communication about sex was begun in the therapy room, and Mrs. C. was given permission to continue such communication at home with her husband. Mrs. C. was also given relevant information about the variety of possible sexual positions in use (including the female-superior position) a matter about which she was entirely ignorant. The Joy of Sex (Comfort, 1973) was given to her to illustrate this point and to help her initiate communication about this and other sexual matters with her husband. In addition Mrs. C. was given authoritative permission to engage in intercourse in the female-superior position if she wished, and the physical and psychological aspects of her attempts at home were discussed with her in subsequent sessions.

By the fourth and final interview (at which the husband was persuaded to be present) considerable change had occurred in the couple's sexual life. Mrs. C. was now regularly reaching orgasm in the formerly prescribed position. In addition the sexual communication catalysed between the couple by the prescribed reading and therapist permission had improved the quality of their sexual life.

Comment on Case Report No. 3.

The limitation of having only one spouse present in the majority of interviews was successfully circumvented in this case by an unusually favourable set of circumstances: the presenting problem was a minor one, the couple's marital and sexual relationship were good, while at home the husband was interested and co-operative. Where these factors are not present the attempt to implement the Masters and Johnson paradigm is likely to end in failure. (See Case Report No. 8, pp. 95 below.)
Section 6: Emendations and modifications to the Masters and Johnson model.

It may be helpful to summarize the various modifications and additions which were found necessary in attempting to apply the Masters and Johnson model in the setting of the Marriage and Family Counselling Agency. (See Appendix B, pp 107 for further details.)

1) The time-limited programme of 3 weeks (for residents of the same city) was found to be generally impracticable. Interviews therefore were generally weekly, and were continued as long as the therapist and clients considered necessary.

2) Even though the Masters and Johnson prototype initially influenced the writer to regard a brief period of "intensive therapy" involving frequent interviews and the social isolation of the couple as the ideal, this was generally found to be impracticable.

3) The use of the "dual-sex therapy team" was also initially regarded by the writer as the ideal, and was used where possible. However it was found to be too cumbersome and inconvenient for general use.

4) The method of assessment as described by Masters and Johnson was preserved. But since interviews could generally be scheduled only weekly, the assessment phase was extended over a longer period of time.

5) The routine medical examination of both partners prescribed by Masters and Johnson was found not to be practicable. Referrals for medical examination and assessment were made when deemed desirable.

6) A wide range of individual, marital and family problems was encountered for which the Masters and Johnson model does not provide effective guidelines. The writer found it necessary to employ a variety of theoretic orientations on an ad hoc basis to deal with these. In particular, he made use of elements of psychodynamic theory, Transactional Analysis, Gestalt Therapy, and various types of marital therapy.
7) The "sensate focus" exercises as described by Masters and Johnson were too advanced for several couples. A series of simpler erotic experiences had to be introduced as preliminary steps, e.g. simple face-caressing, showering and bathing together, sleeping together in the nude, massage, etc.

8) The full programme of graduated erotic experiences designed by Masters and Johnson for the treatment of specific dysfunctions was found to be unnecessary in several instances. In simpler cases the acquisition of appropriate information, and improvements in marital and sexual communication made during the assessment phase produced substantial positive changes in sexual adequacy. In two other cases of female sexual arousal difficulty, it was not necessary to proceed further than the simple "sensate focus" exercises.

9) When the more advanced treatment methods described by Masters and Johnson were used, a good deal of improvisation was found to be necessary. Thus pleasuring in turns rather than mutually, the "squeeze technique", the position for non-demand genital caressing of the female, and the female-superior coital position were not helpful to some couples. The technique of "Guided Imagery" combined with elements of Ellis' Rational Emotive Therapy (Ellis, 1975) were found to be useful adjuncts in dealing with difficulties encountered in the structured erotic experiences.

10) The complete embargo on intercourse prescribed by Masters and Johnson during the preliminary treatment phases had to be relaxed, when the therapy extended over weeks rather than days. Periods in which intercourse was permitted were included as appropriate in order to afford the non-dysfunctional partner some sexual relief.

11) The provision of appropriate reading material for the clients was found to be a most useful adjunct to therapy. It supplied relevant information, and could be used to promote the sexual communication of the couple.

In the use of the Masters and Johnson model in this fashion the present writer was moving towards a type of integration that was later to be more fully elaborated and systematized by Kaplan (1974).
Section 7: Summary of Strengths and Limitations of Masters and Johnson model.

1. Strengths of the Model.

Within the setting of the marriage and family agency the Masters and Johnson model made a contribution to the treatment of sexual dysfunction that was far superior to the methods of individual and marital therapy previously available. Clinical experience indicated that its most serviceable features were:

a) the emphasis on the couple as the patient rather than the dysfunctional individual;

b) emphasis on the ongoing sexual interaction of the couple in their here-and-now rather than on other features of the marital relationship;

c) the identification of various psychological blocks which inhibit spontaneous sexual response;

d) the combination of office therapeutic interviews with a graded series of structured erotic experiences carried out by the couple at home.

e) The concept of "non-demand pleasuring" was found to be the single most useful feature of the experiential component.

f) The most generally useful features of the office therapeutic interview devised by Masters and Johnson were found to be:

1) the provision of relevant authoritative information;

2) the planning and reviewing of the series of structured erotic experiences;

3) the facilitation of open sexual and marital communication between the partners.
2. **Limitations of the Model.**

The limitations of the model chiefly stemmed from its attempted application in a therapeutic setting with goals, resources and a clinical population for which it was not specifically designed.

a) Within the setting of the marriage and family counselling agency, various features were found to be impracticable i.e.:-

1) routine medical examinations for both partners;

2) an intensive time-limited programme comprising daily interviews and the social isolation of the couple;

3) the general use of cotherapy.

b) Other features were found to be unsatisfactory in the setting i.e.:-

1) insufficient flexibility of the experiential component;

2) inadequate guidelines to meet the difficulties and obstacles to treatment stemming from concomitant and related individual, marital and family problems;

3) inadequate categorization of the types of sexual dysfunction, particularly the confusion of arousal and orgasm difficulties in women;

4) the unsuitability of the model for the treatment of the unaccompanied marital partner.

3. **Necessary modifications to the Model.**

To adapt the model to the exigencies of a different therapeutic setting various modifications had to be made:

a) Medical examinations were prescribed only as necessary.

b) Interviews were scheduled weekly rather than daily.
c) The couple lived at home and carried on their normal occupations rather than in social isolation.

d) Treatment was conducted by a single therapist rather than a dual-sex team.

e) The experiential component of therapy was expanded and adapted more flexibly to the needs of the particular couple.

f) Supplementary elements derived from the literature of individual and marital therapy were required to deal with the difficulties and obstructions encountered in the treatment process.

These modifications were made on an ad hoc basis. However, in adapting the model to a different setting, the present writer independently moved in a direction that was later to be formally systematized by Kaplan. (cf. Appendix B, pp. 107-115 below).
Section 1: Outline of the Kaplan Model.

After the publication of the Masters and Johnson prototype in 1970, a number of attempted modifications appeared. These can be divided into two groups:


The model propounded by Helen Kaplan (1974a, 1974b, 1975, Kaplan and Sollard 1976) constitutes the fullest, the most detailed, and the most widely-known account that has yet appeared of the issues involved in the application of the Masters and Johnson model to the more normal conditions of clinical practice.

Kaplan attempted to provide a new synthesis by integrating the contribution of Masters and Johnson with other elements derived from current knowledge, theory, and clinical practice which she believed to be relevant to the understanding and treatment of sexual dysfunction.

Her key concept is that sexual dysfunction is a psychosomatic disorder, i.e. one for which there are both physical and psychological determinants. The sexual response is a visceral response innervated by the autonomic nervous system. Given intact organicity and adequate stimulation it will proceed from the excitement phase through to orgasm and resolution unless it is impeded by the stress of negative affect (principally in the form of anxiety). Various contemporary psychological frameworks are required in order to conceptualize adequately and to intervene successfully to remove this stress (the dominant one being the psychodynamic). Her approach therefore is "multicausal" and eclectic. She hopes that her model will provide
a thoroughly rational approach to treatment (i.e. one in which clear principles guide each interventive step) rather than one which is merely empiric (i.e. one which may work on occasions but for reasons that are obscure) (Kaplan, 1974, pp 1).

An account of the Kaplan model can best be furnished under the following headings:

a) the physical determinants of sexual dysfunction;

b) the psychological determinants of sexual dysfunction;

c) the treatment process.

A. Physical determinants of sexual dysfunction.

The basic requirement for sexual adequacy is that the sexual organs themselves and the supporting vascular, neurological and endocrine systems should be sound. Estimates of the number of sexually dysfunctional patients who have some related organic deficiency range from between 3% to 25%. Hence the assessment of sexual dysfunction must include a medical and drug evaluation since it cannot be assumed that a condition is psychogenic unless physical factors have been excluded. Kaplan points to four major classes of physical factors which may be associated with sexual dysfunction:

1. Psychophysiological states e.g. depression, stress and fatigue.

Kaplan notes that depression, stress and fatigue profoundly affect the sexual response and are frequently involved in the etiology of sexual dysfunction, although the mechanism involved is not understood. Her practice is to treat such conditions first, and to postpone sex therapy until the patient's condition has improved. (Kaplan, 1974, pp 75-77).

2. Physical illnesses with general and non-specific effects on sexual functioning.

Some illnesses have a general and non-specific effect on sexual interest and functioning. Any debilitating and/or painful illness lowers or extinguishes erotic interest. Thus renal disorders tend to diminish sexual interest, and in the case of hepatitis, diabetes and multiple sclerosis the impairment of sexual interest and responsivity may
be an early clinical indication of the onset of the disease (Kaplan, 1974, pp 77).

3. Diseases (or surgical procedures) with specific effects on sexual functioning.

Other diseases (or surgical procedures) may impair sexual response by specifically damaging the sexual organs themselves or their vascular and nervous supports, or by reducing the effective androgen level. Thus surgical removal of the pituitary, adrenals, or gonads may diminish sexual interest in both sexes because of the reduction of androgen level. Similarly, multiple sclerosis is a frequent unsuspected cause of erectile and orgasmic disorders because it impairs the nervous supply to the reproductive organs (Kaplan, 1974, pp 77-79).

4. Common drugs and medication.

Four categories of drugs and medication in common use may impair sexual interest and response by producing chemical alterations of the nervous pathways involved, the nett effect depending on the site affected, i.e. (1) alcohol and the barbituates, (2) narcotics (e.g. heroin, morphine and codeine), (3) the anti-androgens (e.g. estrogen and progesterone, cortizone, aldectazine and aldectone), and (4) anti-autonomic drugs (anticholinergic and antiadrenergic).

Hence Kaplan recommends that a survey of all medication taken by a client should be made before the commencement of sex therapy. She notes that often an alternative drug can be substituted which deals effectively with the target medical symptoms, but which does not have sexually destructive side-effects (Kaplan, 1974, pp 86-103).

B. Psychological determinants of sexual dysfunction.

In the psychological assessment and treatment of sexual dysfunction, Kaplan has attempted to broaden the approach of Masters and Johnson with elements derived from psychoanalysis, dyadic marital therapy and learning theory.
In her view there have been four major schools of thought on the causality of sexual dysfunctions:

a) the psychoanalytic school which sees them as symptoms of unconscious conflict deriving from childhood experiences;

b) the systems view of psychopathology, according to which pathological transactions between the lovers create a sexually destructive environment;

c) the view of learning theory, according to which specific conditioned reactions impairing the sexual response are acquired because adverse contingencies follow sexual behaviour;

d) the growing clinical experience of "sex therapists" (i.e. those who employ some version of the Masters and Johnson model) which indicates that patients improve dramatically if certain immediate obstacles to sexual functioning are modified, even though factors proposed by the other major theoretical models remain unresolved.

Kaplan attempts to harmonize the contributions of these points of view with the idea derived from medical science that the same disorder can be understood from the vantage point of discrete scientific disciplines, each utilizing its own distinctive conceptual system. Thus Kaplan claims that the contributions of the four major psychological schools are not contradictory but complementary: i.e. they describe the same phenomena from different points of view. She attempts to bring these diverse contributions into more intelligible relationship with her distinction between immediate and remote causes, a distinction which she says is central to psychomatic medicine as a whole.

Kaplan illustrates the meaning and implications of these concepts by their application to another psychosomatic condition: peptic ulcer. The immediate cause of the peptic ulcer is excessive hydrochloric acid secretion damaging vulnerable duodenal tissue. A great number of more remote psychological factors may ultimately be responsible for this condition. Treatment of the ulcer consists of intervening to stop the immediate damaging cause: i.e. by stemming the acidic secretion by neutralizing it chemically. However, this is not enough
to prevent recurrence of the ulcer. Later, or simultaneously, the more remote or deeper causes of acid secretion i.e. internal psychological conflicts, familial problems or environmental stresses must also be resolved to effect a final cure of the ulcer and prevent its recurrence.

Kaplan urges that the strategy in dealing with sexual dysfunctions is similar. The first priority is to attempt to modify the immediate obstacles to sexual functioning such as those identified by Masters and Johnson (e.g. performance fears, spectator role, etc.). Often these can be dealt with effectively by the experiential techniques pioneered by these authors. However, in more difficult cases such immediate obstacles may be merely "the tip of the iceberg" which cannot be dealt with without an understanding of the more remote and deeper causes. And for this task, the perspective of several additional psychological frameworks is required (Kaplan, 1974, pp 120).

I The Immediate Causes of Sexual Dysfunction (Kaplan, 1974, pp 121-36).

The sexual response consists of a complex series of reflexes innervated by the autonomic nervous system. These mechanisms are in a state of extremely delicate equilibrium, and can proceed only if the person is in an emotionally calm state. The balance can readily be disturbed by negative affect (e.g. fear or anger) or excessive emotional control. Hence effective sexual functioning demands that "the individual must be able to abandon himself to the erotic experience" in an atmosphere of openness and trust. The immediate causes of sexual dysfunction are those which operate in the "here-and-now" at the moment of lovemaking to impede such erotic abandonment, and thereby impede the autonomic process.

In her own account of the immediate causes Kaplan systematizes those identified by Masters and Johnson, with some further clarification and additions of her own, under the following headings:

1. Failure to engage in effective sexual behaviour.

The couple avoids or fails to engage in behaviour which is exciting and sufficiently stimulating to both, due to (a) the ignorance,
myths and misconceptions about sexual functioning noted by Masters and Johnson or (b) anxiety and guilt.

