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Life Events and Cognitive Processing
In Sexually Dysfunctional Individuals

Marilyn Jeanette Cobain, BA(CIT); Grad Dip Couns(RMIT)

Submitted in fulfilment of the requirements for the award of a
Master of Arts Degree

Health and Behavioural Sciences
Deakin University (Burwood)

June 1996
FORM B

DEAKIN UNIVERSITY

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LIFE EVENTS AND COGNITIVE PROCESSING
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ABSTRACT

The aim of this study was to make an assessment of the role of the cognitive component in the development of sexual dysfunction.

Past studies have largely focused on the impact of particular events on sexual dysfunction and have not assessed the role of the perception of these events. A number of theories on sexual dysfunction have been developed to explain the influence of cognitions, but these have not been empirically tested.

This study investigated the role of the cognitive evaluation of sexual experiences among 30 sexually dysfunctional participants and 30 control participants who were matched on age, marital status and biological sex.

The Cognitive Aspects of Sexual Dysfunction Measure (CASDM) was constructed to evaluate sexual dysfunction. This measure was designed to tap into the major events in participants’ lives and, more importantly, the participants’ perceptions of these events.

The components assessed were the intergenerational (family of origin), individual, current life and relationship aspects of the person’s life. These factors were measured from the responses to questions regarding the participant’s cognitions about past experiences, the effect of the past experience on the participant at the time it occurred and the influence this experience had on the participant’s sense of self now, their relationship now and sexual functioning now.

The main findings in the intergenerational area were that past experiences were perceived by the sexually dysfunctional group to be having an impact on the self, relationships and their sexual functioning although there were no actual differences between the sexually functional and the sexual dysfunctional participants in the occurrence of the event.

For the individual factors, there were differences between the sexually functional and sexually dysfunctional participants in both values and lifestyle, although these were not perceived to be having an impact on the self, relationship and sexual functioning.

In the relationship area, anger was the major factor separating the sexually functional and sexually dysfunctional groups. Anger was high among the sexually dysfunctional participants and was perceived to be having an impact on self, the couple’s relationship and their sexual functioning. The importance of all these variables in providing a better understanding of the cognitive factors in sexual dysfunction was discussed. The findings demonstrate the importance of cognitions in influencing sexual functioning.
Clinicians should not simply deal with the life experiences of sexually dysfunctional people when attempting to change their behaviour, but should focus on changing cognitions about the behaviours in relation to sexual functioning.
PLAIN LANGUAGE SUMMARY

Candidate: Marilyn Jeanette Cobain

Title of Thesis: Life Events and Cognitive Processing in Sexually Dysfunctional Individuals

Degree: Master of Arts

Supervisor: Professor Marita McCabe

This study was designed to examine the influence of people's cognitions about their experiences on their level of sexual functioning. Sexually functional and sexually dysfunctional respondents were asked about experiences and their reaction to these experiences in childhood, within their current life and in their relationships.

The main findings from childhood were that experiences were perceived by the sexually dysfunctional group to be having an impact on the self, relationships and their sexual functioning, although there were no actual differences between the sexually functional and the sexually dysfunctional subjects in the occurrence of the experience.

For the individual factors, there were differences between the sexually functional and sexually dysfunctional subjects in both values and lifestyle, although these were not perceived to be having an impact on the self, relationships or sexual functioning.

In the relationship area, anger was the major factor separating the sexually functional and sexually dysfunctional groups. Anger was higher among the sexually dysfunctional subjects and was perceived to be having an impact on the self, relationships and sexual functioning.

The importance of all these variables in providing a better understanding of the cognitive factors in sexual dysfunction was discussed. The findings demonstrate the importance of cognitions in influencing sexual functioning.
CHAPTER 1

INTRODUCTION

Adequate sexual functioning is a crucial element of physical and psychological well-being. The psychological literature devotes considerable theoretical and empirical attention to the topic of human sexuality and the treatment of sexual disorders. The conceptualisation of sexual function and dysfunction has been stated, debated, compared and discussed, and as a result, numerous advances have been made in the understanding of the psychological processes of sexuality. However, the vast majority of the writings have been based on the reports of clinicians involved in the treatment of men and women with sexual dysfunction rather than on research evidence.

Thus, a significant proportion of the knowledge base concerning normal sexual functioning has been extrapolated from clinical descriptions of dysfunctional performance. It is possible, then, that some incorrect assumptions have been made concerning normal sexual functioning. As a result of this, attempts to treat dysfunctional performance may have been hampered.

While past research has provided important findings relevant to the area of sexual dysfunction, the literature is hampered by a number of key areas of concern. Firstly, past models of sexual dysfunction fail to include the total sexual response cycle, but rather focus on one specific aspect, e.g. the desire phase. Secondly, other models tend to neglect the numerous variables that may contribute to an individual's breakdown in his/her sexual functioning. Thirdly, due to the lack of development and breadth of these models, it is difficult for the therapist to operationalize the model and thereby treat effectively subjects presenting with sexual dysfunction.

The present thesis attempts to address some of the shortcomings in the literature. Both clinical and non-clinical participants will be evaluated using the McCabe (1991) model which encompasses the full sexual response cycle. The questionnaire emanating from this study is useful for therapists working in the area of sexual dysfunction. The usefulness of this model in discriminating between sexually functional and dysfunctional respondents will be evaluated. In this way the role of the cognitions that respondents have about various aspects of their lives in the development of sexual dysfunction will be assessed.
SEXUAL DYSFUNCTION

The DSM-IV (American Psychiatric Association, 1994) gives a formal definition of a sexual dysfunction as “that which is characterised by a disturbance in the processes that comprise the sexual response cycle or by pain associated with sexual intercourse” (p.493). Thus, sexual dysfunction, is characterized by psychological or psychophysiological symptoms which impair sexual functioning. These symptoms may have been lifelong or of recent onset; they may be situational or global. These conditions may occur within a relationship, outside a relationship or prevent a relationship from forming, but relationship issues are not considered in the diagnoses. Since DSM-IV classifications are not always used in the literature, it is often difficult to determine the specific nature of the sexual dysfunctions being considered.

PHASES IN SEXUAL RESPONSE CYCLE – DSM-IV

The DSM-IV divides the sexual response cycle into four phases and states that breakdown can occur in one or more than one of the phases. Dysfunction in any phase will cause subjective levels of distress and/or problems in interpersonal relationships. The phases are Desire, Excitement, Orgasm, Resolution. Subtypes are given to indicate the onset, context and etiological factors associated with sexual dysfunction. The subtypes are Lifelong, Acquired, Generalized or Situational and may be due to psychological or combined factors.

Within the Desire phase, there are two disorders and these two disorders may affect both males and females.
1. Hypoactive Sexual Desire Disorder: The individual experiences an absence of sexual fantasies and desire for sexual activity.
2. Sexual Aversion Disorder: The individual experiences an aversion to and active avoidance of genital sexual activity and this is associated with feelings of anxiety, fear or disgust when in a sexual situation.

Within the Excitement phase, females experience Female Sexual Arousal Disorder. The essential feature of this is a persistent problem in females attaining or maintaining lubrication sufficient enough for sexual intercourse. For males, the persistent problem is one of difficulties in attaining or maintaining an adequate erection. For some males, this may involve the inability to obtain an erection prior to intercourse, for others it may involve losing tumescence at some stage in the sexual interaction.
For females, Female Orgasmic Disorder denotes persistent or recurrent delay or absence of orgasm after experiencing normal levels of sexual stimulation. For males, Male Orgasmic Disorder is experienced as persistent or recurrent delay or absence of orgasm after experiencing normal levels of sexual stimulation. Also, males may experience Premature Ejaculation which is persistent or recurrent onset of orgasm and ejaculation after minimal stimulation before or shortly after penetration and before the person wishes it to occur.

There are no disorders listed under the Resolution phase. This is unusual, as individuals experience disorders of satisfaction which impinge on partner satisfaction.

Sexual Pain Disorder: Dyspareunia is general pain associated with sexual intercourse, generally during intercourse, but may occur before, during or after intercourse. It may occur for both males and females. There is a wide range of pain from mild discomfort to sharp pain. Vaginismus is recurrent or persistent involuntary contraction of the perineal muscles when penetration is attempted. This includes muscular spasm even with the thought of penetration. There is a wide range in severity from mild to severe muscular spasms.

Before considering the causes of sexual dysfunction it is important, therefore, to have a clear view of what constitutes a sexual dysfunction.

**OTHER DEFINITIONS**

Within the literature, the term ‘sexual dysfunction’ is interchangeably used with sexual inadequacy and marital maladjustment (Baucom, Epstein, Sayers & Sher, 1989), interference with sexual arousal (Hale & Strassberg, 1990), sexual difficulties (Snyder & Borg, 1983), sexual relationship maladjustment, or sexual disorder and sexual aversion. Sometimes it is used in a general sense, sometimes it is used to refer to a specific disorder.

Bozman and Beck (1991) examined the effects of anger and anxiety on sexual desire and sexual arousal. They saw anger as related to psychological, social and cultural processes while anxiety was characterized by physical responses. Bozman and Beck described the effects of anger and anxiety on sexual desire and sexual arousal as sexual disorders.

Baucom et al. (1989), in their use of cognitively oriented marital therapy, refer to problems in emotional and behavioural responses between spouses as “marital malad-
justment”. This global term refers to both affective disturbances and physical difficulties in response. Cahill, Llewelyn and Pearson (1991), when investigating the long-term effects of childhood sexual abuse, referred to “problems with sexuality” as one of the difficulties experienced in adulthood by victims. “Sexual distress” was used by Snyder and Berg (1983) as a general term to describe sexual dissatisfaction while “sexual dysfunction” was used to describe a partner’s lack of response, affection and infrequent intercourse. In a review of the conceptualization and treatment of sexual disorders, such as male erectile disorder and female orgasmic dysfunction, Beck and Barlow (1984) referred to these disorders as a subset of sexual dysfunction.

Hawton (1993) discusses the confusion caused in the literature by the lack of classification or definition of sexual dysfunction. Hawton emphasises the importance of sexual satisfaction within the dimension of human sexuality and insists that this dimension be included in any dialogue of sexual dysfunction. Hawton’s working definition of sexual dysfunction is ‘the persistent impairment of the normal patterns of sexual interest or response’. This classification accommodates nearly all people who seek treatment for sexual problems in a clinical practice. The dysfunctions are grouped by Hawton into four categories, namely; sexual interest, arousal, orgasm and other problems. As in DSM-IV, two other important dimensions of classification are required for consideration. Firstly, the time of the onset of the problem and secondly, the situation in which the problem occurs. The most frequent manner in which sexual dysfunctions are conceptualized is summarized in Table 1.1.

<table>
<thead>
<tr>
<th>Aspects of sexuality affected</th>
<th>SEXUAL DYSFUNCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women</td>
</tr>
<tr>
<td>Sexual interest</td>
<td>Impaired sexual interest</td>
</tr>
<tr>
<td>Arousal</td>
<td>Impaired sexual arousal</td>
</tr>
<tr>
<td>Orgasm</td>
<td>Orgasmic dysfunction</td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td>Other types of dysfunction</td>
<td>Vaginismus</td>
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<tr>
<td></td>
<td>Dyspareunia</td>
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<tr>
<td></td>
<td>Sexual phobias</td>
</tr>
</tbody>
</table>

**TABLE 1.1: Classification of the Sexual Dysfunctions of Women and Men**

The term ‘sexual dysfunction’ has many types of expression. Each is seen to stem from either a physiological or psychological problem or both, and includes disturbances in male and female desire, sexual arousal or orgasmic functioning. However, these terms are used differently by different theorists: sometimes they refer to
some dysfunctions; sometimes to all dysfunctions; sometimes only to the actual physiological response; sometimes to both physiological and affective responses, which may also include relationship factors. It is apparent, therefore, that this lack of a clear definition makes a precise understanding of what actually constitutes sexual dysfunction unclear, and so an evaluation of the causes of sexual dysfunction is limited by this lack of clarity. The DSM-IV definitions of sexual dysfunction provide clear and concise guidelines and as such will be used in this thesis.

**PREVALENCE OF SEXUAL DYSFUNCTION**

The prevalence of sexual dysfunction among the general community is difficult to estimate since many studies are based on clinical populations. While some data have been collected for particular dysfunctions, it is difficult to get a view of the overall incidence of the full range of sexual dysfunctions. Weizman and Hart (1987, p.188) estimated that 10% of males at age 30 experience erectile problems and this increases to 76% at age 80 years. Of course, these figures are difficult to interpret because of the different meanings people give to the term impotence. Spector and Carey (1990) estimated that the prevalence rates of premature ejaculation are 36-39%, for hypo-active sexual desire disorder 6% and for inhibited male orgasm 1-10%. However, it is not clear how these percentages vary across age nor whether these problems affect the respondents all of the time or are episodic in their occurrence.

The prevalence of female disorders are even more difficult to assess. Osborn, Hawton and Garth (1988) estimated that 17% of women experienced impaired sexual interest, 17% vaginal dryness, 16% infrequency of orgasm and 8% dyspareunia. Only 32 of the 142 women who took part in the study indicated they had a sexual problem. This contrasts with data collected by Ende, Rockwell and Glasgow (1984) who estimated that 55% of female patients who were attending a general medical outpatient clinic were experiencing sexual problems. As noted by Spector and Carey (1990), a large percentage of the population who experience sexual problems may not seek professional help and may not even realize that they have sexual problems. So, if prevalence rates are based on this percentage of people who present for treatment, then the incidence of sexual dysfunction is likely to be grossly underestimated. The labelling by an individual, or even a professional, of a problem as a sexual dysfunction may influence their perceptions, their level of information and the extent to which the individual is prepared to acknowledge the existence of the difficulty. Thus, it is very difficult to obtain an accurate account of the prevalence of sexual dysfunction in the community.
CAUSES OF SEXUAL DYSFUNCTION

Historical Perspective

Considerable changes have occurred in the approaches to sexual dysfunction over the past century. Psychoanalytic theory dominated in the first half of the century and opinions concerning the nature of sexual dysfunction were influenced accordingly. Sexual dysfunction was viewed as an indication of more serious underlying problems—symptoms of deep-seated psychological disturbance of personality originating in early childhood experience. Treatment followed suit, involving patients in lengthy expensive analyses with discouraging success rates (Hawton, 1993).

Kaplan (1974) maintained that the aspect of psychoanalytic theory relevant to sexual dysfunction is the unconscious motivation by children towards incest and its subsequent repression, the importance of childhood experiences in shaping a person’s future and the oedipal conflict which produces sexual conflict. Serious developmental psychopathology is claimed to take place as a result of these unresolved early conflicts. These conflicts, which are outside a person’s awareness, are claimed to have a destructive effect on the sexual aspect of their life. For example, people may enjoy sex but have an unconscious fear of doing so, along with a fear of punishment. These irrational and contradictory forces, which the person does not understand, are pervasive and potent and lead to an inability to gain any pleasure from the sexual experience, and result in feelings of guilt, shame, fear and self-hate (LoPiccolo & Heiman, 1978).

Negative sexual experiences in childhood are claimed to inhibit normal sexual maturation and drive the adult to a compulsive repetition of the original situation (Finkelhor, 1979; Lo Piccolo & Heiman, 1978; Segraves, 1981). Two specific causes of sexual dysfunction are postulated in Psychoanalytic theory. These are the oedipal conflict and penis envy in girls and castration anxiety in boys. For the girls, “if the oedipal conflict is not properly resolved, her subsequent sexual patterns and activities will reflect its pathological outcome” (Kaplan, 1974, p.354). The woman may, for example, be inhibited in her sexual responses because her lover reminds her of her father and her previous thoughts have never been completely renounced. She may feel too guilty about either her incestuous wishes or her hostility towards her mother to enjoy sex. She may feel, on an unconscious level, that if she enjoys sex too much she will be destroyed by a jealous mother, or alternatively, she may be abandoned by her mother. “Psychoanalytic theory also postulates that unconscious penis envy is a universal phenomenon” (Kaplan, 1974, p.354) which is experienced by girls between the ages of three and five years. If this envy continues, sexual dysfunction may occur in later
life. The girl must, therefore, adjust to the fact that she is deprived of a penis and be able to cope with the attending emotions or rage, inferiority, envy and guilt. According to Freudian theory, boys experience sexual dysfunction in the form of erectile dysfunction (impotence) because of deep underlying psychopathy or unconscious intrapsychic conflicts caused by unresolved oedipal problems and the attending feelings of fear and guilt. If this oedipal conflict is not resolved, early incestuous wishes, together with the guilt and anxiety feelings they elicit, are relived whenever sexual excitement is experienced. Sexual intercourse is avoided by disturbances of potency (Finkelhor, 1979; Kaplan, 1974).

LoPicollo and Heiman (1978) further claimed that Freud believed sexual desire was a male phenomenon which left women with few psychoanalytically sanctioned ways to express their sexuality. The psychoanalytic viewpoint attempted to explain female sexuality within a male framework. Women who were interested in sex would experience feelings of guilt, shame, fear and self-hate and women, it is surmised, must attempt to suppress feelings of sexual pleasure. The healthy male, in turn, must be erect throughout the sexual encounter and on guard against the woman who shows any sexual enjoyment as this was seen as a masculine trait. The male was culturally expected to be the pursuer, and should he sustain erectile problems, he was considered to have an unresolved oedipal problem. If the women showed too much interest, she was viewed as masculine or polymorphously perverse (LoPicollo & Heiman, 1978).

The literature abounds in criticisms both of the psychoanalytic theory and the psychoanalytic counselling techniques. An evaluation of the validity of these views is dependent upon an examination of the factors which contribute to sexual dysfunction, and the emotions experienced by dysfunctional individuals. If childhood experiences of the type described above are associated with negative emotions and sexual dysfunction in adulthood, Freud's theory would be given some support. However, psychoanalytic theories do not have a great deal of empirical support. Predicted patterns of behaviour have not been found in sexual offenders and people with sexual dysfunction do not show the childhood traumas and 'warped' parental relationships predicted (Finkelhor, 1979).

The development of more directive treatment of sexual dysfunction occurred with the advent of behavioural therapies in the 1950s and 1960s. Learning theory and the behavioural point of view stand in contrast to the psychoanalytic approach to the understanding of human sexuality and sexual dysfunction. One of the basic assumptions from learning theory is that all behaviour is learned. This implies that it is possible for the individual to un-learn and re-learn behavior. Psychopathology or dysfunction is understood in terms of the learning of maladaptive behaviours or the failure to learn
adaptive behaviours (Pervin & Leiblum, 1980). Therapy involves the application of the basic principles of learning to the areas of behavioural change. Exponents of the behavioural view conceptualize this as behaviour modification and focus on changing the actual behaviour, rather than attempting to resolve an individual’s inner conflicts.

Now, as then, there is no single learning or behavioural theory, but in fact several individuals have contributed to a behavioural view, such as Pavlov’s classical conditioning, Skinner’s operant conditioning and Hull’s Stimulus-Response learning. Each of these theorists has added his own interpretation to the known principles of learning and subsequent understanding of the individual’s behaviour. With the passing of time, their influence has been replaced by other approaches but their presence remains as the theory, research and therapy continue to evolve.

A striking example of this is the work of Joseph Wolpe (1968). Having studied the writings of Pavlov and Hull, he came to hold the view that a neurosis is a persistent, maladaptive, learned response that is almost always associated with anxiety. Consequently, the therapy emanating from this understanding involves the inhibition of anxiety through the counter-conditioning of a competing response. A variety of anxiety inhibiting responses could have been used for counter-conditioning purposes, but the one chosen by Wolpe was deep muscle relaxation. Thus Pavlov’s classical conditioning lead Wolpe to the therapeutic technique known as systematic desensitization.

A number of clinical and laboratory studies have indicated that systematic desensitization can be a useful treatment procedure (Friedman, 1968; Haslam, 1965). These successful results led Wolpe and others to question the psychoanalytic view that as long as the underlying conflicts remained untouched the patient is prone to develop a new symptom in place of the one removed (symptom substitution) (Lazarus, 1965). According to the behaviourist’s point of view, there is no symptom that is caused by unconscious conflicts but, rather, the symptom is a maladaptive learned response. A change in the maladaptive or dysfunctional behaviour enables the occurrence of adaptive or functional behaviour. From this behavioural theory, a multitude of treatment programs burgeoned in the clinical field for individuals experiencing many different types of problems. However, it took some time before behavioural treatment programs were available to individuals with sexual problems. Pioneers in this field were Masters and Johnson and with the publication of their book, Human Sexual Inadequacy (1970), a quantum leap forward occurred in the area of sexual therapy. Masters and Johnson (1970) described several potential pathways to the onset of sexual dysfunction including alcohol intoxication, religious-based guilt and unsuccessful attempts to
control premature ejaculation. None of these, according to Masters and Johnson were as significant to sexual dysfunction as was anxiety. They stated fear/performance anxiety was the basis of sexual dysfunction. They conceptualized the processes of spectatoring and performance anxiety.

Masters and Johnson developed their own model of sex therapy and, though modified by others, it still remains the basic approach in sex therapy today. It has a number of general procedures for the treatment of all dysfunctions supplemented by specific strategies for particular conditions (Kachaturian, 1989).

**Recent Perspectives on Causes of Sexual Dysfunction**

1. **Childhood and Adolescent Factors**

There have been a number of studies that have evaluated the impact of childhood and adolescent experiences on sexual dysfunction. However, the area that has received the most evaluation is the impact of sexual abuse.

Coerced sexual interaction in childhood may be defined either as incest or childhood sexual abuse. The acts themselves range from exhibitionism such as nudity, disrobing and genital exposure in front of the child which makes the child feel uncomfortable, to various forms of sexual interaction (Dolan, 1991). For simplicity of discussion, the words ‘childhood sexual abuse’ will be used throughout this paper to include both sexual abuse and incest.

Dolan (1991) maintained that there are many complex factors involved in determining the degree of trauma likely to be experienced by the sexually abused victim. These include variables such as frequency, duration, relationship to offender, age of victim when the abuse occurred, the reaction of others and the support available to the victim.

There are several general comments made by researchers on the effects of childhood sexual abuse. For example, Dolan (1991) maintained that the degree and duration of past traumatic symptoms vary, but research has found that there are rarely no damaging consequences. Those victims who have experienced incest over a long period are those who suffer most, but trauma is lessened if a victim receives support upon disclosure and responsibility “is placed clearly on the perpetrator by the perpetrator’s acceptance of responsibility” (p.2). Courtois (1988) concluded that in comparative studies, incest victims have been found to experience more sexual problems than non-victims and these problems develop at the time of the abuse or later.
In a review article of the long term effects of child sexual abuse, Beitchman, Zucker, Hood, DaCosta, Akman and Cassaria (1992) concluded that women who had reported a history of child sexual abuse experienced higher levels of sexual dysfunction and greater evidence of fear and anxiety than women who had not experienced such abuse. Further, they found that symptomology was greater among women who had experienced abuse for a longer period of time, who had experienced force during the abuse or who had experienced penetration. Adjustment was also poorer when the abuse involved a father or a stepfather, or if the victim was a male.

Although people who had been abused showed greater sexual disturbance, there was no difference between people who had been abused and people who had not been abused in the development of personality disorders (Beitchman et al., 1992). These findings are at variance with the results obtained by Greenwald, Leitenberg, Cado and Tarran (1990) who evaluated psychological and sexual functioning and the experience of childhood sexual abuse among 1500 nurses. Fifty-four women reported that they were sexually abused as children and these were matched with fifty-four control subjects. Greenwald et al. found that although the abused subjects were more likely to experience higher levels of depression and anxiety, there was no difference between the two groups in their reported levels of sexual satisfaction and sexual dysfunction. These findings were even evident after controlling for perceived parental emotional support.

Courtois (1988) cited a range of studies which found sexual problems such as desire, arousal and orgasmic disorders and coital pain occurred in survivors of childhood sexual abuse. Other cognitive and automatic symptoms such as "...inability to relax... confused sexual orientation... instability, mistrust and abuse in intimate relationship..." (p.111) also impeded sexual functioning. Likewise, Feinauer (1989) found that even women who reported that they had adjusted to their childhood sexual abuse continued to experience disturbances in their sexual functioning.

The results of a survey conducted by Johnson and Shrier (1987) into the long term effects on young males molested by females, showed that "the victims of both female and male molesters appear to be at increased risk of sexual dysfunction. The marked anxiety and feelings of helplessness and guilt described by many victims of sexual abuse appear to be reawakened by attempts at later sexual activity" (p.652). The subjects who participated in this study completed a comprehensive medical and psychosocial history including questions on sexual behaviour and were age matched with a control group who denied molestation. It can, however, be argued that the subjects were still too young and sexually inexperienced for it to be known whether the molestation would have any long term effect and it was also noted that none of the
subjects had reported the abuse to the police, hospital or a sexual abuse facility. Disturbance due to the incest was also not the chief reason for visiting the adolescent medical clinic. Greenwald et al. (1990) found that, although child sexual abuse did not affect the sexual functioning of adult females, it did produce a long-term negative impact on their psychological adjustment. They statistically controlled for the victims' perceptions of the caring and warmth given by parents to counter for any perceived parental punitiveness, rejection and other family negative dynamics, because they reasoned that it may be that lack of family support which accounts for differences between those subjects who were abused and those who were not. In fact, this suggestion has been supported in a study by Higgins and McCabe (1994) who found, that once the level of family violence was accounted for in adult adjustment, the experience of sexual abuse in childhood did not explain any further variance in the levels of adjustment.

Many of the studies reviewed above have used clinical samples from which to collect data and to draw conclusions regarding the impact of sexual abuse on adult adjustment. However, there are difficulties when drawing conclusions from this subject base. Subjects are generally relying on retrospective recall, with all of the problems this involves (see Green, 1994, for a complete discussion of the problems regarding retrospective recall). Other problems include the limited variables that are evaluated. As noted by Finkelhor and Browne (1988), it would seem that childhood sexual abuse leads to problems in adjustment in adulthood, but the exact nature of these adjustment problems is difficult to specify. Depending upon the circumstances surrounding the abuse and the reaction to the abuse at the time, women may experience relationship problems, sexual difficulties, sleep disturbances, depression, anxiety and a whole range of other problems (Asher, 1988; Browne & Finkelhor, 1986; Finkelhor & Browne, 1988; Palmer, 1990). In an earlier paper, Finkelhor (1981) even proposed that in some circumstances incestuous experiences may have positive outcomes for the victim. He suggested this is most likely to apply in circumstances that involve siblings.

Due to the conflicting findings reported in past research, it is not possible to draw very firm conclusions from these studies on the effect of child abuse on adult sexual functioning and more research is needed to completely understand whether child abuse leads to the development of sexual dysfunction in adulthood and, if this is the case, the circumstances under which this occurs.

In terms of other childhood factors that may influence sexual functioning in adulthood, Raboch and Raboch (1992) found that females who experienced inorgasmia and were distressed by this disorder were more likely than orgasmic females to have lost either
their mother or father early in life and have experienced an unhappy childhood. However, it may not be specific events from childhood that are related to sexual dysfunction, but rather a more global perception of this stage of life: Brooks-Gunn and Furstenberg (1989) suggested that the general attitudes of the family of origin may have a significant impact on sexual functioning, particularly in respect to the attitudes and messages about sex and sexuality that are communicated, often indirectly.

A substantial study conducted by Heiman, Gladue, Roberts and LoPicollo (1986) examined the impact of historical and current factors on sexual dysfunction. The findings in relation to historical factors will be discussed here and the findings in relation to Relationship Factors will be discussed below. The participants in the study were 94 clinical couples and 110 non-clinical couples selected from the same community. All subjects completed a Personal History Questionnaire which evaluated experiences and perceptions of these experiences during childhood and within the current relationship. The findings discriminated between the clinical and the non-clinical participants. Non-clinical men reported fewer friends in school, less frequent use of imagining fantasy themes, for example, having an imaginary sexual partner, and more use of unusual themes, for example, being paid to have sex.

The major historical factors discriminating clinical from non-clinical women was that clinical women were more attached to their first partner and were more upset when that relationship ended. Clinical women were less likely to have experienced affection from their mother in childhood or, in fact, any kind of emotion in their childhood and indicated a lower frequency of physical affection between their parents.

