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A COMPARISON OF GROUP AND SELF-DIRECTED TREATMENT
FORMATS IN THE MANAGEMENT OF PREMATURE
EJACULATION IN MALES WITHOUT
STEADY PARTNERS

DISSERTATION

Presented in Partial Fulfillment of the Requirements for
the Degree Doctor of Philosophy in the Graduate
School of The Ohio State University

By
Doreen Seidler-Feller, B.A., M.A.

* * * * *

The Ohio State University
1980

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This dissertation is dedicated
to all the members of my family -
may their memories be for a blessing -
who perished
in the European Holocaust
and
to the very precious two
who
survived.
ACKNOWLEDGEMENTS

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CHAPTER I

Introduction

This study was designed to test the efficacy of a treatment program for rapid ejaculators without regular sexual partners under conditions of varying therapist and peer contact. Although rapid ejaculation has long been defined as a sexual difficulty, and is considered the most common male sex dysfunction,\(^1\) outcomes for treated populations have varied widely and remained uninterpretable until recently owing to the great diversity in definitions, screening criteria, etiologic formulations, treatment approaches and outcome criteria. The traditional complexities involved in psychotherapy outcome research (sample size, controls, differential attrition, etc.) place additional constraints upon interpretation. Many of the studies reporting outcomes are either case report descriptive studies (Finkelstein, 1975; Zeiss, 1977) or are correlational in nature (Cooper, 1968a; Johnson, 1965). Very few involve random assignment, controls and other hallmarks of experimental design (Heinrich, 1976).

\(^1\)This assertion is commonly made despite the facts that no (adequate) incidence or prevalence studies on premature ejaculation exist and, since controlled studies are few, very little is known about untreated premature ejaculation, its natural history and course.
Absence of quantitative data in the context of controlled studies, rather than empirical reports yielding inconclusive or disconfirming evidence, has made evaluation of psychodynamic and family systems interventions impossible. The "common sense" methods for treating premature ejaculation (anesthetic ointments, reassurance, distraction to inhibit arousal, etc.) either offer no outcome data whatsoever (Aycock, 1949; Levitt, 1975) or offer data in such a sketchy, incomplete and arbitrary fashion (Johnson, 1965; Schapiro, 1943) as to render appraisals meaningless. Studies employing pharmacologic treatment for ejaculatory management are not encouraging, unless the prematurity involves organic components of certain kinds (Boneff, 1972), and/or the client is maintained on chemical agents on a chronic basis (Bennett, 1961). In any event, the data are very limited and vague, the series are small and the outcome criteria purely subjective, where articulated (Bennett, 1961; Goodman, 1977; Haslam, 1975; Peberdy, 1969; Taylor, 1975). Therefore, assertions on the efficacy of pharmacologically based interventions, even for special subpopulations of the clinical group in question, are unwarranted at this time. Hypnotherapeutic accounts of treatment outcomes are too infrequent in the literature, and too incomplete to permit objective evaluation. In overall terms, it is difficult to judge either the

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2This author's review of the psychoanalytic literature yielded only one comprehensive single case study of premature ejaculation in which the analyst's claim was that, following a 2½ year analysis, the symptom was lessened (Finkelstein, 1975). The interested reader is referred to Masters and Johnson (1970) and Kaplan (1974) for more detailed assessment of the propriety and adequacy of psychoanalytic therapies in the management of common sex dysfunctions.
rate or quality of successes claimed by the advocates of the various intervention strategies described.

An apparently effective treatment method was reported more than two decades ago (Semans, 1956), but its putative merits were overlooked until Masters and Johnson (1970) and Kaplan (1974) exploited the renewed interest in behavioral treatment methods by refining and applying them to the domain of the common sex dysfunctions. In uncontrolled clinical trials, the currently popular "sensory training" methods have been reported to consistently yield successful outcomes, ranging from 89% (Yulis, 1976) to 97.8% (Masters & Johnson, 1970) and 100% success (Kaplan, 1974; Semans, 1956). Historically, these methods have had two major commonalities: (a) the regimen was couples or group rather than individually focused and partner cooperation was deemed essential to the therapeutic process (Kaplan, 1974; Kaplan et al., 1974; Masters & Johnson, 1970; Semans, 1956) and (b) the approach repeatedly centered on the man's attention to sensations premonitory to orgasm as the chief mechanism by which ejaculatory control was promoted (Kaplan, 1974).

Semans (1956) was the first investigator to build both components into his approach and subsequently to collect outcome data. Case studies were provided on 8 patients, a sample selected because of "adequate followup," which varied from 5 weeks to 15 months. Indefinite ejaculatory delay, pending onset of female orgasmic response, was the outcome criterion. Semans reported 100% success, with no relapses and no known development of other sexual dysfunctions. It is not clear to what extent Semans' selections on the grounds of
"adequate followup" data may have biased the outcomes. It is likely though, that other potentially important selection factors were operative in his sample and data. None of the patients in the series was older than 47 or younger than 25. While all were married, duration of marriage and number of prior marriages varied. Moreover, all patients were motivated sufficiently to see a specialist in a private practice context. In addition, major psychiatric and/or organic pathology had been ruled out in all cases. Finally, Semans relied on self-report and spousal cooroboration in the determination of treatment effectiveness.

Masters and Johnson (1970), using a similar definition of treatment outcome and a similar regimen couched in an expanded format, based their findings on an unsystematic series of 186 case reports. They reported that only 4 men (2.2%) in the acute phase of therapy3 failed to learn ejaculatory control such that orgasm was experienced by the partner at least 50% of the time. In 23 of the treated couples, transient periods of secondary erectile difficulty were reported immediately before or after acute phase termination. This was attributed to the suddenly elevated demand for coitus among post-treatment couples.

The 2.2% failure rate in such a large clinical sample seen over an 11 year period constitutes an impressive outcome, particularly in

3Three of the failures were married couples; the fourth was a divorcee who had brought a "replacement partner" to the program. For 2 of those couples, a marked lack of motivation on the part of the male was thought to contribute to failure. No specific explanations for the 2 remaining failures were offered.
view of the demanding cure criterion used. However, the limitations of this work must be borne in mind. Among its limitations are the absence of reports on followup for all cases in the series, the lack of controls and insufficient operationalization of relapse. The question of relapse is handled by Kaplan (1974) in similar anecdotal fashion. She mentions the possibility of transient ejaculatory dys-control briefly, but makes no mention of the transient erectile failure reported by Masters and Johnson. Levine (1976) reports persistent problems including ongoing male anxiety regarding the return of the dysfunction, failure to achieve unlimited ejaculatory control and the continuing inability to be the recipient of pleasure in a sexual context. Lowe and Mikulas (1975), while reporting highly significant findings under controlled conditions, also report the relative infrequency of ejaculatory control. The significance of gathering followup data is further underscored by Clarke and Parry's (1973) report on a 7 session Masters and Johnson-based program, in which their 2 cases achieved ejaculatory control during the treatment period. However, relapse occurred within 2 months in both cases. The authors attributed this development to inadequate followup support.

Kaplan's (1974) couples data yielded the result that among 32 cases presenting to the Cornell Sex Therapy program, all couples who

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4Lobitz and LoPiccolo (1972), using both the Masters and Johnson definition and approach, reported a 100% success rate in a series of 6 premature ejaculators. However, they conceded that the crucial factors in successful outcome remained indeterminate in view of the absence of separate evaluations of the individual modules in their treatment program.
completed the treatment developed ejaculatory control. The number of couples who did not complete therapy, and their reasons for termination were not clarified. No control group was used. The lack of reported followup data on this group leaves questions regarding maintenance measures, long-term treatment effects, symptom recurrence and a host of other questions unanswered.

Much of the subsequent research has sought to increase the economy and generalizability of the treatment model.\(^5\) Kaplan (1974) for example, suggested that a single therapist could treat couples as effectively as the dual-sex cotherapy team prescribed in the Masters and Johnson model. Clarke and Parry (1973) abbreviated the regimen from the standard 14 day to a 7 day format with apparent success. A number of investigators have experimented with group formats for the treatment of rapid ejaculation (Golden et al., 1978; Kaplan et al., 1974; Leiblum, Rosen, & Pierce, 1976; Zeiss et al., 1978; Zilbergeld, 1975). Promising outcomes have been reported with the use of various group treatment formats.