2. Sexual anxiety.

There are some highly prevalent and obvious sources of disruptive anxiety which were overlooked before the work of Masters and Johnson, namely (a) anticipatory anxiety, (b) demand for performance by the spouse or the dysfunctional partner himself, and (c) excessive need to please the partner.

3. The "spectator role".

According to Kaplan, this phenomenon noted by Masters and Johnson interferes with the suspension of cognitive control and abandonment to erotic experience which is required for adequate sexual functioning.

4. Inadequate sexual communication.

This was noted by Masters and Johnson and other authorities.

II Intra-psychic Causes of Sexual Dysfunction (Kaplan, 1974, pp 137-154).

In Kaplan's view sexual dysfunction is not always a product of a destructive sexual system operating between the couple. Sexual conflict within one of the partners (i.e. an antagonism between the wish to enjoy sex and fear or anxiety about doing so) may often be an important contributory factor. Such conflict is often unconscious, i.e. although the person is unaware of its existence it nonetheless influences behaviour and in principle it can become the object of conscious attention. In dealing with sexual conflict Kaplan employs classical Freudian concepts with some substantial modifications of her own.

The prime concern of sex therapy is with what classical psychoanalysis would regard as superficial conflicts, i.e. those which operate immediately in the "here-and-now" at the moment of lovemaking, e.g. conflict between a client's desire to have intercourse with his wife and the anxiety which emerges at the moment of lovemaking to impair his erectile and/or orgasmic response. The classical Freidians would regard such conflicts as surface symptoms of deeper
pathology which itself should be the prime focus of treatment.

Kaplan agrees with Freud that such superficial conflict may be merely a symptom of deeper conflicts stemming from earlier experience, and that "repressed", "unconscious" elements may be involved. However she criticizes Freud with being unnecessarily restrictive in his view of the deeper origins of sexual conflict. According to Kaplan two key sources of sexual conflict in contemporary society stand out:

1. **Early incestuous experiences in the nuclear family.**

Kaplan accepts in broad outline Freud's theory of infantile sexuality according to which the sexual drive manifested in sexual wishes and fantasies is present from early infancy on. She accepts in its entirety Freud's account of the process of the classical oedipal conflict as being verified in at least some cases. She agrees also that occasionally an unresolved oedipal conflict may contribute to sexual dysfunction. However, she denies Freud's contention that this is the **specific and sole cause of all sexual pathology.**

2. **Sexual conflict caused by other factors.**

Cultural factors to which Freud did not give attention are seen by Kaplan as the key reason for the prevalence of sexual problems in contemporary society. She notes that while human sexuality is irrepressible and the most pleasurable of all the drives, it can also be readily associated with painful affect, especially guilt and fear. **Contemporary society tends to equate sex and sin.** Hence, especially throughout the critical childhood years, every manifestation of a person's craving for sexual pleasure is apt to be systematically followed by disapproval, shame, punishment or denial.

In fortunate individuals, such negative contingencies result in the appropriate control of sexual impulses. In less fortunate people even appropriate expressions of sexual desire are apt to be crippled by guilt, fear, or the denial of sexuality as an integral part of the personality ("sexual alienation"). Children from families which have restrictive and punitive moral codes (especially when linked with
strict religious orthodoxy) are particularly vulnerable in this regard (Kaplan, 1974, pp 145-148).

III The Marital Relationship: Dyadic Causes of Sexual Dysfunction.

Features which characterize the marital system itself are often the chief cause of sexual dysfunction, according to Kaplan, and the optimum site for intervention. In her attempt to specify the relevant aspects of the marital relationship involved, Kaplan employs a wide range of concepts from psychodynamic marital therapy, Transactional Analysis, Gestalt Therapy and "Contractual Marital Therapy" (Sagar et al. 1972; Sagar, 1976).

She stresses that two questions must be answered in order to understand a sexually destructive marital relationship:

a) Why do the partners destroy each other sexually? (i.e. what is the basis of their motivation?)

b) How do they accomplish this? (i.e. by what mechanism?)

1. Why partners destroy each other sexually.

According to Kaplan, two neurotic and destructive emotions predominate in clinical experience:

a) rebellious fear and rage towards the partner;

and

b) fear of rejection and abandonment.

Kaplan refers the reader to the literature of marriage and family therapy for a full treatment of transactions involving these two themes, but cites as common examples: (1) transferences from childhood experiences, (2) lack of trust, (3) marital power struggles, and (4) "contractual disappoints", i.e. implicit "contracts" the terms of which may be beyond the immediate awareness of the partners (cf. Sagar et al. 1972; Sagar, 1976).
2. *How marital conflicts produce sexual dysfunction.*

Kaplan cites three ways by which such marital difficulties are commonly translated into sexual dysfunction:

a) **Rage and fear of abandonment** resulting from the marital conflict may directly inhibit the sexual response of the conflicted partner.

b) **Sexual sabotage.** The angry or fearful partner may subtly attempt to punish, frustrate, or undermine the other's sexual confidence in a way that is not recognized by either, e.g.:

1) by picking a quarrel when lovemaking is a possibility;

2) by suggesting to make love when one is aware that one's partner is not in the mood;

3) by making oneself sexually unattractive, e.g. by smoking cigars, being careless with grooming or toilet, or by moving in an ungainly manner (Kaplan, 1974, pp 162-166).

c) **Communication failure.** Effective sexual interaction requires adequate communication. But the woman who profoundly fears rejection by her husband, for example, may not tell him of her need for prolonged and patient stimulation because she may be afraid that he will be displeased with her and abandon her (Kaplan, 1974, pp 166-167).

**IV Learned Causes of Sexual Dysfunction.**

Kaplan concedes that learning theory has made a substantial contribution both to the understanding and treatment of sexual problems. From the point of view of the learning theory model, sexual responses are natural "unconditioned" reactions, and sexual dysfunctions are learned inhibitions. Conditioning and reinforcement are the two basic mechanisms used to explain the acquisition and the maintenance of sexual dysfunctions from this perspective (Kaplan, 1974, pp 173-174).
Sexual inhibition arises through conditioning when the sexual response becomes associated with negative contingencies. For example: if his erection is followed by pain, fear, guilt or the hostility of his partner, a man may learn to inhibit this response. A wide range of negative contingencies may be associated with sexual inhibition: physical punishment for sexual misdemeanors, fear or anticipation of criticism, humiliation, or rejection by one's partner (Kaplan, 1974, pp 173).

Reinforcement is the process by which the onset or occurrence of a subsequent event is contingent upon the eliciting of a response (Mikulas, 1972, pp 87). An analysis of covert reinforcement contingencies may explain how a sexual dysfunction persists despite the pain it occasions to the patient. For example, if a man unconsciously wishes to punish his wife, her expressions of frustration may constitute the covert reinforcement which maintains his pattern of retarded ejaculation (Kaplan, 1974, pp 174).

Kaplan believes that the principle of focusing therapeutic intervention on specific and modifiable mechanisms at the "molecular" level has revolutionary implications not only for the development of sex therapy but for psychiatry in general (Kaplan, 1974, pp 182). Her main criticism of the behavioural approach is that "excessive reliance on behaviour therapy neglects the deeper problems and profound roots of sexual problems" which can be formulated in terms of the psychodynamic and the marital systems models. The value of behavioural approaches for Kaplan are enhanced when they are viewed as an addition to, rather than as a substitute for other therapeutic modes (Kaplan, 1974, pp 182).

C. The Treatment Process.

The key features of the therapeutic process as expounded by Kaplan are as follows:

1. **Limited and task-specific goal.**

   Sex therapy has a specific and limited goal: the relief of the sexual dysfunction itself. For Kaplan this is the major criterion
which distinguishes her approach from traditional psychoanalysis and marital therapy from which she derives many of her basic concepts (Kaplan, 1974, pp 187-188). Psychoanalysis and marital therapy are both used to treat people who complain primarily of sexual dysfunction. But for both of these modalities, says Kaplan, this is seen as a secondary "symptom" of more basic underlying pathology whose removal is the primary objective of treatment.

Sex therapy, on the other hand, is concerned simply with the removal of the symptom itself. Unconscious intrapsychic conflict and destructive marital transactions may be dealt with in the course of therapy as a means to this end. However, when the symptom has been removed sex therapy has been completed, even if the underlying intrapsychic and marital pathology remains (Kaplan, 1974, pp 188).

2. Focus on the marital relationship.

Kaplan regards Masters and Johnson's focus on "the couple as the patient" in the treatment of sexual dysfunction as "one of the most important advances in the behavioural sciences" (Kaplan, 1974, pp 155-6). She incorporates this orientation into her own model with some modifications and refinements.

a) She does not agree with Masters and Johnson's implied contention that sexual problems are always a function of the marital relationship, since the intrapsychic conflicts of one partner can sometimes be a key determining factor (Kaplan, 1974, pp 198).

b) While agreeing with Masters and Johnson that sex therapy requires the co-operation and commitment of both partners, Kaplan is much more flexible than these authors in the extent to which she requires conjoint partner participation in every therapy session. Thus if for some reason one partner is prevented from attending the interviews, the other spouse may be seen alone, and then may be given instructions for activities which the couple can carry out at home together (Kaplan, 1974, pp 200).

3. Combination of prescribed erotic tasks and psychodynamic psychotherapy.

Masters and Johnson pioneered the concept of the concurrent use of office interviews and a graded series of structured erotic experiences
carried out by the couple in private, by which their behaviour is gradually shaped towards more effective sexual functioning. This procedure has been adapted in various ways by numerous workers (cf. pp 51 above). Kaplan repeatedly insists that her essential and specific contribution consists in the integrated use of such systematically structured experiences in counterpoint with psychodynamically based office therapy in which are explored:

   a) the relevant unconscious intrapsychic conflicts of each partner;

   and       b) the relevant dynamics of marital interaction (Kaplan, 1974, pp 193).

In their office interviews, Masters and Johnson employ procedures which are basically educational, and which focus on the immediate obstacles to sexual functioning which they were the first to document. Kaplan however also takes account of individual and marital dynamics which Masters and Johnson ignored. For Kaplan, office interviews are essentially psychodynamically-based individual and dyadic psychotherapy, directed above all to deal with the defences against sexuality and the resistances both to improved sexual functioning and to the treatment process itself, which emerge as the couple attempt to engage in the prescribed erotic tasks (Kaplan, 1974, pp 227-334; 1975, pp 169-172).

Used in this integrated way, Kaplan claims that office psychotherapy and prescribed erotic tasks are mutually reinforcing. Together they constitute an instrument of great power for effecting behavioural change which neither would possess were it used in isolation:

"The sexual tasks reveal individual conflicts and marital pathology far more rapidly and dramatically than mere discussion, and this material is worked with extensively and intensively in the psychotherapeutic sessions." (Kaplan, 1974, pp 199).

Kaplan summarizes the range of procedures used in her model in this way:
"Essentially, I view sex therapy as a task-centred form of crisis intervention, which presents an opportunity for rapid conflict resolution. Toward this end the various sexual tasks are employed, as well as the methods of insight therapy, supportive therapy, marital therapy, and other psychiatric techniques as indicated." (Kaplan, 1974, pp 199; Sollard and Kaplan, 1976, pp 145.)

4. The prescribed erotic tasks.

An essential interventive measure in Kaplan's approach is the use of a series of graded erotic activities carried out by the couple in private to achieve specific goals. Examples are the "sensate focus" exercises, non-demand coitus for non-orgastic females, the "squeeze technique" as an aid in gaining ejaculatory control.

These experiences have several functions in the therapeutic process according to Kaplan:

1) They tend to modify the destructive sexual system of the couple. The marital partners are asked to abandon their established pattern of sexual interaction, and to adopt a new approach with limited and attainable goals.

2) They tend to foster rapid resolution of sexual conflict by compelling the partners to confront situations and sensations which they have previously avoided.

3) The experiences tend to force previously unrecognized intra-psychic and dyadic conflicts into consciousness, so that they can then be explored in the therapeutic sessions. They can then be dealt with by the powerful combination of insight and experiential therapy.

4) The couple's reaction to each specific task assists the therapist to form a more accurate assessment of the factors which inhibit and those which enhance the couple's sexuality (Kaplan, 1974, pp 206-211).

Kaplan differs from Masters and Johnson, who popularized this approach, in two important respects:
a) Whereas Masters and Johnson employed a series of graded erotic experiences in routine fashion, Kaplan stresses the principle of flexibility. She has no pre-packaged programme. Each erotic experience is structured to meet the specific present needs of the individual couple as is indicated by the ongoing assessment of the immediate and deeper obstacles to sexual functioning which are operating in their particular case at a particular time. Thus, the "sensate focus" exercises which Masters and Johnson propose to all couples entering their programme regardless of the presenting dysfunction (Masters and Johnson, 1970, pp 69) are employed by Kaplan only when specifically called for (Kaplan, 1974, pp 205).

b) She further diverges from Masters and Johnson by explicitly calling on psychodynamic concepts to deal with concomitant resistances and individual and marital conflicts which interfere with the couple's progress in the experiential aspect of therapy (Kaplan, 1974, pp 226-234; 1975, pp 169-181).

5. The office therapeutic interviews.

The idea of integrating structured erotic experiences carried out by the couple at home with interleaving office interviews was derived by Kaplan from Masters and Johnson. For Kaplan and for Masters and Johnson the over-riding aim of these interviews are identical: to help the couple complete the series of therapeutic erotic tasks with positive and increasing satisfaction. To this end the therapist:

1) conducts a detailed review of the couple's conduct of the therapeutic tasks with the emphasis on the specifics of behaviour and the positive or negative emotional impact of the experience;

2) assists the couple to establish effective sexual communication both in the interview room and in their interactions at home;

3) in the case of a negative response, he attempts to ascertain the nature of the obstacle, and to deal with this;

4) he plans and structures the next experience which will take the couple one further step towards more adequate sexual functioning.
The specific difference between the two approaches is that for Kaplan the comprehensive framework involving immediate and deeper unconscious causes of sexual dysfunction guides the assessment of the obstacles and indicates the interventive steps to deal with them. For Kaplan, some of the main obstacles which emerge in practice are defences against the emergence and enjoyment of sexual feelings, and resistances either to the treatment process itself or to the successful outcome of therapy (Kaplan, 1974, pp 221-222, 236-234; 1975, pp 169-172). Hence in her system there is a constant interplay between the emotional impact of the structured erotic experiences and interventions aimed at dealing with the previously unconscious elements that they tend to stir up.

The over-riding principle in therapy for Kaplan is to focus primarily on removing the immediate obstacles to sexual functioning. These yield at least in part, as Masters and Johnson had discovered, to education, the clarification and correction of sexual misconceptions, improved communication, and above all to the structured erotic exercises which expose the couple to previously avoided experiences (Kaplan, 1974, pp 221).