These data suggest that childhood experiences played a much more important role for women than for men. They emphasised the importance of the mother-daughter relationship and also the impact of the first sexual experience for women. This emphasises the importance of the attachment of the woman to their mother and also their first sexual partner. If the attachment is a negative experience or unsatisfactory, then this leads to long term psychological damage which may be, in this case, expressed as sexual dysfunction.

Although Heiman et al. (1986) evaluated both the recall of events and the perception of the events, the major emphasis of the study was on the contribution of particular events to sexual dysfunction. However, the few items which assessed perception were strongly associated with sexual dysfunction in adulthood. This finding was particularly important for women. Future studies need to explore the role played by perceptions in greater detail so that a comprehensive understanding of their role in sexual dysfunction can be achieved.
2. Individual Factors

Writers of virtually every theoretical persuasion consider anxiety to play a role in the development and maintenance of sexual dysfunctions for both men and women. Barlow (1986) refers to Fenicikel (1945) and Wolpe (1958) as two of the earliest theorists to consider anxiety as a major contributing factor in sexual dysfunction. Masters and Johnson (1970) seem to leave no doubt that anxiety is a major factor in the etiology of sexual dysfunction. Masters and Johnson's concept of sexual anxiety is performance anxiety/fear. They observe "the prevalent roadblock is one of fear" (p.196) and describe both performance anxiety and fears of inadequacy as co-existing for the individual who experiences sexual dysfunction. Masters and Johnson reported that slightly different anxiety processes operate for males and females. For example, orgasmic dysfunction is said to result from negative messages from parents and psychosocial sanctions concerning female sexuality. Learned in childhood, the female is likely to take these messages into her adult sexual relations. With the negative effects from tension and apprehension already present, she is unable to achieve the high levels of arousal necessary for orgasm. Beliefs such as 'sex is dirty' and 'nice girls don't do this' create a negative situation for the adult female and impair her ability to both perform effectively and enjoy sex. The male experience of erectile incapacity and premature ejaculation creates fears of performance with each sexual interaction. For the male, the immediate and overpowering concern is whether or not he will be able to achieve an erection; will he be able or capable of performing as a normal man. He is constantly concerned not only with achieving, but also with maintaining an erection of quality sufficient for intromission (Masters & Johnson, 1970). Masters and Johnson suggested that performance fear leads to 'spectatoring' - the experience of detaching oneself from the sexual experience as though one were an uninvolved observer. It is the fear and the accompanying anxiety process that affects the attention of the male and this negative affect diminishes arousal by reducing awareness of pleasurable sensations and increasing the man's concerns about the quality of his erection.

So, while the source of performance fears is conceptualized differently for males and females, the anxiety or fears concerning sexual performance are viewed as the common maintaining factor in sexual dysfunction.

Kaplan (1979) also attributes a central role to anxiety as a maintaining factor in sexual disorders and views anxiety as the primary psychological mechanism underlying the interference in the sexual response cycle. Kaplan's three phase model of the sexual response cycle – Desire → Excitement → Orgasm – illustrates how significant the level of the individual's anxiety is on the sexual response. Kaplan (1979) provides a
pains-taking enumeration of the mild, mid-level and severe sources of anxiety, which lead to sexual dysfunction.

Since the 1970s, the clinical literature is replete with descriptions of the negative effects of anxiety on the general response of the individual (Jehu, 1979; Kaplan, 1979; Masters & Johnson, 1970). This conceptualization of the impact of anxiety continues to form the underpinnings of many treatment programs available today for individuals experiencing sexual dysfunction. In fact, treatment innovations since the publication of Human Sexual Inadequacy (Masters & Johnson, 1970) have been only minor and most approaches continue to focus on reducing or determining the cause of sexual anxiety (Kaplan, 1981; LoPicollo & Lobitz, 1972). The success rates of these approaches, and the commonalities among them, have been reviewed many times (e.g. Cooper, 1981; Crown & D’Ardenne, 1982; Mills & Kilmann, 1982) and it is reported that approximately one half to two-thirds of sexually dysfunctional patients will show some improvement immediately following treatment geared to the reduction of anxiety.

However, more recent laboratory-based studies suggest that the impact of anxiety on sexual arousal may not be so clear. For example, the chemical production of the physiological symptoms of anxiety (via epinephrine injection) produced no concomitant decreases in sexual arousal (Lange et al., 1981), as did the strategy of exposing subjects to anxiety provoking material (e.g. films of fatal accidents prior to exposure of erotic material) (Hoon et al., 1979; Wolchick et al., 1988).

The most productive researchers in this area, Beck and Barlow and their colleagues, used the threat of electric shock as the source of anxiety for sexually functional men. The influence of anxiety on plethysmographically assessed sexual arousal had varying effects; to decrease (Beck & Barlow, 1986a, Beck et al., 1987) no effect (Beck et al., 1987) and no increase in sexual arousal (Barlow et al., 1983). These same researchers worked with sexually dysfunctional subjects and also report their reactions and responses to experimentally manipulated anxiety as varied and inconsistent.

So, in the 1980s a contradiction emerged, as on the one hand, the clinical literature based mainly on treatment studies from sex therapists argued unanimously and strongly for an inhibition effect of anxiety upon sexual functioning, while laboratory evidence for such inhibition was, at best, inconsistent.

Part of the confusion may be related to the concept of anxiety, which is, in itself, a complex construct. As early as 1968, Lang had shown that anxiety can be viewed as having separate components (cognitive or subjective, physiological and behavioural)
that do not necessarily covary. Influenced by this, Norton and Jehu (1984), in their
review of the role of anxiety in sexual dysfunction, concluded that the studies, in gener-
al, suggested that anxiety was common among people with sexual dysfunctions but that
the level and nature of anxiety may vary greatly between individuals (Ansari, 1975;
Wolpe, 1981); that anxiety reduction procedures improve some but not all aspects of
sexual dysfunction (Barlow 1986); and that recent research has begun to identify some
anxiety-related factors that can disrupt sexual arousal (Wincze 1980). The purpose of
the review was to see if the studies could help identify the specific mechanisms through
which anxiety impairs sexual functioning. Is it cognitive, physiological or behavioural?
It would seem that while anxiety remains defined as a unitary construct, the
understanding of its effect and its role in sexual dysfunction is both confusing and
limiting. Beck and Barlow (1984) stated the present situation quite clearly: “anxiety
connotes different meanings for different authors, ranging from inhibitions based on
moral sanctions, to generalized discomfort over being sexually intimate, to fear over
loss of control, to spectatoring” (p.5). The definitional problems become increasingly
evident as one attempts to interpret results of studies reviewed thus far. Recently,
Barlow (1988) has re-emphasised the usefulness of the approach that defines anxiety as
a more loosely integrated cognitive affective structure and fear as a highly integrated
response configuration. Recent studies from Barlow (1986) indicate the utility of a
multi-response system approach to the investigation of anxiety and sexual arousal.
Although the physiological correlates of induced anxiety either do not inhibit (Beck et
al., 1984; Lange et al., 1981) or even facilitate (Barlow et al., 1983, 1984) arousal in
sexually functional people, they may inhibit sexual arousal in dysfunctions (Beck et
al., 1984). However, the cognitive components of anxiety, such as distracting,
performance-related negative cognitions, may have a very different effect on these
two groups.

In the last twenty years, stress has been acknowledged as affecting both the
physiological and psychological health of individuals (Morokoff & Gilliland, 1993).
Baum, Singer and Baum (1981) reported that stress is related to sleep disturbances,
difficulty in concentrating, hyper-alertness and mood disturbance. Holmes and Masuda
(1974) and Rabkin and Struening (1976) noted life stress is related to a variety of
illnesses and physical symptoms. Clinicians have frequently reported that major life
stresses are common in clients presenting with sexual dysfunction (Brechir, 1977).
However, despite these and many other observations, little research attention has been
given to the relationship of stress to sexual functioning until Morokoff and Gilliland’s
(1993) investigation. This study examined the relationship between stress and sexual
functioning, with marital satisfaction as a moderating factor. In addition,
employment status was selected because unemployment has often been viewed as a
stressor and has been shown to be associated with factors likely to have an impact on sexual functioning, e.g. depression (Cobb & Kasl, 1977). Stress was found to be related to sexual functioning, for example, erectile dysfunction was associated with unemployment. Problems with attaining an erection were also related to age — older men reported more erectile difficulties than younger men. A significant interaction showed that the difficulty in attaining an erection increased with age for both employed and unemployed men. In a sample of women whose husbands were unemployed, a significant relationship was found between unemployment of the male and difficulty in maintaining an erection. In this sample, unemployment was not found to predict sexual dysfunction in women. According to the authors, a possible explanation is that these women were unemployed by choice and this unemployment did not affect the economic status or hardship of the family. Findings seem to suggest that stressors are not associated with sexual dysfunction unless the psychological meaning signifies something important for sexual functioning, for example, unemployment: where the male partner is unemployed, the unemployment signifies less fulfilment of the traditional male gender role.

This study highlights the importance of not only obtaining objective information on the occurrence of events, but also obtaining and understanding the meaning of the event for the respondents. In some circumstances, an apparent stressor may in fact facilitate sexual arousal whereas for another individual, it may lead to sexual dysfunction. This study demonstrates the importance of the meaning placed on life events rather than the occurrence of the events per se in influencing sexual dysfunction.

Ackerman and Carey (1995) also noted the role of lifestyle factors that act as risk factors for erectile dysfunction. They noted particularly the importance of smoking, alcohol use, inadequate exercise and non-sexual sources of anxiety. Although they did not provide empirical evidence or substantiating details, they noted the importance of cognitions and performance concerns on the development of erectile disorders.

Anderssen and Cyranowski (1995) explored the role of individual factors on the sexual functioning of women. They found women who were high on neuroticism and who had poorer body image were more likely to experience sexual dysfunction. However, there was no relationship between other personality variables and sexual functioning. They noted the importance of women’s self views or cognitive representations of their sexuality. They suggested that women with positive cognitive representations enter sexual relationships more willingly and with a more optimistic view of the sexual outcomes. They noted the importance of further study of these sexual schemas in explaining women’s sexuality and self concept.
Research conducted over the past decade has provided the groundwork and structure for new models of functional and enjoyable sexual performance and has also generated additional hypotheses which await empirical validation. These results are needed for furthering the understanding of the role of individual and lifestyle factors on an individual’s experience of sexual dysfunction.

3. Relationship Factors

It is not hard to understand that conflict, discord or disagreement between individuals may lead to problems in a broad range of areas for individual adult experience. The extent to which discord leads to sexual dysfunction is difficult to determine. Interpersonal discord between partners may range from mild to very severe and include verbal or physical violence. The conflict may be openly expressed or couples may remain distant and never intimate. Discord may also be constant or episodic. When anxiety, anger, sadness, fear or any negative emotions are directed towards a partner, sexual arousal may be inhibited (Beck, 1988; Kaplan, 1974).

Hawton (1993) believed that discord in a relationship is the most frequent cause of sexual dysfunction. Although some couples may be able to maintain a satisfactory sexual relationship in spite of disharmony, this is rare. He claimed that “for most couples sexuality, affection, trust and general harmony are tightly intertwined, a disturbance in one of these factors affecting all the others…” (p.70).

Factors leading to marital conflict include infidelity, the discovery of which, commonly leads to sexual dysfunction such as loss of interest or arousal disorders. Guilt over unfaithfulness may also contribute to sexual dysfunction by the offending partner. Hostility, rage, feelings of abandonment or rejection experienced by the innocent partner may also lead to an unsatisfactory sexual interaction (Hawton, 1993).

Another factor which inhibits a satisfactory relationship is lack of intimacy or distancing between partners, which leads to difficulties in communication. Kaplan (1974) maintained that this may inhibit sexual performance, which will, in turn, perpetuate or contribute to sexual dysfunction. If a couple are unable to communicate their sexual preferences, then satisfactory love-making may be inhibited. Communication difficulties may also be caused by “culturally induced attitudes of shame or guilt” (Kaplan, 1974, p.166), or fear of rejection, or inadequacy.

Another relationship factor contributing to sexual dysfunction is covert punishment of one partner to the other, which leads to discouragement or undermining of the sexual
confidence of the partner. This is known as sexual sabotage and is often subtle and unacknowledged by both parties. Sexual sabotage can be engineered by creating pressures and tension before love-making, by, for example, starting quarrels, criticizing and insulting one's partner and making reference to anxiety-provoking topics like money concerns (McCabe, 1991). Another effective pressuring method is to make unrealistic demands on the partner, for example, requiring instant erection on the commencement of sexual interaction. Inappropriate timing such as when one partner is tired, inebriated or worried may also inhibit sexual responses. Lack of grooming, care and lack of cleanliness or withholding pleasurable activities which are known to be enjoyed by the partner may also be contributing factors to sexual dysfunction (Kaplan, 1974). Women are more likely than men to experience sexual dysfunction when they perceive their partner to lack sex appeal and when the sexual and/or marital relationship is perceived to be unsatisfactory (Donahey & Caroll, 1993).

Roffe and Britt (1981) concluded that marital discord gives rise to sexual conflict as individuals strive to meet power, intimacy, dependency or hostility needs. Any combination of these may give rise to sexual dysfunction. Beck and Barlow (1984) and Snyder and Berg (1983) concurred with this, but add that inadequate sexual skills are also a contributing factor. Snyder and Berg (1983) included lack of affection for one's partner as an important determinant of sexual dysfunction. Fichten, Libman and Rothenberg (1988) demonstrated that in poor marital relationships, the partner is more likely to blame the dysfunctional individual, make fewer efforts to improve the sexual relationship and have lower expectations of success with therapy.

In contrast to these studies, Hartman (1980) claimed that it is not always obvious to what degree marital and sexual factors interact in a relationship. He administered a self-report measure of marital satisfaction and discovered that "competence in couple functioning may be preserved in the presence of an unsatisfactory sexual relationship" (p.579). In fact, an unsatisfactory sexual relationship may even allow for better marital adjustment. However, with a sample size of 20 couples as respondents who were divided into four groups of five couples, these results cannot be considered conclusive. Simkins-Bullock, Wildman, Bullock and Sugrue (1992) also found that there was no relationship between marital adjustment and duration of erectile dysfunction. However, there was no control group in this study so it is not possible to determine if marital adjustment was related to the initial development of the disorder.

Snyder and Berg (1983) were also interested in determining the relationship between sexual dysfunction and general interpersonal difficulties among couples. All individuals in the 45 couples completed a symptom checklist ranging in content from specific sexu-
al dysfunction such as erectile dysfunction to more general sexual difficulties, for example, too little or too frequent sex. The study found that there was an association between interpersonal difficulties and sexual distress or sexual satisfaction, but not the actual level of sexual dysfunction. This would suggest that relationship difficulties may lead to general dissatisfaction with the relationship including the sexual aspects of the relationship, but not actually increase the incidence of sexual dysfunction. However, Zimmer, Borchardt and Fischle (1983) found that marital therapy led to an enhancement of sexual functioning, but it is not clear whether this was the actual level of sexual functioning or satisfaction with sexual functioning. There would seem to be some association between relationship and sexual functioning, but the nature of this association needs further exploration.

Heiman et al. (1986) evaluated the importance of relationship factors in discriminating between sexually functional and sexually dysfunctional men and women. Very few of the relationship factors contributed to sexual dysfunction for men. The major factor was that dysfunctional men expressed a greater need for emotional closeness and for a good sexual relationship. Perhaps this is due to the fact that they were experiencing a dysfunction and perceived a higher need for intimacy.

Non-clinical women reported more orgasms in partner sex, higher levels of dependency and conflict avoidance and higher levels of care and affection for the partner. These findings suggest that non-clinical women are more invested in their current relationship and adopt strategies to ensure a lack of turmoil in the relationship ensuring the relationship continues. Overall, the findings indicate a high concordance between difficulties in the marital relationship and sexual dysfunction for both men and women.

Morokoff and Gilliland (1993) explored the role of a range of factors on the sexual functioning of males and females. As would be expected, a positive relationship was found between marital satisfaction and frequency of intercourse, but a negative relationship was found between sexual desire and marital satisfaction in men. The authors suggest that marital satisfaction depends in part on the extent to which the partner is perceived as meeting one’s sexual expectations. The results in general indicate that good relationships may be found among those experiencing misfortune, whereas good fortune does not ensure a happy relationship.

4. Multiple Causes of Sexual Dysfunction

In an attempt to develop a broad understanding of the etiology of sexual dysfunction, McCabe (1991) grouped contributing factors into three categories: intergenerational
factors, that is family, religious or cultural factors which result in loyalty conflicts, values, secrets, sexual intrusiveness, lack of accurate information and silence about sexual issues; individual (or intrapersonal) factors which are currently exerting influences such as high performance standards, sensitivity to rejection, negative attitudes towards sexuality; and finally the relationship (or interpersonal) factors. These may be any form of marital discord, marital harmony, power struggles, intimacy, dependency needs, anger and lack of affection, or dislike for one’s sexual partner.

In support of this model, Block and Loveless (1987) concluded that “each person’s sexuality is a totally unique phenomenon which is influenced by factors which may be developmental, pathological, individual or cultural” (p.18). Talmadge and Talmadge (1986) also believed influences of family of origin, physical health and social context have a major effect on the development of the sexual aspects of a relationship. McConaghy (1993) evaluated the psychological factors that contributed to sexual dysfunction and included many family of origin, intrapersonal and interpersonal variables in his review.

The influence of many of the intergenerational factors was reviewed earlier in this paper when the psychoanalytic approach to sexual dysfunction and the impact of child sexual abuse was considered. Intrapersonal factors have received little attention within the dysfunctional literature. Life style and body image are claimed to have an impact on sexual functioning but the exact nature and extent of this impact is not clear. Andersen and LeGrand (1991) found a weak association between negative body image scores and lack of sexual desire, but there was no significant association between body image and overall sexual behaviour.

In a comprehensive study among 165 men and women, Morokoff and Gilliland (1993) explored the role of stress, life events, hassles and marital functioning on sexual dysfunction. They found that unemployment was a strong contributor to sexual dysfunction in men and not in women. Marital satisfaction was a strong contributor to the sexual functioning score. Surprisingly, the experience of major life events was not associated with sexual functioning after accounting for age. The experience of daily hassles was found to increase the level of sexual desire. Perhaps people use sexual intercourse to release the tension that accompanies daily hassles. However, it is difficult to interpret the findings that relate to the impact of these variables without having a clearer idea of their meaning for the individuals concerned. In future studies, not only do we need to explore the incidence of life events and daily hassles and the stress that accompanies these, but we also need to understand how they are interpreted, so we can better explain their impact on sexual dysfunction. As suggested by McCabe (1991), it may not be the childhood, personal and relationship factors in themselves that cause sexual dysfunction but rather the personal interpretation that is placed on these experiences. The role of these cognitive factors is reviewed in the next chapter.
CHAPTER 2

COGNITION AND SEXUAL DYSFUNCTION

Recent research in human sexuality has emphasised the importance of understanding cognitive processing in the development and modification of sexual dysfunction. This chapter is concerned with examining the meanings of cognition and cognitive processing, the major tenets of cognitive theory/therapy and its contribution to the understanding of sexual dysfunction.

Cognitive Psychology

Simply stated, human cognition is mental activity; the way the human species perceives and processes information. Each individual has a unique mind set of cognitions and to understand the individual's behaviour, it is necessary to understand cognitive processing in general, and the individual's own processing and interpretation in particular. Cognitive psychology involves the total range of psychological processes, from sensation to perception, pattern recognition, attention, learning, memory, concept formation, thinking, imaging, remembering, language, emotions and developmental processes and cuts across all fields of psychology. This approach sharply contrasts with the behaviourist perspective which emphasises behaviours that are observable, the psychoanalytic perspective which focuses on unconscious emotions, and the humanistic perspective which emphasises personal growth and interpersonal relationships.

In some ways, cognitive psychology should not be seen as the latest development in the family of psychological perspectives, as human thought processes have intrigued philosophers and other theorists for more than 2,000 years. For example, the Greek philosopher Aristotle proposed laws for learning and memory and emphasised the importance of mental imagery (Meycr, 1965). Hearnshaw (1987) noted cognitive psychology is both the oldest and newest component in the history of psychology. The emergence of contemporary cognitive psychology occurred in the 1950s with the disenchantment with behaviourism and to be more specific, in 1956, when a large number of researchers published influential books and articles on attention, memory, language, concept formation and problem solving (Mahoney, 1993).

Cognitive psychology has had an enormous effect on the discipline of psychology as researchers recognise the importance of mental representation and thought processing (Gardner, 1985).
The theoretical underpinnings of cognitive psychotherapy will now be considered before evaluating the formulation of cognitive psychotherapy in the area of sexual dysfunction and so developing an argument for this thesis.

However, a consideration of these theoretical underpinnings is extremely difficult as the major cognitive psychotherapies emerged either before, or simultaneously with, the theory of cognitive psychology. It seems that the practice of cognitive therapies developed alongside the development of the theory rather than flowing from the theory.

**DEVELOPMENT OF COGNITIVE THEORY**

Clinical applications of the cognitive perspective generally predated the formal theory associated with cognitive psychology. In 1980, there were five or six basic types of cognitive psychotherapy: Kelly's personal construct approach, Ellis' rational-emotive therapy, Beck's cognitive therapy and the problem solving approaches which incorporated a loosely grouped set of 'coping skills', techniques associated with cognitive behaviour modification and logotherapy (Holt & Lee, 1989). By 1990, there were more than twenty different varieties of cognitive psychotherapy and there were significant changes in at least some of the original approaches (Haaga & Davison, 1991). In many respects, the conceptual development within the cognitive psychotherapies had raced ahead of much of the research in this area. The conceptual developments, in turn, appear to have emerged from the practical experiences of service providers, a phenomenon that has often occurred in the history of psychotherapy.

The cognitive perspective and its development has had a confusing history. The nature of a theory in this area is twofold: first, to provide an explanatory framework by which to account for human behaviour; and, second, to use the explanatory framework for the design of treatment strategies. However, cognitive theory and practice has not followed this pattern. The reason for this would seem to be the way the area has developed. Treatment strategies were developed and used by clinicians for their effectiveness without concern for their theoretical heritage (Holt & Lee, 1989; Latimer & Sweet, 1984). It seems that only after the cognitive psychology revolution gathered momentum that a critical evaluation of the theoretical structure commenced. As will be discussed later, a similar process occurred in the development of theory and therapy for sexual dysfunction.

Despite its confusing theory/therapy history, Mahoney (1993) suggested that over the past three decades, the major theoretical developments in the cognitive psychotherapies have clustered around six basic themes.
1. Rationalist and Constructivist Approach

The first of these themes was the differentiation between the rationalist and constructivist approaches to cognition. The essential differences between these approaches is that the rational approach views information processing as being similar to a computer, whereas the constructivist accepts this in part, but argues for the inclusion of emotions and the experiential nature of humans. Rather than viewing the mind as operating in a pre-determined, programmed manner like a computer, cognitive processing has an additional component – the emotional and experiential aspect which has a significant influence on how material is processed and also on the response to specific situations. Within the constructivist conceptualisation, the complexity of human experience is acknowledged, as are the operations of unconscious ordering processes and a developmental process-focused approach to knowing.

Rationalist thought is characterised by three related assumptions, 1) irrationality is the primary source of neurotic psychopathology, 2) explicit beliefs and logical reasoning can overpower and guide emotions and behavioural action and, 3) the core process in effective psychotherapy is the substitution of rational for irrational thinking patterns (Ellis, 1976). Constructivist thought is more complex and abstract. Its theory adopts a more proactive view of cognition and the organism. It emphasises unconscious core ordering processes and promotes a complex systems model in which thought, feeling and behaviour are interdependent expressions of a life-span developmental unfolding of interactions between self and social systems (Machinery & Lyddon, 1988). Both approaches have positive contributions to make in the understanding of cognitive processing.

2. Biological and Social Factors

The second theme outlined by Machinery (1993) was the increasing importance attributed to biological and social factors in the etiology, maintenance and treatment of psychological disorders. For example, Ellis (1976) posits an inherited tendency toward irrational beliefs that may biologically predispose individuals toward developing common patterns of dysfunction. Now, cognitive therapists acknowledge the importance of the therapeutic relationship in effective therapy. Previously, the therapy focused on changing the behaviour through set homework tasks and the experience for the client was objective rather than subjective. The constructivists' contribution has been to highlight the bodily origin of higher mental activities where the cognitive therapist has a greater respect for clients' emotionality and the use of more experientially-based exercises. Recognition of these issues forms the second major conceptual development.
3. Unconscious Processes

The relatively recent acknowledgement by cognitive psychologists of the important and extensive role played by the unconscious processes in human experiences is the third major theme. Surprising as it may seem, cognitive therapists reputed as anti-psychoanalytic and rejecting of that tradition in both theory and therapy, have shifted in certain aspects and thus reduced the distance between these formerly polarised conceptualisations. For example, the source of automatic thoughts are now acknowledged by cognitive psychologists as being outside the individual's awareness and these same therapists know by working backwards from the emotional and behavioural effects, such thoughts can be made explicit and are then amenable to modification. Theoretical concepts, such as cognitive schemata, illustrate another acceptance of certain unconscious processes as does acknowledgement of the tacit processes of self-organisation and core ordering.

4. The Self and System Dynamics

A fourth theme centres around the cognitive therapists' changed views on the self and system dynamics. Guidano (1987; 1991) addressed the centrality of self system issues to all forms of psychotherapy and his writings discussed the complex dynamics of the experience of self in the major psychological disorders of anxiety, depression, obsessive-compulsive and eating disorders. Whereas the earliest writings of Ellis seemed to indicate a change in self-talk will change behaviour, psychotherapists today know it is not that simple. A rediscovery of the self, the complexities of the self and the understanding of resistance and the difficulty of core personality change are central to the concerns of the 1990s cognitive therapist.

5. Emotions and Experience

A fifth theme centres around emotionality and experiential emphasis. Traditionally, the rationalist therapist viewed emotions as the sources of problems that could be corrected through reason, while the constructivist argued that emotion would have more power than reason. With the reappraisal of the role of emotions in adaption and development, cognitive psychotherapists have moved significantly in the direction of experiential aspects of therapy. Clients are encouraged to actively experience, explore and express a much broader range of affect and may be given exercises and taught techniques that originally came from experiential therapies. ‘Corrective emotional experiences’ experienced via psychoanalysis are very often similar to those reported to be important in cognitive, behavioural and humanistic approaches (Stolorow & Atwood, 1992).
6. Integration

Finally, cognitive therapists have a major role in the contemporary movement known as psychotherapy integration. They have entered into productive dialogues with colleagues from each major force in psychology. Several writers have argued that cognitive perspectives are the most promising sources of language, theory and research methods for exploring the possibility of a new psychotherapy that is open to all past understanding and co-operates in the development of new conceptualizations that will benefit individuals with any dysfunction (Alford & Norcross, 1991; Beck 1991; Goldfried 1982; 1991, Horowitz 1991).

The integration movement has equally had an undeniable impact on cognitive psychotherapy as the influence of concepts and practices from other psychological traditions have been incorporated into cognitive theory.

These six themes illustrate the commitment cognitive psychotherapists have to continuing self-examination and reflect the centrality of exploration and enquiry into the continuing coalition of psychological science and clinical science.

Cognitive Behavioural Therapy (C.B.T.)

Many researchers and clinicians, working in the area of cognitive psychology, describe themselves as Cognitive Behavioural Psychologists or Therapists as they believe the essence of their work combines aspects of both the cognitive and behavioural theory and practice.

The status of cognitive behaviour therapy, theory and practice was reviewed by Holt and Lee (1989). Their research presented the developmental dilemma that has occurred in cognitive behaviour psychology and indicates the problematic issues arising from the existing paradigmatic uncertainty. On the one hand, C.B.T. is claimed to represent a superior therapeutic approach in modifying emotional disorders (Schwartz, 1982), but on the other hand many critics cite inconsistencies in the theory and practice (Skinner, 1987). C.B.T. is a relatively recent approach in assisting persons to overcome their emotional and behavioural problems and comprises a diverse number of therapeutic procedures. Its clinical orientation is twofold: behaviour therapy and cognitive therapy. Central to the behavioural approach are the assumptions that pathological behaviour is learned from past experiences; that the cause of the pathological behaviour lies in some aspect of the environment and with manipulation of the relevant environmental variables, the individual will unlearn the pathological behaviour (Nelson & Hayes, 1983).
Central to the cognitive approach is the primacy of cognitions over emotions and behaviours. The individual’s faulty thoughts, assumptions or beliefs influence the dysfunctional behaviour and trigger negative emotions. Cognitive therapy focuses on altering the dysfunctional cognitions.