Kaplan and associates (1974) pioneered couples group treatment for premature ejaculation. Of the 4 selected couples constituting their treatment group, 2 met the outcome criterion\(^6\) during the

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\(^5\) Concerns along these lines include the cost of therapy to clients and health care delivery systems, the efficient utilization of clinic personnel and extension of the range of clinical applications and modalities in various ways.

\(^6\) The Kaplan associates' criterion of successful outcome is attainment of voluntary ejaculatory control with consequently prolonged coitus agreed to by both partners (p. 451).
therapeutic course (six 45 minute group sessions) while the other 2 couples reached criterion 2 months later. No control group was used. At 4 months followup, 3 of 4 couples reported retention of control and even some improvement in sexual functioning. However, the language used to describe outcome was unique to each couple, arousing the suspicion that client and/or therapist demand variables were influencing outcome reports, or that outcome reports were reflecting variables such as general improvement in sexual functioning or greater emotional intimacy along with or in lieu of ejaculatory control as such. Fundamentally, the distortions possible in outcome descriptions spring from the private self-based phenomenology embodied in the Kaplan outcome criterion.

As is the case with many clinical studies, Kaplan et al.'s sample was small and highly selected. All couples were screened and evaluated to yield a sample of stably married couples, without severe psychopathology in either partner, and with a primary complaint of premature ejaculation. In 2 of the 4 couples, unarticulated secondary anorgasmia was also present. Interestingly, the apparent resolution of these difficulties is not discussed in the outcome summaries. Thus, although the intention may have been otherwise, the couples group was, in effect, a mixed sex dysfunction group. This raises

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7This term seems to have been first used by Leiblum et al. (1976) in describing couples groups where dysfunctions vary. Of the 6 couples on whom data was collected in their study, 2 involved premature ejaculation. Over the treatment course (10 sessions), one client achieved "greater control of ejaculation" (p. 319) while the other was able to "delay ejaculation for upward of 5 minutes" (p. 320). These data, for a wide variety of reasons, must be regarded with extreme caution. One especially noteworthy point, made by the
some provocative questions with respect to incidental group learning, and the relationship, if any, between the dysfunctions in terms of etiology, maintenance and resolution.

Golden, Price, Heinrich and Lobitz (1978) compared the relative efficacy of single couple versus group couple formats using male-female cotherapists in a 12 session sequence involving educational, behavioral and attitude modification components. Three mixed sex co-therapy teams each saw one group (consisting of 3-4 couples) and 4 couples separately. Eleven couples were seen in group settings, while 12 couples were seen as individual units. Assignment to conditions was "non-random" and there was no control group. No further clarification on the procedural aspects of subject assignment was provided. The subjects completed a variety of pre and post-treatment measures, both at termination and at a 2 month followup. The results indicated that, whereas all patients improved, those in groups showed a slight trend in the direction of more rapid improvement as compared with those couples seen individually. Additionally, more men in the group format reported latencies to ejaculation exceeding 5 minutes at the conclusion of treatment as compared with men seen in couples units. However, at followup, no significant latency differences were reported. Regardless of format, subjects reported increased latencies to ejaculation, increases in the amount of pleasure experienced and

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(Continued) authors themselves, is that empirical evidence on the effectiveness of homogeneous problem group formats is lacking. Even less evidence exists for heterogeneous group formats. Moreover, there is considerable controversy over the relative merits of the homogeneous versus the heterogeneous group context from a clinical (as well as research) perspective.
increased satisfaction with orgasmic ability. Neither format significantly affected marital relations. The study is intriguing insofar as it suggests that couples groups may be no less effective than single couple formats.

Just as there has been no controlled comparison of the "sensory training" method with others, there have been no controlled comparisons among varying treatment formats (group, couple, individual). Thus, the claims made for the methodology and its derivatives are, at best, suggestive. The plethora of treatment approaches generated in the last few years have given rise to a wide variety of questions, very few of which have been the object of systematic research.

Another problem suggested by a review of the relevant literature involves the kind(s) of populations selected for study. One facet of this problem is that studied populations are highly selected (for a variety of reasons and in many ways), and that the effect of patient population characteristics has received little recognition (Wright, Perreault, & Mathieu, 1977) in the research literature. A second important facet of the problem concerns target populations. Most clinical and research work has been developed and tested on (married) couples in committed relationships. However, clinicians have come to recognize that clients without partners constitute a large, neglected population as far as sex dysfunction and sex therapeutic work are concerned (Barbach, 1974; Zeiss et al., 1978; Zilbergeld, 1975).

Three approaches have been reported to treat clients without partners: use of surrogate partners, sex therapy groups for women
(Barbach, 1974; Heinrich, 1976) and, more recently, sex therapy
groups for men (Zeiss et al., 1978; Zilbergeld, 1975). Whereas
Zeiss et al. (1978) developed an all-male group treatment context,
participants had regular sex partners and ongoing relationships,
Zilbergeld (1975) recruited men whose partners were unwilling or
unable to enter treatment and those without regular partners or
committed relationships.

It is clear that a continuum of single persons presenting them­selves for sex therapy exists. On one extreme are those individuals
who are involved in serial, committed relationships (Zeiss et al.,
1978; Zilbergeld, 1975), without being married. On the other hand
are those who never or rarely date, rarely engage in interpersonal
sexual behavior and who demonstrate apparent social skills deficits.
Roughly in the middle of the continuum are those daters in uncom­mitted relationships (Zilbergeld, 1975). To the extent that single
clients represent a population different from married persons (the
conventionally treated group), special treatment adjuncts (e.g.,
assertion and/or relaxation training) warrant consideration. The
same may be argued with respect to the various single subpopulations.
Research along these lines is preliminary and has not succeeded in
generating data clearly involving clients without steady partners
under controlled conditions. The realization is growing, however,
that the marital status/relationship variable may have considerable,
differential impact(s) on treatment design, theoretical and outcome
questions.
Concern with treatment efficacy and broad-based application to various populations (including the partnerless) has prompted a variety of innovations including the development of behavioral self-help programs for the management of premature ejaculation (Lowe & Mikulas, 1975; Zeiss & Zeiss, 1975). Premature ejaculation, it is argued, lends itself well to a self-directed format since success rates using behavioral treatment modalities are high, and the treatment is easily standardized, discrete and straightforward (Zeiss et al., 1978).

Two studies have reported outcome data using self-directed treatment formats for premature ejaculation. Lowe and Mikulas (1975) conducted a controlled outcome study in which 5 randomly assigned couples used a written, self-directed manual in conjunction with twice weekly telephone contact with a therapist. The other 5 couples were waitlisted. After 3 weeks (the average elapsed time for use of the program), the control couples were given the program.

Over time, treated couples reported significant improvement in terms of latency to ejaculation. The pre-treatment latency mean (baseline) for the 5 males in the control condition was 1.4 minutes; for those in the treatment condition it was 1.8 minutes. The post-treatment latency mean was unchanged for the control males and for the treated males it was 37.7 minutes. Subsequently, the post-treatment latency mean for males initially in the control group rose to 18.6 minutes.

While the results of this self-help approach are provocative, caution must be exercised in interpreting the data due to the
potential sources of uncontrolled variance. These include the use of two or more "therapist-consultants," the use of 2 distinct regions of the country, the use of different recruitment processes (referral versus advertising), and the small samples. In addition, the authors acknowledge the problem associated with using a single, self-report outcome measure for ejaculatory control. Further, although both groups, after treatment, reported means significantly different from the mean for control males, the discrepancy between scores for males in the treated condition and males initially in the control condition (and subsequently treated) is large and unexplained. Finally, in the absence of followup data, no way is provided to assess the duration of the treatment effects using a written, self-administered program.

Zeiss and Zeiss (1975) independently developed another couples-oriented, self-directed regimen. In an initial, uncontrolled case study, Zeiss (1977) reported on two couples who used the self-help manual successfully in conjunction with minimal telephone contact with a therapist. Data on followup 8 months after treatment revealed that therapeutic gains had been maintained. Taken together, (Lowe & Mikulas, 1975; Zeiss, 1977) these studies suggested that self-directed treatment for rapid ejaculation may offer an effective, inexpensive treatment modality for motivated couples. However, each study had its shortcomings which prevented more confident conclusions regarding the efficacy of self-help approaches.