However defences against sexual feeling, resistances and other elements of individual and marital conflict are constantly being mobilized in the course of treatment. In order to deal with these Kaplan finds it necessary to go beyond the therapeutic armoury provided by Masters and Johnson, and to call upon methods derived principally from psychodynamic theory (Kaplan, 1974, pp 234). These essentially consist in bringing previously unconscious factors to the client's attention, and if necessary, in helping him to resolve conflict by promoting insight (Kaplan, 1974, pp 227, 233).

Kaplan employs a range of interventive procedures which could be approximately graded in terms of preferred use. The methods of Masters and Johnson, with modifications from behaviour therapy, are used in preference to insight methods. The attempt is made to promote insight into more immediate obstacles to sexual functioning rather than into deeper conflicts. The latter are dealt with only as a last resort (Kaplan, 1974, pp 227). In the following list, the
interventive methods used by Kaplan have been placed in what appears to be the approximate order of preferred use:

a) **The methods of Masters and Johnson.**

1) structured erotic tasks;
2) education, information;
3) clarification of sexual misconceptions;
4) promotion of communication.

b) **Behavioural methods.**

When there is mild negative response to the erotic tasks the following behavioural methods are used:

1) simple repetition of the prescribed task;
2) "bypassing" the anxiety by providing "temporary defences";
3) restructuring the experience;
4) "bypassing" the experience altogether, and proceeding to the next in the series.

c) **Insight methods.**

When the negative response to the prescribed erotic task is more severe, it may be necessary also to call upon the following interventive measures:

1) simple confrontation with unconscious feeling with no attempt to resolve the underlying conflicts;
2) promotion of insight into more immediate individual and marital conflicts;
3) promotion of insight into deeper conflict.

Section 2: Clinical Population, Kaplan Model.

The Kaplan model was employed as the principle guide to treatment in ten cases of Series II. Table 11 sets out the target sexual problems encountered in the two samples. (N.B. Some partners had more than one target problem.)

TABLE 11 TARGET SEXUAL PROBLEMS IN MASTERS AND JOHNSON AND KAPLAN SAMPLES.

<table>
<thead>
<tr>
<th>Sex</th>
<th>Target Sexual Problem</th>
<th>Instances in M. &amp; J. Sample (N=12 couples)</th>
<th>Instances in Kaplan Sample (N=10 couples)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>erectile difficulty</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>premature ejaculation</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>retarded ejaculation</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Female</td>
<td>arousal difficulty</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>climax difficulty</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>vaginismus</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>dyspareunia</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>behavioural inhibition</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

In 6 out of the 10 cases the "identified patient" was female only. Again, as in the Masters and Johnson sample, the preponderating target problem was female arousal difficulty. The mean duration of the problem was 5.6 years (with a range between 7 months and 18 years) as against a mean of 3.3 years duration for the Masters and Johnson sample. The average age of the husbands was 35 years and of the wives 31 years. The average couple had been married for 9 years (range 7 months - 23 years) and had 2 school-age children of mean age 6 years (range 9 months - 22 years). Both partners were Catholic in over two-thirds of the marriages, and 50% of the sample were practicing the Ovulation Method of family planning. Fifteen of the 20 partners (i.e. 75%) were Australian born.

This sample tended to be of slightly lower socio-economic status than the Masters and Johnson series outlined earlier (pp 18-19 above). The average period of formal education was 11.2 years (as
against 12.8 years for the previous sample). Only 25% had a university degree or other tertiary qualification, as against 42% for the Masters and Johnson series. A total of 6 husbands (60%) were white-collar workers of any type, as against 75% for the Masters and Johnson series. The socio-economic and educational standing of this group seems to be much lower than that encountered by Kaplan herself, in which 79% appear to be from middle or upper middle-class backgrounds (cf Caird and Wincze, 1977 pp 3).

There appeared to be more marital disharmony in this group than in the Masters and Johnson sample. The mean marital functioning rating assigned to this group was 0.5 as against 0.9 for the Masters and Johnson series. Table 12 represents the distribution of the assigned marital functioning ratings for the two samples:

<table>
<thead>
<tr>
<th>Rating</th>
<th>Marital Functioning</th>
<th>M. &amp; J. Series</th>
<th>Kaplan Series</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ 2</td>
<td>very satisfactory</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>+ 1</td>
<td>satisfactory</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>0</td>
<td>ambivalent</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>- 1</td>
<td>unsatisfactory</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>- 2</td>
<td>very unsatisfactory</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Only one marriage was free from notable marital problems complicating the sexual dysfunction. In 6 out of 10 cases (60%) pronounced individual intra-psychic problems also were intertwined with the sexual problems (as against 25% in the Masters and Johnson series). Hence it appeared that there was a greater level of individual and marital problems connected with the sexual dysfunctions of this sample than in the previous one.

Selection was partly responsible for this. When the sexual dysfunction was of short duration (under 12 months) and the
marriage was more harmonious the simpler "PLISSIT" model (Annon, 1974, 1975) was applied in preference to the more complicated Kaplan model. Thus the "PLISSIT" model was used in the treatment of 3 simpler cases in Series II. The Kaplan sample was thus skewed in the direction of more difficult cases.

Section 3. Results, Kaplan Series.

Table 13 represents the outcome of treatment for the Masters and Johnson, Kaplan, and "PLISSIT" series as indicated at follow-up 3 months or more after termination of treatment. Category definitions are as defined at pp 18 above.

<table>
<thead>
<tr>
<th>Clinical Population</th>
<th>Marked Improvement</th>
<th>Improved</th>
<th>Not Improved</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>M.&amp; J. Series</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>(N = 12)</em></td>
<td>3 (25%)</td>
<td>5 (42%)</td>
<td>4 (33%)</td>
</tr>
<tr>
<td><strong>Kaplan Series</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>(N = 10)</em></td>
<td>4 (40%)</td>
<td>3 (30%)</td>
<td>3 (30%)</td>
</tr>
<tr>
<td><strong>&quot;PLISSIT Series</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>(N = 3)</em></td>
<td>3 (100%)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>**Kaplan Series &amp;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;PLISSIT&quot; Series**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>(N = 13)</em></td>
<td>7 (54%)</td>
<td>3 (23%)</td>
<td>3 (23%)</td>
</tr>
</tbody>
</table>

The table suggests a tendency towards improved results with the Kaplan model as against the Masters and Johnson model. This should be weighed with the fact that in the Series II cases
(post-1975) the Kaplan model was reserved for the more difficult problems while the 3 easier cases were treated according to the "PLISSIT" model.

Table 14 is a summary of the cost effectiveness statistics for the 3 series of cases: The Masters and Johnson series, the Kaplan series, and the "PLISSIT" series.

TABLE 14: MASTERS AND JOHNSON, KAPLAN AND "PLISSIT" SERIES: COST-EFFECTIVENESS STATISTICS.

<table>
<thead>
<tr>
<th>Clinical Population</th>
<th>Assessment Sessions per Case</th>
<th>Treatment Sessions per Case</th>
<th>Total Sessions per Case</th>
<th>Therapist-Hours per Case</th>
<th>Approx. Cost per Case</th>
</tr>
</thead>
<tbody>
<tr>
<td>M. &amp; J. Series (N = 12)</td>
<td>9.3</td>
<td>10.6</td>
<td>19.7</td>
<td>28.3</td>
<td>$283</td>
</tr>
<tr>
<td>Kaplan Series (N = 10)</td>
<td>4.4</td>
<td>11.2</td>
<td>15.6</td>
<td>17.1</td>
<td>$171</td>
</tr>
<tr>
<td>&quot;PLISSIT&quot; Series (N = 3)</td>
<td>1.0</td>
<td>3.0</td>
<td>4.0</td>
<td>4.0</td>
<td>$40</td>
</tr>
<tr>
<td>Kaplan Series &amp; &quot;PLISSIT&quot; Series (N = 13)</td>
<td>3.6</td>
<td>9.2</td>
<td>12.8</td>
<td>13.9</td>
<td>$139</td>
</tr>
</tbody>
</table>

All figures represent "mean number per case".

Use of the Kaplan model resulted in a saving of 20% in sessions per case and a saving of 40% in therapist-hours per case. The cost of the Kaplan series was thus 40% cheaper than the Masters and Johnson series. Use of the Kaplan model also entailed a reduction of 53% per case in the assessment phase, partly because use of the Kaplan theoretic framework gave greater salience and economy to the
assessment procedures.

The use of the Kaplan and "PLISSIT" models in tandem resulted in even greater economy. There were approximately 60% less assessment interviews per case when these two models were used in a complementary fashion. There was also a 35% saving in total sessions per case, and a 51% saving in therapist-hours per case. In monetary terms the complementary use of the Kaplan and "PLISSIT" models represented a saving of 51% over the use of the Masters and Johnson model alone.
Section 4: Strengths of the Kaplan Model.

1. Therapy Format.

The format of the Kaplan model was found to be more appropriate to the resources and constraints of the setting of the marriage and family counselling agency than that of the Masters and Johnson model in the following respects:

a) **Time-limit and daily interviews.** The Kaplan model does not employ a brief, time-limited programme of daily interviews. Rather, interviews are scheduled on a weekly or bi-weekly basis, and are continued as long as is necessary (Kaplan, 1974, pp 199). This is more in accord with the socio-economic status of the client population encountered in the setting of the marriage and family counselling agency. (See Part I, Section 5, No. 2, pp 32 above.)

b) **Social isolation of the couple.** The use of the Kaplan model does not require the social isolation of the couple in honeymoon conditions. During therapy they continue to live at home, and carry on with the normal routines of daily living (Kaplan, 1974, pp 199). This likewise is more appropriate to the needs of the client population catered for by the marriage and family counselling agency. (See Part I, Section 5, No. 2, pp 32-33 above.)

c) **Cotherapy.** Kaplan does not insist on the use of the dual-sex therapy team. Treatment is conducted by a single therapist unless the dual-sex team is called for to meet some special difficulty or client need (Kaplan, 1974, pp 238-240). This feature likewise is more attuned to the constraints of the marriage and family counselling agency setting, where the general use of co-therapy had been found to be impracticable. (Part I, Section 6, No. 3, pp 33-5 above.)

d) **Medical examinations.** The Kaplan model does not involve the routine medical examination of both partners (including the non-dysfunctional member) which was required by Masters and Johnson. Rather, such examinations are prescribed when it is suspected that the presenting sexual problem may be related to physical factors.
As an aid to such referral, Kaplan provides an excellent survey of physical conditions which may be linked with sexual dysfunction. (See above pp 52-53.) Again, this parsimonious procedure is more in tune with the resources and limitations of the marriage and family counselling agency setting than that of Masters and Johnson. (Part I, Section 6, No. 1, pp 32 above.)

Apart from these changes, the Kaplan model exploits all the features of the Masters and Johnson model which had been found useful and viable within the limitations of the marriage and family counselling agency setting, i.e. the emphasis on the couple as the patient rather than the dysfunctional individual, emphasis on the sexual interaction of the couple in the here-and-now, the combination of office therapeutic interviews with structured erotic experiences carried out at home, etc. (Part I, Section 4, pp 20-29 above.) Only those elements of the Masters and Johnson model are excluded which cannot be accommodated to the constraints of a less affluent setting, and of a less affluent client population. (Part I, Section 5, Nos. 1, 2 and 3, pp 32-5 above.) The Kaplan model is thus far more attuned to the realities of more normal clinical practice.

2. Fundamental orientation and philosophy.

The fundamental orientation and philosophy of the Kaplan model is more suitable to the needs of the setting of a marriage and family counselling agency. The Masters and Johnson clinic at St. Louis offers a pre-structured programme which includes the use of a dual-sex therapy team, a uniform method of assessment, a time-limited programme, daily interviews, and a predetermined sequence of structured erotic experiences, etc. (Part I, Section 5, Nos. 2, 3 and 4, pp 32-7 above.) It could be compared to a pre-structured educational course, offered in the same form to a wide variety of people, and to which intending students are required to adapt.

However, the keynote of Kaplan's model is flexible and creative adaptation to the specific needs of the individual or the couple. The spouses are not offered a pre-structured programme; rather, elements are introduced and moulded to fit their specific
requirements (Kaplan, 1974, pp 199; Sollard and Kaplan, 1976, pp 140). Thus, although Kaplan's treatment like that of Masters and Johnson focuses on the couple, both partners are not required to attend every interview (Kaplan, 1974, pp 200). Although the model envisions a single therapist, cotherapy is introduced if it appears to be an advantage in a particular case (Kaplan, 1974, pp 239). Finally, in contrast to the Masters and Johnson model, the couple is not guided through a predetermined sequence of structured erotic experiences: rather the experiential element of therapy is tailored to the needs of the particular individual or couple (Kaplan, 1974, pp 205).

3. Flexibility of experiential component.

The greater flexibility of the Kaplan model is seen most clearly in the use made of structured erotic experiences. In the Masters and Johnson programme, all couples, irrespective of the presenting problem proceed through two stages of the "sensate focus" exercises in which each partner takes turns in giving and receiving simple body caresses. In the first stage ("Sensate Focus I") the female breasts and genital areas of each partner are avoided; while in the second stage ("Sensate Focus II") they may be included. When this exercise begins to result in sexual arousal, the couple is ready to proceed to a further set of exercises designed to assist in the eradication of the specific type of sexual dysfunction by a series of pre-planned steps (Masters and Johnson, 1970, pp 67-75, 86-91). The deficiencies of this approach encountered in clinical practice were pointed out above. (Part 1, Section 5, pp 35-37).

Kaplan takes a much more flexible approach. She has no pre-designed programme. The experiential element of therapy is tailored to meet the specific requirements of each couple at each stage of therapy. Thus for many couples contending with premature ejaculation the "sensate focus" exercises may be judged superfluous: they may proceed directly to the use of procedures designed to deal specifically with this difficulty (Kaplan, 1974, pp 205). Similarly, if the preliminary evaluation indicates that the impotent husband can gain erections in some situations, experiences are structured to capitalise on this. Thus treatment may begin with the husband cuddling his wife while clothed, while she stimulates his penis through his clothing (Kaplan, 1975, pp 116).
Kaplan's principle of flexible and creative adaptation to the specific needs of individuals proved useful in treating many couples of Series II. The following two brief case reports provide examples.

Case Report No. 4: Omission of "sensate focus" in treatment of female difficulty of climaxing in intercourse.