Because C.B.T. originated from these two independent paradigms, it is necessarily diverse and allows for different combinations and emphasis. Holt and Lee (1989) illustrated this when they compared the work of three leading clinicians who call themselves Cognitive Behaviour Therapists – Ellis (1962), Beck (1970) and Meichenbaum (1977).

While a commonality exists between the basic significant theoretical assumptions of these three theorists, differences occur in the particular theoretical interpretations used within different approaches. For instance, Ellis' Rational Emotive Therapy (R.E.T.) (1962) is based on the philosophical argument that people are disturbed not by the things that happen to them, but by their perception of the things that happen. Using R.E.T., Ellis attempted to persuade clients of the irrationality of their perceptions and belief systems and taught them how to check and change these thoughts, as he believed these are crucial to the development and maintenance of psychological problems. In practice, Ellis used cognitive methods such as cognitive coping strategies, cognitive distraction, imagery, cognitive modelling, semantic reduction and suggestion in combination with the behavioural methods of operant conditioning, in vivo desensitization, aversive penalties and skills training with clients.

The major tenet underlying Beck's (1970) cognitive theory of emotional disorders is that cognitive distortions are the cause of all types of psychopathology and his emphasis is on the systematic distortions in information processing that cause emotional disorders. Beck has described his therapeutic model as derived from cognitive theory, not behavioural theory, and yet acknowledges the use of behavioural procedures such as role playing and graded tasks as part of the treatment program.

The theory and therapy adopted by Meichenbaum (1977) viewed behaviour change as an interactive process between cognitions and behaviour and Meichenbaum created a self-instructional training approach for clients which used a different combination of behavioural and cognitive processes from Ellis. Meichenbaum believed rapidly occurring thought processes (cognitions) may lead to faulty behaviour and negative emotions. Meichenbaum combined cognitive modelling and verbal techniques with behavioural procedures such as role play, activity schedules and graded tasks in the treatment of clients.
All three proponents have made changes to their treatment strategies from experiences gained from their clinical work. For example, initially, R.E.T. consisted entirely of attempts to persuade clients of the irrationality of their beliefs, but subsequently Ellis developed a broader range of both cognitive and behavioural techniques (Ellis, 1977).

So, within C.B.T., there exists different combinations of treatment procedures, but there is no such amalgamation of the underlying theoretical frameworks. Empirical evidence has challenged the validity of major assumptions established in cognitive behaviour therapy and theory. Holt and Lee (1989) cited several examples which demonstrate that irrational thought processes are not an exclusive or necessary characteristic of psychopathology, but, under certain conditions, clinical and non-clinical clients may exhibit abnormal or normal cognitions. It is difficult to determine what the operative variables are in treatment success and it follows that such a lack of reliability affects the successful prediction of treatment outcomes.

Therapeutic efficacy, central to ongoing clinical work, has been difficult to ascertain and it is not possible to determine which treatment component — behavioural, cognitive or a combination — is most important in therapeutic success (Beidel & Turner, 1981; Latimer & Sweet, 1984). When behavioural techniques are used to change cognitions, it is not clear whether it is the behavioural practice that has resulted in the change or the change in the cognitions that have remediated the behaviour. Research to date has not shown whether C.B.T. methods make a significant, independent contribution to therapeutic outcome or whether these methods are just existing behavioural methods conceptualised in cognitive terms.

Investigation indicates C.B.T. has a broad, loose theoretical framework and its application is born out of a mix of select treatment strategies taken from the different clinical orientations of behavioural and cognitive therapy. With the range of existing paradigms that operate within the cognitive behaviour framework, there is some uncertainty regarding the underlying tenets of this theoretical approach. Is the emphasis on behavioural components or cognitive components? Until this issue is clarified, it is difficult to make any detailed analysis of the cognitive behaviour conceptualization and treatment of any particular disorder.

**MODELS ILLUSTRATING COGNITIVE FACTORS IN SEXUAL DYSFUNCTION**

Since the 1970s, research literature has been replete with theoretical contributions regarding cognitive factors and sexual dysfunctions, and also models to demonstrate the
influence of the individual's cognitions on their sexual functioning. The approaches have attempted to evaluate the link between cognitions and the development of sexual dysfunction. Within therapy, there have been efforts made to alter the manner in which clients view their sexuality and their relationship.

Cognition, or the manner in which individuals make sense of, or interpret, their personal world, is seen by some researchers and therapists to be the most important factor that needs to be reviewed when trying to ascertain what actually causes sexual dysfunction (Gagnon, Rosen & Leiblum, 1982).

Kreitler and Kreitler (1976; 1982) argued for the use of one framework to promote understanding of, and enable prediction in, sexual dysfunction. Cognitive approaches provide an account of how cognitive content, that is, words, meanings, beliefs and attitudes, and cognitive processes, guide human behaviour. There are a number of advantages in using cognitive approaches. Firstly, cognitive theory has a firm empirical base. Secondly, cognitive theory has been applied successfully with other disorders (Kreitler, Kreitler & Carasso, 1987). The third reason is that cognitive theory provides a systematic procedure for exploring motivation underlying overt behaviour. The fourth advantage of using cognitive theory is that it is a comprehensive theoretical framework that enables integration of various theoretical and applied approaches.

Models will now be reviewed that illustrate how cognitions can be integrated into the conceptualization and treatment of sexual dysfunction. Some of these models are designed to explain a single phase of sexual dysfunction, whereas others are more general and may be used to explain breakdown in sexual function at any stage of the response cycle.
MODEL 1: A Cognitive Model to Explain Hypoactive Sexual Desire (Southern, 1986)

Hypoactive Sexual Desire (HSD) by one partner in an intimate relationship is commonly reported, but often not fully understood, by clinicians.

Southern (1986) proposed a cognitive model that aimed to assist in understanding the sequence of cognitive processing that leads to HSD. Southern believes individuals experiencing HSD fail to discriminate cues which signal erotic situations, potential sexual activities and sexual arousal. Central to the model are the dysfunctional individual's restrictive learning history, low cognitive complexity and sexual interpretation of the situation. Cognitive complexity is conceptualized as the number of attributes used and then the way in which these are subsequently joined together in information processing and integration.

Southern believes minimal experiences or inhibiting experiences can limit cognitive development in specific situations. Thus, in the restrictive learning history, the first aspect considered in the model, the individual fails to acquire information about sexuality and fails to learn crucial skills such as sexual foreplay. This then limits the individual's cognitive complexity. There are fewer attributes which are considered sexual and they are linked in a rigid manner, so the perception of sexual opportunities or the recognition of 'desire' is profoundly affected.

Cognitive structure, in the form of generalized interpersonal self instructions, assist the individual in discriminating relevant environmental stimuli and in the development of appropriate sexual responses. Meichenbaum (1977) defined a cognitive structure as that organizing aspect of thinking that seems to monitor and direct strategy, route and choice of thoughts. According to Gagne (1964), the functions of interpersonal instructions are to focus on the sexual situation, to identify appropriate levels of performance for this situation and to recall skills necessary to enhance this performance.

In normal development, the self instructions move from verbal directives, to subvocal speech and eventually to covert or implicit generalisations which result in accurate, effort-free, efficient information processing and a healthy response. HSD results when inadequate self instructions are established in early life and are then strengthened by limited or distorted experience.

Cognitive complexity may interact with the learning histories of individuals to create differences in levels of desire. Cognitive complexity is conceptualized as being made up
of two major inter-related components: firstly, differentiation (the number of categories of information used by an individual in information processing) and integration (the number of concepts formed by joining differential attributes). Dysfunctional people are those who are low in cognitive complexity and function best while situations are highly structured, unambiguous and directly stimulating. Their behaviour is characterized by rigidity, deficient self-instructions and inability to empathise. This low cognitive complexity leads to sexual dysfunction and, in particular, low sexual desire.

According to Southern’s model, individuals presenting with HSD are likely to be low in cognitive complexity and unable to identify salient erotic attributes of potentially sexual situations. They are also unable to generate cues and self instruction that enable self interest, arousal and sexual activity, are easily distracted and most able to recall concrete sensory cues for sexual involvement.

Although the model identifies factors which may contribute to HSD, it is difficult to determine how the constructs would be operationalized for effective implementation of interventions in therapy. The other difficulty with the model is that it has been designed to explain HSD and so may not be useful for other sexual dysfunctions.

**MODEL 2: Proposed Feedback Loop of a Positive Sexual Experience to Explain Disorders of Sexual Arousal (Walen, 1980)**

Walen (1980) claimed cognitive activity can either augment or inhibit the sexual response cycle. Walen examines two major forms of cognitive behaviour: perception and evaluation. Cognitive distortions may occur in either of these two areas and are claimed to operate in most cases among individuals experiencing sexual dysfunction.

Based on Beck’s work on cognitive errors in perception which lead to depression (Beck et al., 1978), Walen applied the same reasoning to the area of sexual dysfunction. Perception involves three processes – detection, labelling and attribution. In sexual dysfunction, detection requires the individual to note the presence of a stimulus, labelling requires the individual to categorize the stimulus and attribution occurs when the individual finds an explanation for the stimulus. All three aspects can be seen in this example: “My breathing has changed, I feel I am panting, that’s because I love this man.” Cognitive errors in perception can occur in each of the three aspects.

Beck lists five cognitive errors which may be involved in the individual’s inaccurate perceptions.
1. Selective abstraction: using a detail to describe a whole experience.
2. Arbitrary inference: coming to a conclusion without, or with contrary, evidence.
3. Over-generalization: drawing a conclusion on the basis of a single event.
4. Personalization: relating events to oneself without clear evidence.
5. Dichotomous thinking: black and white thinking rather than conceptualizing attitudes and events on a continuum.

In applying these five cognitive errors to sexual functioning, Walen stated that unless the perceiver is operating as a scientist and checking out the accuracy of his/her reality by testing, sexual dysfunction is likely to occur. The second aspect of cognitive behaviour in sexual functioning considered by Walen is the evaluation of events. This entails rating events on a continuum from good to bad using Ellis’ cognitive theory of R.E.T. as a theoretical base. How the individual perceives and views the situation is the basis for thinking, feeling and behaving, according to Ellis and Harper (1975). So, the individual’s evaluation of a sexual stimulus has a major influence on his/her sexual response. When the individual’s evaluation and verdict is positive, sexual functioning will be enhanced. Likewise when the stimulus is evaluated as negative, the sexual response will be diminished. It is not necessarily what the individual is experiencing but how the individual perceives the experience. Using Ellis’ conception of awfulizing or catastrophising, exaggerated negative thinking can easily lead to negative behaviour, and in this case, sexual dysfunction. Further, irrational thinking and evaluation will result in an intense cycle of anxiety or guilt and in turn inhibit the sexual arousal of the individual.

So, by synthesising the theoretical contribution of Beck and Ellis, Walen proposed a feedback loop model of sexual arousal which illustrates eight links in the cognitive appraisal for a positive sexual experience (Figure 2.1).

![FIGURE 2.1: Proposed Feedback Loop of a Positive Sexual Experience](image)

The eight links in the chain function as both cue for the next link and a reinforcer for the preceding event. Negative sexual experiences occur when the linkages between stimuli and responses are blocked by incorrect, negative cognitions via faulty perception and/or evaluation.
Link 1 – Perception of a Sexual Stimulus

An awareness, perception or identification of the erotic stimulus is the first link in the model. The individual’s cultural conditioning may have a major influence on what he/she perceives as erotic.

Link 2 – Positive Evaluation

Once the stimulus is identified as erotic, it will be evaluated. If the evaluation is positive, then arousal may follow. If it is judged as negative, arousal will not occur. Probability of arousal will be low for those individuals who have a restricted range of sexual stimuli.

Link 3 – Arousal

An emotional response, as well as a psychological response to arousal is required. Appropriate environmental cues will assist the individual in labelling the stages of sexual arousal (increased heart rate, muscle tension) as sensations of love or sexual excitement.

Link 4 – Perception of Arousal

Accurate perception of arousal is a major aspect of good erotic functioning which will lead to further focusing on erotic sensations and increased sexual behaviour. A significant sex difference exists in the ability to detect and report erotic arousal, according to research by Heiman (1977). Females are less able than males to discriminate their own arousal since their vasocongestive arousal is not as obvious as it is for a male. There is evidence to show cultural taboos and rigid sex norms play a part in this outcome. Some women believe masturbation is inappropriate, or that women should be pleasing their partners rather than focusing on their own enjoyment.

Link 5 – Evaluation of Arousal

Sex positive attitudes are central to positive labelling of arousal. If the individual has learned to label arousal as negative, this evaluation can block the sexual arousal cycle.

Link 6 – Overt Sex Behaviour

The individual will move to initiate further sexual behaviour if he/she has accurately
labelled and evaluated the arousal. Research indicates males do this more freely and positively since females may block the arousal with negative cognitions such as, “He won’t like it if I do that”, “What will he think of me if I lose control”, for example. Thus the male may move onto sexual behaviour unaware that his partner may be at a low level of arousal at this point.

**Link 7 – Perception of Sexual Behaviour**

Individuals may augment further arousal through the accurate perceptions of their own spontaneous expressions of arousal, for example, with cries, laughter, tears or movement. These behaviours may increase cardiac output which in turn will contribute to the general arousal level. The link is broken if the individual engages in spectating or self-rating of their behaviour. The “here and now” experience of pleasure may be lost and act as a distraction from the arousal cycle.

**Link 8 – Evaluation of Sexual Behaviour**

Evaluation of one’s sexual behaviour is central to perception of sexual function or dysfunction. A distinction should be made between disturbance and dysfunction. If the dysfunction causes emotional disturbance it will further inhibit good sexual functioning. If the male is experiencing erectile problems and he and his partner view it as “just one of those odd occasions”, then it is unlikely to result in long-term dysfunction.

Any of these links in the proposed feedback loop model may be problematic for many individuals experiencing sexual dysfunction. The model attempts to facilitate the identification of which links are the troublesome cognitive linkages for the individual, thus providing a more accurate diagnosis from the therapist and leading to more appropriate therapeutic strategies and treatment for the individual.

This model has much to offer in the ongoing research for more effective understanding and treatment of individual experiencing sexual dysfunction. One of the problems with it, however, is that it addresses only one of the phases in the sexual cycle – that of arousal – and in doing so ignores the established research of Kaplan (1979) and the significance of the desire and orgasm phase. Although the model provides a theoretical understanding of the importance of cognition in influencing sexual experience, its use in the clinical setting is limited. A measure needs to be developed to assess the various links so that the therapist is able to access the point of cognitive errors with the individual and then develop a treatment programme to correct the errors and assist the individual to become sexually functional.
MODEL 3: A Cognitive Model of Anxiety to Explain Sexual Arousal (Barlow, 1986)

Historically, there has been an almost universal belief that anxiety is involved in the etiology and maintenance of sexual dysfunction. Treatment programs for a sexually dysfunctional adult are commonly centered around the need to reduce the performance/anxiety/fear construct first discussed by Masters and Johnson (1970) and later expanded upon by Kaplan (1974; 1981). However, these anxiety-based treatment programs have not met with the optimistic results they first promised. Success rates of these approaches have been reviewed by numerous researchers (e.g. Cooper, 1981; Crown & D’Ardenne, 1982; Kuriansky & Sharpe, 1981; Marks, 1981; Mills & Killman, 1982). Overall, the results are pessimistic. For more than a decade, Barlow, Cranston-Cuebas (1990), Craske, Beck (1986a) and others have attempted to carefully construct research projects aimed at evaluating the role of anxiety in sexual arousal. Rather than focus on treatment outcomes, the investigations have explored the means through which sexual anxiety may interfere with sexual responsiveness. Results from their research have indicated it is not enough to characterize the sexual functioning process based on clinical observations of men and women with sexual problems because empirical evidence exposed a different response from those with sexual function to those with sexual dysfunction. According to Cranston-Cuebas and Barlow (1990), sexually functional and dysfunctional subjects differ along five dimensions of sexual response. Differences occur in:

1. The face of demands for sexual performance – dysfunctional and functional subjects respond with different affect, the dysfunctionals report a negative or disinterested affect while the functionals report a more positive affect (Heiman & Rowland, 1983);

2. The perceptions of arousal, e.g. with dysfunctional males underestimating their level of erection while functionals overestimate their level of erection (Beck & Barlow, 1984);

3. The presentation of a non-sexual stimulus – dysfunctionals evidence no decrement in erectile responding whilst functionals show inhibition of erection under the same conditions (Viglione, 1982);

4. Attending, appraising or other processing – dysfunctionals evidence erectile inhibition whilst arousal level for functionals is unaffected (Abrahamson, 1986);

5. Increases in arousal achieved through a variety of manipulations result in a lack of inhibition or facilitation of erection for functionals whereas dysfunctionals evidence decrements in penile tumescence in response to the same conditions (Jones, Carpenter, Bruce & Barlow, 1987).
This evidence from earlier research has lead to the hypothesis that increases in autonomic arousal may result in an increasingly efficient processing of these foci to which one is simultaneously attending.

It is the findings of these lines of research which have been integrated into Barlow's model of sexual dysfunction. The model emphasises the interactive role of cognitive interference and autonomic arousal and the interplay of cognitive and physiological processes in determining sexual arousal.

Barlow conceptualized anxiety as a more loosely integrated cognitive affective structure and fear as a highly integrated response configuration.

Barlow viewed the anxiety construct as one that involves three separate response systems which may not be perfectly correlated – behavioural, cognitive and physiological. This reconceptualization of anxiety as a multi-response system has allowed a more precise investigation and empirical studies demonstrate that physiological correlates of induced anxiety do not inhibit (Beck et al., 1984) or facilitate (Barlow et al., 1983) arousal in functional individuals, but do inhibit sexual arousal in dysfunctional individuals (Beck et al., 1984).

There is a body of literature emerging which suggests that cognitive processes have an enormous influence on sexual arousal. Exploration of the cognitive process's influence on sexual arousal has lead to three lines of research for Barlow.

1. Investigations demonstrated that both functionals and dysfunctions are able to voluntarily suppress their erections in the presence of erotic stimulus. Functional men were aware they were both controlling their erections and conscious of the cognitive processes that enabled them to do so, but dysfunctions were not. This suggests that shifts in attentional focus might be the key to voluntary control.

2. Several empirical studies have been reported that look at the effects of distraction on sexual arousal. In one such study subjects were instructed to attend to sexually explicit audio tapes in one ear while simultaneously performing increasingly complex arithmetic tasks presented in the opposite ear. As subjects increased the distracting task, their remaining attention available to focus on the erotic passage diminished and corresponding decrements in sexual arousal ensued. Thus, as the distracting task became increasingly complex, subjects' penile tumescence decreased (Geer & Fuhr, 1976).

3. Investigations of the role of performance demand and sexual arousal. Results of many investigations provide evidence indicating that a) cognitive processes are involved in mediating sexual arousal and b) sexually functional and dysfunctional males appear
to process tasks that manipulate the cognitive processes in different ways. In general, what distinguishes functional from dysfunctional sexual responding is the difference in selective attention and interpretation involved in the process. Findings along this line viewed anxiety as consisting of performance demand factors and distractors.

The ongoing research has now enabled Barlow to propose a working model of sexually functional and dysfunctional processes (see Figure 2.2).

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This model has come from the empirical findings of a large number of researchers. It provides evidence of the importance of affect, both positive and negative, which is driven by cognitions in the development of sexual dysfunction. In this way, it contrasts with other models that are largely based on clinicians' observation of clients. These observations are necessarily limited and are not readily generalised to people with a broad range of sexual dysfunctions. A major strength of Barlow's model is that it is a culmination of a large number of empirical studies and so it can challenge the old tenets...
that resulted from clinical case studies that focused on anxiety, performance anxiety and the ensuing negative effects they have on sexual performance.

The results of these studies have led to the hypothesis that increases in autonomic arousal may result in an increasingly efficient processing of those foci to which one is simultaneously attending. More simply stated, the model proposes that it is a distraction process which is the mechanism of action through which many experiences act to inhibit sexual responsiveness. When combined with increased autonomic arousal, an inhibition of sexual arousal occurs via the distraction effect. Thus, it is not the physiological aspect that causes the inhibition of arousal, but the cognitive influence that leads to the dysfunctional performance.

Barlow's model highlights the interrelationships between affect, attention and sexual arousal and the effects of these on both functional and dysfunctional individuals. The model exposes the attentional deficit but does not provide an understanding of the source of the problem for the clinician. In order to adequately treat sexual problems, the clinician needs an understanding of how life events are perceived and evaluated and how this may lead to the attention deficit which in turn affects sexual arousal and culminates in sexual dysfunction.

**MODEL 4: A Script Perspective to Explain All Phases of Sexual Dysfunction (Gagnon, 1984)**

The central aspect of this model is its emphasis on the use of scripts to explain sexual functioning. The metaphor of scripts has been used by many behavioural scientists for the shaping and expression of social behaviour. As sexuality is a major aspect of the individual's behaviour, the scripting of sexual behaviour exists as an integral part of this. Through childhood and adolescence every individual develops a sexual script that acts as a record of past sexual activities, a standard for present behaviour and a plan for the future. Laws and Schwartz (1977) defined sexual scripts as a repertoire of acts that are recognised by a social group, together with rules, expectations and sanctions governing these acts and statuses. Like a blueprint, the sex script regulates five key variables: the person with whom one can have sex, what one does sexually, when sex is appropriate (time of life and specific timing), where the proper setting for sex is and why one has sex (Gagnon, 1977). Different people have different blueprints. For some people, their blueprint specifies that they only have sex with their marital partner and that this only involves intercourse, in the evening, in bed, to procreate children. For others, sex is an activity which is recreational and may involve multiple partners.
For the past two decades, Gagnon (1974) and others have been examining sexual conduct from the perspective of the use of scripts. This perspective requires the conceptualization of sexual function and dysfunction in terms of the underlying sexual scripts for the individual. As is common for all theoretical developments, scripting theory has been presented, refined, researched then further developed, refined and re-conceptualized to the point that, at present, five major conceptions form the underpinning of the concept of sexual scripting.

1. Sexual conduct is entirely historically and culturally determined and is not an exemplary function which is the same in all historical times and cultural spaces (Gagnon & Simon, 1973). What is appropriate sexual behaviour in the 1990s is very different, from a cultural perspective, from appropriate sex in the 1950s.

2. Sexual conduct has different individual and social meanings, depending on the social attributes or the persons involved and their social relationships (Gagnon, 1990). Acceptable sexual behaviour for people who are married and in their thirties is different to the accepted sexual behaviour of teenagers.

3. Sexual science is historically and culturally determined and, therefore, lacks universality. There is no fixed standard for correct sexual behaviour, but it varies according to cultural mores.

4. Sexuality is acquired and maintained as a result of the particular learning circumstance of a specific culture. Individuals learn how to be sexual in specific cultures and in specific social groups within any culture.

5. Sexual conduct and gender conduct are learned forms of social practice. There is a difference between reproductive conduct, gender conduct and sexual conduct.

Within this perspective, all social conduct is scripted, not just sexual conduct. Gagnon and Simon (1973, p.18) stated: "Scripts are involved in learning the meaning of internal states, organizing the sequences of specifically sexual acts, decoding novel situations, setting the limits on sexual responses and linking meanings from non-sexual aspects of life to specifically sexual experience".

What sexual behaviour takes place depends on the pre-existence of a script that specifies what a person will do in what circumstances, when they will do it and the feelings that will accompany the act. This will be further modified by the script according to what is appropriate for the different sexes at various ages.

Thus the individual develops a script for sexual activity and it is this script that connects the individual's feelings of desire and pleasure, or disgust and disintegration, with the bodily activities associated with touching and arousal. The response from the individual is not spontaneous but determined by the pre-existence of the script that provides
guidance as to what is or is not a sexual situation and contains those elements that link erotic life to social life in general.

Simon and Gagnon (1986) described sexual scripts as having three levels: the intrapsychic, the interpersonal and the cultural scenario. The intrapsychic script represents the individual's plans for the future, guides to current action and schemes for remembering. These scripts result from the broad cultural domain and the specific interpersonal experiences of the individual. Interpersonal scripts operate at the level of social interaction and are used in the experience of sexual activities. The acceptance and use of these scripts – which are the most cognitivist – form the basis for communication and structured social behaviour. Here the individual is an actor dealing with the expectations of others in his/her life and guiding and responding to his/her behaviour according to the behaviour of the others. These scripts are at the interface between the individual's mental life and interaction with others. The cultural scenarios can be viewed as broad guidelines for sexual behaviour that are passed from one generation to the next. The individual learns the instructions for the roles through narrative scripts which model how to enter a relationship, perform sexual behaviour and exit from this relationship. The relation between cultural scenarios, interpersonal scripts and intrapsychic scripts is complex and differs across cultures, eras and within sub-groups in cultures and individuals within the sub-group.

Scripts need to be developed through our life for enhancement of cognitive and performative aspects of sexual conduct. The script acts as a blueprint for directing sexual actions and anticipating responses from the partner as well as determining the emotional responses and meanings given to the sexual experience. Adults mostly participate in sexual behaviour or fantasies without awareness of the determining scripts and when dysfunction occurs, the individual sees the isolated event rather than the scriptual context.

Other researchers, writers and therapists argue persuasively for the significant role of perceptual and cognitive determinants in sexual dysfunction (Ellis, 1980; Gagnon et al. 1982; Lazarus, 1980; Walen, 1980), suggesting that the cognitive and interpersonal components of sexual dysfunction are better understood if seen in the context of the key script dimensions outlined below.

When the client is describing what actually occurs in the sexual encounter, it is known as a performative script. Alternatively, when the client is describing mental reactions, ideas or fantasies during the sexual experience, this script is known as a cognitive script. The former is what is actually happening whereas the latter is what is perceived to be
happening. It is essential for the therapist to ascertain from the client the type of script that is underlying their dysfunctional behaviour. Once the therapist identifies that this script clarification is in place, therapy goals can be established and the modification of dysfunctional scripts can commence. This model indicates four key attributes that exist within the dysfunctional scripts — complexity, rigidity, conventionality and satisfaction — and these attributes can act as flags for the therapist in the diagnostic phase of working with the client. The nature of these attributes is outlined below.

1. Complexity

In either cognitive or performative scripts, complexity can be assessed by noting the range of elements. Questions to assist the assessment include: Is there a variety of motives, partners, sexual activities, times and places present in the script materials? Are the cognitive scripts, those indicating how the client perceives, more complex than the performative, those indicating what is actually happening? Do they contain parallel materials and sequences? Is the repertoire of scripts interdependent or are they relatively discrete in their elements?

2. Rigidity

Rigidity refers to the degree of routine in cognitive and performative script elements. Do the scripts have the same order, contain the same people, actions, locations and times?

3. Conventionality

When scripts are unconventional it may be difficult for the therapist to maintain a value-free position. With performative scripts, the range of unacceptability may be from mild disappointment to criminal sanctions. These same issues exist in cognitive scripts where socially disapproved fantasies may evoke guilt or fear of potential performance.

4. Satisfaction

During diagnosis, the therapist may find that satisfaction is likely to be different for individuals within a relationship; it is usually the dissatisfaction of one that has lead them to therapy. Examples of questions to be resolved are: How satisfied are the individuals with the cognitive scripts they have? How pleased are they by their fantasies? Do their plans gratify them? Is the mental activity congruent with the performance satisfaction? Do they like their memories? Are they satisfied with the
concrete elements of their sexual performances in terms of who they are having sex with, what they are doing, why, and the range of contexts in which it is done? These key script dimensions need to be assessed on an individual basis as often wide disparities exist for the partners in one or more aspects.