Subsequently, Zeiss et al. (1978) undertook a controlled study on self-directed treatment in which 3 treatment conditions were compared.
One group of clients received standard sex therapy in which both partners of the dysfunctional couple regularly saw a clinic therapist. A second experimental group consisted of couples who entirely self-administered the treatment, while the third group was provided minimal therapist phone contact along with the manual.

All couples in standard treatment and 5 of 6 couples in the minimal contact condition were classified as successfully treated at post treatment, according to study criteria. None of the 6 couples in the no contact condition were successful; 5 of the 6 dropped out in the early weeks of treatment. In both standard and minimal contact conditions, strong treatment effects (significantly increased ejaculatory latencies) were reported. Further, between these two groups, no significant differences on mean timed latency, estimated latency, or "quality of sexual relationship" score emerged. Pre-post main effects on all three measures were significant. On followup, 4 of 8 couples were considered to have maintained treatment gains according to study criteria. Three of the 4 couples had received standard in clinic treatment while one had been in the minimal contact condition.

Zeiss' results suggest that individual therapists can successfully treat couples in stable relationships with chronic histories of rapid ejaculation and that selected couples can successfully direct their own treatments with a guide and minimal therapist phone contact provided that gains are well established prior to termination. The brief, non-specific nature of the phone contact seems to imply that the treatment exercises incorporated into the manual are
sufficient to promote behavior change. Phone contact appears to facilitate, motivate and maintain couples along the treatment course. However, all three of the foregoing studies selected couples to test self-directed treatment formats and none compared self-directed formats with group formats.

Summary

Studies investigating behaviorally based treatment formats in the management of premature ejaculation suffer from numerous methodological problems, many of which are tied to the realities of clinical practice. Populations are highly selected, samples small, control groups lacking. The unsystematic nature of the work in directive sex therapy yields a wide variety of problems in design (e.g., uncontrolled non-sexual psychopathology). To the extent that investigators define ejaculatory dyscontrol distinctively, comparisons across outcome studies are compromised in value. Treatment approaches are diversifying at an explosive rate within the directive sex therapy tradition, raising all manner of research questions simultaneously. None of the questions raised have been competently or confidently answered at this time. Despite the problems inherent in existing research and the magnitude of the research agenda, certain central tendencies in the available data are discernable. With selected populations, the evidence is suggestive on the efficacy of directive treatment. The more ideal the conditions (motivated volunteers, couples—whether partner is treated or not) the better the outcomes. Reports of outcome studies published in the early part of the last decade also seem to be more favorable than later reports. This raises the
possibility that different populations are being drawn into treatment, or that later research has been more careful, or both.

Statement of Problem

The present study addressed itself to some of the questions implied in the above review. Can men without partners be successfully treated in group settings using self-directed formats? How salient is the group process and contact with therapist(s) in the treatment of premature ejaculation? To what extent will outcomes vary as a function of group versus self-directed treatment setting? In order to test these questions this study compared two treatment conditions, with each subject acting as his own control. A manual was developed by the author, based, in part, upon Zilbergeld's (1978) treatment exercise series and suggestions founded on clinical work done at The Human Sexuality Program, UCLA. Men in the Group Condition received a manual, a series of films and miscellaneous educational materials, homework assignments and their weekly review within the context of an all-male participant group led by a male-female cotherapy team. Men in the Self-Directed Condition received all of the educational materials, films and the manual (including homework assignments) in a one-day seminar. Subsequently, they directed their own treatment (with minimal phone contact with a therapist) over the eight week period. Males in this group received weekly phone calls from their therapists to check on and encourage progress.

Theoretical Background

Until approximately one decade ago, the psychodynamic view was the most prominent and typical way of understanding and treating
human sexual problems. Psychodynamic theories approach sex dysfunctions as symptomatic of deep-seated, underlying themes and conflicts of the individual personality, involving fixation and regression to various critical psychosexual points of development. Given the basic assumption that resolution of such conflicts obviates the need for sexual (or other) symptoms, psychoanalytic psychotherapy focuses almost exclusive attention on the alleged underlying conflict(s) and related processes. Symptom removal then, is neither the raison d'être nor even the primary goal of effective therapy. In fact, mere symptom removal, in the absence of basic personality change, is often viewed as counterproductive and likely to result in the emergence of new symptoms or in the re-emergence of old ones.

Such was the prevailing view until Masters and Johnson (1970) pioneered brief, directive sex therapy. Apart from the investment of time, energy and financial resources, which makes psychoanalytic treatment prohibitive for the vast majority of people, clinicians had their doubts about the efficacy of analytic treatment as applied to sex dysfunctions. As already noted, where they existed, analytic outcome data were qualitative rather than quantitative, based solely on uncontrolled, isolated case reports (Wright et al., 1977), and were oriented to the assumptions and biases of psychoanalytic theory and practice. The need for a new theoretical model which would promote alternative sets of questions, methods of investigation, and therapeutic techniques was clear.

The general model developed by Masters and Johnson was a behavioral model, emphasizing re-education and in vivo systematic
desensitization. Lobitz and LoPiccolo (1972) elaborated the model as follows:

"In the absence of any physical pathology, sexual dysfunction is viewed as a learned phenomenon, maintained internally by performance anxiety and externally by a non-reinforcing environment, principally the partner. In addition, a lack of sexual skill, knowledge, and communication on the part of one or both partners contributes to the dysfunction. (p. 265)

The factors labelled skill, knowledge, and communication already described by Masters and Johnson (1970), Lobitz and LoPiccolo (1972) and others serves to underscore the role ascribed to cognitive phenomena in the genesis and maintenance of sexual dysfunctions. Concomitantly, a range of traditional and innovative psychotherapeutic techniques (e.g., communications and relaxation training) borrowed from other systems of psychotherapy, came to be seen as increasingly relevant to the conceptualization and treatment of sexual dysfunction. While at present, no comprehensive, unified model of sexual dysfunction has been developed, a cognitive-behavioral model is the most widely used in current conceptualization of the sex dysfunctions in general, and premature ejaculation in particular.

The cognitive-behavioral approach assumes that (a) the human responds to cognitive representations of environmental events, rather than external events per se; (b) cognitive representations are functionally related to human learning; (c) most learning is cognitively mediated; (d) that a reciprocal determinism exists between thoughts, feelings and behaviors; and (e) that under appropriate contingencies, new learnings will manifest themselves in overt
behavior. Given the presumed reciprocal relationship between thoughts, affects and acts, a cognitive learning perspective would necessarily predict strong correlations between performance changes and relevant cognitive changes (Bandura, 1969; Brewer, 1974; Mahoney, 1974; Meichenbaum, 1977). A growing body of research (e.g., clinical applications of self-control) highlights the increasing importance of an interactionist, multivariable perspective on human behavior (Bandura, 1971, 1974; Goldfried & Merbaum, 1973; Kanfer, 1970; Mahoney, 1972; Meichenbaum, 1974; Thoresen & Mahoney, 1974).

Etiological factors thought relevant in the generation of sexual difficulties reflect the multifaceted framework just described. Hogan's (1978) broad-based review of the literature implicates the following factors under the historical rubric: sex trauma (Masters & Johnson, 1970), marital problems (Masters & Johnson, 1970), psychological factors, including religious orthodoxy (Masters & Johnson, 1970), homosexuality (Masters & Johnson, 1970), hostility (Gebhard, 1966; Masters & Johnson, 1970), and other sex dysfunctions. Current factors implicated include: illness (Kaplan, 1974; Masters & Johnson, 1970), surgery (Dengrove, 1968), lack of sexual skill and misinformation regarding sex, including negative attitudes and unrealistic expectations (Ellison, 1972; Kaplan, 1974; Lobitz & LoPiccolo, 1972), anxiety (Kaplan, 1974; Wolpe, 1973), depression, lack of communication, and performance concerns (Lobitz & LoPiccolo, 1972).

Some of the factors occupy a prominent place in theorizing about the etiology of premature ejaculation and in designing treatment interventions. The matter of sexual performance, for example, has
been variously analyzed in terms of its verbal/cognitive component (Masters & Johnson, 1970) and in terms of its affective (anxiety) component (Wolpe, 1971, 1973). The role of performance anxiety in the production of patterned premature ejaculation appears complex and remains controversial. On one hand, Wolpe (1973) theorizes that anxiety which, like the ejaculatory reflex, is sympathetically mediated, may promote rapid ejaculation. Kaplan (1974) on the other hand, assigns a mediational role to anxiety, asserting that it prevents the male from focusing on internal sensations premonitory to orgasm. According to this view, the absence of voluntary control, secondary to the lack of sensory feedback needed to bring any reflex function under control (Kaplan, 1974, p. 300), lies at the heart of premature ejaculation. Explicit in her argument is the idea that anxiety blocks sensory feedback, which in turn, diminishes or disables ejaculatory control.