Mr. and Mrs. D. were a young couple in their early twenties with two young children. Mrs. D. complained of reaching climax too early, and hence of being unable to climax in intercourse. Since the ability of this couple to give and receive pleasure, their sensitivity to each other's needs and their sexual communication seemed more than adequate, the "sensate focus" exercises of Masters and Johnson were dispensed with. Instead, the couple were instructed to make love in the way which was usual for them while Mrs. D. learned to recognize the signs of impending climax. When she had gained facility in this the couple were then instructed in the technique of the "Bridge Maneuver" described by Kaplan (1975, pp 87-94) in which the male delays entry until the female signals she is on the verge of climax. In the third stage they were guided to arrange the point of entry at an earlier phase of the wife's arousal so that her climax was triggered when she was ready by more vigorous thrusting.

Case Report No. 5: Specifically tailored erotic experiences in the treatment of severe female arousal difficulty.

Mr. and Mrs. E. were in their early thirties and had three children. The presenting problem was that Mrs. E. experienced extreme distaste for all sexual contact and arousal. Attempts to introduce this couple to "sensate focus" gradually, through a less threatening form of massage, failed (Downing, 1972). However it was discovered that Mrs. E. did enjoy kissing and cuddling in bed while clothed, though she had taken care to hide this fact from her husband. The experiential element of therapy therefore began at this point. Later, breast and genital caressing were added as Mrs. E. felt ready for them. Within a few sessions she was enjoying intercourse. (Full details of the conduct of this case are given in Case Report No. 6, pp 85-88 below.)


Important though limited contributions to the understanding of sexual function and dysfunction have been made by various branches of the biological sciences, and by a number of discrete traditions within the behavioural sciences. The major achievement of Helen Kaplan
has been to show how the contribution of Masters and Johnson can be integrated into a wider conceptual framework which utilizes the findings, theories, and accumulated experience of these disparate disciplines and traditions each of which has something to offer. Kaplan's formulation was found clinically useful not as a replacement of the concepts of Masters and Johnson, but rather as an extension and development. A consideration of the contribution which each of the two models make to the clinical assessment of sexual dysfunction will highlight the contribution made by Kaplan.

In the assessment of the factors involved in sexual dysfunction Masters and Johnson recur to a model which involves input from two "interdigitating" systems: the biophysical and the psychosocial (Masters and Johnson, 1970, pp 66-7, 75-76, 219-222, 224-226, 235-237). Kaplan also utilizes the same basic idea, but she develops and articulates the features of each in the light of a wider framework of research and theory.

a) The physical determinants of sexual dysfunction (the "bio-physical system").

Masters and Johnson's concept of the biophysical system is dominated by the viewpoint of their prior pioneering study of the human sexual response (Masters and Johnson, 1966). This important work, though without question a landmark in the field, dealt with only certain aspects of the anatomy and physiology of the human sexual response. It was principally concerned with the reactions of the genital organs and certain non-genital body areas (e.g. breasts and total body musculature of both sexes) through the four stages of the sexual response cycle.

However, in her discussion of the physical causes of sexual dysfunction Kaplan has articulated in systematic fashion the present state of knowledge concerning many other aspects of the anatomy and physiology of the sexual response which have clinical relevance. Kaplan fills out the picture sketched by Masters and Johnson (along with some refinements of her own) with a systematic resume of the present state of knowledge on the role of the central nervous system and the endocrine system in normal sexual functioning, and of the effects of the ageing process, various illnesses, and the use of drugs on sexual responsivity (Kaplan, 1974, pp 1-116). Each of these additions has clinical relevance. Thus she provides the clinician
with a useful complement to Masters and Johnson's more detailed but more restricted view of the "biophysical system".

b) The psychological determinants of sexual dysfunction (the "psychosocial system").

In addition to that of Masters and Johnson and their followers, three other major psychological traditions have historically made substantial and distinctive contributions to the understanding of the factors involved in sexual dysfunction, namely: the psychoanalytic (psychodynamic), marital therapy, and learning theory traditions. Kaplan has shown how these four traditions, each with its own special focus and emphasis can be utilized conjointly in the assessment of sexual dysfunction. The psychological framework which she provides is thus more comprehensive in its scope and more fully articulated than the "psychosocial system" of Masters and Johnson.

Specifically, the Kaplan formulation proved to be more adequate than that of Masters and Johnson in the clinical assessment of sexual dysfunction in the following respects:

1. Kaplan's clarifying distinction between the intra-psychic system of the individual marital partner and the inter-personal system constituted by the marital couple, though obvious in retrospect, proved to be of great practical utility in assessment. Kaplan's formulation allows balanced consideration to be given to the intra-psychic and inter-personal factors using the relevant aspects of the major theoretical traditions.

2. Kaplan's distinction at once makes it clear that the most glaring deficiency of the Masters and Johnson model is the inadequate emphasis given to the multiple variables of the marital relationship (the inter-personal system) in the assessment and treatment of sexual dysfunction. This point has been noted by several other writers who have attempted to adapt the model to the exigencies of more normal clinical practice (e.g. Gochos, 1971; Messersmith, 1976; Jackman, 1976). Kaplan has produced the fullest and the most detailed integration of the Masters and Johnson model with the concepts of contemporary marital therapy that has yet appeared.

3. Masters and Johnson's concept of the "psychosocial system" (with its components of the "sexual value system" and the
"social value system"), its use in assessment, and the precise treatment which it entails, are in many respects obscure. Moreover, its authors give no indication as to how their own ideosyncratic theory can be related to other theories currently in vogue as a basis for psychotherapy. By relating the Masters and Johnson concepts to three influential and established psychological traditions Kaplan has provided the clinician with a useful map to survey the wider intra-psychic and inter-personal terrain. When the clinician reaches the limits of applicability of the narrowly-focussed Masters and Johnson concepts he can still proceed with confidence for he is on familiar ground (cf. Jerome D. Frank, 1975, pp 19).

4. A close study of the conceptual structure of the Masters and Johnson model, a survey of the literature on which it is based (Masters and Johnson, 1970, pp 393-450) and some practical experience in its use suggests that the psychological traditions selected by Kaplan for its elucidation and extension are particularly apposite. Although the total synthesis produced by Masters and Johnson is original, few of the constituent elements are. Many of the components can be traced back to influences emanating from precisely those three traditions selected by Kaplan:

1) The debt of Masters and Johnson to learning theory is most obvious in their insistence that theirs is an educational process in which appropriate verbal and non-verbal behavior is learned particularly through limited and hierarchically ordered steps, in which pleasurable experience and partner approval function as reinforcements (cf. Wolpe, 1958).

2) Their debt to a systems model of the marital relationship is also obvious from their insistence throughout that it is not the dysfunctional partner but the marital relationship that is the focus of therapy (cf. Satir, 1964), from their emphasis on the role of communication in marital therapy (cf. Jackson and Weakland, 1961; Haley, 1963; Satir, 1964), and from their adoption of the idea of the dual-sex therapy team (Bellville et al. 1969; Goodwin and Mudd, 1966; Gullerad and Harlan, 1962; Reding and Ennis, 1967).
3) Masters and Johnson's system is a reaction to the psycho-dynamic tradition (cf. Masters and Johnson, 1970, pp 21). Yet their unacknowledged debt to that tradition can be gleaned from the place which they accord in therapy to assisting the partners to gain insight into past developmental influences linked with their dysfunction (e.g. Masters and Johnson, 1970, pp 260-261, 263-264). It is also made evident from the use which they make of such Freudian concepts as "identification" (ibid. pp 233), "repression" (ibid. pp 218), "resistance" (ibid. pp 226, 305) and the influence on sexual functioning of unconscious or subconscious factors operating below the level of awareness (ibid. pp 226, 312). Furthermore, insistence on the dual-sex therapy team reveals their sensitivity to the implications of transference relationships between therapists and clients (ibid. pp 7-8, 29).

Thus Kaplan's formulation in many respects is an explication and further development of elements that are present in the Masters and Johnson model in an implicit and embryonic form.

5. Difficulties and obstacles in the treatment process.

The Kaplan model provides a most useful counterpoint to that of Masters and Johnson in highlighting the difficulties and obstacles which are actually encountered in the clinical application of the paradigm (cf. Part I, Section 5, No. 5, pp 37ss above). Sex therapy, according to Kaplan is frequently a turbulent process, in which the therapist is confronted with difficulties and obstacles to progress emanating from the intra-psychic conflicts of the individual spouses, and the destructive marital transactions of the couple. These difficulties particularly come to light as the partners attempt to engage in the prescribed structured erotic experiences. The emphasis in Kaplan's account is on the management of this aspect of the clinical phenomena which was neglected by Masters and Johnson. Kaplan attempts to describe the types of difficulties and obstructions to treatment that emerge at various stages of the therapeutic process, and to show how they can be comprehended and dealt with in terms of the eclectical theoretical framework which she has fashioned.
For the unwary practitioner using the Masters and Johnson model alone, such difficulties first appear as annoying and extraneous phenomena which are not emphasized or explicable in terms of the paradigm, but which must be dealt with by unsystematic and ad hoc measures (cf. Part I, Section 5, No. 5, pp 42, and Part I, Section 6, pp 47). But for Kaplan they are an expected and significant feature of the therapeutic process. In fact, they constitute the key challenge of sex therapy (Kaplan, 1974, pp 222).


As compared with that of Masters and Johnson the interventive repertoire of the Kaplan model is more extensive and more delicately nuanced to deal with the difficulties and obstacles which emerge to interfere with the progress of therapy.

a) The key interventive measures formulated by Masters and Johnson have been incorporated in the Kaplan model, e.g.:

1) the use of graduated and structured erotic experiences in conjunction with the therapeutic interview;

2) the imparting of relevant sexual information;

3) use of an educational process to deal with the "spectator role", goal-oriented behaviour, performance fears, etc.;

4) facilitation of effective marital and sexual communication, both verbal and non-verbal;

5) clarification of past and present factors linked with the dysfunction, so that the learning of more effective sexual behaviour is reinforced with appropriate cognitive restructuring.

In the Kaplan model however, the use of the dual-sex therapy team, and the time-limited programme involving daily interviews and the social isolation of the couple are omitted.

b) The explicit use of learning theory principles gives the behavioural interventions (the structured erotic experiences) greater flexibility, and allows them to be tailored to individual
needs rather than to be presented in a predetermined structured programme (Kaplan, 1974, pp 181-182).

c) *Psychodynamic concepts guide the explicit interventions of the therapist.* Thus Kaplan suggests three basic techniques for dealing with the negative reactions to the prescribed tasks; repetition, insight or bypass (Kaplan, 1975, pp 56):

1) When anxiety and defences are mild, repetition of the exercise along with the support and encouragement of the therapist is sufficient to surmount the obstacles.

2) When rapid resolution of conflict is not feasible in the brief-therapy format, temporary "defences" against anxiety may be provided by the therapist. Thus the client may be given permission to be temporarily selfish, and to abandon himself to his feelings.

3) Distraction with erotic fantasy during sexual stimulation is suggested as another way of bypassing resistance.

4) Resistances may also be bypassed by changing the prescription. Thus, if a man experiences too much anxiety when his partner fondles his genitals, he might be instructed to caress his partner without her caressing him.

d) *Interpersonal therapeutic approaches* also provide the therapist with a number of interventions to be used appropriately in order to modify the marital relationship.

The therapist should be alert to various "deeper" sources of marital discord operating in the couple such as transferences, lack of trust, power struggles, contractual disappointments, sexual sabotage, and communication failures (Kaplan, 1974, pp 155-167). When these begin to interfere with enjoyment of the erotic tasks, various strategies are suggested, e.g.:

1) Isolation of the problem. The couple is instructed to "keep the problem out of the bed-room" until the sexual difficulty is resolved.

2) If this is not feasible, the therapist may attempt to
clarify and resolve the deeper problem by a number of interventive means derived from psychodynamically-oriented marital therapy, e.g.

(i) techniques of psychodynamic marital therapy (Green, 1970);

(ii) techniques of Transactional Analysis, i.e. by identifying, clarifying and influencing the partners to change certain types of destructive marital interactions (Berne, 1961, 1972; Harris, 1970);

(iii) techniques of "Marital Contract Therapy" (Sagar, 1972, 1976).


Kaplan's classification and theoretic systematization of the male and female sexual dysfunctions is a contribution of clinical relevance.

Masters and Johnson proposed that the sexual response cycle of the human male and female consists of four phases: excitement, plateau, orgasm and resolution. The utility of this model can be gauged by the use to which it was put by its originators in their Human Sexual Response (Masters and Johnson, 1966). In this monumental and pioneering study the physiological changes in key body organs were discussed in terms of these four phases. This model however implicitly contains the idea that the sexual response cycle is a unitary and continuous process.

Kaplan proposes a revision of this now widely accepted model and suggests that the sexual response cycle of both genders is anatomically and physiologically "bi-phasic". By this she means that rather than being a single unitary process, the sexual response cycle consists of two distinct and relatively independent components: a) the vaso-congestive phase which results in penile erection in the male and lubrication-swelling in the female; and b) the reflex clonic muscular contractions which constitute orgasm in both genders (Kaplan, 1974, pp 13). The two components involve different anatomic structures and are mediated by different parts of the nervous system. Thus male erection is mediated by the parasympathetic
division of the nervous system while ejaculation is primarily a sympathetic function (Kaplan, 1974, pp 13).

The first advantage of this revised model is that it enables Kaplan to provide a physiological and anatomical interpretation of the clinical distinction between general sexual dysfunction and orgastic dysfunction in women.

It has already been pointed out that Masters and Johnson's category of female "orgasmic dysfunction" was found to be clinically unsatisfactory (cf. Part I, Section 5, No. 6 pp 42 above). Kaplan likewise criticizes Masters and Johnson in their use of this term for failing to identify the two separate elements of the sexual response cycle (i.e. the lubrication-swelling phase and the orgasm phase) and for focussing solely on the orgasm (Kaplan, 1974, pp 340). She distinguishes two distinct clinical syndromes which had been confused by the Masters and Johnson terminology:

a) General sexual dysfunction. On the psychological level, this condition is characterized by lack of erotic feelings. Physically, it involves the impairment of the vaso-congestive phase of the sexual response cycle: the woman does not lubricate, her vagina does not expand, and there is no formation of the orgasmic platform (Kaplan, 1974, pp 343-3).

b) Orgastic Dysfunction. This refers to an impairment of the orgastic component of the sexual response. The condition does not necessarily include disturbance of general sexual arousal (though secondary inhibition of the arousal or vaso-congestive phase may occur). Women presenting with this problem may fall in love, experience erotic feelings, lubricate copiously, and show genital swelling. Their essential difficulty is failure to attain orgasm, in varying degrees (Kaplan, 1974, pp 343).