This model suggests sexual dysfunctions can be categorized in terms of the key script dimensions and that careful assessment of these variables is crucial in leading to script modification in therapy. Therapy interventions focus on:

1. Making changes in the content of the performative script, that is, re-scripting overt behaviours to reduce performance ineptitude and incompatibilities;
2. Integrating cognitive and performative scripts to reduce discrepancies between what occurs and what is desired;
3. Re-scripting cognitive scripts which may involve addressing cognitive myths.

The goal of the therapist is to assist the client to move from dysfunctional behaviour to functional. This model uses the theory of scripting to assist the clinician in understanding the dysfunctional behaviour in terms of dysfunctional scripts. Remembering the performance of all sexual acts draws upon scripts at three levels (individual, interactional and cultural). Potential changes in sexual conduct can emerge from changes at any level of scripting, thus the therapist works to modify faulty scripts in a way that will change the client's scripts and, thereby, change the behaviour.

This perspective offers much to the understanding of the cognitive components in sexual dysfunction in that it places the dysfunction in the context of the individual's social behaviour, within which sexual conduct plays a significant part. As it is claimed that all social behaviour is scripted, so too is sexual behaviour. This model outlines the elements that are important in contributing to scripts and how these scripts contribute to sexual dysfunction. However, it fails to present a mechanism whereby the scripts can be assessed and, so, is of limited practical utility within the clinical setting.

**MODEL 5: A Model to Explain the Development of All Phases of Sexual Dysfunction Within a Relationship (McCabe, 1991)**

The four theoretical models presented so far indicate clearly the significance of a cognitive component in sexual functioning. While some treatment strategies have emerged from the therapists' use of the models, there has been no long-term empirical data collection to confirm the theories. Southern's model is confined to the desire phase of sexual dysfunction while both the Walen model and the Barlow model are concerned with sexual arousal and Gagnon's perspective suggests guidelines for clinicians but has not been operationalized and tested.
With an awareness of the limitations of any model that looks only at the desire or arousal phases of sexual dysfunction, and the need to develop a user-friendly method for clinicians, McCabe (1991) proposed a model of sexual dysfunction within a relationship (see Figure 2.3 below). This model attempts to understand the etiology of sexual dysfunction and to explain the chain of associations linking psychological factors and the development of sexual dysfunction. The model explains how a range of personal characteristics are brought by both individuals into a relationship. These personal characteristics may be derived from intergenerational factors i.e. family of origin attitudes and individual's own experiences or the current influences of the relationships on each person's life. These factors are evaluated by both parties and influence what each individual brings to the relationship. Factors operating in the relationship also form part of the evaluating process. Depending on what is perceived by each individual and the way in which each individual interprets or evaluates the perceptions, there may be a reaction to one's self, one's partner or the relationship. If the reactions are negative, rather than being directly expressed they may be indirectly expressed in the form of sexual dysfunction.

**FIGURE 2.3: Model to Explain the Development of Sexual Dysfunction Within a Relationship**

The etiological factors contributing to sexual dysfunction are grouped into one of three categories: Intergenerational, individual and relationship causes. These are summarized in Table 2.1 below.

<table>
<thead>
<tr>
<th>1. INTERGENERATIONAL FACTORS:</th>
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<tbody>
<tr>
<td>Loyalty conflicts</td>
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<td>Values</td>
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<tr>
<td>- intimacy</td>
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<tr>
<td>- sexual behaviour</td>
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<tr>
<td>Secrets</td>
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<tr>
<td>- incest</td>
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<tr>
<td>- unwanted pregnancies</td>
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<tr>
<td>- extramarital affairs</td>
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<tr>
<td>Sexual intrusiveness</td>
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<tr>
<td>Information</td>
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<tr>
<td>Silence</td>
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<tr>
<th>2. INDIVIDUAL FACTORS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Values</td>
</tr>
<tr>
<td>- Lifestyle</td>
</tr>
<tr>
<td>- Biological health and function</td>
</tr>
<tr>
<td>- Body image</td>
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<tr>
<td>- Information</td>
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<td>- Fantasies</td>
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<tr>
<th>3. RELATIONSHIP FACTORS:</th>
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</thead>
<tbody>
<tr>
<td>Anger</td>
</tr>
<tr>
<td>Control (power)</td>
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<tr>
<td>Intimacy</td>
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</tbody>
</table>

**TABLE 2.1: Predisposing and Current Factors Contributing to Sexual Dysfunction.**
Intergenerational factors are family, religious or cultural factors which result in loyalty conflicts, values, secrets, sexual intrusiveness, lack of accurate information and silence about sexual issues. The literature strongly demonstrates the existence of a relationship between childhood experiences and the transmission of family values and adult adjustment (Boszormenyi-Nagy & Spark, 1973; Harter, Alexander & Neimeyer, 1987a; Herman, 1981; Nelson, 1987; Schreiner-Engel & Schaivi, 1986).

'Being loyal' as a family group member is a major binding force on family members and result from the internalization of part of the family's belief system. Values associated with gender intimacy and sexuality are most central to family life, hence messages from the family are carried by the individual into the relationship and when these messages are negative, in relation to the expression of the individual's sexuality, the cause may be understood in terms of the influence of those intergenerational factors. For example, if the mother's attitude to sex was perceived to be always closed, it is likely the adult son or daughter will carry a negative response to sex in their relationships.

Individual factors include the values and lifestyle the individual adopts, attitudes towards bodily health, body image, also the assessment of personal attractiveness, sexuality and freedom to engage sexual fantasies. The amount of time and priority given by the individual to him/herself will determine the type of relationship formed (Avery-Clark, 1986). These individual attributes combine with those contributing factors from the family of origin and, together, influence the interactions that occur. If one partner values fitness and slim body image, negative feelings may emerge when one of the two becomes overweight. Shame and guilt are just two possible reactions to this situation and these feelings may be responsible for the sudden lack of libido experienced by the individuals.

Relationship factors include anger, control and intimacy. The individual may feel anger at the partner's misrepresentation of what married life would be or may feel controlled by new financial circumstances. The fear of intimacy may prohibit closeness for either partner. The resultant behaviour from these strong feeling experiences may exhibit in sexual dysfunction. As sexual interaction often produces intimacy, sexual dysfunction can be used to create the needed distance when the couple is feeling too close (Fish, Fish & Sprenkle, 1984).

The cognitive theoretical underpinnings for this model are based on Kelly's Construct Theory (1955). Individuals use their constructs, or thoughts, to anticipate the future. When events are familiar through repetition, the constructs may be modified to lead to more accurate predictions. The individual tests his constructs in terms of their
predictive efficiency. Individuals guess at anticipating a particular event or set of events. If the anticipated event does not occur, the construct has been invalidated and the individual must develop a new construct or must expand the old construct to include the prediction of the event that took place.

In relation to sexual experience, the construct system of an individual represents a network of meaning through which he/she can handle a variety of sexual experiences, possibly both in reality and fantasy. The construct system represents more than a system of attributions about sex: it involves an interplay of a range of meanings attributed to all factors which influence the meanings and interpretation of sexual experience. Sexual dysfunction involves a breakdown in this construing process. For example, the male observes his partner preparing for bed. She is involved in a familiar ritual of brushing her hair, perfuming herself, selecting a glamorous nightgown. He presumes, as a result of interpreting her behaviour, that they will enjoy sexual activity together tonight. However, when he makes a typical advance, that previously has lead to intimacy and foreplay, she rebukes him. He is surprised, shocked, maybe feels angry and silly and notes the loss of erection. If this scenario is repeated a few times, he is confused and sexual dysfunction could well occur.

A sexual dysfunction may indicate the development of inappropriate constructs from the transmission of intergenerational values and loyalties in one or both partners or individual difficulties. Problems in the relationship may indicate a lack of congruence between the construct systems of the two individuals involved in the sexual relationship.

This model has drawn on past research to identify the causes of sexual dysfunction and categorize them to make them more readily understandable. The model then demonstrates how these factors affect the individual, causing negative emotions which in turn may lead to sexual dysfunction. The McCabe (1991) model considers the total sexual response cycle integrating intergenerational, individual and relationship factors. Past researchers have really only considered one aspect of dysfunction or another. This has hindered the proper diagnosis and consequent treatment of clients with sexual dysfunction. This thesis considers a range of variables that integrate both theory and practical application in the diagnosis and treatment of sexual dysfunction. The resultant data will contribute to the existing knowledge in this field.

In order to operationalize this model, it is necessary to find a way to evaluate the roles played by the components of the model in the development of sexual dysfunction. This thesis attempts to address this situation.
FUTURE RESEARCH

In seeking to understand further the cognitive aspects in sexual functioning, Everaerd and Laan (1994) emphasized the importance of the individual's inaccurate perception of stimuli and the irrational processing of this information that leads to sexual dysfunction. Everaerd and Laan focused on the kinds of cognitive processes that determine the sexual experience and the ways in which such knowledge is useful in gaining more understanding of the sexual process. Behaviour is the outcome of what the individual perceives has happened or the interpretation of the experience. This conceptualization places a strong emphasis on both perception and processing.

The representations of sex in memory have been conceptualized by several theorists. Money (1980) used templates. Gagnon (1977) used scripts. Masters and Johnson's (1970) original model proposed a pre-programmed sexual mechanism that is established by adaptive sexual stimuli and then influences future sexual responses. But what Masters and Johnson's model does not show is how an inhibition of the response occurs. The models which have since developed, based on cognitive emotional theory or information processing, attempt to fill this gap. Many theorists agree that stimuli are cognitively transformed into messages that result in a sexual response and in subjective sexual experience for the individual. The stimulus is not intrinsically sexual but becomes sexual by the interpretation placed on it by the individual. Thus the perception of the stimulus is transformed in an idiosyncratic way. It seems stimuli activate the physiological component of the sexual response, but physiological arousal alone is not enough to produce the subjective sexual experience. This requires the individual awareness and definition of the response as sexual (Rosen & Beck, 1988).

It is important to remember that the same stimulus may convey numerous meanings for different individuals depending on this person's history. As well as conveying a sexual meaning, the stimuli may also elicit other emotions such as feelings of anxiety, anger or joy. The different meanings will be processed as different messages which result in divergent physiological and behavioural responses and subjective experiences.

Everaerd and Laan's (1994) findings note the difference in the perception of and processing of sexual experience among males and females. Men's sexual response may be attributed more to the contribution of sensations in the genitalia, that is, the presence of vasocongestion which is processed by the person as "I feel sexual". Women, on the other hand, seem to be more responsive to situational cues. This attention to different cues by men and women results in those cues being transformed in a different manner by the senses and so to divergent physiological, behavioural and subjective experiences.
The processing of sexual stimuli is the result of the awareness of the individual and as such can be described as the individual's conscious cognitions. But, Everaerd and Laan suggest that there may be a form of automatic processing that also influences sexual response. They observe that excitement comes in many sexual experiences without effort, that is, spontaneously. Therefore, it would seem there is both a conscious and an automatic way of processing sexual experiences. However, the automatic response requires much more research before the therapist can understand divergent physiological, behavioural and subjective responses and assist the dysfunctional client who comes seeking such advice.

CONCLUSION

While each of the models reviewed here illustrate the centrality of the cognitive components and the importance of these contributions in facilitating change for the sexually dysfunctional individual, inadequacies remain. For instance, all but one of the models fail to address the total sexual response cycle, but rather focus on the desire or arousal phase. Secondly, all the models lack the necessary operationalization required for the clinician and thus require further development. Thirdly, the models do not give a clear enough indication of the range of factors or variables that may cause breakdown in the individual's experience of his/her sexual functioning and how this may affect the relationship, thus diagnosis for treatment is hindered. These are just some of the challenges for future research.

The McCabe model (1991) will be used in this thesis. This model has been selected because it examines events from many relevant life experiences that have been previously associated with sexual dysfunction. In the evaluation of these life events, subjects' reactions are also measured. The McCabe model has been devised as a result of past research findings and is applicable to a range of sexual dysfunctioning. It must be noted that this model still requires further testing and evaluation.

The study described in this thesis addresses some of the shortcomings of the models reviewed. A measure was devised to evaluate the cognitive component of events and their impact on sexual dysfunction. Data were then obtained from sexually functional and dysfunctional respondents to determine the areas of perception in which they are different from one another. In this way the contribution of cognitive processes to sexual dysfunction could be more clearly identified.
CHAPTER 3

METHOD

Peoples' explanations for their behaviours may be referred to as cognitions. Cognitions or cognitive processes are terms used in this thesis to describe explanations for behaviours or beliefs.

Participants

Participants were drawn from a clinical and non-clinical population. All subjects volunteered to participate in the study and were assured of confidentiality.

The clinical group consisted of 16 males and 14 females from the Sexual Behaviour Clinic of Deakin University. Participants were referred from general medical practitioners, urologists and the Family Planning Association of Victoria. Participants' age ranged from 21 to 65 years. The categories of sexual dysfunction after participants completed the Sexual Dysfunction Scale (McCabe, 1992) were: for males, premature ejaculation (n=1), erectile dysfunction (n=15), and for females, dysfunction was reported as inorgasmia (n=9) and lack of desire (n=5).

The non-clinical group was matched to the clinical group on the variables of age, level of education, relationship status, socio-economic status and gender. Staff, students and their associates from Deakin University supported the request for participants. Of the 30 non-clinical respondents, 34% were post-graduate students, 20% were staff members and the remaining 48% were associates. These participants responded to advertisements placed on notice boards at both the Burwood and Toorak campuses of Deakin University (see Appendix A for a description of the participants in the study). No participants withdrew from the study after they initially agreed to participate.

Materials

1. The materials used for this study were the Cognitive Aspects of Sexual Dysfunction Measure (CASDM) and the Sexual Dysfunction Scale (SDS) (McCabe, 1992).
2. The level of sexual dysfunction was measured by using the Sexual Dysfunction Scale. This Scale determined the nature of the sexual dysfunction experiences by males and females (see Appendix A).
A dysfunctional score was obtained through combining three aspects of dysfunction: (a high weight was given to lack of sexual desire and the lowest weight was given to orgasm phase problems), the reported length of time the dysfunction has occurred (within the last 12 months, within the last 5 years, more than 5 years, during adolescence) and the reported frequency of the dysfunction (less than 10% of the time, 10%, 25%, 50%, 75% or all of the time). (McCabe & Jupp, 1989).

**Construction of Measure**

The Cognitive Aspects of Sexual Dysfunction Measure (CASDM) attempts to evaluate the roles played by the different components of the McCabe (1991) model in the development of sexual dysfunction. The CASDM is designed to evaluate the cognitive contribution to sexual dysfunction. The components, or categories, are the intergenerational, individual and relationship aspects. For each of these components a number of factors emerge as relevant, and each factor is measured with questions that evaluate the interviewee’s cognitions about the event, the effect of the event on the participant at the time it occurred and the influence this experience had on the the participant’s sense of self now, their relationship to partner now and sexual functioning now. In this way, the measure was designed to tap into the major events in participants’ lives and, more importantly, the participants’ perceptions of these events.

The evaluation of the perceived impact of the event when it occurred and the current perceived impact of the event in various areas of the respondent’s life can be said to measure whether cognitive evaluations play a significant part in sexual function, and the nature of this role. It may be that some types of evaluations impact on sexual function (for example, perceived impact on self), but others do not (for example, perceived impact on the relationship). It may be found that this impact varies from one set of variables to another. For example, impact on self may play an important role for intergenerational factors, but impact of event on relationship may play a more important role with the relationship variables. By evaluating this broad range of aspects of cognitive evaluation it will be possible not only to determine whether or not cognitions play a role in sexual functioning, but also the specific nature of this effect. The CASDM was designed to achieve this aim.

In order to determine whether the design of the CASDM was understandable and comprehensible in terms of tapping the cognitive contribution to sexual dysfunction, it was administered to two clinical and two non-clinical participants. One male and one female who were sexually dysfunctional and one male and one female who were not sexually dysfunctional were asked the following questions after completing each
section of the CASDM.
(a) Did you understand the question?
(b) Were the possible responses associated with the question appropriate and comprehensive enough to answer the question?

At the end of each category (intergenerational, individual and relationship areas), respondents were asked whether there were other issues that had not been covered within the category that should be added. The CASDM was modified on the basis of these responses to the format used in the major study.

Since there are no alternative measures that evaluate the cognitive component of sexual dysfunction, it was not possible to use a measure with the CASDM to determine if the responses were valid. Sexually dysfunctional participants completed the CASDM on their second visit. The treatment program commenced from their third visit. Because of the intervening treatment process it was not considered relevant to conduct test retest reliability analysis. The treatment intervention would alter the participant's responses and so invalidate the purpose of test retest reliability.

The CASDM is included in Appendix A. The design of the CASDM is described below.

Category 1: Intergenerational Factors

These are factors which may be brought to the relationship from the family of origin. Items were constructed for each of the six factors specified in the McCabe model. The factors being:

1. Loyalty
2. Values a – intimacy
   b – sexual behaviour
3. Secrets a – incest
   b – unwanted pregnancies
   c – extra-marital affairs
4. Sexual intrusiveness
5. Sexual information
6. Silence

Questions were developed to measure the way in which these family of origin factors influenced the individual during childhood, and the impact on current sense of self now, their relationship and sexual functioning.
For example, Factor 5 (Item 10 on CASDM): This question asks about the amount of sexual information you were given as a child.

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<thead>
<tr>
<th>CHECK ONE COLUMN FOR EACH ITEM</th>
<th>ALWAYS</th>
<th>ALMOST ALWAYS</th>
<th>FREQUENTLY</th>
<th>OCCASIONALLY</th>
<th>NOT VERY RARELY</th>
<th>NEVER OFTEN</th>
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<tbody>
<tr>
<td>(i) Do you feel your family of origin gave you sex information appropriate to your age?</td>
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<td>(ii) Were you free to ask questions on sexual issues?</td>
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<td>(iii) Did you receive informative answers?</td>
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(iv) How did you respond to this experience then?

(v) What, if any, has been the impact of this experience on

(a) your sense of self now?

(b) your relationship with your partner now?

(c) your sexual functioning now?

Scoring on Factor 5 (Item 10 on CASDM):
Part (i)-(iii)
Scores ranged from 7-1 on the table with 7 being the highest score given to the 'always' response and 1 given to the 'never' response.

Part (iv)
This response entailed a brief discussion between interviewer and interviewee and the interviewee nominated the experience as either 'positive', 'neutral' or 'negative'. These responses were scored by the interviewer as positive=3, neutral=2, negative=1.

Part (v)
Similarly there was a brief discussion on the impact and the interviewee chose the words 'positive', 'neutral' or 'negative' for the impact on (a) sense of self now, (b) relationship with your partner now and (c) sexual functioning now. This was scored the same as (iv) above.

**Category 2: Individual factors**

These variables were designed to tap into the current factors impacting on the individual. Items were constructed for each of six factors specified in the McCabe model. The factors being:

1. Values
2. Lifestyle  
3. Biological health and function  
4. Body image  
5. Information  
6. Fantasies  

These factors lie within the individual and the impact of these experiences on self now, their relationship and sexual functioning was evaluated. Questions were asked about the desire to change feelings and the possibility of doing so.

For example, Factor 4 (Item 15 on CASDM): Body Image is how we see ourselves and feel about our bodies.

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<tr>
<th>CHECK ONE COLUMN FOR EACH ITEM</th>
<th>ALWAYS POSITIVE</th>
<th>ALMOST ALWAYS POSITIVE</th>
<th>OCCASIONALLY POSITIVE</th>
<th>NEITHER POSITIVE NOR NEGATIVE</th>
<th>OCCASIONALLY NEGATIVE</th>
<th>ALMOST ALWAYS NEGATIVE</th>
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<tr>
<td>(i) HOW DO YOU FEEL ABOUT YOUR BODY?</td>
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(ii) How does this impact on  
(a) your sense of self?  
(b) your relationship with your partner?  
(c) your sexual functioning?  

(iii) Do you want to change these feeling in any way?  
(iv) Do you think it possible to change your feelings in any way?

Scoring Factor 4 (Item 15 on CASDM):  
Part (i)  
Scores ranged from 7-1, with 7 being the highest score given to the ‘always positive’ response and 1 given to the ‘always negative’ response.  
Part (ii) – (a), (b) & (c)  
This response entailed a brief discussion on the impact of the interviewee’s feelings towards his/her body and then the interviewee selected one of the three words – ‘positive’, ‘neutral’ or ‘negative’ – to describe this impact. These words were scored as positive=3, neutral=2, negative=1. This was repeated for both (b) and (c).  
Part (iii) & (iv)  
Similarly, a brief discussion occurred and the interviewees responded with a ‘yes’ or ‘no’ which was scored by the interviewer as yes=2, no=1.

**Category 3: Relationship Factors**

Influences stemming from the interaction between the couple are categorized as
relationship factors. We know that events occurring in the relationship have an impact on sexual function, so this section was designed to investigate three possible factors within the relationship that might influence sexual dysfunction. The factors evaluated were:

1. Anger
2. Control
3. Intimacy

The way these current life factors impacted on the current sense of self, relationship and sexual functioning was evaluated in this section of the questionnaire. Participants were also asked whether they wanted to change these feelings or thought it was possible to change these feelings.

For example, Factor 1 (Item 18 on the CASDM): This question focuses on the feeling of anger.

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<th>CHECK ONE COLUMN FOR EACH ITEM</th>
<th>ALWAYS</th>
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<th>OCCASIONALLY</th>
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<td>(I) DO YOU FEEL ANGRY IN THIS RELATIONSHIP?</td>
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<td>(II) DO YOU ACKNOWLEDGE THIS ANGER TO YOURSELF?</td>
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<td>(III) DO YOU ACKNOWLEDGE THIS ANGER TO YOUR PARTNER?</td>
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<td>(IV) DO YOU EXPRESS YOUR ANGER?</td>
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<td>(V) DO YOU EXPRESS ANGER WITH YOUR PARTNER?</td>
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<td>(VI) DO YOU ACHIEVE RESOLUTION WITH YOURSELF?</td>
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<tr>
<td>(VII) DO YOU ACHIEVE RESOLUTION WITH YOUR PARTNER?</td>
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</table>

(viii) How does this anger impact on
(a) your sense of self?
(b) your relationship with your partner?
(c) your sexual functioning now?
(ix) Do you want to change this impact?
(x) Do you think is possible to change this impact?

Scoring Factor 1 (Item 18 on CASDM):
Part (i)-(vii)
Scores ranged from 7-1 on the table with 7 being the highest score given to the ‘always’ response and 1 given to the ‘never’ response.

Part (viii): (a), (b) & (c)

The responses entailed a brief discussion between interviewer and interviewee on the impact of anger on sense of self and then the interviewee indicated the word best suited from ‘positive’, ‘neutral’ or ‘negative’ to describe this impact. These responses were scored as positive=3, neutral=2 and negative=1. The same discussion took place for parts (b) and (c) and were scored in the same way.

Part (ix)-(x)

Similarly, a brief discussion occurred and the interviewee’s response of ‘yes’ or ‘no’ was recorded and was scored by the interviewee as yes=2 and no=1.

The number of questions relating to the different categories varied from one category to another. The total number of items was 20. There were 11 items in the intergenerational category, six items in the individual category and three items in the relationship category.

Scoring

Category 1: Intergenerational Factors

Participants obtained a score for the impact of the event on self then, self now, relationship now and sexual functioning now.

For the impact of the event, the scores varied according to the number of questions of the event that were evaluated. For example, for Mother’s Level of Intimacy, five questions were evaluated on a 7-point Likert Scale whereas Mother’s Attitude to Sex contained seven questions which were evaluated on the 7-point Likert Scale. Thus, the scores on Mother’s Intimacy ranged from 5-35, whereas scores on Mother’s Attitude to Sex ranged from 7-49.

For impact on self then, scores ranged from 1-3, with 1 being negative and 3 being positive.

Scores on impact on self now, relationship now and sexual functioning now also ranged from 1-3, with 1 being negative and 3 being positive.

Category 2: Individual Factors

The number of questions on the items in Category 2 varied. For some items, two
questions were evaluated, for others, five questions were evaluated. For example, only two questions were evaluated for Lifestyle, but five questions were evaluated for Current Knowledge.

For Lifestyle, scores ranged from 2-14, for Information and Current Knowledge, scores ranged from 5-35.

As for Category 1, the impact of the event on self now, relationship with partner now and sexual functioning now ranged from 1-3, i.e. positive=3, neutral=2 and negative=1.

Participants were also asked whether they wanted to change, or thought it was possible to change, the various aspects of their lives. Responses were scored as yes=2, no=1.

Category 3: Relationship Factors

The number of questions for each of the items varied from seven to eight. There were seven questions evaluating Anger, eight evaluating feelings of Control and seven evaluating Intimacy.

Thus, the scores ranged from 7-42 for Anger and Intimacy and 8-56 for Control.

The impact of the event on self now, relationship with partner and sexual functioning now was scored in the same way as for the individual variables in Category 2. Scores ranged from 1-3, with 1 indicating a negative response and 3 indicating a positive response. Wanting to change and perceiving it is possible to change was scored as yes=2, no=1.

Procedure

Dysfunctional Population

After the study had received ethical approval (Appendix B), notices describing the nature and purpose of the study were given to clients attending the Sexual Behaviour Clinic. Before commencing, potential participants were required to read a ‘Plain Language Statement’ (Appendix C) describing the nature and purpose of the study and the procedures employed. Potential participants were also required to sign the Informed Consent Form (Appendix D) acknowledging that they understood they could withdraw from participation in the study at any time and any information obtained would be destroyed if requested. Participants’ responses were anonymous and confidential.
Interview times were arranged for participants and participants were interviewed in the clinical setting. The interview took approximately one hour. Both the interviewer and interviewee had a copy of the CASDM. Participants responded to questions verbally and the interviewer recorded these responses. A limitation of this format is the possibility of interviewer bias, however, it was believed that this format would provide the clearest responses.

The CASDM requested that respondents provide personal and potentially distressing information concerning aspects of their family background, sexual experiences during childhood and adolescence, current attitudes towards themselves and their previous and current symptomatology. As the researcher was aware of the potential risk of abreaction and the need to alleviate any distress caused by the procedure (although unintentional), respondents were advised of the availability of a counselling service and recommended to avail themselves of the service if they found the subject matter upsetting or distressing.

The SDS was given to participants on completion of the interview. Participants were instructed to return mail the completed questionnaire to the researcher. The SDS required participants to indicate by circling, ticking or crossing responses to questions about their history and current factors re sexual functioning. The questionnaire took about 15 minutes to complete.

**Non-dysfunctional Population**

The study required a non-clinical group to match the clinical population on variances of age, level of education, relationship status, socio-economic status and gender (see Appendix A). Advertisements for such participants were placed on university notice boards, shopping centre notice boards and workplace staff rooms. Respondents’ details were checked by the researcher and, if appropriate, an appointment was made for an interview. The interview for these participants was the same as interviews conducted for the clinical participants. At the completion of the interview, each participant was requested to complete the SDS measure and return it to the researcher by mail.

Once all questionnaires were returned, a letter thanking each respondent for their participation and a debriefing statement was forwarded.
CHAPTER 4

RESULTS

Data were obtained from 60 subjects (32 males, 28 females).

The age range for both groups was 21-65 years with a mean age of 42 years for the non-clinical subjects and 43 years for the clinical subjects.

No males from the non-clinical group reported sexual dysfunction. Three females from the non-clinical group reported sexual dysfunction with one of them reporting inorgasmia and two of them reporting lack of sexual desire.

A dysfunctional score was obtained through combining three aspects of dysfunction: the level of sexual dysfunction (a high weight was given to lack of sexual desire and the lowest weight was given to orgasm phase problems), the reported length of time the dysfunction has occurred (within the last 12 months, within the last 5 years, more than 5 years, during adolescence) and the reported frequency of the dysfunction (less than 10% of the time, 10%, 25%, 50%, 75% or all of the time).

INTERCORRELATIONS

Intercorrelations were performed to examine the correlation between sexual dysfunction and intergenerational, individual and relationship factors. These correlations examined the relationship between sexual dysfunction and the occurrence of the event, the impact of the event on self then, self now, the relationship now and sexual functioning.