Implicit in this view is the cognitive-behavioral claim that attentional factors are salient dimensions in any learning process. Applied to this phenomenon, the implicit argument seems to be that it is not merely anxiety, but in addition, its attention redistributing power and its cognitive sequelae which disturb ejaculatory control. Performance concerns, and the anxieties to which they give rise, are importantly enlarged by lack of sexual skill, poor interpersonal communication and/or social skills deficits, and major cognitive factors, pre-eminently misinformation about sexuality, myths, and unrealistic beliefs, fantasies, and expectations.

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8The term they employ in this connection is "spectatoring."
In sum, from this perspective, the most significant etiologic factors appear to be anxiety related to performance concerns, lack of sexual skill and information and poorly developed interpersonal skills.

From this matrix of diverse, potential etiologic elements, an empirical and multi-variable approach to treatment has evolved. Mahoney (1977a), in the light of rapid, multimodal developments, has argued that most effective therapy programs have emphasized: (a) task relevant motor performance; (b) task relevant visual stimulation; and (c) task relevant auditory stimulation. Similarly, therapy guidelines developed by cognitively oriented theorists (Beck, 1976; Mahoney, 1977b; Meichenbaum, 1974, 1977; Raimy, 1975) refer to three target areas: (a) perceptual skills, (b) performance skills and (c) associative skills. Perceptions, cognitions and behaviors are equally prominent in treatment guidelines, as they are in etiologic formulations. In this connection, Mahoney (1977a) observes:

The client is taught to make fine perceptual discriminations regarding environmental inputs and internal stimulation (thoughts, feelings, images, biochemical changes, etc.). This rather sophisticated and comprehensive "awareness" is supplemented with training in the development of critical evaluation of associations (e.g., beliefs, expectancies, perceived contingencies). As a matter of fact, one of the first associations emphasized is that between cognition and performance or affect. The client is shown that thoughts and images may play an important role in adjustment and phenomenology. Finally, the client is often given training in performance skills that will increase his options in regulating external and/or internal environments. (p. 12)
Owing to their broad construction of learning principles, and their emphasis on the modifiability of cognitions, cognitive learning theorists such as Mahoney (1977a) stress the following factors when considering therapeutic guidelines: (a) client motivation and incentive, (b) demand characteristics, (c) performance and outcome expectancies, (d) meaningful contexts and rationales, (e) use of graduated performance tasks, (f) adequate and relevant perceptual focusing, (g) use of optimal encoding, retention and retrieval means and (h) emphasis on practice or rehearsal. The development of guidelines such as these has prompted LoPiccolo (1978) to observe that "...it seems more reasonable to conceive of direct therapy procedures as complex and multifaceted packages of many different components" (p. 2).

Many sex therapy formats attempt to deal comprehensively with guidelines suggested by cognitive behavioral theorists. Information and education are conceived as necessary, though not necessarily sufficient, to the success of most brief therapy formats. Sexual anatomy and physiology, the sexual response cycle, and information on the range and diversity of sexual behavior is usually supplied. The provision of information and the correction of misconceptions are guided by a cognitive behavioral outlook, and by the recognition of the general ignorance regarding sex in clinical populations (Lazarus, 1971; Leckie, 1964). These elements of sex education provide a

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9 Further, Wright et al. (1977) argue that, given the above described multimodal treatment approaches which increasingly characterize the field, "component analysis studies" are ever more desirable forms of empirical investigation.
"meaningful context and rationale" for upcoming therapeutic work, and are likely to have an impact on "performance and outcome expectations" (Mahoney, 1977a). Educational components have been used to modify attitudes and behavior in cases of erectile failure (Roen, 1965; Stone & Levine, 1950), general sexual dysfunction (Stone & Levine, 1950), and orgasmic dysfunction (Robinson, 1974). Further, Lazarus (1978) claims that such sex education and re-education is effective alone in cases of dysfunction due entirely to ignorance or misinformation. Annon (1976) makes a similar claim. Closely allied to information dissemination is the principle of promoting attitude change. Restructuring negative or dysfunctional psychosexual attitudes which issue from past trauma, parental influences and general social influences are considered important therapeutic elements.

These twin principles are most commonly enacted either in group or couples contexts, both directly by the therapist(s) and vicariously through the use of film, videotape and written materials. Performance and attitude changes have been reported with the use of film and video as means of vicarious learning (Fryrear & Werner, 1970; Mann, 1969, 1972; Sarason & Ganzer, 1973; Wincze & Caird, 1973). Successful video use has been reported both before and after clients have received structured exercise assignments (More, 1972; Renick, 1973).

"Permission giving" (Annon, 1976) is another constituent part of the initial process of providing information and restructuring attitudes. Clients may initially require permission to be sexual persons, to masturbate, etc. Such permission may be accomplished either
directly (verbally) or vicariously (audiovisually). Instructional media presentations in the clinical setting meet Mahoney's (1977a) task relevant visual stimulation and motor performance guidelines. The work of Zilbergeld (1978) and others, moreover, suggests that structured fantasy, another imagery-based methodology, would also appear to meet the above criteria. (See Appendix A, for illustrative material on structured fantasy sequences used in this treatment program.)

The hallmark of brief sex therapy formats, and the usual next step in treatment programs, is the structured sexual experience. Such experiences are entirely congruent with Mahoney's (1977a) notion of "graduated performance tasks" enunciated in his therapeutic guidelines. This is the level at which behavior change is mandated and in which vicarious learning methods are most used.

Structured exercises frequently begin with masturbation techniques, which are useful in an initial desensitization hierarchy (Kaplan, 1974) insofar as they reduce anxiety (Lazarus, 1978) and provide the fundamentals for learning and its eventual transfer. In the latter regard, they are especially important for clients without partners (Annon, 1976). Even where partners are present, masturbation assignments, via successive approximation, set the stage for the later learning of the "pause" and "squeeze" techniques, and they do so in the absence of partner-based performance demands. With the elimination or dissipation of performance anxieties, the gradual acquisition of new motor behaviors (increased ejaculatory latency) and task relevant performance skills (pause, squeeze and relaxation
techniques), along with coaching and reinforcement from his own successes and/or the therapeutic milieu, the client is free to focus his attention on physical sensations rather than on self-defeating behaviors and cognitions related to a performance ideal (Jemail, 1973; Kaplan, 1974). Whereas, Tanner (1973) contends that the mechanism involved in the successful use of the "pause" and "squeeze" in learning ejaculatory control is operant shaping, LoPiccolo (1975) invokes Guthrie's principle of "crowding the threshold," in which stimulus-response connections between minimal stimulation and ejaculation are extinguished. The mechanisms underlying these techniques and their successful use are the subject of continuing debate.

Structured exercises vary along three dimensions: (a) whether they are graduated or not; (b) the means used to overcome attendant anxieties; and (c) the type of involvement in the experience, whether actual, imaginal or vicarious (Hogan, 1978). The theoretical base for structured exercises rests upon Wolpe's (1958) model of reciprocal inhibition, in which a response antagonistic to anxiety is elicited in the presence of anxiety provoking stimuli, causing suppression of the anxiety response. The bonds between such stimuli and typical responses to them are thus weakened. A hierarchy of sexual experiences, along with relaxation training, serves to check anxiety, according to this model. Since stimulus graduation is central to the model, graded, structured exercises are generally used.

All modes of involvement in the exercises are thought to produce change through counterconditioning, extinction and/or positive reinforcement. Direct involvement with a partner provides the opportunity
to shape skills and solicit partner feedback. Vicarious involvement(s) present(s) opportunities to develop novel response patterns, to disinhibit behavior(s) subsequent to viewing model's behavior(s), and to facilitate sexual responses, due to the legitimization of depicted sexual activities (Austin & Liberman, 1973). On these matters, Bandura (1971b) has suggested that:

As long as the representation of actions serves a response guidance function, changes in behavior through vicarious learning can occur even though the desired behavior may be presented in such symbolic forms as pictures or words. (p. 36; underscore added)

In a recent study of anorgasmic women, Robinson (1974) reported that a variety of sexual behaviors were acquired or increased through purely vicarious means. Wincze and Caird (1976) found that a graduated video series and relaxation training were slightly more effective than imaginal systematic desensitization in women with anorgasmia or general sexual dysfunction. The growing consensus among cognitive behaviorists on the means to enhance vicarious learning effects includes the following elements: providing clear pre-therapy instructions, presenting material incrementally, using models resembling client(s), providing clients the chance to view the positive, affective consequences accruing to the model as a function of behavior change, and having the models provide verbal reinforcement and guidance, where appropriate.