Kaplan's categorization of female sexual dysfunction is more satisfactory than that of Masters and Johnson, and accords with the clinical experience of the present writer (cf. Part I, No. 5, pp 44 above).
Kaplan's formulation also sheds new light on the parallels between male and female sexual dysfunction. Thus the normal operation of the vaso-congestive phase results in erection in the male and vaginal lubrication-swelling in the female. Male erectile difficulty (impotence) and general sexual dysfunction (arousal difficulty) are the corresponding male and female manifestations of impairments of this phase. Both sexes experience the clonic muscular contractions of the orgasmic phase. Complete inhibition of this phase results in retarded ejaculation in the male and failure to climax in the female. Inadequate control over the orgasmic phase results in premature ejaculation in the male. The corresponding lack of orgasmic control in the female is logically possible, but is not often encountered as a clinical problem. However the case of Mrs. D. reported above (Case Report No. 4, pp 75 above) constitutes one instance. In the treatment of Mrs. D. direct use was made of the parallel drawn by Kaplan between male and female sexual dysfunction. The same methodology used to assist males to gain ejaculatory control (i.e. teaching them to recognize the premonitory orgasmic sensations as described by Kaplan, 1974, pp 306) was successfully employed to help Mrs. D. gain orgasmic control.

8. Other versions of the Masters and Johnson model compared with Kaplan's contribution.

The various versions of the Masters and Johnson model which have come to the attention of this writer were listed on pp 51 above. Despite its deficiencies, Kaplan's account compares very favourably with these other attempted adaptations in a number of respects:

1. "Kaplan (1974a, 1974b, 1975) & Kaplan and Sollard (1976)" constitute the fullest and most detailed account that has yet appeared of the issues which are involved in the application of the Masters and Johnson model within the constraints of normal clinical practice.

2. Kaplan provides the fullest account of the phenomenology of the therapeutic process, i.e. of the behaviour and experiences of both clients and the therapist. The detailed, clear and lively case histories presented by Kaplan, makes the therapeutic process come alive.
3. She has offered the fullest account of the nature of the difficulties and obstacles that tend to obstruct the treatment process as described by Masters and Johnson. These difficulties are often not acknowledged in other accounts. Only Bancroft (1974, 1975) attempts to give some systematic account of how crippling negative attitudes which frequently arise in the treatment process may be dealt with.

4. Several writers point to the influence of the marital relationship in the process of sex therapy (e.g. Prochaska and Marzelli, 1973; Powell et al. 1974; Proctor, 1975; Messersmith, 1976). But Kaplan alone offers a theoretically integrated method for simultaneous intervention in the sexual and marital relationship.

5. Several writers have suggested that the principles of Masters and Johnson must be supplemented by elements from other therapeutic frameworks. Murphy and Mikulas (1974) offer an admirable account of how the principles of learning theory can be used to supplement the behavioural aspect of the Masters and Johnson programme. Bancroft (1974, 1975) suggests a tentative theory for promoting attitude change in conjunction with changes in overt behaviour. Messersmith (1976) briefly indicates how the Masters and Johnson model could be integrated with systems theory. Finally Jackman (1976) describes how the principles of Masters and Johnson could be applied within the context of marital and family therapy. However Kaplan's had been the most ambitious attempt to relate the principles of Masters and Johnson to a range of contemporary psychological theory bearing on overt sexual behaviour, the marital relationship and the individual psyche.

The following two case reports illustrate the utility of the Kaplan model.

Case Report No. 6. Use of the Kaplan Model in the Treatment of Severe Female General Arousal Difficulty.

Mr. and Mrs. E. were referred for therapy by a marriage counsellor because Mrs. E. found sex repugnant, intercourse was a rare event, and the sexual conflict of the couple was severely damaging the marriage. Certain aspects of this case were briefly reported above (Case Report No. 5, pp 75).

Mr. E., a process worker aged 35 and his wife aged 32, had been married for 10 years and had 3 children. Both had emigrated from a Southern European culture which had highly negative and restrictive attitudes towards female sexuality.
Sex was repugnant to Mrs. E. from the day of the honeymoon. Throughout the marriage she had been "terrified of pregnancy", but for some reason had been able to relax and enjoy sexual encounters during each of her pregnancies. Over the years the couple had sought help from several doctors concerning the sexual difficulty. The last medical consultant diagnosed the problem as being due to fear of pregnancy, and recommended that a tubal ligation be performed with the birth of the last child (now aged 3). The operation was duly performed, but subsequently the problem still remained. Over the last three years sexual contact has dwindled to 7 or 8 times a year, and Mrs. E. would enjoy only 2 or 3 of these encounters.

Factors of family and cultural background had strongly influenced the attitudes of Mrs. E. towards sex, marriage and pregnancy. She was the third member of a large family of 12 children - 7 boys and 5 girls. She detested her father because he gave the boys freedom while placing the girls under severe restrictions and supervision; but most of all because he treated her mother as a "slave" whose role was simply to bear his children, look after them and minister to his needs. When quite young she had "vowed" that when she grew up she would never be like her mother, i.e. living in "misery", the slave of a boorish man, and continually pregnant with his children. In her view, all men were out to dominate women, and she would have none of it.

The prominent feature of the marital relationship was a power-struggle. In fact the couple valued and admired each other highly, but they were each careful to keep this a dark secret, for they were each afraid that if the other were to find this out it would "go to his/her head". Mrs. E. admitted to enjoying being kissed, embraced, cuddled and fondled by her husband, but she kept this a strict secret partly through embarrassment, but mainly because she felt that if he knew "it would go to his head", she would lose control over him, and he would begin to dominate her. All men, she believed, were out to dominate women and make them their slaves, as her father had dominated her mother. She said she had no interest in intercourse itself.

Treatment. The first step in treatment was intervention in the marital power struggle. At the sixth interview (the "round-table" session) the couple were directly confronted with the fact that each was trying to dominate the other. Mrs. E. in particular was made aware that she was transferring her resentment against her father to her husband where it did not apply. The therapist pointed out to the couple that each held the other in high esteem, but was withholding all expression of appreciation for fear that the other would get out of hand. This revelation proved to be a gratifying surprise to both. To capitalize on this, the couple were helped to directly express positive feelings towards each other in the interview, and were instructed to continue this practice at home. Over a number of succeeding interviews, with therapist facilitation and encouragement, the couple's ability and confidence in expressing positive feelings towards each other gradually increased, and mutual trust...
began to replace the struggle to dominate.

Meantime, with a more favourable marital atmosphere, an attempt was made to intervene in the couple's sexual system. In the seventh interview, massage was suggested as a first step toward introducing the couple gradually to "sensate focus". However the attempt at massage in the nude turned out to be extremely traumatic for Mrs. E. It became clear at this point that nudity was the occasion of severe anxiety for her. The therapist therefore decided to "change the prescription" (Kaplan, 1975, pp 59) and to structure experiences that were closer to the pattern acceptable to Mrs. E.

In the eighth interview Mrs. E. was asked to fantasize how love-making would begin if it were to be good for her. In her fantasy she imagined her husband talking gently to her, cuddling her, kissing her and rubbing her back. This was the antithesis of his usual rough and direct approach. It also accorded with the account which Mrs. E. had given in the assessment interviews of the positive aspects of love-making which she had been keeping secret from her husband. Hence from this point intercourse was forbidden, and physical contact was limited to mutual kissing, cuddling and caressing in the manner fantasized by Mrs. E. The following week the couple reported an improvement in marital communication, and frequent cuddling and kissing in bed. The next week (the ninth interview) the wife was ready to include the caressing of her breasts in their shared activities and genital caressing in the week following. However, she still expressed disgust and distaste for the act of intercourse itself, presumably it now appeared, because of a penis aversion.

In the eleventh interview, surprisingly, the couple reported satisfying intercourse. This had been the culmination of increasing trust, improved marital communication and the gradual and gentle approaches to his wife that Mr. E. had been learning over the preceding weeks. Increasingly satisfying intercourse was reported in the twelfth and thirteenth interviews.

In the fourteenth interview the couple reported great satisfaction with their marital and sexual life and contemplated termination of treatment since they said they could not see how their sexual life could improve further. However several factors made the therapist fear that the improvement may not be permanent: nudity, and particularly, looking at and touching her husband's penis were still a source of great anxiety to Mrs. E., while she was still reluctant to express her sexual preferences openly to him. The therapist therefore suggested relaxation training and systematic desensitization in imagination to deal with the two former problems (Husted, 1975). But after an explanation of what this approach would entail, Mrs. E. rejected the idea as being too threatening.

As a last resort, the therapist again suggested that the couple experiment with massage. This time Mrs. E. showed considerable interest. The the sixteenth and seventeenth sessions the couple reported increasingly satisfying experiences with massage, and had even weathered the chance
intrusion of the children with equanimity. Mrs. E. was becoming much more relaxed and at ease with nudity and in expressing her preferences during pleasuring sessions. These experiences had drawn the couple closer together. Meantime intercourse was becoming more satisfying for Mrs.E., and the couple reported several instances of simultaneous climax. There was no more mention of disgust and distaste at penetration. The fact that the whole household, including the children, was now much happier further reinforced the maintenance of the new patterns of interaction. Therapy was terminated here. By the time of the three-month follow-up the improvement in the marital and sexual relationship had been maintained.

Comment on Case Report No. 6.

Several features of this case illustrate the specific contribution of Kaplan's formulation over and above that of Masters and Johnson. The sexual problem was linked with a marital power-struggle (Kaplan, 1974, pp 160-161), and hence the single most important step in therapy was the confrontation of the couple with the bearing of this on their marital and sexual happiness. The power-struggle in turn was linked with intra-psychic conflicts of Mrs. E. stemming from early childhood experience and family modelling, which had distorted her objective perception of her husband. The promotion of some insight into the dynamics of these conflicts helped her to correct these perceptual distortions. Hence, in order to pave the way for effective use of the experiential component of therapy, it was necessary to intervene appropriately to mitigate both intra-psychic and marital conflict.

The experiential element of therapy itself was tailored specifically to the needs of Mrs. E. rather than applied in the stereotyped fashion of Masters and Johnson. "Sensate focus" as described by these authors was judged as being too advanced for Mrs. E. as a starting point - a judgment which was corroborated by her negative reaction to massage.

Nonetheless, the influence of the Masters and Johnson model pervades the conduct of the whole case. It can be seen particularly in the joint use of structured erotic experiences and therapeutic interviews, and in the central role in behavioural change played by improved marital and sexual communication.
Section 5. Limitations of the Kaplan Model.

1. Kaplan model over-inclusive.

A basic limitation of the Kaplan model is that it is an attempt to deal with the whole range of sexual dysfunction in marriage by means of a single, all-embracing model. Kaplan appears to wish to define the whole field of sex-therapy in terms of one limited paradigm - essentially that of Masters and Johnson:

"Sex therapy differs from other forms of treatment for sexual dysfunction in two respects: first its goals are essentially limited to the relief of the patient's sexual symptom and second, it departs from traditional techniques by employing a combination of prescribed sexual experiences and psychotherapy." (Kaplan, 1974, pp 187.)

This restricted viewpoint derives from Kaplan's failure to appreciate the contribution of the many behavioural writers who are responding to influences outside the Masters and Johnson tradition:

"The evidence indicates that sex therapy which employs sexual tasks to be performed by the couple at home is far more effective than office behaviour therapy in the treatment of sexual dysfunctions." (Kaplan, 1974, pp 180. Italics mine.)

She concedes that such "office" procedures as systematic desensitization might be useful as a preparation for the real sex therapy to follow - but not as an integral part of the main treatment process itself:

"Office behavioural methods may be employed in rare instances by some therapists to prepare the frightened or phobic patient for sex therapy." (Kaplan, 1974, pp 180.)

However, the evidence now suggests that effective sex therapy cannot be restricted simply to versions of the Masters and Johnson paradigm. In his survey of the literature of the treatment of sexual dysfunction, Wright (1977) summarized and critically evaluated the published reports dealing with ten or more cases that had appeared to that date. Eighteen studies in all were noted. Of these, three used psychoanalytic or insight therapy as the principle treatment mode, four used the Masters and Johnson paradigm, while ten
used other behavioural methods. Of the 15 uncontrolled studies reviewed, four employed the Masters and Johnson paradigm, while eight used other behavioural approaches. Of the three controlled studies noted only one employed the Masters and Johnson paradigm (i.e. Ansari, 1976) while two dealt with other behavioural approaches (i.e. Wincze and Caird, 1976; Obler, 1973). The focus of treatment of eight out of the ten behavioural studies was on the individual rather than the couple. Treatment included various combinations of relaxation training (progressive or drug-induced), various types of systematic desensitization (fantasy, video, slides, in vivo), assertion training, social skill training, masturbation training and self-monitoring.

A more recent survey of the literature dealing with the direct treatment of sexual dysfunction (Hogan, 1978) reinforces the view that a range of interventive methods have been found effective or promising. In this context, the Masters and Johnson "package" (along with the Kaplan version) would seem to be only one possible approach among many.

At this point in time it would seem that it would be unwise for the therapist to restrict himself to one model or paradigm in the treatment of sexual dysfunction. He should be able to consider a range of theories, models and procedures which can be applied according to the requirements of the individual case. The various versions of the Masters and Johnson paradigm (including Kaplan's) offer one series of options. Other alternative behavioural models now available have been reported in Annon (1974, 1975), Fisher and Gochros (1977), Caird and Wincze (1977) and LoPiccolo and LoPiccolo (1978).

2. Insufficient exploitation of potential of behaviour therapy.

Other critics have pointed out the inadequate grasp of the theory and application of behaviour therapy to sexual problems which is betrayed by Kaplan's account (Franks and Wilson, 1975; Eysenck, 1975; LoPiccolo, 1975). Particularly regrettable is her failure to appreciate and exploit the full contribution which behavioural theory and methodology could make to the treatment of sexual dysfunction even within the restricted confines of the Masters and Johnson paradigm.
Despite her claims to be incorporating the perspectives of learning theory into her model, Kaplan's book of over 500 pages contains only one reference to any work dealing with behavioural principles and methods, i.e. Yates' *Behaviour Therapy* (1969), a text which was published before the full account of the Masters and Johnson model had seen the light of day. The bulk of the now considerable literature of the behavioural tradition of sex therapy which had developed independently of the Masters and Johnson model, is dismissed as containing little of value (cf. Kaplan, 1974, pp 180, quoted pp 89 above).

The most important contribution of learning theory to her model, according to Kaplan, is in the construction of the prescribed therapeutic tasks to be carried out by the couple at home (Kaplan, 1974, pp 180). Admittedly she shows greater flexibility in structuring the experiential component of therapy than Masters and Johnson (cf. Kaplan, 1975, passim). However this appears to have been achieved by intuitive and pragmatic means. For Kaplan nowhere describes how such tasks could be designed by the rigorous application of behavioural principles as has been done for example, by Murphy and Mikulas (1974).