Intergenerational Factors

The correlations demonstrated no significant relationship between sexual dysfunction and the Intergenerational Factors: that is, the occurrence of events in childhood or adolescence. However, there were significant negative correlations between sexual dysfunction and the perceived impact of the following events on self then: mother's attitude to sex (r = .23, p < .05), privacy issues as a young adult (r = -.22, p < .05), sexual information as a child (r = -.24, p < .01) and discussion of sex as a child (r = -.21, p < .05).
There were also significant negative correlations between sexual dysfunction and the perceived impact of the following events on self now: mother's attitude to sex \( (r = -0.31, p < 0.01) \), secrets \( (r = -0.39, p < 0.01) \), sexual information as a child \( (r = -0.29, p < 0.01) \) and discussion of sex as a child \( (r = -0.43, p < 0.001) \).

There were also significant negative correlations between sexual dysfunction and the perceived impact of the following events on the relationship: mother's attitude to sex \( (r = -0.45, p < 0.001) \), father's attitude to sex \( (r = -0.19, p < 0.05) \), secrets \( (r = -0.37, p < 0.05) \), privacy issues as a young adult \( (r = -0.20, p < 0.05) \) sexual information as a child \( (r = -0.41, p < 0.001) \) and discussion of sex as a child \( (r = -0.40, p < 0.001) \).

There were also significant negative correlations between sexual dysfunction and the perceived impact of the following events on sexual functioning: mother's level of intimacy \( (r = -0.30, p < 0.01) \), father's level of intimacy \( (r = -0.33, p < 0.01) \), mother's attitude to sex \( (r = -0.47, p < 0.005) \), father's attitude to sex \( (r = -0.29, p < 0.01) \), secrets \( (r = -0.37, p < 0.05) \), privacy issues as a young adult \( (r = -0.25, p < 0.01) \), sexual information as a child \( (r = -0.47, p < 0.001) \) and discussion of sex as a child \( (r = -0.36, p < 0.001) \).

There were no differences between the functional and dysfunctional subjects in their experiences of incest as a child. Also, there was no difference between the two groups in the perceived impact of these events on self then, self now, the relationship or sexual functioning.

**Individual Factors**

The correlation between Individual Factors and sexual dysfunction resulted in the following significant negative correlations: the impact of the event was negatively correlated with sexual dysfunction for values \( (r = -0.20, p < 0.05) \), lifestyle \( (r = -0.24, p < 0.01) \), body image \( (r = -0.32, p < 0.001) \), information \( (r = -0.22, p < 0.01) \) and sexual thoughts and fantasies \( (r = -0.20, p < 0.05) \).

There were also significant negative correlations between sexual dysfunction and the perceived impact of the event on self for the following variables: values \( (r = -0.27, p < 0.01) \), lifestyle \( (r = -0.25, p < 0.01) \), body image \( (r = -0.32, p < 0.01) \), information \( (r = -0.39, p < 0.001) \) and sexual thoughts or fantasies \( (r = -0.29, p < 0.01) \).

Significant negative correlations occurred between sexual dysfunction and the perceived impact of the event on relationship for the following variables: lifestyle \( (r = -0.19, p < 0.05) \), health and wellbeing \( (r = -0.20, p < 0.01) \), body image \( (r = -0.22, p < 0.05) \), information \( (r = -0.26, \)
p<.01) and sexual thoughts and fantasies (r=-.23, p<.05). In response to ‘want to change’ a significant negative correlation was reported on the item sexual thoughts and fantasies (r=-.27, p<.01) No significant differences were reported in response to ‘possible to change’.

**Relationship Factors**

The correlations demonstrated no significant relationship between sexual dysfunction and the occurrence of the events on the relationship. However, there was a significant negative correlation between sexual dysfunction and the perceived impact on the self in relation to intimacy (r=-.10, p<.05). There was also a significant negative correlation between sexual dysfunction and the perceived impact of the anger on relationship: (r=-.41, p<.001). There was also a significant negative correlation between sexual dysfunction and the perceived impact of the anger on sexual functioning: (r=-.24, p<.01).

In response to ‘want to change’ a significant negative correlation was reported between ‘wanting to change level of anger’ and level of sexual dysfunction (r=-.32, p<.001). There was no significant correlation between sexual dysfunction and the perception that it was possible to change any of the relationship variables.

**ANALYSIS OF VARIANCE**

In order to examine the difference between clinical and non-clinical subjects, analysis of variance calculations were conducted. The independent variables were membership of the clinical group versus the non-clinical group and the dependent variables were the occurrence of the event, impact on self then, self now, relationship and sexual functioning.

The first set of analyses completed were designed to investigate the difference between the clinical and non-clinical groups on Intergenerational Factors. The variables considered were: Mother’s Level of Intimacy, Father’s Level of Intimacy, Mother’s Attitude to Sex, Father’s Attitude to Sex, Privacy Issues as a Child, Privacy Issues as a Young Adult, Sexual Information as a Child and Discussion of Sex as a Child.
### Table 4.1: Analysis of Variance Between Clinical and Non-Clinical Subjects on Intergenerational Factors

<table>
<thead>
<tr>
<th>Intergenerational Factors</th>
<th>Event</th>
<th>Self Then</th>
<th>Self Now</th>
<th>Relationship</th>
<th>Sexual Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother's Level of Intimacy</td>
<td>0.10</td>
<td>0.02</td>
<td>1.63</td>
<td>1.83</td>
<td>8.60**</td>
</tr>
<tr>
<td>Father's Level of Intimacy</td>
<td>0.22</td>
<td>0.72</td>
<td>0.74</td>
<td>0.66</td>
<td>9.44**</td>
</tr>
<tr>
<td>Mother's Attitude to Sex</td>
<td>1.25</td>
<td>2.44</td>
<td>7.12**</td>
<td>13.33***</td>
<td>14.44***</td>
</tr>
<tr>
<td>Father's Attitude to Sex</td>
<td>0.74</td>
<td>1.16</td>
<td>3.21</td>
<td>8.79**</td>
<td>9.71**</td>
</tr>
<tr>
<td>Privacy Issues as a Child</td>
<td>0.19</td>
<td>0.00</td>
<td>0.79</td>
<td>2.09</td>
<td>2.24</td>
</tr>
<tr>
<td>Privacy Issues as a Young Adult</td>
<td>3.69</td>
<td>0.93</td>
<td>1.94</td>
<td>3.44</td>
<td>6.28**</td>
</tr>
<tr>
<td>Sexual Information as a Child</td>
<td>1.02</td>
<td>0.34</td>
<td>3.17</td>
<td>5.09*</td>
<td>5.84*</td>
</tr>
<tr>
<td>Discussion of Sex as a Child</td>
<td>0.26</td>
<td>0.46</td>
<td>7.29**</td>
<td>5.54*</td>
<td>2.66</td>
</tr>
</tbody>
</table>

* p < .05;     ** p < .01;     *** p < .001

### Table 4.1 demonstrates that:

1. There were no differences between clinical and non-clinical subjects for the occurrence of the event or the perceived impact as a child.

2. The clinical group was more likely to perceive that the following events were having a negative impact on their sense of self now: mother's attitude to sex (F=7.12, p<.01) and discussion of sex as a child (F=7.29, p<.01).

3. The clinical group was more likely to perceive that the following events were having a negative impact on their relationship: mother's attitude to sex (F=13.33, p<.001), father's attitude to sex (F=8.79, p<.01), sexual information as a child (F=5.09, p<.05) and discussion of sex as a child (F=5.54, p<.05).
4. The clinical group was more likely to perceive all variables, except for privacy issues as a child (F=2.24, p>.05) and discussion of sex as a child (F=2.66, p>.05), had a negative impact on their sexual functioning.

The second set of analyses completed were designed to analyse the difference between the clinical and non-clinical groups in Individual Factors. The variables considered were: Values, Lifestyle, Health & Well-being, Body Image, Information, Sexual Thoughts & Fantasies.

**TABLE 4.2: Analysis of Variance Between Clinical and Non-clinical Subjects on Current Factors**

<table>
<thead>
<tr>
<th>Individual Factors</th>
<th>Event</th>
<th>Self</th>
<th>Relationship</th>
<th>Sexual Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Values</td>
<td>10.20*</td>
<td>2.02</td>
<td>0.05</td>
<td>1.40</td>
</tr>
<tr>
<td>Lifestyle</td>
<td>7.28*</td>
<td>2.65</td>
<td>0.16</td>
<td>0.73</td>
</tr>
<tr>
<td>Health &amp; Well-being</td>
<td>2.72</td>
<td>0.30</td>
<td>2.60</td>
<td>0.95</td>
</tr>
<tr>
<td>Body Image</td>
<td>3.04</td>
<td>5.67*</td>
<td>4.41*</td>
<td>9.26**</td>
</tr>
<tr>
<td>Information</td>
<td>4.88*</td>
<td>3.34</td>
<td>1.07</td>
<td>1.74</td>
</tr>
<tr>
<td>Sexual Thoughts and Fantasies</td>
<td>0.25</td>
<td>1.46</td>
<td>0.83</td>
<td>1.41</td>
</tr>
</tbody>
</table>

* p < .05;  ** p < .01;  *** p < .001

**Table 4.2 demonstrates that for Individual Factors:**

1. The clinical group were more likely to have negative individual factors in the following areas: values (F=10.20, p<.01), lifestyle (F=7.28, p<.01), information (F=4.88, p<.01).

2. The clinical group were more likely to perceive that body image had a negative impact on self (F=5.67, p<.05).

3. The clinical group were more likely to perceive that the body image had a negative effect on their relationship (F=4.41, p<.05).
4. The clinical group were more likely to experience that body image had a negative effect on their sexual functioning ($F=9.26$, $p<.01$).

5. There were no differences between the clinical and the non-clinical groups in other areas.

The third set of analyses completed were designed to analyse the difference between the clinical and non-clinical groups in Relationship Factors. The variables were Anger, Control and Intimacy.

**TABLE 4.3: Analysis of Variance Between Clinical and Non-clinical Subjects on Relationship Factors**

<table>
<thead>
<tr>
<th>Relationship Factors</th>
<th>F VALUES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Event</td>
</tr>
<tr>
<td>Anger</td>
<td>3.75*</td>
</tr>
<tr>
<td>Control</td>
<td>1.38</td>
</tr>
<tr>
<td>Intimacy</td>
<td>0.14</td>
</tr>
</tbody>
</table>

* $p < .05$; ** $p < .01$; *** $p < .001$

**Table 4.3 demonstrates that for Relationship Factors:**

1. The clinical group were more likely to experience more anger ($F=3.75$, $p<.05$), to perceive that anger had a greater impact on self ($F=13.7$, $p<.001$), a more negative impact on their relationship ($F=4.95$, $p<.05$) and a more negative impact on their sexual functioning ($F=4.13$, $p<.05$).

2. There were no differences between the groups in terms of the experience of control and intimacy in the relationship nor the impact of these variables on self, relationship or sexual functioning.

In order to explore the impact of intergenerational factors on event, self then, self now, relationship and sexual functioning, the same variables as for clinical and non-clinical contrasts were used.
A median split was used to separate the subjects into high and low dysfunctional groups. The scores used to determine these groupings were subjects' scores on the Sexual Dysfunctional Scale.

The fourth set of analyses completed were designed to analyse the difference between high and low dysfunctional subjects in Intergenerational Factors.

**TABLE 4.4: Analysis of Variance Between High and Low Dysfunctional Subjects on Intergenerational Factors.**

<table>
<thead>
<tr>
<th>Intergenerational Factors</th>
<th>Event</th>
<th>Self Then</th>
<th>Self Now</th>
<th>Relationship</th>
<th>Sexual Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother's Level of Intimacy</td>
<td>0.66</td>
<td>0.86</td>
<td>1.50</td>
<td>2.47</td>
<td>8.48**</td>
</tr>
<tr>
<td>Father's Level of Intimacy</td>
<td>0.20</td>
<td>0.39</td>
<td>0.24</td>
<td>0.12</td>
<td>7.89**</td>
</tr>
<tr>
<td>Mother's Attitude to Sex</td>
<td>1.65</td>
<td>2.59</td>
<td>7.94**</td>
<td>15.00***</td>
<td>16.28***</td>
</tr>
<tr>
<td>Father's Attitude to Sex</td>
<td>0.19</td>
<td>0.99</td>
<td>1.41</td>
<td>4.11*</td>
<td>6.20**</td>
</tr>
<tr>
<td>Privacy Issues as a Child</td>
<td>0.21</td>
<td>0.08</td>
<td>0.76</td>
<td>1.43</td>
<td>0.65</td>
</tr>
<tr>
<td>Privacy Issues as a Young Adult</td>
<td>8.18**</td>
<td>2.64</td>
<td>3.38</td>
<td>4.48*</td>
<td>7.94**</td>
</tr>
<tr>
<td>Sexual Information as a Child</td>
<td>1.33</td>
<td>0.66</td>
<td>2.46</td>
<td>7.64**</td>
<td>14.10***</td>
</tr>
<tr>
<td>Discussion of Sex as a Child</td>
<td>1.29</td>
<td>2.32</td>
<td>11.37***</td>
<td>9.53**</td>
<td>5.49*</td>
</tr>
</tbody>
</table>

* p < .05;    ** p < .01;    *** p < .001

Table 4.4 demonstrates that:

1. No differences were found between subjects who have high or low sexual dysfunction for the occurrence of the event or the perceived impact as a child. The exception was for the event 'privacy issues as a young adult' (F=8.18, p<.01).

2. There were no differences between the groups in the perception of the impact of the event when it occurred.
3. Subjects with high or low sexual dysfunction were more likely to perceive the following events as having a negative impact on their sense of self now: mother's attitude to sex (F=7.94, p<.01) and discussion of sex as a child (F=11.37, p<.001).

4. Subjects with high sexual dysfunction were more likely to perceive the following events as having a negative impact on their relationship: mother's (F=15.00, p<.001) and father's (F=4.11, p<.05) attitude to sex, sexual information as a child (F=7.64, p<.01) and discussion of sex as a child (F=9.53, p<.01).

5. Subjects with high sexual dysfunction were more likely to perceive the following events as having a negative impact on their sexual functioning: all variables except privacy issues as a child (F=0.65, p<.05).

6. Due to the small number of subjects who had experienced incest as a child and the low level of reported secrets within the family as a child it was not possible to include these two variables in the analysis of variance calculations.

The fifth set of analyses completed were designed to analyse the difference between high and low dysfunctional subjects and Individual Factors.

**TABLE 4.5: Analysis of Variance Between High and Low Dysfunctional Subjects on Individual Factors**

<table>
<thead>
<tr>
<th>Individual Factors</th>
<th>Event</th>
<th>Self</th>
<th>Relationship</th>
<th>Sexual Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Values</td>
<td>17.67***</td>
<td>3.03*</td>
<td>0.48</td>
<td>0.79</td>
</tr>
<tr>
<td>Lifestyle</td>
<td>5.71*</td>
<td>1.34</td>
<td>0.64</td>
<td>3.07</td>
</tr>
<tr>
<td>Health &amp; Well-being</td>
<td>2.29</td>
<td>0.45</td>
<td>3.05</td>
<td>1.25</td>
</tr>
<tr>
<td>Body Image</td>
<td>5.70*</td>
<td>6.59**</td>
<td>2.87</td>
<td>6.40**</td>
</tr>
<tr>
<td>Information</td>
<td>7.18**</td>
<td>7.21**</td>
<td>2.81</td>
<td>3.42</td>
</tr>
</tbody>
</table>

* p < .05; ** p < .01; *** p < .001
Table 4.5 demonstrates that for Individual Factors:

1. Subjects with high sexual dysfunction were more likely to have negative individual factors in the following areas: values (F=17.67, p<.001), lifestyle (F=5.71, p<.05), body image (F=5.70, p<.05) and information (F=7.18, p<.01).

2. Subjects with high sexual dysfunction were more likely to perceive that the following events had a negative impact on self: values (F=3.63, p<.05), body image (F=6.59, p<.01) and information (F=7.21, p<.01).

3. There were no differences between the two groups in terms of impact of events on relationship.

4. Subjects with high sexual dysfunction were more likely to perceive that body image (F=6.40, p<.01) had a negative impact on sexual functioning.

The sixth set of analyses completed were designed to analyse the difference between high and low dysfunctional subjects on Relationship Factors.

**TABLE 4.6: Analysis of Variance Between High and Low Dysfunctional Subjects on Relationship Factors**

<table>
<thead>
<tr>
<th>Relationship Factors</th>
<th>Event</th>
<th>Self</th>
<th>Relationship</th>
<th>Sexual Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anger</td>
<td>3.30</td>
<td>13.46***</td>
<td>4.81*</td>
<td>5.48*</td>
</tr>
<tr>
<td>Control</td>
<td>1.25</td>
<td>1.51</td>
<td>0.01</td>
<td>1.98</td>
</tr>
<tr>
<td>Intimacy</td>
<td>0.78</td>
<td>0.16</td>
<td>0.17</td>
<td>0.61</td>
</tr>
</tbody>
</table>

*p < .05; ** p < .01; *** p < .001

Table 4.6 demonstrates that for Relationship Factors:

1. Although there were no differences between the two groups in the occurrence of anger, subjects with high sexual dysfunction were more likely to perceive that anger had a negative impact on self (F=13.46, p<.001), their relationship (F=4.81, p<.05) and their sexual functioning (F=5.48, p<.05).

2. There was no impact in any area of control or intimacy factors.
A median split was used to separate the participants into high and low dysfunctional groups. The scores used to determine these groupings were participants’ scores on the Sexual Dysfunction Scale.

Means and Standard Deviations of the participants’ perceptions of the events for each factor on the scale were compared for functional and dysfunctional participants (see Table 4.7).

**TABLE 4.7: Comparison of Means and Standard Deviations on Events Subscale of CASDM for Functional and Dysfunctional Participants**

<table>
<thead>
<tr>
<th>SCALE</th>
<th>FUNCTIONAL</th>
<th></th>
<th></th>
<th></th>
<th>DYSFUNCTIONAL</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MEAN</td>
<td>SD</td>
<td>MEAN</td>
<td>SD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHILDHOOD FACTORS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mixed loyalties</td>
<td>1.67</td>
<td>.49</td>
<td>1.67</td>
<td>.48</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother’s intimacy</td>
<td>25.23</td>
<td>6.15</td>
<td>23.9</td>
<td>6.89</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father’s intimacy</td>
<td>23.61</td>
<td>6.66</td>
<td>23.44</td>
<td>7.01</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother’s attitude to sex</td>
<td>17.35</td>
<td>11.37</td>
<td>13.64</td>
<td>9.65</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father’s attitude to sex</td>
<td>16.40</td>
<td>10.99</td>
<td>15.48</td>
<td>9.90</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Privacy as a child</td>
<td>41.56</td>
<td>10.81</td>
<td>42.30</td>
<td>11.78</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex Information as a child</td>
<td>11.04</td>
<td>7.10</td>
<td>9.25</td>
<td>6.99</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion of sex as a child</td>
<td>10.85</td>
<td>6.86</td>
<td>9.21</td>
<td>6.26</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CURRENT FACTORS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Values</td>
<td>16.04</td>
<td>3.60</td>
<td>11.40</td>
<td>4.43</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifestyle</td>
<td>10.63</td>
<td>1.90</td>
<td>9.12</td>
<td>2.87</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well being</td>
<td>22.00</td>
<td>3.45</td>
<td>20.18</td>
<td>4.92</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information and knowledge</td>
<td>29.40</td>
<td>3.52</td>
<td>25.79</td>
<td>6.10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual fantasies</td>
<td>7.85</td>
<td>2.49</td>
<td>8.06</td>
<td>2.71</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INTERPERSONAL FACTORS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anger</td>
<td>33.74</td>
<td>6.99</td>
<td>30.60</td>
<td>7.17</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>36.56</td>
<td>6.71</td>
<td>34.60</td>
<td>6.80</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intimacy</td>
<td>17.84</td>
<td>3.04</td>
<td>17.39</td>
<td>3.21</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4.7 summarizes the Means and Standard Deviations for the subscales of the CASDM for functional and dysfunctional participants. The method of obtaining these scores is outlined in Chapter 3 and a high score indicates a positive response to the subscale. For Means and Standard Deviations of items in CASDM for total sample, see Appendix A.
CHAPTER 5

DISCUSSION

This study resulted in the development of a new measure to assess factors that contribute to sexual dysfunction. The measure assesses intergenerational, individual and relationship factors for sexually dysfunctional individuals and was designed to evaluate both the event and the perception of the event. Furthermore, the measure aims to evaluate the extent to which the individual’s perceptions may impinge on their sexual functioning.

For the functional participants there was very little relationship between the family of origin factors and the current and relationship factors in the way in which the experience of events related to one another. For example, the level of mother’s intimacy as a child had little impact on current relationship factors for the functional participants.

Similar findings were found for the dysfunctional participants, although there were a larger number of significant associations between childhood and current factors. This means that events that occurred as a child for functional and dysfunctional participants seem to have little association with current individual and relationship factors. It would be expected that for dysfunctional participants there would have been strong associations between events that occurred as a child and both individual functioning and relationship functioning. Although these findings indicate the occurrence of events in childhood are not associated with current functioning, it may be the meaning associated with the event that will demonstrate an association. This will be discussed later with the analysis of variance. These results seem to differ from past studies, however, most past studies fail to have a control group. Further exploration is required with a larger number of participants to further investigate this aspect of the study.

For both functional and dysfunctional participants there were a large number of significant associations between the events of childhood. This result is not surprising as it confirms there was a strong consistency between mother’s attitude to sex, father’s attitude to sex and the level of discussion of sex and information provided as a child. These factors are acting as a coherent set of variables. These results validate the CASDM measure in that they indicate a consistency of responding that would be expected. For example, if the family environment is positive in some aspects, e.g. mother’s intimacy, it is likely to be positive in other aspects, e.g. mother’s attitude to sex, sex information as a child and discussion of sex as a child.
Equally, for dysfunctional participants where the family environment is negative in some aspects, e.g. mother’s attitude to sex, it is likely to be negative on other aspects, e.g. mother’s attitude to intimacy, father’s attitude to sex, privacy as a child, sex information as a child and discussion of sex as a child. This consistency exists for both functional and dysfunctional participants.

For both functional and dysfunctional participants, responses in the current scales showed little interaction, apart from the values scale. For both functional and dysfunctional participants, health and well-being was associated with lifestyle, whereas information and knowledge and thoughts and fantasies did not have an impact on lifestyle. These results are consistent with expectation in that lifestyle would be expected to be associated with health and well-being, but not necessarily with knowledge, thoughts or fantasies, for both functional and dysfunctional participants.

None of the individual factors impacted on the relationship scales for functional participants however, for the dysfunctional participants, there was a strong association between lifestyle and the three relationship variables. Dysfunctional participants appeared to have a flow-over from the individual factors into the relationship factors while the functional participants appeared to separate these two areas of life. So, for the dysfunctional participants, negative individual experiences affected the relationship and events in the relationship affected the individual.

This raises the issue of whether sexually dysfunctional participants are dysfunctional in many aspects of their lives and whether it is possible to separate specific aspects of dysfunction. This is an area for further research. There was no inter-relationships between the relationship scales for functional participants, but there was an association between control and anger for the dysfunctional participants. A high level of anger was associated with a high level of control. This suggests that when there is a high response on these two scales in the relationship area, this may be associated with sexual dysfunction. The nature of these relationships needs to be explored with further research.

The similarity in the way in which functional and dysfunctional participants responded to the CASDM is somewhat surprising. However, the analysis of variance, which is discussed below, demonstrates there may be differences in the way in which events are perceived by the functional and dysfunctional participants and so the cognitive processing may account for differences in the sexual functioning between the groups.

The following discussion will commence by considering the role of the event as opposed to the cognitive meaning of the event in the Intergenerational, Individual and
Relationship areas. This will be followed by a discussion of the meaning of these results in terms of the role of cognitions in the development of sexual dysfunction. The implications of these results for therapy will then be considered and finally, directions for future research will be discussed.

THE IMPACT OF EVENTS AND THEIR MEANING

Intergenerational Factors

The results of the analysis of variance indicated that the occurrence of particular events in childhood, e.g. mother’s attitude to sex, was not associated with sexual dysfunction. There was no difference between functional and dysfunctional subjects in relation to childhood experiences. These results are consistent with the findings of Greenwald et al. (1990) who found that although sexually abused subjects were more likely to have higher levels of depression and anxiety, there were no differences between the abused and non-abused groups in their levels of sexual functioning.

However, Feinauer (1989) found that women who had experienced childhood sexual abuse continued to experience sexual problems in adulthood. Most of the women reported they would respond to sexual stimulation and reach orgasm but did not enjoy the experiences.

Likewise, Johnson and Shrier (1981) found that the experience of sexual abuse in childhood had an impact on sexual functioning in adulthood. As for the other studies reviewed, Johnson and Shrier only evaluated the impact of the event and not the meaning of the event for the person who was abused. Johnson and Shrier, however, failed to have a control group and so it is not possible to determine whether the problem in sexual functioning was due to the abuse or some other variable. On the other hand, Higgins and McCabe (1994) found that sexual abuse had no impact on sexual adjustment once family background was taken into account. These findings highlight the importance of control groups in partialing out the effect of other variables when evaluating the role of sexual abuse in adult adjustment.

A review paper by Courtois (1988) examined the long term effect of abuse but did not report on the cognitive evaluation of the abuse nor the impact of this on sexual functioning. Courtois reported that incest survivors experienced high levels of sexual dysfunction, but it is not clear from the studies reviewed whether these survivors and their level of sexual dysfunction were compared to people who had not experienced abuse.
In contrast to these findings, the present study found very few incidents of incest reported. Although there was no impact of sexual abuse on sexual functioning, this finding may be due to the low number of respondents who reported sexual abuse. In order to determine the role of incest in the development of sexual dysfunction, future studies would need to utilise a larger subject pool and include people in the subject population who had and who had not experienced abuse.

Feinauer (1989), Johnson and Shrier (1981) and Courtois (1988) failed to use control groups in their research and so it is not possible to attribute the sexual problems to the abuse since people who have not been sexually abused may also experience high levels of sexual dysfunction in adulthood. As noted by Maltz and Holman (1987), there is a broad range of factors that can influence sexual functioning in adulthood and sexual abuse may not be as important as other authors have claimed.

Earlier studies have evaluated the effect of other childhood factors on sexual dysfunction in adulthood: the impact of an unhappy childhood (Raboche & Raboche, 1992), the general attitude in the family (Garrison, 1989) and the level of affection from the mother (Heiman et al., 1986). Although these authors found these aspects have an effect, the present study did not find this to be the case. This study found no difference between the functional and dysfunctional participants in the attitudes to sex in the home nor in the perceived impact of those events on the person as a child. One major difference between the groups was that these factors were more likely to be perceived by the dysfunctional group to be affecting their sexual functioning. That is, the dysfunctional group was more likely to blame events that were outside their control on their current difficulties in the sexual area, although there was no evidence that this group had experienced greater problems in these areas when they were compared to the non-clinical group. This level of blame extended to most of the variables that were assessed in the intergenerational area.

The report of mother's attitude to sex was also perceived by the dysfunctional group to be having a continued negative impact on their own sense of themselves now and also on their relationship. These findings occurred despite the lack of difference between the dysfunctional and functional groups in the reports of their mother's attitude to sex. This blaming of events which are outside the respondent's control for current difficulties in the relationship extended to father's attitude to sex, sexual information as a child and discussion of sex as a child. None of these areas indicated differences in the occurrence of events between the two groups and yet relationship difficulties were attributed by the clinical group to difficulties in these areas as a child. These results highlight the importance of people's perceptions of events and the impact of those perceptions on
current levels of adjustment. It is not the occurrence of childhood events which has caused a difference in the sexual functioning of the clinical and non-clinical subjects, but rather the way in which these events are perceived to influence the relationship and, most importantly, sexual functioning.

**Individual Factors**

Values, lifestyle, body image and information about sex were different for the dysfunctional and functional participants. These factors were strongly correlated with the level of sexual dysfunction.