Another element of importance in many sex therapy formats is communication skills training. This adjunct is oriented to teaching clients how to: engage in general sexual discussion (Tanner, 1973),
discuss sexual feelings, sensations and fears (Kaplan, 1974), discuss specific stimulation techniques and other sexual behaviors enjoyed (Fodor, 1974; LoPiccolo, 1975), discuss disliked sexual behaviors (Fodor, 1974; LoPiccolo, 1975), share in sexual fantasies (LoPiccolo, 1975). In many therapeutic endeavors, general communication skills are closely tied to assertion skills. Thus, clinicians have recognized, as Hogan (1978) does, that:

Sexual behavior does not take place in an interpersonal vacuum...Before engaging in sex, a person must have certain social skills and be able to overcome inhibitions about making social contacts, forming interpersonal relationships and maintaining these relationships. Assertiveness is an important element in this process. It is also important in the area of communication about sexual needs and preferences. (p. 77)

Additionally then, communication or social skills training also addresses the significance and means of giving feedback during sexual activity (Masters & Johnson, 1970), use of physical touch to convey feeling (Masters & Johnson, 1970), ways to initiate and refuse sex (Lobitz & LoPiccolo, 1972; LoPiccolo, 1975), and the expression of non-sexual feelings (Lobitz & LoPiccolo, 1972; Zeiss & Zeiss, 1975). Assertion training along these lines has been used as a component in the treatment of premature ejaculation (Yulis, 1976).

**Description of the Study**

This study sought to ascertain whether a previously unstudied population (men without steady partners) could benefit by brief directive sex therapy under Self-Directed and Group Conditions which varied the amount of peer and therapist contact in the treatment context.
In so doing, it attempted to extend the application of the brief sex therapy model and to provide controlled comparisons among Group and Self-Directed Conditions.

In the present design, many of the elements outlined in various therapeutic guidelines (e.g., Mahoney, 1977a; Meichenbaum, 1977) have been explicitly translated into forms of therapeutic action. The questions of information, correction of myths and misconceptions, "permission-giving," and attitude modification received particular emphasis in the early sessions of the Group treatment format (see Appendix A) and in the opening hours of the Self-Directed format. To some degree, these elements were present throughout the course of treatment. They were designed to have impacts on what Mahoney (1977a) might term "performance and outcome expectancies." The present study made some attempt to incorporate notions on hierarchy and graduation of tasks (Mahoney, 1977a; Wolpe, 1958) stressed in the behavioral literature, in the carefully structured exercises, which proceeded from simple to complex tasks gradually, as well as in the general flow of the treatment program. It was assumed that information and attitude modification were least anxiety provoking, followed by self-stimulation without partner, stimulation with partner if possible, and lastly, social and sexual interpersonal communications. Both treatment groups were exposed to therapeutic tasks in the same, graded, systematic fashion.

On the evidence of past research (Lowe & Mikulas, 1975; Zeiss, 1977; Zeiss et al., 1978), the technical materials designed for the treatment of premature ejaculation provided, in terms Mahoney (1977a)
might use, "adequate and relevant perceptual focusing" and "meaningful contexts and rationales" for treatment. The Group and Self-Directed treatment formats attempted to accommodate both direct and vicarious exposure in relation to the sexual exercises. In the last half (weeks 4-8) of the Group format, work with a partner was verbally encouraged; the same encouragement was given to clients in the Self-Directed Condition at an analogous point in treatment. The attempt to include both direct and vicarious exposure, and the sustained, progressive nature of the structured sexual exercises over the course of treatment, gave substance to the concern with "practice or rehearsal" and "motivation and incentive" (Mahoney, 1977a).

The selected films (see Appendix B) incorporated guidance by the model (both verbal and non-verbal) at each step of treatment, used models similar in age and sexual concerns to the client group, and demonstrated the positive, affective consequences attributable to the exercises and the program in general. The film and video materials were also intended to have the effects of addressing performance and outcome expectancies, heightening the meaningfulness of the structured exercises by placing them in a concrete, everyday context, and providing salient perceptual and sensory foci.

Communication issues and the skills associated with them were addressed in the last phase of both group and self-directed treatment formats (Appendix A) in the belief that they were best learned against a background of permission, information and education, and structured sexual experiences, where some control and success had likely been achieved. This appeared especially to be the case for a
group of men without steady partners. Additionally under such circumstances, one of the clear advantages of a dual-sex cotherapy team was their capacity to model a positive relationship, thus facilitating communication (Reding & Ennis, 1964).

Finally, the two groups in this study varied in their learning (Group versus Self-Directed) contexts. Predictions on all outcome measures varied as a function of group of assignment. All predictions favored the Group over the Self-Directed Condition. Group contexts have shown great promise in the treatment of premature ejaculation (Golden et al., 1978; Kaplan, 1974; Zeiss et al., 1978).

Predictions favoring outcomes in the Group context derived from a consideration of the theoretical elements of group functioning and from empirical data on group processes, as well as the sex therapy outcome studies referred to above. In the group context, a commonly noted therapeutic factor is that, clients, in the course of sharing problems, reactions, etc., shed their debilitating sense of isolation and abnormality (Stone & Levine, 1950). Other regular features of group process include support and empathy, peer modeling, ongoing technical instruction and correction, coaching and constructive interpersonal feedback by group members (Kaplan, 1974; Lazarus, 1961, 1968). While these processes are not unique to groups, they are endowed with special force in group contexts, especially in behaviorally oriented group work. One reason for this is the simple fact that groups provide participants with a wide variety of live models, quite apart from the overt modeling and social influence demonstrated by the therapist(s). The variety of models means that clients are
generally exposed to a wider range of opinions (Lazarus, 1968), delivered by persons with varying interpersonal styles and personal characteristics. This factor enhances the credibility of suggested change, along with maximizing the generalizations of behavior change since new behaviors thus acquired are more likely to fit social norms (Lazarus, 1968).

General evidence exists to indicate that model characteristics influence model effectiveness as a change agent (Bandura, 1969). In this respect, group participants can be highly effective peer models for one another. Proximity in the social hierarchy, and perception of similarity between the member and the model increase the member's willingness to identify with the model, and to imitate the model's behavior. Peer models, by virtue of lesser social distance from other group members, are likely, furthermore, to be self-disclosing, to reveal the positive, affective outcomes related to changes in their attitudes and behaviors, and to dispense useful and credible guidance based on their experience. Moreover, there is evidence to suggest reciprocity in helping relationships. Reissman (1965) has indicated that helpers often gain as much from helping others as do the intended recipients of the help. This "helper therapy principle," as Reissman has dubbed it, is likely operative in many helping contexts. Since group contexts usually encourage substantial member interaction and general participation, this process may be quite prevalent in groups with some measure of an activist or self-help ideology.

Both Group and Self-Directed Conditions provided participants with the same learning materials in the same graded sequence.
Information, education and attitude restructuring opportunities and materials were provided to subjects in both conditions. Structured exercises, relaxation training, communication skills and tailored maintenance programs were also provided to each group. Both saw the same films and received the same handouts. However, the peer group process was not available to clients in the Self-Directed Condition. Such peer group interaction, facilitated by weekly review of homework assignments (including successes and failures experienced), peer modeling and reciprocal helping, coaching, peer reinforcement, behavior rehearsal and role-play, and the legitimizing effects of stable group membership, were expected to have powerful impacts on learning in the Group context. Any effects associated with being in an introductory seminar prior to embarking on the self-directed format (e.g., the normalizing effect of merely seeing other clients with the same, defined problem) were expected to be weak and indirect. Thus, changes in the behavior and/or attitudes, cognitions and affects of these clients under these circumstances would plausibly be attributable to the learning materials primarily, rather than to the combined effects of the treatment materials and the various social facilitation effects of stable group membership.