It has already been pointed out that Kaplan is unwilling to concede that "office behavioural therapy" could play anything but a minor and preparatory role in sex therapy (cf. pp 89 above). However the research literature and the clinical experience of the present writer suggest that such methods as systematic desensitization, guided imagery, audio-cassette tapes, and modelling by the use of audiovisual aids, could be an essential part of the treatment repertoire, even within the limited format of the Masters and Johnson paradigm. The following case report illustrates a fuller exploitation of behavioural methodology than is envisaged by Kaplan:

**Case Report No. 7: Kaplan Model Supplemented by Fuller Exploitation of Behavioural Methodology.**

Mr. and Mrs. F., both in their early twenties, had been married a year and as yet had no children. Mr. F. was a computer technician, while his wife had a full-time job as a shop assistant. The presenting problem was that sexual relations were distasteful for Mrs. F., and she failed to be responsive on most occasions. The difficulty had persisted since the beginning of the marriage and was steadily getting worse. The couple still appeared to be very much in love. They had a warm and close marital
relationship in which Mrs. F. was the dependant partner lacking somewhat in self-confidence, who leant on her husband for support.

An assessment of the couple using the methodology of Masters and Johnson (1970) and Kaplan (1974) highlighted the following factors:

1) After working all day on her feet, Mrs. F. frequently came home fatigued.

2) While being caressed by her husband Mrs. F. was anxious as to whether she would respond, and projected herself into "the spectator role" (Masters and Johnson, 1970, pp 11-13).

3) Mrs. F. had a sister whose marriage had recently foundered, and she feared that the same fate could befall herself. In her sexual relations therefore she was excessively concerned to please her husband to keep the marriage intact, rather than to enjoy herself. In addition, she had derived from her mother the idea that sex is for a husband's enjoyment, not the wife's.

4) Mr. F.'s own goal-oriented behaviour was involved. Since he was distressed at his wife's lack of response he caressed her in an urgent "demanding" way, seeking to make her sexually aroused rather than just to give her enjoyment.

5) Fears stemming from early childhood conditioning by her mother made Mrs. F. uneasy about being seen nude by her husband.

6) Communication about sexual interests and preferences was non-existent. Again this was mainly due to Mrs. F.'s childhood-induced shame about showing any interest in sex.

7) Above all, Mrs. F. could not accept genital touching or caressing. She reacted to this with great anxiety and felt that it was wrong, because of values derived from her mother.

Hence several factors operating in Mrs. F. stemmed from childhood prohibitions and negative valuations of sexuality derived principally from her mother. Her husband, on the other hand, seemed to have had an unusually balanced psychosexual development.

Treatment. The first steps in therapy followed lines suggested by Kaplan (1974, 1975) supplemented by Hartman and Fithian (1972). Showering together and bathing each other followed by massage gradually eased Mrs. F.'s inhibition about being seen nude by her husband. The couple then proceeded with increasing enjoyment to Sensate Focus I (non-genital caressing). However, as they advanced to Sensate Focus II (in which genital caressing is included), Mrs. F.'s aversion against genital touching emerged and blocked further progress. It now became clear to the therapist and the couple that she "switched off" as
her genitals were approached: "It makes me jump".

Following Kaplan (1974, pp. 137-154) an attempt was made to resolve the conflict by promoting insight into its dynamic origins through the methods of Transactional Analysis (Berne, 1961; James and Jongeward, 1971). This was only partially successful. Since anxiety connected with genital touching still threatened the success of Sensate Focus II, it was decided to deal with it by relaxation training and systematic desensitization in imagination and in vivo (cf. Husted, 1975).

Mrs. F. was taught progressive relaxation in the office and the couple practiced assiduously at home with the help of cassette-tape recordings (Lazarus, 1970). Meantime, with the aid of the Sexual Fear Inventory (Annon, 1975a) a hierarchy was built on the theme of body-caressing, leading gradually to genital exploration and caressing. Mr. F. was present during the ensuing imaginal desensitization in the office to give his wife support (cf. Murphy and Mikulas, 1974, pp. 226). Meantime the couple continued their caressing sessions at home, but limited their behaviour to the items desensitized in the imaginal hierarchy in the office (Madsen and Ullman, 1967).

After the systematic desensitization sessions, improvement was rapid. Increasing insights into the dynamic origins of the conflict promoted in the concurrent office interviews appeared to aid in the cognitive restructuring which gave the formerly prohibited activities a higher valuation for Mrs. F. (cf. Kaplan, 1974, pp. 208). By the tenth interview the couple reported increasingly pleasurable genital caressing. Mrs. F. now felt ready to proceed to intercourse, surprised at "how quickly it had all come together" after the desensitization sessions. Use of a cassette-tape at home (Lazarus, 1970) helped the couple cope with difficulties in sexual communication that now came to the fore.

Over the next few weeks the couple progressed without further major difficulty to intercourse in the female-superior position, and finally in the lateral position (Masters and Johnson, 1970, pp. 306-314). Therapy was terminated at the seventeenth joint session with enjoyable intercourse now well established. Two months after termination the couple spontaneously wrote to report:

"Since our last session we have found that we are enjoying our lovemaking more and more. Words are impossible to express our gratitude. We believed we had a problem that was impossible to remedy, and within a few weeks after we had finished with you the problem was so far away that we almost laugh that it was any problem at all."

Comment on Case Report No. 7.

This case demonstrates the application of behavioural methodology in a way that is not envisaged in the Kaplan model.
In the estimation of the therapist the psychodynamic insight methods of the Kaplan model were inadequate for the rapid resolution of Mrs. F.'s intra-psychic conflict re genital caressing. Hence he employed relaxation training and systematic desensitization, whose value is well attested by research, even though it is underestimated by Kaplan. This case also provided evidence that imaginal systematic desensitization and psychodynamic insight methods can be mutually reinforcing in the resolution of intra-psychic conflict, as has been noted, e.g. by Brady (1968) and Wachtel (1977).

3. Inadequate definition of precise content of the model.

The Kaplan model is so wide-ranging that it is difficult to define the precise content of the over-arching theoretical framework and the range of interventions entailed. Freudian psychoanalysis, psychodynamic marital therapy and learning theory are each broad fields with an expanding literature, and each cover considerable variation in theory, interpretation and interventive technique.

Some of this imprecision with its resulting confusion to the therapist could have been avoided had Kaplan included precise references to the relevant literature in her text, to indicate to the reader exactly what element of theory and intervention she is incorporating into her model, and what she is excluding. However, she does not do this, but merely cites some representative examples of the literature of each field as a guide to further reading. It would appear, therefore, that in practice each clinician would have a different version of what the Kaplan model is.

4. Lack of research basis.

The most regrettable feature of the Kaplan model is that it is inadequately supported by research data. Kaplan provides no outcome data at all for the model as a whole - not even a simple tabulation of the type and number of cases dealt with and the results at termination and follow-up. All the evidence provided is impressionistic and anecdotal. Yet she consistently asserts that her results are "comparable" with those of Masters and Johnson (Kaplan, 1974, pp 435-445). For this failure in systematic reporting she has justly been taken to task by critics of the behavioural school (LoPiccolo, 1975; Eysenck, 1975; Franks and Wilson, 1975).
The evidence supporting the efficacy of the separate elements of the model - particularly the kind and sequencing of the various specific interventions indicated by the over-arching eclectic framework is even more tenuous. No controlled factorial studies dealing with the main elements of the model are reported. The details of the model and the method of its operation therefore depend on Kaplan's clinical impressions, and these could be contaminated by a host of non-specific variable (Gomes-Schwartz, Hadley and Strupp, 1978, pp 435-446).

5. Difficulties in applying the model to the unaccompanied marital partner.

We have seen that the applicability of the Masters and Johnson model is restricted by the focus on the marital couple as a unit, and by the requirement that both partners take part conjointly in the therapy sessions. It was noted that the model is generally inapplicable when the non-symptomatic partner is either unwilling or unable to participate (cf. Part I, Section 5, No. 7, pp 45 above). Kaplan has sought to mitigate the rigid requirements of the original Masters and Johnson paradigm by attempting to accommodate her model to the unaccompanied marital partner. For her, conjoint therapy remains a desirable ideal, but it is not in all cases mandatory. Structured erotic experiences, jointly shared by both marital partners remain an essential component of therapy in all cases, however. If the symptomatic partner is seen alone, he/she transmits the details of the graded behavioural prescriptions to the absent partner at home. The essential requirement is that the absent marital partner should be co-operative with the therapy regimen (Kaplan, 1974, pp 237-8, 498-9).

A successful application of this principle was illustrated by the case of Mrs. C. above (Case Report No. 3, pp 45-6). However the case of Mrs. G. demonstrates how the attempt to accommodate the model to the unaccompanied marital partner can easily end in failure:

Case Report No. 8: Failure of the Kaplan Model in dealing with Unaccompanied Marital Partner.

Mrs. G. was a vivacious, articulate woman of 30 who had formerly been a nurse. Her husband, 34, a tradesman, was
of European origin, and was less well-educated and less articulate than she. They had been married for 7 years and had 3 young children.

Mrs. G.'s complaint was that she failed to reach climax in intercourse. Three years previously, during intercourse, she had experienced orgasm for the first time in her life. This had been a totally unexpected and quite shattering experience. Since that date she had striven repeatedly to reach climax without success, and with increasing frustration and disappointment. She had withdrawn from treatment for this problem at another clinic because solitary masturbation-training had been suggested, a procedure which conflicted with her value system.

The factors involved seemed to be that Mrs. G. was striving too hard and too self-consciously for orgasm (in "the spectator role"), while preparatory caressing was not sufficiently prolonged or adequate to meet her needs. Because of guilt feelings about accepting sexual pleasure for herself (derived from early maternal training), Mrs. G. tended to "switch herself off" as arousal increased. Orgasm was fantasized as a catastrophic event and as climax was impending, memories of her first shattering climactic experience made her fearful of "letting go". Mr. G. had little understanding of his wife's experience, attitudes, fears or needs.

Dissatisfaction with the marital relationship was also a factor. Mrs. G. felt resentful towards her husband for his "selfishness" in leaving the initiative in many spheres of the marriage to her. But the main marital conflict stemmed from a cultural clash: Mrs. G. of Australian middle-class origins, was striving for a marriage of equality; whereas Mr. G., in accordance with his own European cultural traditions, was trying to keep her in the dependent role of housewife-mother.

Treatment. The couple were first seen together for the intake interview at which it was agreed that after separate assessment sessions they would be seen conjointly throughout the treatment phase. However subsequently, the husband refused to attend further interviews. Because the wife remained enthusiastic and was evidently teachable, and because the husband agreed to co-operate in the homework sessions, it was decided to attempt treatment in single sessions with the wife alone along the lines of the Kaplan model (Kaplan, 1974, pp 200, 237, 498).

Verbal instructions regarding homework experiences given in the interviews were supplemented with reading and audi-cassette tapes to supply each partner with appropriate information and to help catalyze sexual communication (Farmer, 1974; Pion, 1974).

The couple passed through Kaplan's stages of Sensate Focus I, Sensate Focus II and female genital caressing with little difficulty. By the fourth interview Mrs. G. reported enthusiastically that she had reached a new level of sexual satisfaction. Sexual communication had improved, marital conflict had lessened and several times she had felt that she was on the verge of climax. Her husband
so far had been interested and co-operative. Up to this point the prognosis for the reversal of the condition seemed excellent.

However, in the fifth interview Mrs. G. reported that her husband was becoming bored with the prolonged pleasuring she seemed to require, and annoyed at the way he was required to accommodate his behaviour to her needs. In addition, Mrs. G. was growing increasingly resentful at the "selfish" way in which he left all the initiative to her in many areas of the marriage. Since it now seemed unlikely that the sexual life of the couple could be further improved until the marital difficulties now emerging were addressed, the therapist suggested that Mr. G. should again be asked if he would attend at least one interview.

In the final session Mrs. G. announced that her husband had again refused to attend a further session with her, thereby deeply wounding her. In addition she reported further marital conflicts - particularly her continual struggle for a marriage of equality in the face of her husband's persistent efforts to lock her into the dependent housewife-mother role. Her intensifying resentment towards him was by now submerging her sexual interest. At this point she terminated treatment saying that she would return later when there was a more favourable marital atmosphere. In fact, she did not make contact again.

Comment on Case Report No. 8.

This case highlights one of the basic limitations of the Masters and Johnson and Kaplan models. One could scarcely hope for a better subject for any form of therapy than Mrs. G.; she was willing, co-operative, insightful, enthusiastic, teachable, and ardently desired to achieve her goal. Yet in the face of an unco-operative marital partner, this was to no avail in a form of therapy in which the focus is on the marital couple as a unit rather than on the individual partner. Mrs. G. had already rejected a form of treatment involving graduated masturbation-training as being incompatible with her value system (e.g. LoPiccolo, 1972a, 1972b, 1976, Annon, 1973). A form of treatment focussed on the individual rather than the couple such as the relaxation-training and systematic desensitization proposed by Obler (1973) and Caird and Wincze (1978) may have been more appropriate to the constraints of Mrs. G.'s marital situation. However, even this may have been prejudiced by Mr. G.'s unco-operative attitude (cf. Caird and Wincze, 1979, pp 106-7).
Section 6: The Clinical Application of the Kaplan Model.

In order to round out the treatment of the strengths and limitations of the Kaplan model, it would be useful to indicate how it was employed in clinical practice.

1. The Kaplan model was used only as one of several possible options to be chosen according to the needs of the particular couple. When the marital relationship was harmonious and the sexual problem of shorter duration (less than 12 months) the simpler "PLISSIT" model (Annon, 1974) was preferred. Thus, in the 13 cases of Series II the Kaplan model provided the principle treatment concepts for 10 cases and the "PLISSIT" model for three.

2. The models referred to provided the principle treatment concepts only. In any one concrete clinical case, elements derived from several models were used as required (cf. Hogan, 1978, pp 65). There was no "pure" case in which concepts from the Kaplan model alone were used. In practice it was supplemented with elements derived from Masters and Johnson (1970), Hartman and Fithian (1972), Annon (1974, 1975) and the vast behavioural literature. Some of these have been cited in the text and Case Reports above.

3. Whenever the Kaplan model was applied the concepts and methodology of Masters and Johnson (1970) in particular permeated the whole treatment process. This writer finds it difficult to see how the Kaplan model could be utilized without a thorough prior familiarity with and grasp of that of Masters and Johnson. Hence the Kaplan model appeared as an extension and development of the latter rather than as a distinct and self-sufficient therapeutic system.