Although each of the variables was strongly correlated with levels of sexual dysfunction in terms of their perceived impact on self, this relationship was not found when the respondents were divided into high and low dysfunctional groups. When this division was made and the Analysis of Variance calculated, the only difference between functional and dysfunctional groups was in the way in which body image was perceived to impact on the self.

Each of the variables was perceived to have a minimal impact on the relationship and sexual functioning. Further, respondents did not show a desire to change nor think it was possible to change any of these factors. The exception to this was that dysfunctional respondents wanted to increase their levels of sexual fantasy, but they did not perceive that this change was possible.

Although the study showed actual differences between functional and dysfunctional subjects in values, lifestyle, body image and information about sex, dysfunctional subjects did not perceive these factors impacted on their perception of sense of self, their relationship or on their sexual functioning. It is possible that these individual factors are having an influence on these dimensions of self and relationship, but they are not being acknowledged by the respondent. These aspects of people's lives can be altered by choice. Perhaps dysfunctional subjects choose not to acknowledge their importance because of their resistance to change. This is particularly evident in the lack of association between sexual dysfunction and wanting to change or perceiving it is possible to change these variables.

Ackerman and Carey (1995) found that lifestyle factors put at risk the individual's performance. Smoking and drinking alcohol, inadequate exercise, financial difficulties work-related stresses and child rearing concerns are examples of lifestyle factors that were tested. These are all non-sexual sources of anxiety but may impair the desire for sexual relations with a partner and the ability to maintain arousal. Morokoff and
Gilliland (1993) reported that erectile difficulties can occur as a result of a combination of chronic and acute stress.

All of these variables lead to anxiety or stress reactions which in turn have been shown to be associated with sexual dysfunction. Similar results were obtained in the current study, although the variables were different. Negative values, lifestyle, body image and lack of sexual information may all cause an individual to experience anxiety and stress and all of these variables were associated with sexual dysfunction. However, it is not possible to draw definitive conclusions from these results because anxiety was not directly evaluated. The potential source of anxiety, rather than the level of anxiety, was evaluated in the current study.

In a review paper, Andersen and Curanowski (1995) cited findings of Costa, Fagan, Piedmont, Ponticus and Wise (1992) which demonstrated that women seeking treatment for sexual dysfunction who scored high on neuroticism reported lower levels of sexual information and poorer body image. Both of these findings concur with the results of the present study, in that respondents with poor body image and lack of information were more likely to experience sexual dysfunction.

In each of these three studies (Ackerman & Carey, 1995; Costa et al., 1992; Morokoff & Gilliland, 1993), the researchers reported the link between affect, sexual dysfunction and cognitions. Results indicated that what the respondent is actually experiencing is not as influential as what he/she is telling himself/herself about the experience.

Ackerman and Carey (1995) indicated that performance concerns and apprehension can lead to interfering thoughts and distraction from erotic cues which, in turn, may be associated with sexual dysfunction.

Morokoff and Gilliland’s (1993) findings suggested that stresses are not associated with sexual dysfunction unless their psychological meaning signifies something important for sexual functioning with the couple. Results show an association between male unemployment and erectile dysfunction but no such association between female unemployment and sexual dysfunction is evident. It would seem the unemployed male experiences a sense of failure if he is not successful in fulfilling the traditional male gender role and this failure is expressed in impotence.

Morokoff and Gilliland’s study places emphasis on the meaning of life events rather than just the occurrence of events and the effects the meaning has on the individual’s sexual functioning.
As indicated earlier in this thesis, anxiety is well documented as being a major contributing factor associated with sexual dysfunction. Fenic D (1945) reported that anxiety contributes to various types of sexual dysfunction in men and women. Masters and Johnson (1970) introduced the concept of performance anxiety and underlined performance fear in individuals and couples to be a major concern in sexual dysfunction. Kaplan (1974, 1981), in several theoretical papers, put anxiety as the key interference in the response cycle and therefore central to sexual dysfunction. More recently, Beck (1984) and Barlow (1983) indicated the importance of determining the effects anxiety is having on the individual as their more recent studies indicate, anxiety increased arousal rather than decreased it in certain situations. Findings from Beck et al. (1984) showed a difference between sexually functional individuals and sexually dysfunctional individuals in their experiences of shock. Arousal increased for the sexually functional group but decreased for the sexually dysfunctional group. The construct of anxiety was not tested in the present study as a separate issue but there can be no doubt anxiety is experienced in the lifestyle factors.

**Relationship Factors**

Although the correlations demonstrated there was no association between sexual dysfunction and levels of anger, control and intimacy, different results were obtained when respondents were divided into high and low dysfunctional groups. Although there was still no difference between the groups in levels of control and intimacy, the dysfunctional group experienced higher levels of anger than the functional group.

This lack of association between sexual dysfunction and control and intimacy was also apparent in the perceived impact on the self and the relationship and sexual functioning. However, anger was perceived to have a negative impact on both the relationship and sexual functioning by the clinical subjects. Further, functional and dysfunctional participants were different in their perception of the impact of anger on self, relationship and sexual functioning. A higher perceived impact of anger was apparent for sexually dysfunctional subjects. Interestingly, subjects with high levels of dysfunction showed a reluctance to want to change their levels of anger.

There is much evidence from clinical impressions that discord in relationships is a common cause of sexual dysfunction. Hawton (1993) describes how these are predisposing factors that influence the individuals from childhood and are repeated later in a relationship. Where there has been disturbed family relations and a poor model of warmth it may be difficult for the couple to experience warmth together and this will impinge on their ability to create and experience intimacy. Restrictive upbringing leaves
family members with attitudes that are not conducive to open, warm, loving relations. Inadequate information in the form of sex education, perpetuation of myths and old wives’ tales provided by the parents may well disadvantage the relationship.

Kaplan (1974) wrote of the lack of intimacy inhibiting performance and creating communication difficulties for the couple which lead to sexual dysfunction. Kaplan also reported lack of cleanliness, grooming or personal hygiene as being significant in a loss of sex appeal. McCabe (1991) noted covert punishment operating in relationships where one partner would sabotage sexual involvement by raising issues of finance or child rearing at inappropriate moments. This had a negative effect and lead to loss of desire. Roffe and Britt (1981) demonstrated how sexual conflict occurs when individuals in the relationship try to meet their own power or intimacy needs.

Although it has been theorized that intimacy levels will be a factor in sexual dysfunction, the lack of impact of intimacy in this study may be due to the fact that there was no significant difference between the groups, so lack of intimacy was not a discriminating factor in this study.

**Multiple Causes of Sexual Dysfunction**

It would seem adequate sexual functioning occurs naturally for many individuals. However, for many others their sexual experience is dysfunctional. The sexual dysfunctions have both organic and psychogenic causes and a specific dysfunction can be mostly organic, mostly psychogenic or mixed. It is well established that sexual dysfunctions are invariably multi-determined and that a single cause is rare. The results of the present study demonstrate that the psychological focus for understanding the etiology of sexual dysfunction should include the psychological determinants from intergenerational factors, the individual and relationship issues. It is these specific factors from the three categories (intergenerational, individual and relationship) that are embodied in the McCabe model (1991).

Bleck and Loveless (1987) suggest an additional component to the Kaplan-Singer model of the 3-phase Sexual Cycle (desire, arousal and orgasm), that being: sexual thinking. They contend sexual thinking is a constant force throughout sexual activity as it colours every aspect of sexual experience. If, in any phase of the sexual cycle, the thinking is negative, it diminishes the pleasurable potential of the sexual response within that phase.
Bleck and Loveless see negative sexual thinking as a combination of rational thinking (left brain) which evaluates and analyses sexual behaviour and inner mind (right brain) thinking which feels and senses sexuality. Since inner mind thinking contains old messages from the past, individuals often make connections between current and previous sexual experiences. These can trigger emotions and memories that are positive or negative and, in the case of malfunctioning, highly negative.

Belief systems may be another aspect of negative sexual thinking. A belief system is a set of mental affirmations and images which have been accepted by the individual as true, self-evident and valid. Belief systems are described as insidious culprits in negative sexual thinking because they lurk behind all attitudes and values. Faulty beliefs propel expectation and this produces negative inner thinking.

The current study indicates that on the variables evaluated from the intergenerational factors there were some old messages from the past leading to negative thinking which, in turn, may be associated with sexual dysfunction. That is, there were no differences between the functional and dysfunctional subjects in terms of the occurrence of the events in childhood and the perceived impact of these events now. The only exception was mother's and father's attitude to sex. It is possible that consistent with Bleck and Loveless (1987), it may be these attitudes which currently lead to negative thinking and influence sexual dysfunction. An evaluation of a broader range of messages from the past would allow the role of these factors on sexual dysfunction to be evaluated. However, this was not done in the current study because of the difficulties in retrospective recall and the doubtful validity of such recollections.

Talmadge and Talmadge (1986) focus on the intrapsychic issues within the partners as they intersect with the interpersonal issues between them. Talmadge and Talmadge describe the sexual relationship as a vital part of the personality of the marriage. The sexual character which the relationship develops, emerges from the partners' personalities, sexual habits and behaviour. Sexual character develops as a result of the partners' interaction and the indirect and direct influence of their families of origin, their physical health and their social context.

As opposed to the findings of Talmadge and Talmadge, the current study demonstrated no significant relationship between sexual functioning and intergenerational factors. Attitudes from both the mother and father may be affecting sexual functioning, but the perception of health and lifestyle factors played very little role in the development of sexual dysfunction.
Within the current study, the contribution of only one partner was accounted for and so it is difficult to know what the other partner contributed or what the two partners together may have contributed (that is, the effect of the relationship).

Andersen and LeGrand (1991) examined the content and valence of women’s body image attitudes and found that women evaluated their body parts with two distinct measures. Firstly, general: body, facial and sexual items and secondly, assessing weight: on hips, thighs and buttocks. They noted females had a negative response style as compared to male responses on the measures. Andersen and LeGrand believed if the body image construct is to play a role in the understanding of phenomena in psychopathology - physical attractiveness, sexual dysfunction or physical illness - further theoretical and psychometric development is necessary. Consistent with the findings of Andersen and LeGrand, body image played some role in the development of sexual dysfunction in the present study.

Morokoff and Gilliland’s (1993) study indicated stressors were found to be related in a number of ways to sexual dysfunction. Erectile dysfunction was associated with unemployment, as was age. Sexual dysfunction was not associated with unemployment in women, however, unemployed women indicated a faster age-related decline in desire for sexual intercourse.

Morokoff and Gilliland hypothesized that marital satisfaction would interact with stressors in predicting sexual dysfunction. This was true for women whose husbands were unemployed and had erectile dysfunction – the less satisfying the marriage the greater the erectile dysfunction.

Morokoff and Gilliland evaluated a broad range of factors which impact on stress levels and which may lead to sexual dysfunction. They found that a number of these factors were associated with sexual dysfunction and others were not. Likewise, in the current study, a number of factors which may lead to stress were associated with sexual dysfunction. It may be that the individual factors are interpreted by people in different ways. Sometimes these interpretations lead to stress which in turn leads to sexual dysfunction and sometimes they do not. It is the individual’s interpretation that is placed on the event that is most important. Sometimes events can be having an impact but their contribution is denied (values and lifestyle). Sometimes there may be no difference between functional and dysfunctional but there is perceived to be a difference, for example, mother’s and father’s attitude to sex. It is here that the importance of the cognitive explanation is highlighted.
COGNITIVE INTERPRETATIONS OF EXPERIENCES AND ITS IMPACT ON SEXUAL FUNCTIONING

The results demonstrate that there are differences between sexually functional and sexually dysfunctional groups in the way they perceive both past events and the current events in their lives. Although there were no differences in the reporting of childhood experiences, sexually dysfunctional people were more likely to believe that the experience of these past events was currently having an impact on their sense of self, their relationship and their sexual functioning.

As stated earlier, they attributed the blame for their current level of sexual dysfunction and even other problems in their lives on events over which they had no control. These findings support the claim that it is not the experience of negative events in childhood that are associated with problems in sexual functioning in adulthood, but rather the way these events are perceived. The role of cognitions in shaping sexual functioning is also demonstrated in the difference between sexually functional and sexually dysfunctional subjects in the individual and relationship areas. Sexually dysfunctional subjects were much more likely than functional subjects to have negative values, stressed lifestyles, poor body image and lack of information. Undoubtedly, these factors were affecting levels of dysfunction. However, they were not perceived to be having an impact (except for body image) and subjects did not indicate that they either wanted to change (except for sexual thoughts) or perceived it was possible to change these aspects of their lives. Thus, the dysfunctional subjects, because of the way they perceived these events to be affecting their lives, were not motivated to alter aspects of their lives that were having a detrimental effect on their sexual functioning.

Similar findings were obtained in the Relationship area, particularly for anger in the relationship. There was a higher level of anger among sexually dysfunctional subjects than sexually functional subjects and this was perceived to be having an impact on their lives and this included the sexual functioning of those respondents. Although respondents indicated they wanted to change the level of anger in their relationship, they did not feel this change was likely to occur.

These findings suggest that although sexually dysfunctional respondents were aware of the high levels of anger in their relationship, perceived them to be having a negative impact and even indicated they wanted to change this impact, they did not feel this change was possible. They seemed to be relinquishing the responsibility of the high levels of anger in their relationship. This may be because they perceived their partner
was responsible for this aspect of the relationship and they perceived that they were not able to change (or were not prepared to change) this aspect of their relationship.

Results indicate no differences in the items Intimacy or Control on the relationship. This unexpected finding needs further exploration with a larger sample.

**COGNITIVE MODELS TO EXPLAIN RESULTS**

The first model reviewed in the introduction was developed by Southern in 1986. Although this model was only developed to explain disorders of sexual desire, many of the elements of the model have been used for people with other forms of sexual dysfunction. The essence of Southern's model is that people with sexual dysfunction do not detect situations as erotic because of their restrictive learning history and minimal levels of sexual experience. As a result, people with sexual dysfunction have a lack of sexual skills and sexual information. These people rigidly link particular events leading to sexual stimulation and are unable to perceive of other events having the potential of a sexual experience.

In contrast to Southern's model, the current study found no difference between functional and dysfunctional subjects in their learning experiences or in their level of sex information. However, the sexually dysfunctional respondents perceived their decrements in sexual functioning to be due to their restrictive upbringing and the lack of information they received about sexual issues. If Southern's model is based on perception of the impact of childhood experiences, then it is supported by the results of the present study. However, if it is based, as it seems to be, on the impact of the occurrence of particular events then it is not supportive, since there were no differences between sexually functional and sexually dysfunctional subjects in this area.

The second model reviewed in the introduction comes from Walen (1980). Walen's model was developed to explain the arousal phase of the sexual response cycle. According to Walen, sexual dysfunction is due to distortion in either the perceptions or evaluations of the individual. Perceptions involve being sensitized to events as being sexual and labelling those events as sexual. Having labelled an event as sexual, the person evaluates the event on a continuum from good to bad. This rating of the event then determines the sexual response of the individual. So, in order for a person to experience a positive sexual response, a stimulus needs to be both detected and labelled as sexual and then it needs to be evaluated in a positive manner. It is the individual's perception of stimuli rather than the objective view of stimuli which is essential in
determining the sexual response in the individual. Although the current study was not directly assessing perceptions and evaluations of events, conclusions can be drawn on these aspects of cognition. Interpreting the intergenerational variables it would seem that the way in which these events were labelled and, most particularly, the way in which they were evaluated, may be associated with sexual dysfunction among respondents in the clinical group. There were no differences between the functional and dysfunctional subjects in the occurrence of events, but consistent with Walen's model, the dysfunctional subjects were more likely to rate these events in childhood as bad in terms of the individual variables, although the dysfunctional subjects were no different from the functional subjects in the extent to which they perceived them to be having an effect. The results demonstrated that the intergenerational variables were in fact different between the two groups.

Interpreting the present study's results through Walen's model, it would seem that both functional and dysfunctional subjects detect events from both intergenerational and individual areas as sexual, but dysfunctional subjects rate the events as bad whereas functional subjects rate them as good. This difference in the way in which the stimuli are perceived leads to sexual dysfunction among the clinical group. Finally, in the relationship category, anger seems to be more likely to be detected and labelled among the dysfunctional group and then rated as being negative. This leads, in turn, to sexual dysfunction.

The results of the current study provide support for Walen's model. However, this model only provides part of the explanation for the development of sexual dysfunction and does not deal with other aspects of the cognitive process nor does it attempt to identify the particular variables that might be implicated in the area of the dysfunction.

The third model presented in the introduction was developed by Barlow (1989). Barlow's model focused mainly on the role played by sexual response in men. This model was developed essentially from empirical studies of functional and dysfunctional males. Barlow proposed that sexually functional men respond to anxiety and sexual stimuli in a different manner to sexually dysfunctional males. Functional males are more likely to attend to sexual situations, have a lower perception of a demand for performance, experience more positive affect in sexual situations and find that low levels of anxiety enhance rather than detract from their sexual performance. Barlow's model emphasised the interaction between affect, attention and sexual arousal and exposed the attention deficit experienced dysfunctional males.
The current study did not look specifically at the construct of anxiety and its impact on sexual dysfunction. It is possible that the family of origin variables resulted in different levels of anxiety between functional and dysfunctional respondents even though there was no in the occurrence of the event. The difference between the functional and dysfunctional respondents in values, lifestyle, body image and information could also result in different anxiety reactions for the individual which then may be associated with sexual dysfunction. Likewise, the higher levels of anger experienced by the sexually dysfunctional participants may also be associated with higher levels of anxiety which in turn leads to sexual dysfunction.

The results of the current study are not inconsistent with Barlow's model. However, Barlow only focused on the relationship between affect, attention and sexual arousal whereas the present study suggests other factors may effect sexual arousal. Further, Barlow did not consider which variables may lead to high levels of anxiety. His model was been developed through experimental work with males and so it is unclear how the model would generalize to the explanation of sexual dysfunction among females.

The fourth model was developed by Gagnon (1984). Gagnon's model focused principally on the scripts the individual has on various situations and how these scripts lead to sexual dysfunction. The scripts for each individual are learned from the culture in which the person is raised and they govern the behaviour of both the individual and what the individual perceives to be appropriate behaviour for males and females. These scripts shape both performance and cognition of the individual in a sexual situation. The scripts connect with the feelings and the prior experiences and then trigger the behavioural response. Sexual dysfunction may result from an individual script or the incompatibility between the scripts held by two people within a relationship.

The results of the current study are consistent with Gagnon's model. The same experiences during childhood may lead to different interpretations of these events and so different scripts will exist for the two groups. The sexually dysfunctional respondents are likely to have more negative values, to adopt a more negative lifestyle and more negative attitudes to their mothers than functional subjects, even though these variables are not generally perceived to be having an impact on sexual functioning. The higher levels of anger experienced by the dysfunctional subjects within the relationship may be due to the difference in the scripts held by the different partners and so this anger may lead to a breakdown in sexual functioning in both or one partners. Although Gagnon's model provides a mechanism whereby people may experience sexual dysfunction, it fails to identify the particular variables which may be implicated in sexual dysfunction or to predict the nature of the dysfunctional response and how this might be different for males and females.
The fifth model considered in the introduction was developed by McCabe (1991). This model proposed that intergenerational, individual and relationship factors are cognitively evaluated by each individual in a relationship. Depending upon the nature of these factors and, more importantly, the way in which they are evaluated, an individual may develop a sexual dysfunction. The current study operationalized this model by devising a measure to evaluate the components of the model to determine their relative contribution to sexual dysfunction.

The McCabe model incorporates events from many life experiences which has previously been thought to be associated with sexual dysfunction in an attempt to evaluate the cognitive assessment of the events in sexual dysfunction. The present study has allowed us to determine whether the measure, which was developed to operationalize the McCabe model, adequately assesses it, and how the predisposing and current factors contribute to the individual’s sexual dysfunction. The study also allows the contribution of the event, as opposed to the cognitive evaluation of the event, to be measured and so the extent to which the cognitive appraisal of events in a range of areas affects sexual dysfunction can be determined.

The three sections of the measure are based on the three categories of etiological factors known to cause sexual dysfunction: intergenerational, individual and relationship. It was surprising that there was little support for the impact of intergenerational factors on sexual dysfunction. Although sexually dysfunctional participants were more likely to believe that a number of the events from childhood were affecting their sense of self now and their relationship, the effect of the cognitive component on sexual dysfunction is demonstrated, for example, in mother’s attitude to sex. There were no differences between functional and dysfunctional participants in relationship to the event, but there was a difference on self now, relationship and sexual functioning. In the light of the reported importance of intergenerational factors from past studies, it is important to consider whether the outcomes from this study were affected by the sample size, the interview/questionnaire model, the retrospective recall or some other underrated variable. These issues need to be addressed in future studies, although it seems that the cognitive evaluation of intergenerational factors plays some part in the development of sexual dysfunction.

In the individual category, there were no differences between functional and dysfunctional participants in the occurrence of the event and how the participants saw that impinging on the self. For example, there were differences in the way they perceived the values, body image and information scales. There were no differences between the groups in terms of how they saw these scales affecting their relationship and only with body image did the group differ in terms of the perceived impact of these scales on their
sexual functioning. This provides limited support for the model in that the cognitive
evaluation of the individual's events as they relate to themselves is different between the
functional and dysfunctional participants. However, it was not supported in relation to
how these events may affect their relationship or sexual functioning.

In the relationship category, anger was perceived to be significant in affecting self, rela-
tionship and sexual functioning. From these findings questions can be raised about the
lack of differences between the groups for control and intimacy aspects of the relation-
ship. It seemed that it was easier or perhaps more acceptable to talk about anger than
either the constructs of control or intimacy. The issue of timing emerges here. The ther-
apist may facilitate more effective work with the sexual dysfunction clients if questions
on control and intimacy are explored at a later date and not in the first interview.

The results provide some support for the inclusion of each of the components of the
model in an explanation of sexual dysfunction. The way in which each component con-
tributes to sexual dysfunction is different, with some components having a greater
impact than others. These factors do not necessarily have an additive effect. It is possi-
ble that problems in one area may result in sexual dysfunction whereas problems in a
whole range of areas may not lead to sexual dysfunction for some individuals. It would
seem that it depends on the way in which the particular event is perceived and evaluated
by the individual as to whether a sexual dysfunction occurs.

Overall, the results of the study were not strong in their support for the model in its
entirety. It is therefore necessary to consider whether the measure adequately opera-
tionalizes the model and or whether the measure should be modified in some way. To
operationalize any theoretical model is difficult and this is perhaps the reason why there
is an absence of this endeavour in the literature on sexual dysfunction. It must be
remembered that this is a preliminary study, one that attempted to construct a measure
to evaluate the different components of sexual dysfunction. The measure achieves this
end but requires a much larger sample size to see if the same picture is occurring. If so,
refinement may be necessary. The measure as it stands is a useful tool for the therapist
for use in both diagnosis and intervention.

CONCLUSION

The present study has resulted in the development of a measure that evaluates the
cognitive components of sexual dysfunction. This is a substantial advance on other
studies that have theorized about the cognitive contribution to sexual dysfunction but
have not developed a measure to assess this contribution. With this study, it has not been possible to validate the measure (CASDM) against other measures because of the lack of comparable instruments that assess the cognitive components in sexual dysfunction. However, the findings from the present study are consistent with other cognitive theories of sexual dysfunction and this would seem to lend some support to the validity of the instrument. The results suggest that people with sexual dysfunction have difficulty being aware or understanding the process contributing to their sexual dysfunction. They are more likely to blame events in their past (although there are no differences between functional and dysfunctional people), to blame their anger on their partner and are less likely to perceive their current lifestyle patterns, which are in fact different from functional people, to be responsible for their sexual dysfunction.

For therapy with sexually dysfunctional people to be successful, it would seem that the role of their cognitions must be considered. Their views about past events need to be addressed and they need to become aware of the role their current lifestyle and their relationship is playing in their sexual dysfunction. They need to perceive that it is possible to change their perceptions on aspects of their lives and their relationship and have a desire to change these perceptions. For the current population, there was neither a perception that change could occur nor was there a real desire to change. Before therapy can be successful, these attitudes would need to be identified and addressed in therapy.

**IMPLICATIONS**

There are limitations to the interpretations of the present results and their generalizability to other populations. The sample size of thirty clinical and thirty non-clinical subjects is restrictive and results can only be interpreted as those of a pilot study. Also, within that clinical sample, the range of sexual dysfunction was limited. The most common dysfunction for males was erectile failure while for females it was inorgasmia. Results from this population would indicate a very low percentage of people experience other dysfunctions such as lack of desire (males) and vaginismus (females). We know this to be incorrect. People in the study were all Anglo-saxon and so whether these results would apply to other cultural groups needs to be determined. The setting of the clinic in university grounds may have prohibited some clients from presenting as may the fee charged for services. On enquiry into the clinical population, it is clear that a commonality exists in the educational and socio-economic status of the people, thus biasing the sample accordingly. Although the impact of events and cognitions were evaluated by the measure (CASDM), the actual emotional responses were not, for example, anxiety, stress and guilt. So, no conclusive statement can be made
about the role of feelings in the development of sexual dysfunction. Another issue is that the results of the current study were reliant on what happened to the individual as a child and their reactions to the event at the time. The validity of these reports is unknown due to retrospective recall. On the other hand, it could be argued that whether the events were negative or positive, reactions occurred or not, it is the perception of the events and the emotional reactions that is the context of the research. So, it is not what happened to the person, but how the person perceives what has happened. If one is of the view that there needs to be accurate recall of the events and retrospective data are not acceptable, then one would need to conduct a longitudinal study in order to understand the role of events, and the reaction to these events at the time, on sexual dysfunction.

FUTURE RESEARCH

These findings demonstrate the importance of cognitions and their association with sexual functioning. Gender differences need to be further explored.

It is clear both researchers and clinicians must continue to collaborate if the work is to move forward. Clinicians should not simply deal with the past events and present behaviours of the client, but focus on the client’s perceptions of these events and how they may be associated with dysfunction. It is necessary to work with the clients to help them move to the point where they want to change and perceive it is possible to change their dysfunctional behaviours.

This study is a first attempt at operationalizing a model that explores the impact of cognitions on sexual dysfunction. The CASDM requires some refinement if it is to be a useful diagnostic tool for the clinician to facilitate the client’s expression and understanding of the sexual dysfunction. In this study the interviewer was not blind to the group membership of respondents. In future studies it would be useful for the interviewer to be unaware of the dysfunctional status of respondents as this may influence the interpretation of responses.

As with all clinical research, the ultimate goal remains to relieve suffering associated with functional impairment in sexuality through the development of more efficient and effective treatment techniques. Future research should endeavour to focus on this ultimate goal.
REFERENCES


APPENDIX A

ASSESSMENT INSTRUMENT:

COGNITIVE ASPECTS OF SEXUAL DYSFUNCTION MEASURE
(COBAIN, 1993)

SEXUAL DYSFUNCTION SCALE
(McCABE, 1991)

BACKGROUND INFORMATION

MEANS AND STANDARD DEVIATIONS
COGNITIVE ASPECTS OF SEXUAL DYSFUNCTION MEASURE

(CASDM)

Marilyn Cobain
1. If you were required to make a choice between attending an important celebration for someone from your family of origin (for example, mother, father, brother) or your spouse because the celebration occurred on the same day, at the same time:

(i) What would you do?

(ii) What would you think?

(iii) How would you feel?

(iv) Has this ever happened to you?

If no, go to Question 2. If yes, continue.

(v) What impact, if any, do you think the above process has had on

(a) you now?

(b) your relationship with your partner now?

(c) your sexual functioning now?
2. On the scale below record how you see your mother's level of intimacy with people when you were a child.

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<tr>
<th>Check one column for each item</th>
<th>Always close</th>
<th>Almost always close</th>
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(vi) How did you respond when you were a child to your mother's level of intimacy with you?

(vii) What influence, if any, do you think this experience has had on

(a) your sense of self now?

(b) your relationship with your partner now?

(c) your sexual functioning now?
3. On the scale below record how you see your father’s level of intimacy with people when you were a child.

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(vi) How did you respond when you were a child to your father’s level of intimacy with you?

(vii) What influence, if any, do you think this experience has had on

(a) your sense of self now?

(b) your relationship with your partner now?

(c) your sexual functioning now?
4. On the scale below record how you see your mother’s attitude to sex.