In sum, this study compared Group and Self-Directed brief treatment formats in the management of premature ejaculation in a sample of single males without regular sexual partners. Following a variable length control period, each of 16 volunteers was randomly assigned to one of the treatment conditions. Both conditions provided clients with a variety of educational materials relevant to the attainment
of ejaculatory control. Group participants met for 2 hours per week over an 8 week period in a group setting directed by a male-female cotherapy team. Self-directed participants met in a one-day seminar and subsequently self-directed (with minimal weekly phone contact) their treatment over the 8-week period. The chief distinction between the formats was the presence or absence of a therapist-supervised group process.

**Hypotheses**

Intervention effects assessed after treatment and at followup were expected to be significantly greater for the Group Condition as compared with the Self-Directed Condition as follows:

1. Increases in mean ejaculatory latencies assessed in a variety of ways.
2. Degree or frequency of ejaculatory control in foreplay and intercourse activities.
3. Subjective satisfaction with ejaculatory control and other aspects of sexual functioning.
4. Increases in mean amount of time spent in foreplay and intercourse activities.
5. Increases in mean dating frequency and quality.

Since no prior, published, controlled outcome research in the area has employed the measures described below, the hypotheses were posed in exploratory terms. They predicted effects in the same direction as those above:

1. Increases in mean amount of communication with partners regarding sexual preferences, sensations, affects and other
responses as measured by the Communications subscale of the Sexual Background Inventory.

2. Increases in mean ratings of private self-consciousness as measured by the Self-Consciousness Scale (Fenigstein et al., 1975) and ratings of internal locus of control as measured by the Rotter (1966) Internal-External Locus of Control Scale.

3. Decreases in mean negative attitudes toward masturbation (Negative Attitudes Toward Masturbation Scale, Abramson & Mosher, 1975), sex guilt (Mosher Sex Guilt Scale, 1966), social anxiety and public self-consciousness (Self-Consciousness Scale, Fenigstein et al., 1975).

4. Increases in ejaculatory latency and control variables correlated with predicted attitude changes as elucidated in exploratory hypotheses 2 and 3 above.

Along with the demographic data, the exploratory hypotheses were designed to yield a pool of descriptive data concerning sexual attitudes, behaviors and affects for a sample of premature ejaculators without steady partners who seek treatment. Beyond that, assessment of these variables was included here since, as noted, previous research has suggested their importance in ejaculatory control problems and sex dysfunctions generally. These data should interest researchers in the field, theoreticians and clinicians.
Chapter II

METHOD

Subjects

Selection: All clients were either self or professionally referred adult males who met the following criteria: (a) they were dating, minimally 2-3 times per month; (b) they were not dating a steady partner who was seen more than once per week,\(^1\) nor were they cohabiting; (c) they were heterosexually oriented; (d) they had no prior, formal sex therapy; (e) they gave evidence of an established diagnosis of premature ejaculation, namely a report of dissatisfaction with control over timing their ejaculations, and a reported subjective estimated latency under three minutes\(^2\) over a period of at least six months. Occasional erectile dysfunction, secondary to pre-existing premature ejaculation, was not a basis for exclusion from this study; (f) the absence of any major addictions, organic disorders or major psychopathology, as assessed by a personal interview and an MMPI (Hathaway & McKinley, 1943).

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\(^1\) Men dating steady partners more than once per week were referred for couples treatment.

\(^2\) An attempt was made to collect timed latency estimates prior to the onset of treatment.
All potential subjects were screened via an initial telephone interview to establish compliance with the above criteria, to verify a diagnosis of ejaculatory dyscontrol, to inform each regarding the experimental nature of the program and its requirements, and to set up an appointment for a personal interview with the principal investigator. Along the standard pathways by which clients come to sex therapy, as well as in response to a series of advertisements and program announcements made in the local print and broadcast media, some ninety calls of inquiry were recorded. Of those, a total of 26 men were personally interviewed and subsequently accepted for treatment. Seventeen of those 26 accepted the clinic's offer of treatment and agreed to the terms of the offer. Each subject signed an Informed Consent Form, an Incentive Deposit Agreement, and a "Subject's Bill of Rights" (see Appendix D) prior to entering the study. Of those who declined, one did so because he expressed a preference for private treatment, two relocated without notice, two improved spontaneously, one was abroad during the treatment period, one declined for unknown reasons, and two declined for expressed financial reasons. Three applicants were rejected by the interviewer: two on the grounds that their histories of drug and alcohol abuse respectively and their psychiatric histories made them poor candidates for a sex research and treatment program, and the third because he had been treated in a sex therapy program previously.

The remaining 62 never progressed beyond the telephone interview stage for a variety of reasons, including cost (7); failure/refusal to follow through on requisite steps in the screening process (6);
inappropriate diagnosis (9); failure to meet relationship status criteria, namely being married, coupled or reporting absence of partner(s) or sexual interaction for six months or longer (8); no reason given (16); and the remainder for miscellaneous reasons such as scheduling conflicts, pending relocation plans, insufficient commitment, etc. Where possible and requested, other treatment referrals were provided.

Subjects agreed to fulfill all study requirements, including completion of homework assignments and outcome measures at specified points in time. For this reason, subjects agreed to remain in the greater Los Angeles area for at least two months following the treatment period. In addition, each subject was required to deposit an incentive fee of $40.00, refundable contingent upon compliance with the above described requirements. Clients were charged along a sliding scale established by the UCLA Neuropsychiatric Institute in an attempt, in part, to meaningfully weigh the cost of treatment against personal income. Those persons whose financial liability was set at zero were required to deposit an additional $80.00 treatment incentive with the Human Sexuality Program. At the conclusion of the eight week treatment course, treatment incentive deposits were refunded to program participants. Probably as a result of the incentive deposit system described above, there was no mortality of subjects over the entire study phase. All subjects completed all study requirements through the Six Month Followup.

All but one of the 17 subjects accepted for this program were randomly assigned to the two treatment Conditions, resulting in eight
men in each Condition. For those subjects randomly assigned to the Self-Directed Condition, subsequent assignment of cotherapists for phone contact purposes was made on a random basis. Thus, the female cotherapist followed four Self-Directed subjects, while the male cotherapist followed five subjects. Similarly, assignment of Group Condition subjects to cotherapists for medicolegal and other procedural purposes was also randomly achieved.

Description. The sample of 16 males was characterized demographically in the following ways. The age range was 18 through 43 with a mean of 28.6 (SD = 8.4), for the Group Condition; the mean age for the Self-Directed men was 27.3 (SD = 6.9). There was no significant baseline difference between Conditions in terms of age, $F(1,14) = .10$, $p > .10$. The sample was exclusively white. Pre-treatment, two of the men were separated, four were divorced, and ten of the men were in the single, never married category. At the Six Month Followup, six were divorced and ten were in the single, never married category. The average length of marriage for those previously married was 9.5 years, ranging from four through 18 years. Of the men previously married, four had children.

In terms of religious status at birth, the sample was 25% Catholic, 31.3% Jewish and 43.8% Protestant. In terms of current religious

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3 The nonrandomly assigned subject was treated clinically, but the data thus generated were excluded from all analyses. His assignment was to the Self-Directed Condition.

4 Where appropriate, the Yates corrected chi-square and Fisher Exact Tests (Two-Tail) were applied to the data. No significant relationships were found for group membership and any of the descriptive variables discussed in this chapter.
affiliation, one subject designated Catholic, five designated Protestant, four designated Jewish, one designated "other," and five designated "none" at the pre-treatment test point. At Six-Month Followup, the distribution remained, essentially, the same.

The sample reported substantial changes in degree of religious activity over time. Whereas two rated themselves devout, eight rated themselves moderately active, and six occasionally active in childhood, none designated devout, only two designated moderate activity, while eight rated themselves occasionally active and six rated themselves inactive in adulthood. An analysis of variance on religious activity in childhood indicated a significant difference between Conditions at baseline, $F(1,14) = 18.67$, $p < .001$, with Self-Directed subjects reporting greater religious activity in childhood. In contrast, an analysis of variance on current religious activity yielded no significant Condition ($F(1,14) = 0.01$, $p > .05$) or Period ($F(3,42) = 0.79$, $p > .05$) effects.

Owing both to the solicitation procedure and the campus setting of the clinic, the sample attracted was highly educated. Prior to treatment, only one was a high school graduate, seven had received some college education, one was a college graduate, two each had received some graduate education or the M.A. degree and three had earned the Ph.D., M.D., or J.D. degree. A majority were enrolled in college or graduate school during the course of treatment and follow-up such that an analysis of variance on highest educational level attained showed a significant main effect for Period, $F(3,42) = 2.80$, $p < .05$, indicating increases in educational attainment over time for
subjects in both Conditions.