4. In the clinical treatment of related and concomitant intra-psychic conflict of the individual marital partner, this writer deviated considerably from the guidelines laid down by Kaplan. Her handling of such intra-psychic conflict is derived directly from Freudian psychoanalytic theory (Kaplan, 1974, pp 138-144, 150-154). However, in the treatment of such problems in his own clinical practice the writer also drew from the literature of the Rogerian school (Rogers, 1942, 1951, 1961) and from that of Transactional Analysis (e.g. Berne, 1961, 1972; James and Jongeward, 1971; Harris, 1967). Like Freudian psychoanalytic theory, these
two approaches are also concerned with resolving unconscious conflict by promoting insight into its dynamic origins. For examples see above Case Report No. 1, pp 26-7; Case Report No. 2, pp 40; Case Report No. 3, pp 46; Case Report No. 7, pp 93).

5. The most notable deficiency of the Kaplan model is the inadequate weight given to the contribution of contemporary behavioural research and methodology. Hence in its clinical application the model had to be supplemented with general principles and specific treatment methods derived from the expanding current behavioural literature. Case Report No. 7, pp 93 above provides an example.
CONCLUSION

1. Overview of the Study

This study rests on the basic idea that the Kaplan model is a modification and development of that of Masters and Johnson. Hence it was proposed that the Kaplan model could be evaluated by comparing and contrasting it with the strengths and limitations of the Masters and Johnson prototype as applied in the same setting.

The primary clinical data consisted of 2 series of cases culled from the writer's own clinical files. Series I comprised 13 consecutive cases begun before 1975 for which the Masters and Johnson model provided the principle therapeutic concepts and guidelines; and Series II comprised 13 consecutive cases begun after 1975, i.e., after the writer had acquired knowledge and familiarity with the models of Kaplan (1974, 1975), J.S. Annon (1974, 1975) and the wider behavioural literature. The detailed written records of these cases constituted a rich clinical deposit of 394 interviews of which 192 were cotherapy sessions.

A systematic method of retrospective analysis was devised appropriate to the clinical material in hand, and including both qualitative and quantitative dimensions. Because of certain limitations entailed in this methodology (particularly that of experimenter bias) the findings are presented as a tentative personal viewpoint only.

Part I of the study is a report of the findings on the strengths and limitations of the Masters and Johnson model as evident in the casework within the specific clinical setting. Since these are summarized in Part I, Section 7, pp 48(a)-50 above, it is not necessary to repeat them here. Part II is a report on the application of the Kaplan model within the same setting, in which the Kaplan's contribution is evaluated particularly by reference to that of Masters and Johnson. The key findings can be summarized as follows:
2. Contribution of the Kaplan Model.

a) Kaplan incorporates key strengths of the Masters and Johnson model.

The clinical experience indicated that the Kaplan model capitalizes on the salient features of the Masters and Johnson prototype which were viable and effective in the new setting, viz:-

1) the emphasis on the couple as patient rather than the dysfunctional individual;

2) emphasis on the ongoing sexual interaction of the partners in the here-and-now;

3) the combination of therapeutic office interviews and structured erotic experiences;

4) a carefully graded series of structured erotic experiences;

5) the basic elements of the therapeutic interview as formulated by Masters and Johnson.

b) Some key limitations of the Masters and Johnson model are met.

In addition, Kaplan has met some of the key limitations of the Masters and Johnson model that were evident in its application within the setting of a marriage and family counselling agency, viz:-

1) The therapy format is more appropriate to the more usual clinical setting in which brief time-limited therapy, daily interviews, the social isolation of the couple, routine medical examinations of both partners, and the general use of cotherapy are impractical ideals.
2) The principle of flexible and creative adaptation to the needs of the individual or the couple replaces the somewhat stereotyped pre-structured programme offered by Masters and Johnson.

3) The experiential component of therapy is deployed with greater flexibility.

4) The theoretic framework for assessing the physical and psychological determinants of sexual dysfunction in more adequate.

5) The difficulties and obstacles encountered in the treatment process are not only identified and theoretically interpreted, but are emphasized as the key challenge of therapy. In their presentation Masters and Johnson tend to ignore such phenomena.

6) Kaplan's multi-modal interventive repertoire, drawing from important current psychotherapeutic traditions is more adequate than Masters and Johnson's ideosyncratic system used alone.

7) Kaplan's classification and theoretic systematization of male and female sexual dysfunction is more in harmony with the clinical data than that of Masters and Johnson. In particular, the distinction between "general female dysfunction" and "female orgastic dysfunction" was found to be clinically more appropriate.

8) Adaptations and modifications of the Masters and Johnson paradigm to other clinical settings have been attempted by a number of writers. Of these, Kaplan offers the most thorough account and the most ambitious theoretic systematization of the key issues involved in such transposition.

C) Remaining Deficiencies of the Kaplan Model.

Some notable deficiencies of the Kaplan model remain:
1) The attempt to deal with the whole range of sexual dysfunction in marriage by means of a single all-embracing paradigm (fundamentally that of Masters and Johnson) is mistaken. In particular, Kaplan under-estimates the considerable contribution of the behavioural tradition of sex therapy which has developed independently of the Masters and Johnson model.

2) The Kaplan model is so wide-ranging that it is difficult to define its precise theoretic content. Hence in practice every clinician is likely to have a different version of the model.

3) The model rests on the clinical impressions of its author, rather than on an adequate research base.

4) Like the Masters and Johnson model, it can be applied to the unaccompanied marital partner only when specially favorable circumstances prevail.

3. Summary

Masters and Johnson have made an enormous contribution to the understanding of sexual dysfunction. However, their treatment methodology as originally described was too complex and too expensive to be applicable within the normal restraints of clinical practice. Moreover, their ideosyncratic theoretic framework is difficult to relate to other psychotherapeutic traditions currently in vogue.

Kaplan has shown how the contribution of Masters and Johnson can be adapted to the restraints of less endowed clinical settings, and has provided a systematic integration with some important current psychotherapeutic traditions bearing on the intra-psychic
and marital systems. Although her model is grounded in clinical experience rather than in rigorous research, it constitutes a valuable position paper in the field of sex therapy.

However in order to identify and modify the diverse components involved in sexual dysfunction it would seem that the present-day clinician should be versed in a number of theoretic viewpoints. Kaplan's synthesis while ambitious, is only one approach which is coloured largely by the contribution of Masters and Johnson. In particular, she has not fully capitalized on the rich resources of the current behavioural literature.
APPENDIX A

SEX THERAPY PROGRAMME:

CATHOLIC FAMILY WELFARE BUREAU, MELBOURNE

(Extract from "Annual Report, 1976-7")
Sexual Difficulties in Marriage

Sexual difficulties of married couples (such as arousal and climax problems of both men and women) are by no means uncommon, even where the marital relationship is in other respects quite satisfactory. Contrary to appearances, these distressing and perplexing problems are generally not physical in origin. Nor are they necessarily the sign of deeper psychological disturbance, as was formerly believed. Rather, they are often due to much more immediate factors such as inadequate information, ineffective communication, misplaced guilt, and various sources of anxiety and tension such as fear of failure, over-anxiety to succeed, fear of disappointing a partner, or fear of being rejected or humiliated by one's spouse. Stresses stemming from such readily understandable sources may be quite sufficient to interfere with the delicate neural mechanism involved in the sexual response.

People are much more ready to seek help with this kind of problem today, partly because they now feel more free to speak about this intimate area of their lives than in the recent past, and partly because sexual happiness is presently becoming a much more important component of the total marriage relationship. Fortunately, brief and highly effective methods of treatment have been made available by recent progress in the medical and behavioural sciences, and doubtless they will continue to be improved. Consequently, many afflicted marriages can now be enriched immeasurably.

The new methods are not the complete solution to all sexual problems in marriage however. They are appropriate for basically loving and committed couples who are willing to support and cooperate with each other to achieve a common goal. But where the sexual problem is the expression of other serious conflict or hostility in the marriage, this should be dealt with first by established marriage counselling procedures.

Father John Doenau has been specializing in the treatment of such difficulties at the Bureau for several years, and has kept abreast of the contemporary scientific advances. In addition to his work with couples, over the past year he has conducted 18 two-hour seminars on Sex Therapy in which he has shared the fruits of his knowledge and experience in this field with groups of social work students training at the agency. Currently he is working on a study dealing with clinical methodology in this area, which will be presented as the final written submission for his M.A. in Applied Psychology, due for completion by early 1978. He expects to be available for consultation again after that date.
APPENDIX B

AN ADAPTATION OF THE MASTERS AND JOHNSON MODEL

In the course of my work as a marriage counsellor, a number of cases of couples presenting with sexual difficulties have come my way. I have employed various approaches to deal with these, but by far the most effective have been the various concepts and strategies suggested by the work of Masters and Johnson, particularly their Human Sexual Inadequacy (1970). This book describes a system of therapy based on a medical model, validated by research taking place over 11 years. Theirs is an intensive, rapid-treatment therapy, designed to take place within a time-span of 14 days. I have attempted to construct a social casework approach, employing longer-term therapy, and suitable for a family agency whose clients cannot take extended time off work. I am utilizing some key concepts of Masters and Johnson's research, but I am building in some other elements as well - notably borrowings from Transactional Analysis. The initial results have been most promising.

A. Outline of the Approach to Therapy.

In its ideal form, the approach which I am developing involves several stages:

Stage 1: Intake Assessment of Couple

The couple are seen together by one of the marriage counsellors at the agency to assess the strengths of the marriage, and to determine whether the presenting sexual difficulty should really be the focus of therapy. More often than not another approach is more appropriate. But if the couple is committed to working with the sexual difficulty primarily, and if the marriage appears sufficiently strong otherwise, they are given the opportunity to enter the sex therapy programme.
Stage 2: Induction into the Treatment Programme

The couple meet briefly with the cotherapists to make their initial acquaintance. The commitment of both partners is further tested. At this point the couple is given an outline of the extended treatment programme, and it has been found that this tends to elevate their confidence, particularly in cases where treatment has previously been sought from a succession of other sources without avail.

We also explain here that we do not regard the sexual difficulty as the problem of one of the partners, but of the couple. We tell them that they probably both contributed to it, and certainly the co-operation of both will be required to relieve it. This enables the dysfunctional partner to breathe again; up to this point the problem was something for which he or she bore the sole responsibility.

From this point on, each partner meets separately with the appropriate co-therapist - the man with the man, and the woman with the woman - until the "Round-table" session of Stage 6. When a good relationship has been struck with the co-therapist of the same sex, the cotherapists switch: the male now interviews the female client, while the female interviews the male client. This enables both co-therapists to have some knowledge of each partner from face-to-face contact by the time the "Round-table" session is reached.

Interviews are very carefully written up and exchanged between cotherapists between therapy sessions. The sessions are tape-recorded as a matter of course, so that the therapists may listen at least to especially relevant portions of each other's tapes between interviews. The tapes are also useful in preparing the diagnosis presented to the couple in Stage 6.
Stage 3: Definition of the Problem

An attempt is made here to get a precise formulation of the problem, plus an idea of the major surrounding value systems of each marital partner. This formulation guides the rest of the diagnostic process. This is task-focused case work. Precision is also required in order to make an effective medical referral in Stage 5.

Stage 4: Review of Life-History and Marital History.

The review of the life-history of each partner and the marital history of the couple is guided by the definition of the problem crystallized in Stage 3. The primary aim here is to gather all information relevant to the problem and the value-systems already formulated. Precise information is also obtained for the medical referral of Stage 5.

By this time the partners are actively discussing their problems with each other between sessions, stimulated by the knowledge that they are both being questioned along similar lines. They are also doing some reading together. They are given the opportunity of speaking about their current interaction in the interview, since it provides the very best diagnostic material. These interviews are an educational experience for the client: he is taught to think about the elements and causes of his difficulty, and to find an acceptable language in which to express it. Ultimately it is the partner's ability to communicate about the sexual and affective areas of their lives which is the key to therapy. Hence, throughout the whole therapeutic process the therapists are attempting to educate the partners, and help them communicate. Gradually, not only the sexual area, but the whole marriage is enriched by this process. Even if the sexual difficulty is not solved, the partners are the richer.
Stage 5: Medical Referral

When sufficient information has been gathered, both partners are referred to suitable medical specialists for an investigation into relevant medical aspects. For example if intercourse is painful, we will want to know if there is a physical basis for this, and if so whether physical treatment is available. The medical referral must be made very carefully, since it is sometimes hard to separate the functional from the physical elements. Liaison with suitable medical men on a permanent basis is still one of the jobs that has to be done. For sometimes medical treatment, e.g., hormonal therapy, could go on in parallel with conjoint psychotherapy.

Stage 6: Round-Table Session

The round-table session with the 2 cotherapists and the 2 marital partners presupposes that all the material from the diagnostic interviews (Stages 1-4) and the medical investigation (Stage 5) is in. In this session the two cotherapists mirror back to the clients their view of the nature and causes of the problem. The object is to elicit the reaction of the clients and to work towards formulating a diagnosis which is agreed on by the cotherapists and the partners themselves. The partners must come to an understanding themselves of what has gone wrong. I have found that even people having little education can do this. This formulation is tentative only, to be continually modified by the on-going interaction of the couple in the treatment phase (Stage 7). The general plan of the treatment phase is worked out with the couple as this session, together with the first steps in the treatment process.

a) The diagnostic letter. I have found it effective to summarize the diagnostic understanding reached by the cotherapists and the couple in a letter sent to them after this session. This gives them something definite to talk about together over the next week, and ensures that all the relevant elements will be kept before them on the bedroom table.
For example, if the wife is not sexually responsive, this letter makes sure that the contribution of the husband's over-involvement in work or his hectic pace of life will be kept before both of them. Their reaction to the letter provides some material for the next interview.

b) Reaching a diagnostic understanding of the problem  I am still working on the theory of the diagnostic process. Masters and Johnson speak of sexual responsiveness as being the product of two intermeshing systems: the biophysical system and the psychosocial system. The psychosocial system of the client may either reinforce or impede the operation of the biophysical system. Although this idea is very illuminating, these authors do not describe how one reaches a diagnosis of the factors involved in the sexual dysfunction from the evidence gathered. So this is one of the tasks I have to do, and social work theory offers many models for this purpose.