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<tr>
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<td>(i) Mother with your father when you were growing up?</td>
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<td>(iii) Mother with you as an adolescent?</td>
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<td>(iv) Mother with you and masturbation?</td>
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<td>(v) Mother with the concept of sex before marriage?</td>
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<td>(vii) Mother with community attitudes to sex?</td>
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(viii) How did you respond as a child to the messages you were receiving from your mother?

(ix) What influence, if any, do you think your mother’s attitude to sex has had on

(a) your sense of self now?

(b) your relationship with your partner now?

(c) your sexual functioning now?
5. On the scale below, record how you see your father's attitude to sex.

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<td>(iii) Father with you as an adolescent?</td>
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(viii) How did you respond as an adolescent child to the messages you were receiving from your father?

(ix) What influence, if any, do you think your father's attitude to sex has had on

(a) your sense of self now?

(b) your relationship with your partner now?

(c) your sexual functioning now?
6. From your childhood do you have memories of incestuous experiences between you and any member of your family?

If no, go to Question 7.
If yes, answer Questions 6 (i) to 6 (xii).

(i) You and mother? [ ] Yes [ ] No
(ii) You and father? [ ] Yes [ ] No
(iii) You and grandmother? [ ] Yes [ ] No
(iv) You and grandfather? [ ] Yes [ ] No
(v) You and aunt? [ ] Yes [ ] No
(vi) You and uncle? [ ] Yes [ ] No
(vii) You and brother? [ ] Yes [ ] No
(viii) You and sister? [ ] Yes [ ] No
(ix) How did you respond as a child to the messages you were receiving from your mother?

(x) What influence, if any, do you think your mother's attitude to sex has had on

(a) your sense of self now?

(b) your relationship with your partner now?
(c) your sexual functioning now?

(xii) Do you think anything can be done about this?

(xii) Do you want to change the impact of this event?
7. (i) Were there any sexual occurrences in your family which your parents attempted to keep secret from you when you were a child?

☐ Yes  ☐ No

If no, go to Question 8.
If yes, complete Question 7 (ii) to 7 (iv).

(ii) What were these secrets?

(iii) How did you respond to these secrets then?

(iv) What influence, if any, has this experience had on

(a) your sense of self now?

(b) your relationship with your partner now?

(c) your sexual functioning now?
8. This question asks about your level of privacy as a child.

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<td>(i) Generally did you experience sexual privacy as a child?</td>
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<td>(ii) In regard to censorship of books and films?</td>
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<td>(iv) Generally could you choose your friends?</td>
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<td>(v) Did you experience questions, quizzing after time alone?</td>
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<td>(viii) Was there bathroom privacy?</td>
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(ix) How did you respond to this level of privacy then?

(x) What influence, if any, has this experience had on

(a) your sense of self now?

(b) your relationship with your partner now?

(c) your sexual functioning now?
9. This question asks about your level of privacy as a young adult.

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<tr>
<td>(i) Generally did you experience sexual privacy as a young adult?</td>
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(ix) How did you respond to this level of privacy then?

(x) What influence, if any, has this experience had on

(a) your sense of self now?

(b) your relationship with your partner now?

(c) your sexual functioning now?
10. This question asks about the amount of sexual information you were given as a child.

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<tr>
<td>(i) Do you feel your family of origin gave you sex information appropriate to your age?</td>
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<td>(ii) Were you free to ask questions on sexual issues?</td>
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<td>(iii) Did you receive informative answers?</td>
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<td>(iv) How did you respond to this level of privacy then?</td>
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<td>(v) What influence, if any, has this experience had on</td>
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<td>(a) your sense of self now?</td>
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<td>(b) your relationship with your partner now?</td>
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<td>(c) your sexual functioning now?</td>
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11. This question asks about the level of discussion about sex you had in your family as a child.

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<td>(i) Generally were sexual matters kept silent in your family of origin?</td>
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<td>(ii) Was there denial about sex?</td>
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<td>(iii) Was there a refusal to acknowledge sexual issues?</td>
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(iv) How did you respond to this level of privacy then?

(v) What influence, if any, has this experience had on

(a) your sense of self now?

(b) your relationship with your partner now?

(c) your sexual functioning now?
12. We express relative value on various parts of our lives. We express our personal values through thinking, feeling and behaving in particular ways.

(i) What do you place high value on?

(ii) What do you place low value on?

(iii) In your value system, where do you place your sexual functioning?

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<td>(iv) Is your sexual functioning satisfactory for you?</td>
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<td>(v) Is your sexual functioning satisfactory for your partner?</td>
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<td>(vi) Is your sexual functioning satisfactory for the relationship?</td>
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(vii) What influence, if any, do you think your values have on

(a) your sense of self?

(b) your relationship with your partner?
(c) your sexual functioning?

(viii) Do you want to change your values in any way?

(ix) Do you think it is possible to change your values in any way?
13. **Lifestyle is how we spend our time. This can affect our levels of energy, enthusiasm, enjoyment, anxiety, fatigue, tension.**

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<tr>
<td>(i) Are you satisfied with your present lifestyle for yourself?</td>
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<td>(ii) Are you satisfied with your present lifestyle from the relationship point of view?</td>
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(iii) What influence, if any, has this experience had on

(a) your sense of self?

(b) your relationship with your partner?

(c) your sexual functioning?

(iv) Do you want to change your lifestyle in any way?

(v) Do you think it possible to change your lifestyle in any way?
14. A person’s health and well-being has an effect on his/her functioning.

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<td>(i) How would you describe your general state of well-being?</td>
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<td>(ii) Generally how would you describe your mental health?</td>
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<td>(iii) Generally how would you describe your physical health?</td>
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<td>(iv) Generally how would you describe your emotional health?</td>
<td>( ) ( ) ( )</td>
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</tr>
</tbody>
</table>

(v) Are you aware of any health problems?  
☐ Yes  ☐ No

If no, go to Question 14 (vii).

(vi) If yes, describe your health problems.

(vii) What influence, if any, has been the impact of your health on

(a) your sense of self?

(b) your relationship with your partner?
(c) your sexual functioning?

(viii) Do you want to change your health and well-being in any way?

(ix) Do you think it is possible to change your state of health and well-being in any way?
15. Body image is how we see ourselves and feel about our bodies.

<table>
<thead>
<tr>
<th>Check one column for each item</th>
<th>Always positive</th>
<th>Almost always positive</th>
<th>Occasionally positive</th>
<th>Neither positive nor negative</th>
<th>Occasionally not negative</th>
<th>Almost always negative</th>
<th>Always negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) How do you feel about your body?</td>
<td>( )</td>
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</tr>
</tbody>
</table>

(ii) How does this impact on

(a) your sense of self?

(b) your relationship with your partner?

(c) your sexual functioning?

(iii) Do you want to change these feelings in any way?

(iv) Do you think it is possible to change your feelings in any way?
16. This question focuses on the amount of information and knowledge you have about your sexuality and sexual behaviour.

<table>
<thead>
<tr>
<th>Check one column for each item</th>
<th>Always always</th>
<th>Frequently</th>
<th>Occasionally</th>
<th>Not very often</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Do you feel sufficiently informed about your sexuality?</td>
<td>( ) ( ) ( )</td>
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</tr>
<tr>
<td>(ii) Do you feel sufficiently informed about sexual behaviour?</td>
<td>( ) ( ) ( )</td>
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<td>( )</td>
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</tr>
<tr>
<td>(iii) Do you know what is enjoyable for you in the sexual area?</td>
<td>( ) ( ) ( )</td>
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</tr>
<tr>
<td>(iv) Can you discuss these matters with your partner?</td>
<td>( ) ( ) ( )</td>
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<tr>
<td>(v) Can you discuss these matters with anyone?</td>
<td>( ) ( ) ( )</td>
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</tbody>
</table>

(vi) How does this impact on

(a) your sense of self?

(b) your relationship with your partner?

(c) your sexual functioning?
17. Many people experience sexual thoughts and fantasies.

<table>
<thead>
<tr>
<th>Check one column for each item</th>
<th>Always</th>
<th>Almost always</th>
<th>Frequently</th>
<th>Occasionally</th>
<th>Not very often</th>
<th>Rarely</th>
<th>Never</th>
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</thead>
<tbody>
<tr>
<td>(i) Do you have sexual thoughts?</td>
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<tr>
<td>(ii) Can you discuss these matters with anyone?</td>
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</table>

(iii) When do you have sexual thoughts?

(iv) How do you feel about your thoughts?

(vi) How do these thoughts impact on

(a) your sense of self?

(b) your relationship with your partner?

(c) your sexual functioning?

(vii) Do you want to change this in any way?

(viii) Do you think it is possible to change this in any way?
18. This question focuses on the feeling of anger.

<table>
<thead>
<tr>
<th>Check one column for each item</th>
<th>Always</th>
<th>Almost always</th>
<th>Frequently</th>
<th>Occasionally</th>
<th>Not very often</th>
<th>Rarely</th>
<th>Never</th>
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</thead>
<tbody>
<tr>
<td>(i) Do you feel angry in this relationship?</td>
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<tr>
<td>(ii) Do you acknowledge this anger to yourself?</td>
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<tr>
<td>(iii) Do you acknowledge this anger to your partner?</td>
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<tr>
<td>(iv) Do you express your anger?</td>
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<tr>
<td>(v) Do you express anger with your partner?</td>
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<tr>
<td>(vi) Do you achieve resolution with yourself?</td>
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<tr>
<td>(vii) Do you achieve resolution with your partner?</td>
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</tbody>
</table>

(viii) How does this anger impact on

(a) your sense of self?

(b) your relationship with your partner?

(c) your sexual functioning now?
(ix) Do you want to change this impact?

(x) Do you think it is possible to change this impact?
19. This question focuses on the feelings of control.

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<th>Almost always do</th>
<th>Occasionally do</th>
<th>Neither do nor do not</th>
<th>Occasionally do not</th>
<th>Almost always do not</th>
<th>Always do not</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Do you feel you have a sense of control in your life?</td>
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<tr>
<td>(ii) Are you satisfied with the amount of control in your life?</td>
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<tr>
<td>(iii) Are you too controlled in your life?</td>
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<tr>
<td>(iv) Are you too controlling in your life?</td>
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<tr>
<td>(v) Do you feel you have a sense of control in your relationship?</td>
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<tr>
<td>(vi) Are you satisfied with the amount of control in your relationship?</td>
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<tr>
<td>(vii) Are you too controlled in your relationship?</td>
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<tr>
<td>(viii) Are you too controlling in your relationship?</td>
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</tbody>
</table>

(ix) How does the level of control impact on

(a) your sense of self?

(b) your relationship with your partner?
(c) your sexual functioning now?

(x) Do you want to change this impact?

(xi) Do you think it is possible to change the impact?
20. This question focuses on the feelings of intimacy.

(i) Describe what you mean by intimacy.

(ii) How do you feel about intimacy?

(iii) How do you behave intimately?

<table>
<thead>
<tr>
<th>Check one column for each item</th>
<th>Always</th>
<th>Almost always</th>
<th>Frequently</th>
<th>Occasionally</th>
<th>Not very often</th>
<th>Rarely</th>
<th>Never</th>
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</thead>
<tbody>
<tr>
<td>(iv) Do you experience intimacy with your significant same sex friends?</td>
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<tr>
<td>(v) Do you experience intimacy with your significant opposite sex friends?</td>
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<tr>
<td>(vi) Do you experience intimacy with your partner?</td>
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</tbody>
</table>

(vii) How do you think your experiences of intimacy impact on

(a) your sense of self?

(b) your relationship with your partner?

(c) your sexual functioning now?
(viii) Do you want to change this impact?

(ix) Do you think you can change this impact?
SEXUAL FUNCTION SCALE
HISTORY AND CURRENT FACTORS

MARITA P. McCABE, Ph.D., F.A.Ps.S.

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School of Psychology
Deakin University
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Burwood
Victoria
Australia 3125
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Introduction

This questionnaire is aimed at understanding your sexual education, behaviour, attitudes, beliefs and issues related to your relationships.

It is important that in answering this questionnaire you are as open and honest as possible.

The information obtained from you will be held in the strictest confidence.
1. What is your gender?  
   [ ] Male  [ ] Female

2. What is your age (in years)?  
   _______ years

**CHILDHOOD**

**A. ATTITUDES TOWARD SEX IN THE HOME**

1. Was religion an active factor in your life when you were a child?

   Never  Rarely  Sometimes  Frequently  Always

2. (a) Were you allowed to ask questions about or discuss sexual topics when you were a child?

   Never  Rarely  Sometimes  Frequently  Always

   _______ Unable to remember

   (b) Did you feel that your mother would be uncomfortable if you asked questions about sex?

   Never  Rarely  Sometimes  Frequently  Always

   _______ Didn't know

   (c) Did you feel that your father would be uncomfortable if you asked questions about sex?

   Never  Rarely  Sometimes  Frequently  Always

   _______ Didn't know
3. In what way did your parents display affection to each other?

[TICK ONE BOX]

- Verbally
- Physically
- Both verbally and physically
- Not at all
- Other (please specify)

4. (a) Was your mother affectionate to you when you were a child?

[Never | Rarely | Sometimes | Frequently | Always]

4. (b) Was your father affectionate to you when you were a child?

[Never | Rarely | Sometimes | Frequently | Always]

5. (a) What was your mother's attitude toward sexuality when you were a child?

[Very positive | Positive | Neutral | Negative | Very negative]

Don't know

5. (b) What was your father's attitude toward sexuality when you were a child?

[Very positive | Positive | Neutral | Negative | Very negative]

Don't know
6. What influence did your brothers, sisters and/or friends have on how you thought about sex at this time?

<table>
<thead>
<tr>
<th>No influence</th>
<th>A small influence</th>
<th>Some influence</th>
<th>Substantial influence</th>
<th>Major influence</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

B. EMERGING SEXUALITY

1. (a) At what age do you recall first having pleasurable genital feelings?

   _______ years _______ Not applicable

(b) How did you feel about these sensations?

<table>
<thead>
<tr>
<th>Very bad</th>
<th>Bad</th>
<th>Unsure</th>
<th>Good</th>
<th>Very good</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

   _______ Not applicable

2. (a) At what age did you first experiment with masturbation?

   _______ years _______ Not applicable

(b) How often did you engage in masturbation as a child?

<table>
<thead>
<tr>
<th>Very frequently</th>
<th>Frequently</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

   _______ Not applicable

(c) How did you feel about masturbating?

<table>
<thead>
<tr>
<th>Very good</th>
<th>Good</th>
<th>Unsure</th>
<th>Bad</th>
<th>Very bad</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

   _______ Not applicable
3. Do you remember any upsetting sexual experiences that occurred during childhood?
   □ Yes □ No
   (If YES, describe)

   
   
   
   

PUBERTY AND ADOLESCENCE

A. SEXUAL EDUCATION

FEMALES ONLY

The following section is for females only. All males please go to question 2 on page 8.

1. (a) At what age did you start to menstruate? _______ years
   
   (b) Had menstruation been explained to you in advance?
       □ Yes □ No

   (c) How was menstruation explained to you?

       TICK ONE BOX

       □ By film, books
       □ Verbally
       □ By all the above methods
(d) Who explained menstruation to you? 

- Parent
- Peer
- Teacher, doctor or older acquaintance
- Sibling
- Other person

(e) By placing a cross on the line below, indicate how you felt after menstruation had begun.

Very negative  Negative  Unsure  Positive  Very positive

(f) Did you ever have any menstrual difficulties during adolescence?

Very frequently  Frequently  Sometimes  Rarely  Never

**MALES ONLY**

This section is for males only.

2. (a) How old were you when you had your first nocturnal emission (or "wet dream")?

   ________ years

(b) Had you been told about these in advance?

- Yes
- No

(c) How had you been told? 

- By film, books
- Verbally
- Both of the above
(d) Who told you?

[ ] Parent
[ ] Sibling
[ ] Peer
[ ] Teacher, doctor
[ ] Other person

(e) By placing a cross on the line below, indicate what your reaction was when you first experienced a wet dream.

Very negative | Negative | Unsure | Positive | Very positive

ALL RESPONDENTS

This section is for all respondents, males and females.

B. DATING BEHAVIOUR

1. (a) At what age did you start to date in groups? _______ years

(b) At what age did you start single dates? _______ years

C. PETTING BEHAVIOUR

1. What kinds of petting did you engage in on dates during the adolescent period?
   (a) kissing: [ ] Yes [ ] No
   (b) breast fondling [ ] Yes [ ] No
   (c) genital fondling [ ] Yes [ ] No
2. How frequently did you have sexy thoughts or fantasies during adolescence?

Never | Rarely | Sometimes | Frequently | Always

3. By placing a cross on the line below, indicate what kind of emotional relationship you had to have with someone before you would become involved in petting.

Casual | Some involvement | Steady | Date | Committed | Very committed

4. By placing a cross on the line below, indicate how you responded sexually to these behaviours.

No sexual response | Some sexual response | Definite sexual response | High sexual response | Orgasm

5. By placing a cross on the line below, indicate how you felt about engaging in these behaviours?

No feelings of guilt | Somewhat guilty | Guilty | Strong feelings of guilt | Very strong feelings of guilt

6. Did you ever have any negative petting experiences?

☐ Yes ☐ No

If YES, give details
D. COITAL EXPERIENCES DURING ADOLESCENCE

1. How frequently did intercourse usually occur on dates during adolescence?

Never            Rarely            Occasionally          Frequently          Always

2. Which one of the following conditions was needed by you to have intercourse with someone during adolescence?

TICK ONE BOX

- No emotional involvement was necessary
- Being emotionally involved in some way
- Being in love with each other
- Committed to a long-term relationship
- Engagement
- Marriage

3. What feelings usually accompanied premarital intercourse during adolescence?

- Satisfaction
- Guilt
- Pleasure
- Embarrassment
- Anxiety
- Not applicable

4. Did you ever have any problems with the following during adolescence?

(a) Pain during sex

   Yes  No

(b) Sexually transmitted disease

   Yes  No
5. (a) What form of contraception did you use during adolescence?

TICK ONE OR MORE BOXES

- None
- Pill, IUD, diaphragm
- Condom, spermicidal creams
- Withdrawal
- Rhythm method or Billings Method
- Sterilization of either male or female
- Other (give details)

(b) Who took responsibility for contraception?

TICK ONE BOX

- Generally the male
- Generally the female
- Shared responsibility relatively equally
- Not applicable

E. OTHER EXPERIENCES

1. During adolescence did you read or view erotic material?

<table>
<thead>
<tr>
<th>Never</th>
<th>Less than once a month</th>
<th>Once a month</th>
<th>Weekly</th>
<th>Daily</th>
</tr>
</thead>
</table>

2. (a) Did you have any sexual encounters with a member of the same sex during adolescence?

[ ] Yes  [ ] No
If YES,
(b) What was the nature of this sexual encounter?

If YES,
(c) by placing a cross on the line below, indicate how you felt about this experience.

<table>
<thead>
<tr>
<th>Very negative</th>
<th>Negative</th>
<th>Unsure</th>
<th>Positive</th>
<th>Very positive</th>
</tr>
</thead>
</table>

3. Did you have any unpleasant sexual experiences during adolescence?

(a) by strangers  
☐ Yes  ☐ No

(b) by family members  
☐ Yes  ☐ No

(c) by a friend  
☐ Yes  ☐ No

(c) other (give details)  
☐ Yes  ☐ No

F. RELATIONSHIP BEHAVIOUR AND FEELINGS

1. Before meeting your present partner were you ever:

(a) engaged  
☐ Yes  ☐ No

(b) married  
☐ Yes  ☐ No

(c) seriously involved in another relationship  
☐ Yes  ☐ No
CURRENT ATTITUDES AND BEHAVIOUR

A. CURRENT ATTITUDES TOWARDS SEX

1. (a) By placing a cross on the line below, indicate what your attitude is toward sex in general.

Very negative  Negative  Unsure  Positive  Very positive

(b) How enjoyable do you find the following sexual activities:

(i) Intercourse

Extremely enjoyable  Enjoyable  Unsure  Not very enjoyable  Not at all enjoyable

(ii) Petting

Extremely enjoyable  Enjoyable  Unsure  Not very enjoyable  Not at all enjoyable

(c) Do you ever feel dirty or guilty about any aspects of sex?

Never  Rarely  Sometimes  Frequently  Very frequently

(d) Do you ever feel dirty or guilty thinking about sex?

Never  Rarely  Sometimes  Frequently  Very frequently
2. TICK the word which best describes your feelings about:

<table>
<thead>
<tr>
<th>(a)</th>
<th>Your genital area</th>
<th>Very Positive</th>
<th>Positive</th>
<th>Neutral</th>
<th>Negative</th>
<th>Very Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>(b)</td>
<td>Menstruation</td>
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<td>(c)</td>
<td>Vaginal secretions</td>
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<tr>
<td>(d)</td>
<td>Self masturbation</td>
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<tr>
<td>(e)</td>
<td>Oral-genital contacts</td>
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<td>(f)</td>
<td>Foreplay</td>
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<td>(g)</td>
<td>Intercourse</td>
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<tr>
<td>(h)</td>
<td>Manual orgasms with a partner</td>
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<td>(i)</td>
<td>Sexual fantasy</td>
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<td>(j)</td>
<td>Anal intercourse</td>
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<td>(k)</td>
<td>Semen</td>
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</tbody>
</table>

3. (a) By placing a cross on the line below, indicate what you think is your partner's attitude toward sex in general.

<table>
<thead>
<tr>
<th>Very negative</th>
<th>Negative</th>
<th>Unsure</th>
<th>Positive</th>
<th>Very positive</th>
</tr>
</thead>
</table>

(b) How enjoyable do you think your partner finds the following sexual activities:

(i) Intercourse

<table>
<thead>
<tr>
<th>Extremely enjoyable</th>
<th>Enjoyable</th>
<th>Unsure</th>
<th>Not very enjoyable</th>
<th>Not at all enjoyable</th>
</tr>
</thead>
</table>
(ii) petting

<table>
<thead>
<tr>
<th>Extremely enjoyable</th>
<th>Enjoyable</th>
<th>Unsure</th>
<th>Not very enjoyable</th>
<th>Not at all enjoyable</th>
</tr>
</thead>
</table>

(c) Do you think your partner ever feels dirty or guilty about any aspect of sex?

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>Very frequently</th>
</tr>
</thead>
</table>

(d) Do you think your partner ever feels dirty or guilty thinking about sex?

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>Very frequently</th>
</tr>
</thead>
</table>

4. **TICK** the word which best describes your partner's feelings about:

<table>
<thead>
<tr>
<th></th>
<th>Very Positive</th>
<th>Positive</th>
<th>Neutral</th>
<th>Negative</th>
<th>Very Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a)</td>
<td>Your genital area</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>(b)</td>
<td>Menstruation</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>(c)</td>
<td>Vaginal secretions</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>(d)</td>
<td>Self masturbation</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>(e)</td>
<td>Oral-genital contacts</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>(f)</td>
<td>Foreplay</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>(g)</td>
<td>Intercourse</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>(b)</td>
<td>Manual orgasms with a partner</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>(l)</td>
<td>Sexual fantasy</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>(j)</td>
<td>Anal intercourse</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>(k)</td>
<td>Semen</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
</tbody>
</table>
5. By placing a cross on the line below, indicate how important sex is in your relationship.

Very unimportant   Unimportant   Neutral   Important   Very important

6. (a) What kind of contraception do you use?

TICK ONE OR MORE BOXES

None
Pill, IUD, diaphragm
Spermicidal creams, condom
Withdrawal
Rhythm method or Billings Method
Sterilization of either male or female
Other (give details) ____________________________

(b) How long have you been using this method?

TICK ONE BOX

For many years (more than 3 years)
For a few years (3 years or less)
For a few months (6 months or less)

(c) Have you ever experienced any problems with the particular contraceptive method?

□ Yes   □ No

(d) Are you concerned about getting pregnant?

□ Yes   □ No
B. **TYPES OF SEXUAL ACTIVITY**

1. (a) From the following list, tick those physical contacts between you and your partner which you enjoy.

   - Kissing
   - Embracing
   - Holding hands
   - Breast petting
   - Caressing other parts of the body
   - Manual genital contacts
   - Oral genital contacts
   - Other (give details)
   - No physical contact

   **TICK ONE OR MORE BOXES**

   (b) In what way would you like to change these physical contacts? (Please place a tick in the most appropriate box for each type of contact)

<table>
<thead>
<tr>
<th></th>
<th>Much less emphasis</th>
<th>Less emphasis</th>
<th>No change</th>
<th>More emphasis</th>
<th>Much more emphasis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kissing</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Embracing</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Holding hands</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Breast petting</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Caressing other parts of the body</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Manual genital contacts</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Oral genital contacts</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>No physical contact</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
</tbody>
</table>
2. Do you get aroused during foreplay?

<table>
<thead>
<tr>
<th></th>
<th>About 25%</th>
<th>About 50%</th>
<th>About 75%</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of the time</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. How often would you feel highly aroused before you have intercourse?

<table>
<thead>
<tr>
<th></th>
<th>About 25%</th>
<th>About 50%</th>
<th>About 75%</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of the time</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Do you ever experience orgasm during foreplay?

<table>
<thead>
<tr>
<th></th>
<th>About 25%</th>
<th>About 50%</th>
<th>About 75%</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of the time</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. Do you ever experience an orgasm during intercourse with your partner?

<table>
<thead>
<tr>
<th></th>
<th>About 25%</th>
<th>About 50%</th>
<th>About 75%</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of the time</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. What kind of stimulation do you receive during foreplay?

(a) kissing

<table>
<thead>
<tr>
<th></th>
<th>About 25%</th>
<th>About 50%</th>
<th>About 75%</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of the time</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(b) general body touching and stroking

<table>
<thead>
<tr>
<th></th>
<th>About 25%</th>
<th>About 50%</th>
<th>About 75%</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of the time</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
(c) **caressing breasts**

<table>
<thead>
<tr>
<th>Never</th>
<th>About 25% of the time</th>
<th>About 50% of the time</th>
<th>About 75% of the time</th>
<th>Always</th>
</tr>
</thead>
</table>

(d) **manual-genital contact**

<table>
<thead>
<tr>
<th>Never</th>
<th>About 25% of the time</th>
<th>About 50% of the time</th>
<th>About 75% of the time</th>
<th>Always</th>
</tr>
</thead>
</table>

(e) **oral-genital contact**

<table>
<thead>
<tr>
<th>Never</th>
<th>About 25% of the time</th>
<th>About 50% of the time</th>
<th>About 75% of the time</th>
<th>Always</th>
</tr>
</thead>
</table>

7. What kind of stimulation do you receive during intercourse?

(a) **kissing**

<table>
<thead>
<tr>
<th>Never</th>
<th>About 25% of the time</th>
<th>About 50% of the time</th>
<th>About 75% of the time</th>
<th>Always</th>
</tr>
</thead>
</table>

(b) **general body touching and stroking**

<table>
<thead>
<tr>
<th>Never</th>
<th>About 25% of the time</th>
<th>About 50% of the time</th>
<th>About 75% of the time</th>
<th>Always</th>
</tr>
</thead>
</table>

(c) **caressing breasts**

<table>
<thead>
<tr>
<th>Never</th>
<th>About 25% of the time</th>
<th>About 50% of the time</th>
<th>About 75% of the time</th>
<th>Always</th>
</tr>
</thead>
</table>

(d) **manual-genital contact**

<table>
<thead>
<tr>
<th>Never</th>
<th>About 25% of the time</th>
<th>About 50% of the time</th>
<th>About 75% of the time</th>
<th>Always</th>
</tr>
</thead>
</table>
8. Which of the following positions do you use for sexual intercourse?