At pretest, the occupational distribution was five professional/technical personnel, one manager, one laborer, one service worker, and eight students. Thirteen subjects were employed at pretest, while three were unemployed. Whereas the percentages of the total frequency had shifted somewhat at Six Month Followup, employment status and group assignment remained independent.

Referral to the program was distributed as follows: eight were self-referred, two came through private professionals, one came through school contact, another through a friend, and four through "other" means.

Subjects' current living situation showed the following pattern of distribution at baseline: seven were living alone, three were living with male roommate(s), two each were living at home with parents or in a collective environment and one designated "other." At Six Month Followup, five were living alone, two with male roommate(s), four with a female sexual partner on a regular basis and one on a part-time basis, two at home with parents, one collectively, one "other."

The changes in patterns of living arrangements suggest a considerable set of relationship changes over time for a sample of men who entered treatment without steady dating partners. All 16 subjects were dating at Pre-pre and 15 were dating at Six Month Followup, while one was not dating.5 When asked whether they were dating one person

5These two cases appear to violate the dating criteria established for this study. The discrepancies arose because subjects either misunderstood or misconstrued the questions, because they presented differently in a personal interview as compared with a questionnaire format, or because the status of their personal relationships fluctuated greatly.
steadily at pretest, fifteen responded negatively while one responded affirmatively. Paralleling the changes in living patterns, at follow-up, six men indicated they were dating one person steadily whereas nine indicated they were not.

An analysis of variance indicated that there was no significant difference between Conditions at pretest on age at which intercourse experience was initiated $F(1,14) = 0.66, p > .10$. Mean age of onset was 18.9 years. Nor was there a significant difference between Conditions at pretest on length of intercourse experience in longest previous relationship, $F(1,14) = 0.65, p > .10$.

In terms of the specific symptom picture, the mean duration of disorder was 7.9 years (SD = 6.1). There were no significant differences between Conditions in duration of problem, $F(1,14) = 0.29, p > .10$. When asked whether the pattern of prematurity had been consistent since onset of coital experience, six responded affirmatively while ten responded negatively at pretest. In response to a question probing subjects' methods of ejaculatory control, two men designated drugs, three mentioned relaxation, five designated frequency of coitus as a chief factor, two referred to lack of excitement, two implicated condoms, two invoked partners' activities and/or attitudes, and one designated treatment techniques in accounting for times when ejaculatory control was experienced. Coital frequency was the most popular means to account for ejaculatory control in this sample. The sample indicated considerable stability in terms of overall ejaculatory pattern, with the problem remaining "about the same" over the pretest period, $F(1,14) = .36, p > .10$. Additionally, there were no significant
differences between the Conditions, $F(1, 14) = 2.07, p > .10$.

A dimension of interest in this study was subjects' own definitions of premature ejaculation (see Appendix C). A frequency table prepared from their categorized responses indicated that two men regarded "before intromission" as the criterion, while three designated "at intromission" as the criterion; four had a partner oriented control criterion, five men regarded "after a few thrusts" as the criterion, and, most frequently, seven indicated that "before I want to" conformed to their definitions of ejaculatory dyscontrol. The data reveal a tendency on the part of this sample to prefer an ideographic, phenomenologically-based definition for ejaculatory dyscontrol, consonant with the Kaplan (1974) view. Interestingly, none referred to an explicit time-based criterion which is characteristic of much of the empirical literature on ejaculatory dyscontrol.

Of concomitant interest was the question of self-generated control strategies on the part of our subjects. When asked about techniques used in an attempt to overcome their dyscontrol, the most frequent responses were: "thinking distracting thoughts" (68.8%), "masturbating before having/anticipating sex" (62.5%), "reading marriage or sex manuals" (50%), and "using the squeeze or stop/start techniques during intercourse" (37.5%). Use of local anesthetics, consultation with physician, use of drugs and sexual avoidance were relatively

6 The figures exceed sixteen (100%) because several subjects indicated plural criteria.

7 In addition, one subject reported "using the Masters and Johnson program on your own."
infrequently employed strategies. The pronounced use of masturbation as a control technique is consistent with subjects' invocation of "frequency" as a means of accounting for times when coital control was present (see discussion on p. 40). The other popular control choices (reading sex manuals/using squeeze or pause) not only suggest the highly educated orientation of the sample, but a marked tendency toward self-help activism and a measure of fluency with the methodology of the "new sex therapy." Some 43.8% of the sample reported having experimented with one or more behaviorally based techniques prior to entering the program and half of the sample had read marriage/sex manuals, including possibly newer behaviorally oriented sex therapy texts. These data then suggest that clients applying for treatment now, in major metropolitan sex therapy programs, may represent a more sophisticated, knowledgeable or intractable group who attempt self-managed behavioral changes first and seek help formally only if and when their own interventions fail.

The distribution of the most recent type of contraceptive method employed at pretest follows. One subject reported using each of the following: nothing, rhythm method, vasectomy and spermicidal foams or gels; three subjects reported using condoms; four reported use of birth control pills; two reported use of intrauterine devices, and one used "other" means. In contrast, the distribution of past contraceptive devices employed, as reported at pretest, was as follows: six subjects reported using intrauterine devices, foams or gels and/or nothing; three used withdrawal; two used rhythm; nine used condoms; ten reported use of birth control pills and one had a vasectomy.
When asked, at pretest, whether their contraceptive practices had any negative effects on their sexual functioning or enjoyment, four men responded affirmatively while twelve men responded negatively. Those subjects who indicated that their customary contraceptive practices interfered with their sexual functioning, whether generally or specifically, were encouraged to adopt alternative, mutually agreeable methods. Over the course of treatment and followup, there was a decline in the number of men who indicated that their contraceptive methods had negative impacts on their sexual functioning. Use of and satisfaction with various birth control technologies are regarded as relevant variables in connection with premature ejaculation insofar as client reliance on particular kinds (withdrawal, rhythm, condoms) may, in varying ways, maintain or exacerbate the rapid ejaculatory pattern.

When asked, at pretest, to list three desired changes with respect to their own sexual behavior, 15 indicated ejaculatory control as a central goal, five each endorsed improved communication and sexual repertoire expansion as chief concerns, and six wanted more confidence and less anxiety in sexual situations. Finally, there was no significant difference between Conditions on their response to an item (Appendix C, Sexual Background Inventory (Pre), item #50) assessing their expectations regarding treatment outcome, $F(1,14) = 0.07$, $p > .10$.

Therapists. A male-female cotherapist team conducted both Group and Self-Directed treatments. Because of the dating and relationship status of subjects in this study, it was seen as desirable, the general empirical research notwithstanding, e.g., Kaplan et al., 1974, to
employ a mixed sex cotherapy team for modeling purposes. The team con­sisted of qualified therapists holding the doctoral degree in clinical psychology who were experienced in the conduct of brief, directive sex therapy. The Self-Directed format, however, was novel to both therapists.

The principal investigator (who did not serve as a therapist in the present study) was responsible for the coordination of all adminis­trative and operational aspects of the research. A treatment format was developed and strictly followed so that the subjects in each Condi­tion were identically treated.

Procedure

In order to test the hypotheses a modification of the basic pre­test-posttest control group design was used. Each subject acted as his own control prior to being randomly assigned to treatment Condition, since it was not possible to generate a large enough pool to run the two treatment Conditions and control Condition simultaneously and independently. The length of the control period varied, and depended upon when subjects volunteered, were screened and accepted into the program. The control period ranged from a minimum of three weeks to a maximum of 21 weeks. Four subjects waited less than two months, two waited three months, and five each waited approximately four and five months for treatment. A t-test procedure performed to elucidate the differences if any, between Conditions (in terms of length of wait for treatment) revealed a significant difference, t(8.1) = 3.31, $p < .025$, indicating that Group subjects waited for significantly shorter time periods than Self-Directed subjects. This low probability outcome
occurred in the context of random assignment of subjects to Condition. The two treatment Conditions (Group, Self-Directed) and the five points of observation or measurement (Pre-pre, Pre, Post, Two Month and Six Month Followup) resulted in a 2 x 5 factorial design. The design was implemented in the terms described below.