Even though the supporting theory is pretty rudimentary at this stage, I am finding that when Stages 1 - 5 as outlined above have been gone through carefully, the diagnosis tends to stand out sharply. It is often a surprise to the clients. It has also explained why various forms of medical treatment undertaken by the client previously were without avail. For example, one couple complained of persistent vaginismus in the wife. They had been to 7 or 8 doctors and gynaecologists over several years. We were able to point out to them that these consultants had limited themselves to the consideration of one of the 2 major systems described by Masters and Johnson. Thus they had either viewed the complaint as being of the physical order (the biophysical system) and prescribed physical treatment; or they had looked on it as psychological (the psychosocial system) and recommended psychotherapy.
However in this case it was necessary to take account of both systems at the same time - and this is what no-one else had done. Although there were weighty psychosocial factors involved, there was currently also an operating physical cause (tender scar tissue from a recent birth): both sets of factors had to be dealt with.

c) Advantages of Cotherapy. From this point on, the couple and the two cotherapists meet together conjointly.

Various advantages flow from this:

1) each marital partner has the point of view of their own sex represented among the therapists;

2) the client does not have the feeling that there are two of the opposite sex "gangs up on him/her";

3) the therapists can reach a more objective appraisal of the dynamics of the relationship by comparing their impressions after the interview;

4) the team work makes the preparation and review of interviews more efficient;

5) the cotherapy process is itself on-going education for the cotherapists: the increased insight affects one's whole case-load.

Stage 7: Treatment Phase

The couple and the two cotherapists now meet regularly. The emphasis is now on current interaction - illuminated by the diagnosis and data from the life-histories of the partners and the history of the marriage. Sometimes a period of intensive treatment is indicated at this stage - i.e. the couple are seen on successive days, or at least several times a week e.g. on the Friday and again on the following Monday.
I am finding that the sexual lives of the partners has already begun to improve by the time we reach this point. This is due to the educational process which takes place in the interviews, working through past experiences where blockages may have occurred, ideas the partners gain from reading, and above all to the improved communication. Frequently the treatment phase simply involves a consolidation of gains already made in the assessment phase.

B. Practical Application of the Ideal Therapy Model.

What I have written above represents an ideal way in which therapy for sexual dysfunction could be carried out. In practice this approach is varied flexibly to meet changing contingencies. For example when one couple reached Stage 6 (the "Round-Table" session), it became apparent that fundamental value conflicts between them urgently required ironing out before the sexual relationship could have any meaning for one of the partners. Another couple have recently seen that their sexual relationship could not substantially improve until the husband drastically reduces his work commitment to allow them to spend sufficient time together. Hence they have postponed a period of intensive therapy until this can be dealt with over a period of some months. Sometimes it is impossible to consider working with the sexual difficulty until a number of other problems have been dealt with. Thus a woman who was under treatment for depression was referred by a psychiatrist for sex therapy. Her failure to be able to respond sexually to her husband was the core of her depression. However, this problem had to be postponed for quite a long time until she could be helped to function more effectively in her relationships with two teenage daughters.

Ideally, it would be helpful to have a man and a woman act as a cotherapy team. However, sometimes this is not possible, and one has to do one's best by oneself.
Sometimes daily contact with the clients over a week or so would seem to be the best way to deal with a problem. In this way the elements could be tackled stage by stage. However, such frequent contact may not be feasible in practice, and the therapist and clients have to make do with whatever frequency is manageable in the circumstances. With some couples I am planning periods of intensive therapy quite a distance ahead - to a holiday period when they will be able to enjoy some leisure together, and when they will have time to work at their relationship.

APPENDIX C

GUIDELINES FOR SEX THERAPY REFERRALS

JOHN DOENAU

Within the last few years the medical and behavioural sciences have made dramatic advances in the understanding of human sexuality. The publication of Masters and Johnson's Human Sexual Response (1966) and their Human Sexual Inadequacy (1970) provided the main impetus for this growth. However, collateral developments have been made on a wide front by psychiatrists, gynaecologists, and psychologists - particularly those trained in Behaviour Therapy.

Since joining the Bureau staff in 1972, I have sought to develop the specialized knowledge and skills required to apply the fruits of these new discoveries for the enrichment of Catholic couples and others. For this task, further training in psychology proved essential.

At the beginning of July, I hope to commence work at the Bureau again, specializing in the treatment of sexual problems in marriage. This will constitute the supervised clinical experience required as a basis for the final written submission for my M.A. in Applied Psychology (Clinical). The following guidelines have been drawn up to assist marriage counsellors, adoption workers, intake workers and others who might wish to make referrals.

1. **Sex therapy is not appropriate for all presenting "sexual problems" in marriage.**

Quite frequently what marital partners initially present to the marriage counsellor as a "sexual problem" turns out to be a secondary effect of some other disturbance in the marital relationship which is more appropriate as the primary focus of therapy. For example: if a wife does not feel secure of her
husband's love, if her affection for him has been damaged, or if she feels overly hostile towards him for some reason, quite likely she will be unable to respond to him sexually as well. However, in this case, therapy should be focussed on improving the basic marital relationship rather than on the ensuing sexual deficiency which is secondary. It is marriage counselling that is called for here, rather than sex therapy.

In short, warmth, affection, tenderness, security and trust constitute the basic pre-requisites for a satisfactory sexual relationship. It is therefore pointless to attempt to deal directly with a sexual problem if these elements are missing. Often enough, when the marital relationship improves, sexual responsiveness spontaneously revives. If not, then is the time for specific sex therapy.

2. Conditions required for successful sex therapy.

Referral for sex therapy is appropriate:

a) when the partners complain of a notable problem in their sexual relationship - especially of one of the major sexual dysfunctions listed in paragraph 4 below;

b) when both partners are seriously committed to deal mutually with the sexual problem in their marriage;

c) when the marital relationship itself is sufficiently sound and stable to make this feasible;

d) it is generally desirable (though not always absolutely necessary) that both partners are willing to come for therapy together. However, good results can often be obtained if the dysfunctional partner is involved in therapy alone, provided that the cooperation of the absent partner at home can be relied upon.
3. Sex therapy and the disturbed marital relationship.

Some qualifications could be added to the point stressed in paragraphs 1 and 2 above, namely that a sound marital relationship is a pre-requisite for sex therapy.

a) When the sexual problem or dysfunction is itself the major cause of marital disharmony, there may be a point in undertaking sex therapy in the hope that as the partners begin to co-operate seriously and actively to deal with the sexual area of their life, the relationship as a whole may revive.

b) Occasionally, even where there are several areas of serious marital discord, the gradual renewal of physical intimacy and the subsequent exploration of its emotional impact with a third person will lead a couple to re-discover and to rekindle a love that has been smothered by conflict.

However, with these reservations the general rule remains: until the marital relationship itself is on a firm footing, sex therapy is not possible.

4. The major sexual dysfunctions

The following are the major failures in sexual functioning ("sexual dysfunctions") which can occur in an otherwise sound marital relationship. It is with these that sex therapy is primarily concerned.

A. In Males

1) Deficiency of sexual arousal ("impotence"): inability to maintain an erection adequate for intercourse.

2) Orgastic deficiency
   a) premature ejaculation: husband consistently reaches climax before he wishes to (very common).
b) **retarded ejaculation**: husband becomes sexually aroused and can initiate intercourse, but is unable to ejaculate. (This condition appears to be somewhat rare).

B. **In Females**

1) **Deficiency of sexual arousal**: wife is unable to become sufficiently aroused to make intercourse satisfactory for her. (The key physical symptom is absence of, or insufficient vaginal lubrication).

2) **Orgastic deficiency**: wife becomes sexually aroused, but is never or only rarely able to reach climax. ("Missed orgasm").

**N.B.** Many women who never or rarely climax appear not to experience this as a problem.

3) **Vaginismus**: muscles of vaginal entrance clamp tight so that intercourse is consistently either painful or impossible.

4) **Painful intercourse** ("dyspareunia"): may be due to (1) or (3) above, or to some other physical or psychological cause.

5. **Other sexual problems**

In addition to these dysfunctions, various other factors may impair the sexual relationship, such as:

1) lack of relevant information;
2) inability to communicate with the partner on sexual matters;

3) irrational fears and guilt (e.g. regarding sexual experimentation);

4) distorted religious ideas (e.g. "It is wrong to enjoy oneself").

Help appropriately given with these can greatly enhance the marital relationship.

- John Doenau,
Catholic Family Welfare Bureau,
Melbourne,
April 25th, 1976.
APPENDIX D

TREATMENT DATA SCHEDULE
APPENDIX D

TREATMENT DATA SCHEDULE

The following standardized schedule was drawn up for the systematic collection of data from the case records.

1. Case identification:  
2. Commencement date:  

3. Target sexual problem (note whether primary or secondary):  
   Husband  
   Wife  

4. Duration of problem:  

5. Other associated sexual problems of spouse (not target problems):  
   Husband  
   Wife  

6. Age of husband:  
   Age of wife:  

7. Husband’s religion:  
   Wife’s religion:  

8. Suburb of domicile:  

9. Years married:  
10. Number of children:  
11. Ages of children:  

12. Method of family planning:  

13. Occupation of husband:  
   Occupation of wife:  

14. Educational level (husband):  
   Educational level (wife):  

15. Past professional treatment for sexual problem:  

16. Past professional treatment for individual or marital problems:  

17. Current non-sexual psychopathology of individual partners:  
   Husband  
   Wife  

18. Non-sexual marital functioning of couple:  

19. Related problems of individual spouses requiring treatment during therapy:  
   Husband  
   Wife  

20. Related marital or family problems requiring treatment during therapy:  

21. Therapy model/models used:

22. Separate elements of therapy model/models used:

23. Emendations, modifications etc. to therapy model/models used:

24. Cotherapy used in this case? Yes: No:
   a) Number of cotherapy sessions: Husband:  Wife:  Joint:  Total
   b) Percentage cotherapy sessions in this case:

25. Intensive therapy used in this case? (i.e. social isolation and daily interviews). Yes: No:
   a) Duration of intensive therapy in days:
   b) Number of sessions of intensive therapy:
   c) Frequency of intensive therapy sessions:

26. Number of therapy sessions in case: Husband  Wife  Joint  Total
   Assessment phase  ****  ****  ****  ****
   Treatment phase  ****  ****  ****  ****
   Total therapy process  ****  ****  ****  ****

27. Results (A): Individual dysfunctional partner as unit of assessment.

   At Termination  At Follow-up  Assessment Categories
   Husband:  Husband:  Marked improvement (MI)
   Wife:  Wife:  Improved (I)
   Not improved (NI)

28. Results (B): Couple as the unit of assessment.

   At Termination  At Follow-up  Assessment Categories
   (as above).

29. Results (C): Effect of therapy on general marital relationship.

   At Termination  At Follow-up

30. Strengths of relevant model noted in conduct of case:

31. Limitations of relevant model noted in conduct of case:

32. Other remarks on case:
APPENDIX E

CLIENT POPULATION: SUMMARY OF DATA

TABLE 15
### TABLE 15: CLIENT POPULATION: SUMMARY OF DATA

<table>
<thead>
<tr>
<th></th>
<th>Series I (Pre-1975)</th>
<th>Series II (Post-1975)</th>
<th>Series B: M. &amp; J. Explan</th>
<th>Series C: &quot;PLISSIT&quot;</th>
<th>Series D:</th>
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</thead>
<tbody>
<tr>
<td>No. of couples in sample</td>
<td>13</td>
<td>13</td>
<td>12</td>
<td>10</td>
<td>3</td>
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<tr>
<td>Sex of dysfunctional partner</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Male only</td>
<td>1</td>
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<td>Female only</td>
<td>11</td>
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<td>9</td>
<td>6</td>
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<tr>
<td>Male &amp; Female</td>
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<td>Target sexual problem: types</td>
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<tr>
<td>Male</td>
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<td>0</td>
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<td>1</td>
<td>2</td>
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<td>Duration of problem</td>
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<td>Mean duration in years</td>
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<td>All individuals (male &amp; fem.)</td>
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## APPENDIX F

### TABLE 16: THERAPY PROCESS: SUMMARY OF DATA

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<th>Series D:</th>
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<td>(Pre-1975)</td>
<td>(Post-1975)</td>
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<td>No. of couples in sample</td>
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<tr>
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<td>Sessions per case:</td>
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<tr>
<td>cotherapy</td>
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<td>5.8</td>
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<td>percent.cother.</td>
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<td>35.9%</td>
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<td></td>
<td>66.2%</td>
<td>35.9%</td>
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<td>Cost-effectiveness</td>
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<td>therapist-hours per case</td>
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<td>28.3</td>
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<td>est. cost per case</td>
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<td></td>
<td>$171</td>
<td>$40</td>
<td></td>
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<tr>
<td>Outcome at follow-up</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>(3 months plus)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>marked improvement</td>
<td>4(31%)</td>
<td>7(54%)</td>
<td>3(25%)</td>
</tr>
<tr>
<td></td>
<td>4(40%)</td>
<td>3(100%)</td>
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<tr>
<td>improved</td>
<td>5(38%)</td>
<td>3(23%)</td>
<td>5(42%)</td>
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<td>5(30%)</td>
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<td>not improved</td>
<td>4(31%)</td>
<td>3(23%)</td>
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<td>3(30%)</td>
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</table>
APPENDIX G

ACHIEVED PROPORTION OF COTHERAPY IN 13 ATTEMPTED CASES:

BASIC DATA

TABLE 17
### APPENDIX G

**TABLE 17: ACHIEVED PROPORTION OF COTHERAPY IN 13 ATTEMPTED CASES:**

#### BASIC DATA

<table>
<thead>
<tr>
<th></th>
<th>Series B (N=9 couples)</th>
<th>Series C (N=4 couples)</th>
<th>Series B &amp; C (9=13 couples)</th>
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<tr>
<td><strong>Assessment Phase</strong></td>
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<tr>
<td>Total no. of interviews</td>
<td>96</td>
<td>18</td>
<td>114</td>
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<td>No. of cotherapy intervs.</td>
<td>71</td>
<td>16</td>
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<td>Percentage cotherapy</td>
<td>73.9%</td>
<td>88.9%</td>
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<td><strong>Treatment Phase</strong></td>
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<td>Total no. of interviews</td>
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<td>Percentage cotherapy</td>
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<tr>
<td><strong>Overall Therapy Process</strong></td>
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<td>Total No. interviews</td>
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<td>No. of cotherapy intervs.</td>
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<td>23</td>
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<tr>
<td>Percentage cotherapy</td>
<td>66.2%</td>
<td>35.9%</td>
<td>59.2%</td>
</tr>
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REFERENCES
REFERENCES


SELECTED BIBLIOGRAPHY
SELECTED BIBLIOGRAPHY

The following is a list of some of the more important works that were used in the compilation of this study.