(a) male on top of female

<table>
<thead>
<tr>
<th>Never of the time</th>
<th>About 25% of the time</th>
<th>About 50% of the time</th>
<th>About 75% of the time</th>
<th>Always</th>
</tr>
</thead>
</table>

(b) female on top of male

<table>
<thead>
<tr>
<th>Never of the time</th>
<th>About 25% of the time</th>
<th>About 50% of the time</th>
<th>About 75% of the time</th>
<th>Always</th>
</tr>
</thead>
</table>

(c) lying on side, face to face

<table>
<thead>
<tr>
<th>Never of the time</th>
<th>About 25% of the time</th>
<th>About 50% of the time</th>
<th>About 75% of the time</th>
<th>Always</th>
</tr>
</thead>
</table>

(d) lying on side, back to front

<table>
<thead>
<tr>
<th>Never of the time</th>
<th>About 25% of the time</th>
<th>About 50% of the time</th>
<th>About 75% of the time</th>
<th>Always</th>
</tr>
</thead>
</table>

(e) various other positions

<table>
<thead>
<tr>
<th>Never of the time</th>
<th>About 25% of the time</th>
<th>About 50% of the time</th>
<th>About 75% of the time</th>
<th>Always</th>
</tr>
</thead>
</table>
9. How often would you and your partner put aside your usual pattern of sexual activity to try something different in technique or position, or perhaps a change in time or place?

(f) various other positions

<table>
<thead>
<tr>
<th>Never</th>
<th>About 25% of the time</th>
<th>About 50% of the time</th>
<th>About 75% of the time</th>
<th>Always</th>
</tr>
</thead>
</table>

10. (a) How often do you currently have intercourse?

TICK ONE BOX

- Never
- Not very often (1-6 times per year)
- Now and then (once per month)
- Once a week
- Several times a week
- Daily or more

(b) How does this compare with your frequency of intercourse in the past year?

<table>
<thead>
<tr>
<th>Much less frequent</th>
<th>Less frequent</th>
<th>About the same</th>
<th>More frequent</th>
<th>Much more frequent</th>
</tr>
</thead>
</table>
When involved in sexual activity with your partner, how often would you:

11.

(a) Comment that you are enjoying something your partner is doing?

<table>
<thead>
<tr>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Almost</th>
<th>Always</th>
<th>Always</th>
</tr>
</thead>
</table>

(b) Say what you would like your partner to do?

<table>
<thead>
<tr>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Almost</th>
<th>Always</th>
<th>Always</th>
</tr>
</thead>
</table>

(c) Ask what your partner enjoys or would like you to do?

<table>
<thead>
<tr>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Almost</th>
<th>Always</th>
<th>Always</th>
</tr>
</thead>
</table>

(d) Comment if you don't like something your partner is doing?

<table>
<thead>
<tr>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Almost</th>
<th>Always</th>
<th>Always</th>
</tr>
</thead>
</table>

(e) Suggest changes in sexual technique if you would like a change?

<table>
<thead>
<tr>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Almost</th>
<th>Always</th>
<th>Always</th>
</tr>
</thead>
</table>

(f) When you're not in the mood for it, tell your partner that you don't want sex right now?

<table>
<thead>
<tr>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Almost</th>
<th>Always</th>
<th>Always</th>
</tr>
</thead>
</table>
(g) Say you don't want to go on with lovemaking when you realize you've "turned off" sexually?

<table>
<thead>
<tr>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Almost always</th>
<th>Always</th>
</tr>
</thead>
</table>

(b) Tell your partner that you're ready or not yet ready for penetration?

<table>
<thead>
<tr>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Almost always</th>
<th>Always</th>
</tr>
</thead>
</table>

(i) Show your partner where and how you like best to be touched?

<table>
<thead>
<tr>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Almost always</th>
<th>Always</th>
</tr>
</thead>
</table>

(j) Suggest using a sex aid, such as lubricating jelly or a vibrator?

<table>
<thead>
<tr>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Almost always</th>
<th>Always</th>
</tr>
</thead>
</table>

12. How often is sexual activity with your partner really enjoyable for you?

<table>
<thead>
<tr>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Almost always</th>
<th>Always</th>
</tr>
</thead>
</table>

13. Does your partner lack caring and sensitivity as a lover?

<table>
<thead>
<tr>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Almost always</th>
<th>Always</th>
</tr>
</thead>
</table>

14. Do you sometimes find you just "turn off" during sexual activity with your partner?

<table>
<thead>
<tr>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Almost always</th>
<th>Always</th>
</tr>
</thead>
</table>
15. How often do you feel unsatisfied with your own sexual response to your partner's caresses?

<table>
<thead>
<tr>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Almost always</th>
<th>Always</th>
</tr>
</thead>
</table>

16. Do you ever take an active role during sex?

<table>
<thead>
<tr>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Almost always</th>
<th>Always</th>
</tr>
</thead>
</table>

17. How often would you have sexual thoughts or fantasies:
   (a) during sexual activity with your partner?

<table>
<thead>
<tr>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Almost always</th>
<th>Always</th>
</tr>
</thead>
</table>

   (b) at other times?

<table>
<thead>
<tr>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Almost always</th>
<th>Always</th>
</tr>
</thead>
</table>

C. SEXUAL IDENTITY

1. (a) By placing a cross on the line below, indicate how you perceive your sexual orientation.

   Exclusively heterosexual  Heterosexual  Bisexual  Homosexual  Exclusively homosexual

   (b) Have you ever thought you would like to experience a sexual activity with someone of the same sex?

<table>
<thead>
<tr>
<th>Very frequently</th>
<th>Frequently</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
</table>
(c) If YES, indicate by placing a cross on the line below how you feel about this.

No feelings of guilt  Somewhat guilty  Guilty  Strong feelings of guilt  Very strong feelings of guilt

2. How comfortable are you with being the sex you are?

Completely comfortable  Comfortable  Neutral  Uncomfortable  Not at all comfortable

D. OTHER RELATIONSHIPS

1. What kinds of social relationships do you have with people of the opposite sex?

TICK ONE OR MORE BOXES

- Close relationships
- Frequent socializing
- Casual relationships
- Sexual relationships
- Other (give details)

2. (a) During your current relationship, have you had any affectionate relationships with opposite-sexed friends which have not involved sexual intercourse?

- Yes
- No
(b) If YES, which of the following behaviours were involved?

TICK ONE OR MORE BOXES

- non physical affection (words or deeds expressing caring)
- physical affection (kissing, embracing)
- petting
- Other (please specify)

(c) How intimate do you view these non-coital affectionate relationships with opposite-sexed friends?

<table>
<thead>
<tr>
<th>Very intimate</th>
<th>Intimate</th>
<th>Somewhat intimate</th>
<th>Not very intimate</th>
<th>Not at all intimate</th>
</tr>
</thead>
</table>

(d) Is your partner aware of these relationships?

- Yes
- No

3. (a) How frequently have you experienced intercourse outside any permanent relationship?

<table>
<thead>
<tr>
<th>Very frequently</th>
<th>Frequently</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
</table>

If you have experienced intercourse outside a permanent relationship, complete (b) - (e) below:

(b) Indicate by placing a cross on the line below how you would best describe this experience.

<table>
<thead>
<tr>
<th>Very unpleasant</th>
<th>Unpleasant</th>
<th>Neutral</th>
<th>Pleasant</th>
<th>Very pleasant</th>
</tr>
</thead>
</table>

(c) Were you orgasmic?

<table>
<thead>
<tr>
<th>Always</th>
<th>Frequently</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
</table>
(d) Would you repeat the experience? □ Yes □ No

(e) Does your partner know of the experience? □ Yes □ No

E. COMMUNICATION

1. (a) Are you and your partner able to talk about most things?

Never □ Rarely □ Sometimes □ Frequently □ Always □

(b) Which subjects do you avoid or find difficult to discuss?

TICK ONE OR MORE BOXES

Sex □
Religion □
Money matters □
Division of household labour □
Children's upbringing □
Other (give details) ____________________________

2. (a) Would you like to change the ways in which you and your partner communicate? □ Yes □ No

(b) If YES, in what way would you like to see your communication patterns change?

TICK ONE OR MORE BOXES

Be more open and direct □
Be less dominating □
Be less passive/submissive □
Be more rational/practical and less emotional □
3. Is it difficult to tell your partner:
   (a) What you like about him/her?
       Always  Frequently  Sometimes  Rarely  Never

   (b) What you don't like about him/her?
       Always  Frequently  Sometimes  Rarely  Never

4. (a) Do you tell your partner what you do and do not like during sex?
       Always  Frequently  Sometimes  Rarely  Never

   (b) Do you feel comfortable sometimes being the initiator of sexual activity?
       Very negative  Negative  Unsure  Positive  Very positive

   (c) How do you feel when your partner initiates sexual activity?
       Very negative  Negative  Unsure  Positive  Very positive

   (d) How do you feel when your partner refuses a sexual advance that you make?
       Very negative  Negative  Unsure  Positive  Very positive

F. RELATIONSHIP

1. (a) Indicate by placing a cross on the line below how you feel about your relationship.
       Very dissatisfied  Dissatisfied  Neutral  Satisfied  Very satisfied
(b) Indicate by placing a cross on the line below how often you get the things you want from your current relationship.

Never   Rarely   Sometimes   Frequently   Always

(c) Which of the following do you see as good aspects of your current relationship?

 TICK ONE OR MORE BOXES

- Sexual activity
- Communication
- Companionship
- Support
- Other (give details)

2. In everyday matters, how often is your partner considerate and caring towards you?

Never   Occasionally   Frequently   Almost always   Always

3. How often do you get on each other’s nerves around the house?

Never   Occasionally   Frequently   Almost always   Always

4. In the evenings do you spend time together talking about the day’s activities?

Never   Occasionally   Frequently   Almost always   Always

5. When you have a disagreement do you talk it through fairly amicably?

Never   Occasionally   Frequently   Almost always   Always
6. Do you sometimes feel your partner is critical of you?

Never  Occasionally  Frequently  Almost always  Always

7. On an ordinary day do you say good-bye or greet each other with a hug or a kiss?

Never  Occasionally  Frequently  Almost always  Always

8. How often does physical affection from your partner lead to sex
   (a) when you're in bed?

Never  Occasionally  Frequently  Almost always  Always

   (b) at other times?

Never  Occasionally  Frequently  Almost always  Always

9. Do you go to bed at the same time as your partner each night?

Never  Occasionally  Frequently  Almost always  Always

10. On some evenings do you go to bed feeling angry with your partner?

Never  Occasionally  Frequently  Almost always  Always

11. (a) Do you feel satisfied with the amount of physical affection you have with your partner?

Very satisfied  Satisfied  Neutral  Dissatisfied  Very dissatisfied
(b) How often is your partner affectionate without necessarily expecting sex to follow?

Never  Rarely  Sometimes  Frequently  Always

(c) How satisfied are you with the amount of nonphysical affection (things that show consideration or caring) by your partner?

Very dissatisfied  Dissatisfied  Neutral  Satisfied  Very satisfied

12. (a) What happens when you argue?

TICK ONE BOX

- Conflict is resolved amicably
- Conflict is resolved with one partner bearing a grudge
- Conflicts are not satisfactorily resolved
- Other (please specify) ____________________________

(b) Which of the following do you argue about?

TICK ONE OR MORE BOXES

- Sex
- Religion
- Money matters
- Division of household labour
- Children’s upbringing
- Other (give details) ____________________________

13. In your current relationship have you and your partner ever:

(a) considered separation  ☐ Yes  ☐ No
(b) considered divorce
   □ Yes □ No

(c) actually separated
   □ Yes □ No

14. Indicate by placing a cross on the line below how seriously you see your sexual difficulties affecting other aspects of your relationship.

Very seriously       Some influence       Unsure       Little influence       Very seriously

15. What areas in your relationship are currently causing trouble to you?

TICK ONE OR MORE BOXES

Money matters
Children's upbringing
Division of household labour
In-laws
Drinking
Gambling
Extra-marital relationships
Other (give details) ____________________________________________

G. PERFORMANCE ANXIETY

1. How often do you have sexual intercourse just because you know your partner wants to?

Never     Occasionally     Frequently     Almost always     Always

2. During sexual activity, does awareness of your partner's eagerness for intercourse make you feel pressured?

Never     Occasionally     Frequently     Almost always     Always
3. Do you ever find yourself monitoring your level of arousal?

<table>
<thead>
<tr>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Almost always</th>
<th>Always</th>
</tr>
</thead>
</table>

4. Do you become irritated or annoyed about being too slow to become sexually aroused?

<table>
<thead>
<tr>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Almost always</th>
<th>Always</th>
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</thead>
</table>

5. If you initially accept and respond to your partner’s sexual caresses, do you feel obliged to continue on to intercourse?

<table>
<thead>
<tr>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Almost always</th>
<th>Always</th>
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</table>

6. Once you are feeling sexually aroused, are you sometimes concerned about "turning off" before reaching orgasm?

<table>
<thead>
<tr>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Almost always</th>
<th>Always</th>
</tr>
</thead>
</table>

7. How often would you have intercourse before you feel ready for it?

<table>
<thead>
<tr>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Almost always</th>
<th>Always</th>
</tr>
</thead>
</table>

8. Do you have distracting thoughts during love-making that take away the focus from your own pleasurable feelings?

<table>
<thead>
<tr>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Almost always</th>
<th>Always</th>
</tr>
</thead>
</table>

9. Do you ever fake experiencing orgasm?

<table>
<thead>
<tr>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Almost always</th>
<th>Always</th>
</tr>
</thead>
</table>
10. How often do you feel you are a failure as a sexual partner?

Never | Occasionally | Frequently | Almost always | Always

H. LIFESTYLE

1. (a) Which of the following situations best sums up your situation at the moment?

TICK ONE BOX

- I work full time
- I work part time
- I am unemployed
- I am involved in home duties full time
- Other (Please specify)  

(b) If unemployed, indicate by placing a cross on the line below how you feel about this.

Very negatively | Negatively | Neutral | Positive | Very positively

(c) How does your work affect your sexual relationship?

Very negatively | Negatively | Neutral | Positive | Very positively

(d) How does your partner's work affect your sexual relationship?

Very negatively | Negatively | Neutral | Positive | Very positively
(e) Is fatigue a problem in your sexual relationship?

Never          Rarely          Sometimes          Frequently          Always

IF YOU HAVE CHILDREN PLEASE ANSWER QUESTION 2 BELOW

2. Indicate by placing a cross on the line below how you feel your children affect your overall relationship with your partner.

Very negatively          Negatively          Neutral          Positive          Very positively

Thank you for your assistance in completing this questionnaire.
BACKGROUND INFORMATION SHEET TO CASDM

NON-CLINICAL

Name: __________________________________________

Suburb of residence: ______________________________________

Age:
Please tick your appropriate age range

20-24 years _____ 25-29 years _____ 30-34 years _____

35-39 years _____ 40-44 years _____ 45-49 years _____

50-54 years _____ 55-59 years _____ 60-65 years _____

Gender:
Male _____________ Female _____________

Income:
What is your approximate personal/family gross income (before tax)?

Less than $10,000 _____ $10,000-$20,000 _____

$20,000-$30,000 _____ $30,000-$40,000 _____

$40,000-$50,000 _____ $50,000-$60,000 _____

More than $60,000 _____
**Occupation:**

a) What is your occupation? ____________________________

b) How many hours per week do you spend working in this role? ______________

**Education:**

What level of education have you reached? ________________

Partly completed secondary school ________________

Matriculation/HSC ________________

Undergraduate degree ________________

Postgraduate ________________

**Relationship Status:**

Single ______ Married ______ De Facto ______

THANK YOU FOR YOUR COOPERATION IN COMPLETING THIS FORM
BACKGROUND INFORMATION SHEET TO CASDM

CLINICAL

Name: ____________________________

Suburb of residence: ____________________________

Age:

Please tick your appropriate age range

20-24 years _____ 25-29 years _____ 30-34 years _____

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$40,000-$50,000 _____ $50,000-$60,000 _____

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Education:
   What level of education have you reached? ________________

   Partly completed secondary school _______________________

   Matriculation/HSC ____________________________

   Undergraduate degree ____________________________

   Postgraduate ____________________________

Relationship Status:
   Single _______  Married _______  De Facto _______

THANK YOU FOR YOUR COOPERATION IN COMPLETING THIS FORM
<table>
<thead>
<tr>
<th>CHILDHOOD FACTORS</th>
<th>MEAN</th>
<th>SD</th>
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<tbody>
<tr>
<td><strong>1. MIXED LOYALTIES</strong></td>
<td></td>
<td></td>
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<tr>
<td>Impact of loyalty on you now</td>
<td>2.1</td>
<td>.85</td>
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<tr>
<td>Impact of loyalty contacts on partner</td>
<td>1.95</td>
<td>.83</td>
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<tr>
<td>Impact of loyalty contacts on sexual functioning</td>
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<td><strong>2. MOTHER'S LEVEL OF INTIMACY WITH PEOPLE WHEN YOU WERE A CHILD</strong></td>
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<td></td>
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<tr>
<td>Her intimacy with your father</td>
<td>4.45</td>
<td>7.68</td>
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<td>Her intimacy with you</td>
<td>5.17</td>
<td>1.85</td>
</tr>
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<td>Her intimacy with your brothers, sisters</td>
<td>5.32</td>
<td>1.69</td>
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<td>Her intimacy with relations</td>
<td>4.80</td>
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<td>Her intimacy with friends</td>
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<td>1.55</td>
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<td><strong>3. FATHER'S LEVEL OF INTIMACY WITH PEOPLE WHEN YOU WERE A CHILD</strong></td>
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<td></td>
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<tr>
<td>His intimacy with your mother</td>
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<td>His intimacy with you</td>
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<td>His intimacy with your brothers, sisters</td>
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<td>His intimacy with relations</td>
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<td>His intimacy with friends</td>
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<td><strong>4. HOW YOU SEE YOUR MOTHER'S ATTITUDE TO SEX</strong></td>
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<td>Mother with your father when you were growing up</td>
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<td>Mother with you as a child</td>
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<td>Mother with you as an adolescent</td>
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<td>Mother with you and masturbation</td>
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<td>1.44</td>
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<td>Mother with the concept of sex before marriage</td>
<td>2.46</td>
<td>2.21</td>
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<td>Category</td>
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<td>Standard Deviation</td>
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<td>Mother with sex in the media</td>
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<td>1.96</td>
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<td>Mother with community attitudes to sex</td>
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<td>2.18</td>
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<td>5. HOW YOU SEE YOUR FATHER'S ATTITUDE TO SEX</td>
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<td>Father with your mother when you were growing up</td>
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<td>Father with you as a child</td>
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<td>Father with you as an adolescent</td>
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<td>You and Father</td>
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<td>You and Grandmother</td>
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<td>You and Grandfather</td>
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<td>You and Aunt</td>
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<td>You and Uncle</td>
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<td>You and Brother</td>
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<td>.18</td>
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<td>You and Sister</td>
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<td>.00</td>
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<td>7. FAMILY SECRETS</td>
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<td>Any sexual ???????</td>
<td>5.96</td>
<td>1.91</td>
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<tr>
<td>What were they</td>
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<td>2.29</td>
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<td>How did you respond</td>
<td>4.11</td>
<td>2.41</td>
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<tr>
<td>What impact has it had</td>
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<td>1.85</td>
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<td>8. LEVEL OF PRIVACY AS A CHILD</td>
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<tr>
<td>Generally did you experience sexual privacy as a child</td>
<td>5.97</td>
<td>1.91</td>
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<tr>
<td>In regard to censorship of books and films</td>
<td>4.95</td>
<td>2.29</td>
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<tr>
<td>Time constraints</td>
<td>4.11</td>
<td>2.41</td>
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<tr>
<td>----------------------------------------</td>
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<tr>
<td>Generally could you choose your friends</td>
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<td>1.85</td>
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<tr>
<td>Did you experience questions, quizzes while alone</td>
<td>4.58</td>
<td>2.60</td>
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<tr>
<td>After being with friends</td>
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<td>Was there bedroom privacy</td>
<td>5.43</td>
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<td>Was there bathroom privacy</td>
<td>6.20</td>
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<td><strong>9. LEVEL OF PRIVACY AS A YOUNG ADULT</strong></td>
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<td>Generally did you experience sexual privacy as a young adult</td>
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<td>Generally could you choose your friends</td>
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<td>Did you experience questions, quizzes while alone</td>
<td>2.25</td>
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<td>After being with friends</td>
<td>2.23</td>
<td>2.23</td>
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<td>Was there bedroom privacy</td>
<td>6.21</td>
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<td>Was there bathroom privacy</td>
<td>6.5</td>
<td>1.45</td>
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<tr>
<td><strong>10. SEXUAL INFORMATION YOU WERE GIVEN AS A CHILD</strong></td>
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<td></td>
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<tr>
<td>Do you feel your family of origin gave you sex information appropriate to your age</td>
<td>3.07</td>
<td>2.46</td>
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<td>Were you free to ask questions on sexual issues</td>
<td>3.69</td>
<td>2.66</td>
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<td>Did you receive informative answers</td>
<td>3.29</td>
<td>2.43</td>
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<td><strong>11. LEVEL OF DISCUSSION ABOUT SEX IN 'YOUR' FAMILY AS A CHILD</strong></td>
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<tr>
<td>Generally were sexual matters kept silent in your family of origin</td>
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<td>2.38</td>
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<td>Was there denial about sex</td>
<td>3.50</td>
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<td>Was there a refusal to acknowledge sexual issues</td>
<td>3.30</td>
<td>2.39</td>
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<td>CURRENT FACTORS</td>
<td>MEAN</td>
<td>SD</td>
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<tr>
<td>--------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td><strong>1. IN YOUR VALUE SYSTEM WHERE DO YOU PLACE YOUR SEXUALITY</strong></td>
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<tr>
<td>Is your sexual functioning satisfactory for you</td>
<td>4.64</td>
<td>1.72</td>
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<td>Is your sexual functioning satisfactory for your partner</td>
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<td>Is your sexual functioning satisfactory for the relationship</td>
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<td><strong>2. LIFESTYLE ISSUES</strong></td>
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<tr>
<td>Are you satisfied with your present lifestyle for yourself</td>
<td>5.13</td>
<td>1.41</td>
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<tr>
<td>Are you satisfied with your present lifestyle from the relationship point of view</td>
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<td>1.50</td>
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<td><strong>3. HEALTH AND WELL BEING</strong></td>
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<tr>
<td>How would you describe your general state of well being</td>
<td>5.35</td>
<td>1.18</td>
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<td>Generally how would you describe your mental health</td>
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<td>Generally how would you describe your physical health</td>
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<tr>
<td>Generally how would you describe your emotional health</td>
<td>5.07</td>
<td>1.38</td>
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<td><strong>4. BODY IMAGE (1 ITEM ONLY)</strong></td>
<td></td>
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<tr>
<td><strong>5. INFORMATION AND KNOWLEDGE ABOUT YOUR SEXUALITY AND SEXUAL BEHAVIOUR</strong></td>
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<tr>
<td>Do you feel sufficiently informed about your sexuality</td>
<td>5.73</td>
<td>1.50</td>
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<tr>
<td>Do you feel sufficiently informed about sexual behaviour</td>
<td>5.80</td>
<td>1.27</td>
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<td>Do you know what is enjoyable for you in the sexual area</td>
<td>5.85</td>
<td>1.37</td>
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<tr>
<td>Can you discuss those matters with your partner</td>
<td>5.05</td>
<td>1.76</td>
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<tr>
<td><strong>6. SEXUAL THOUGHTS AND FANTASIES</strong></td>
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<tr>
<td>Do you have sexual thoughts</td>
<td>4.82</td>
<td>1.27</td>
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<td>Is your partner part of these thoughts</td>
<td>3.15</td>
<td>1.90</td>
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<td>INTERPERSONAL FACTORS</td>
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<td>SD</td>
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<td>-----</td>
</tr>
<tr>
<td>1. ANGER</td>
<td></td>
<td></td>
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<tr>
<td>Do you feel angry in this relationship</td>
<td>4.11</td>
<td>1.20</td>
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<tr>
<td>Do you acknowledge this anger to yourself</td>
<td>5.68</td>
<td>1.19</td>
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<td>Do you acknowledge this anger to your partner</td>
<td>4.63</td>
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<td>Do you express your anger</td>
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<td>Do you express anger with your partner</td>
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<td>Do you achieve resolution with yourself</td>
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<td>1.65</td>
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<td>Do you achieve resolution with your partner</td>
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<td>2. CONTROL ISSUES</td>
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<tr>
<td>Do you feel you have a sense of control in your life</td>
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<td>Are you satisfied with the amount of control in your life</td>
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<td>Are you too controlled in your life</td>
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<td>Are you too controlling in your life</td>
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</tr>
<tr>
<td>Are you too controlling in your relationship</td>
<td>3.63</td>
<td>1.77</td>
</tr>
<tr>
<td>3. INTIMACY ISSUES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you experience intimacy with your significant same sex friends</td>
<td>4.68</td>
<td>1.70</td>
</tr>
<tr>
<td>Do you experience intimacy with your significant opposite sex friends</td>
<td>4.91</td>
<td>1.55</td>
</tr>
<tr>
<td>Do you experience intimacy with your partner</td>
<td>5.11</td>
<td>1.63</td>
</tr>
</tbody>
</table>
APPENDIX B

ETHICS APPROVAL
MEMORANDUM

DATE : 9 July 1991

TO : Marilyn Cobain
     Department of Psychology

FROM : Karen Owen
       Secretary, Victoria College Ethics Committee

SUBJECT : APPROVAL OF MASTER OF ARTS RESEARCH PROJECT: 'THE CONTRIBUTION OF COGNITIVE PROCESSING IN THE DEVELOPMENT OF SEXUAL DYSFUNCTION'

I am pleased to advise you that your research application has been approved by the College's Ethics Committee.

We wish you well in your research.

Karen Owen

C.C. Ian Ball, Chairman, Victoria College Ethics Committee.
     Amanda Lazar, Rusden Campus.
     Marita McCabe, Rusden Campus.
APPENDIX C

PLAIN LANGUAGE STATEMENT
PLAIN LANGUAGE STATEMENT

THE PROJECT:
Life Events and Cognitive Processing in Sexually Dysfunctional Individuals.

MASTER OF ARTS DEGREE
STUDENT: Marilyn J Cobain Ph (03) 9866 1965
SUPERVISOR: Prof Marita McCabe Ph (03) 9244 6856

PROJECT DESCRIPTION:
The purpose of the research is to investigate the predisposing and current factors contributing to sexual dysfunction and evaluate the impact of the cognitive appraisal of child and current sexual experiences and the individual's sense of self, relationship and sexual functioning. The study is to be conducted by way of interview with the researcher using a questionnaire and a second questionnaire to be completed by you in your own time. The interview will take approximately one hour and the second questionnaire approximately 40 minutes to complete.

The questions asked by the researcher pertain to your parents' attitudes to sex and how that may or may not have affected your sense of self now, your relationships now and your sexual functioning now and whether you believe it is possible to change these effects.

The second questionnaire to be completed by you asks about your sexual function history and current factors pertaining to your sexual functioning.

Should you agree to participate, you will be required to sign an Informed Consent form, indicating that you are aware that participation in the study is completely confidential, anonymous and voluntary, and that you are free to withdraw your consent at any time, in which event your participation in the research study will immediately cease and any information obtained destroyed if requested by you. Your name and student ID will only be recorded on the consent form, which will be collected separately from the questionnaire. There will be no personally-identifying information requested on the questionnaire.

If you decide to participate, please fill in the consent form provided and begin answering the questionnaire. After the consent form is signed, you may still withdraw from the study at any time, without penalty of any kind. Whatever your decision on this matter, thank you for devoting some time to reading this statement and considering its contents.
APPENDIX D

INFORMED CONSENT FORM
DEAKIN UNIVERSITY ETHICS COMMITTEE
CONSENT FORM
(to be both submitted and kept separately from questionnaire)

I, ........................................................................................................ (name)
hereby consent to participate in a research study to be undertaken by Marilyn Cobain
and I understand that the purpose of the research is to investigate pre-disposing and
current factors contributing to sexual dysfunction.

I acknowledge that
1. any information that I provide will not be made public in any form that could
reveal my identity to an outside party (i.e. that I will remain fully anonymous);
2. aggregated results of the whole study only will be used for research purposed
and may be reported in scientific academic journals;
3. individual results will not be released to any person;
4. I am free to withdraw my consent at any time, in which event my participation
in the research study will immediately cease and any information obtained
destroyed if requested by me.

Dated the ........................................ day of ........................................ 199

Signature ........................................................................................................