**Testing.** At screening, each subject was administered a Sexual Background Inventory (Pre) along with an MMPI. At the end of the control period, each subject was administered a second pre-treatment battery of measures including the Sexual Background Inventory (Pre)\(^8\), the Goals for Sex Therapy Scale-Male, the Ejaculatory Latency Data Form (Pre), the Negative Attitudes Toward Masturbation Scale, the Sex-Guilt Scale, the Internal-External Locus of Control Scale and the Self-Consciousness Scale (Appendix C). Upon completion of the battery, each subject was randomly assigned to one of the treatment Conditions: Group (\(N = 8\)), Self-Directed (\(N = 9\)).

A post-treatment battery was administered to all subjects nine weeks after treatment was initiated (Post), eight weeks later (Two Month Followup) and, 16 weeks thereafter (Six Month Followup). With the exception of the compliance data, the questionnaires and instruments used at the three post-treatment observation points were identical in sequence and substance. In addition, at Post and Six Month Followup, treatment compliance data were collected. The method used to gather compliance data and the extent and nature of the information

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\(^8\) A smaller number of selected, dynamic items were re-administered.
collected differed at those points in time. In the nine weeks between
the pre and posttests, subjects in each Condition received their
respective treatments.

Measures

In their fairly recent and comprehensive review of the status of
outcome research on sexual dysfunction, Wright et al. (1977) suggest
that:

Ideally, individuals or couples participating in sexual therapy should be assessed
on multiple dependent measures. This will allow...a more comprehensive evaluation of
pre-therapeutic to post-therapeutic change. (p. 889)

In the spirit of this suggestion, this study employed the following
diverse measures:

1. Minnesota Multiphasic Personality Inventory (Hathaway &
McKinley, 1943). This renowned, standardized psychometric test con­
tains 566 true/false items. Its utility and popularity find expres­
sion in many sources. In the present study, the MMPI was used as a
screening instrument. All subjects were carefully evaluated in terms
of their appropriateness for this study in accordance with criteria
defined earlier in this chapter. No applicant was eliminated from
consideration on the basis of his MMPI profile.

2. Sexual Background Inventory. Based upon the inventory by
the same name used at the University of Oregon Sex Research Project
and at the UCLA Human Sexuality Program, this Inventory has been
elaborated and expanded by the investigator for use in this study.
All subjects completed this measure at pre, post and followup points.
The Inventory collects a standard series of demographic data along
with a wide variety of standard sex-related data, ranging from estimated frequencies of particular behaviors to self-ratings of sexual satisfaction, historical and dynamic information regarding ejaculation, etc. (See Appendix C). The Inventory has been slightly revised to reflect the concerns and experiences of men without steady partners, such that it assesses dating frequency, dating quality, satisfaction with social relationship(s) and so forth. In addition, items eliciting subjects' understanding of the contingencies of premature ejaculation and their control strategies along with a subset of items on sexually relevant communications were added. Further, the post-treatment form of the Inventory was revised to include a series of questions on program evaluation, current utilization and appraisal of techniques learned in treatment, the impact of treatment on social relations, and the like.

Data derived from the Sexual Background Inventory were used to assess changes in subjects' sexual behavior and feelings, including masturbatory behavior, latency to ejaculation, dating satisfaction, sexual experience, and self-reported changes in interpersonal communication. Measurement of sexual behavior is particularly difficult owing to the usually private setting in which sexual behavior occurs, and to the ethical injunctions involved in doing sex research. It is, therefore, necessary to rely on a variety of self-report measures in assessing sexual variables of interest. The Sexual Background Inventory is one such measure designed with these purposes in mind.

3. **Goals for Sex Therapy Scale-Male** (1975). Developed by Price and Heinrich at the UCLA Human Sexuality Program, this 10-item self-
report measure assesses degree of satisfaction or goal attainment with a variety of current sexual behaviors and affects along a 7-point continuum ranging from "Much Less Than Satisfied" (1) to "Much More Than Satisfied" (7). The goal statements are primarily concerned with premature ejaculation (see Appendix C). Space is provided to list up to three additional goals with respect to subject's sexual functioning, and to rate his current level of satisfaction with each. In their review of methodological issues in sex research, Bentler and Abramson (1978) suggest that this Scale is useful in the assessment of sex dysfunctions. However, no reliability or validity data have been reported, and it has never been used in a controlled study. It was administered in this study at pre, post and followup points in order to assess changes in subjects' self-reported goal attainment with respect to ejaculatory control in varied sexual activities.

4. Ejaculatory Latency Data Form. Developed by Zeiss at the University of Oregon Sex Research Project, this form has been revised for use with the current population. The original version attempts to objectify and quantify latency estimates during "normal" intercourse. Because it appeared unlikely that a sample of minimal daters would willingly subject themselves and their partners (if any) to timing coital ejaculatory latency, especially prior to treatment, the pre form was revised to assess ejaculatory latency during self-stimulation. The Ejaculatory Latency Data Form (Pre-Masturbation) was administered to all subjects prior to treatment. At post-treatment observation points, both variants of the form, reflecting timed latency estimates in masturbatory and coital activity, were administered to
all subjects, and the forms were identical to one another at each followup point. As inspection of the variant forms (Appendix C) reveals, the post version requested subjects to provide multiple latency estimates under varying instructions. With these variants, a greater variety of objective latency estimates, along with subjective self-reported latency estimates, became available for analysis.

5. **Negative Attitudes Toward Masturbation Scale (1975).** The Negative Attitudes Toward Masturbation Scale (Abramson & Mosher, 1975), a 30-item sampling of diverse attitudes and beliefs about masturbation, is the most useful and sound measure of experience with masturbation currently available. In their initial report on the scale (1975), the authors indicated that negative attitudes toward masturbation and sex guilt suggest themselves as "two constructs with theoretical significance and usefulness in research in human sexuality as well as in treating at least some forms of sexual pathology" (p. 485). The authors' report demonstrated that negative attitudes toward masturbation were clearly related to a lower frequency of masturbation and less sexual experience. In other work, Mosher and Abramson (1977) reported that the measure differentiated both the sexual arousal and affective responses of subjects to films of masturbation. Abramson and Mosher (1978) found the measure able to account for variability in masturbatory fantasies as well.

Item selection for the scale was based upon the results of an internal consistency item analysis. A factor analysis of the items

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9 Mosher's Sex Guilt measure was used in this study and is described under #6 below.
generated three factors: positive attitudes toward masturbation (12 items), e.g., "Masturbation can provide an outlet for sex fantasies without harming anyone else or endangering oneself," false beliefs about the harmful nature of masturbation (11 items), e.g., "Masturbation can lead to homosexuality," and personally experienced negative affects associated with masturbation (7 items), e.g., "When I masturbate, I am disgusted with myself." The split half reliability coefficient for the measure was .75. Scores on the measure of negative attitudes toward masturbation were significantly negatively correlated with the average frequency of masturbation per month for men \( r = -.26 \) and women \( r = -.40 \).

Since the treatment formats mandated substantial masturbatory activity, it was reasonable to expect changes in subjects' beliefs and attitudes about masturbation, along with increases in masturbatory frequency and/or general sexual experience. Despite the growing centrality of masturbation in treatment formulations for a variety of sex dysfunctions, formats and subpopulations, and the psychometric soundness of the measure, no previous outcome research published in the literature has used the Negative Attitudes Toward Masturbation Scale.

In the present study, the scale was administered at pre, post and followup points in order to index subjects' initial levels of negative attitudes toward masturbation and to record changes in their scores resulting from treatment exposure. Correlations between change scores on the Negative Attitudes Toward Masturbation Scale and change scores on the major dependent measures described here were
performed as well.

6. Mosher Sex-Guilt Scale (1966). The Sex-Guilt Scale (Mosher, 1961, 1966, 1968) was developed in a multi-trait, multi-method matrix procedure. An internal consistency item analysis was used to select forced-choice alternatives. The following are examples of sex-guilt items:

As a child, sex play
a. was a big taboo, and I was deathly afraid of it
b. was common without guilt feelings

When I have sexual desires
a. they are quite strong
b. I attempt to repress them

The scale consists of 28 items whose weighted scores can range from -45 to +37. The corrected split-half reliability for the male form of the scale is .97. The forced-choice measure shows appropriate convergence with similar measures of sex-guilt, and divergence from other subscales (hostility-guilt, morality-conscience), anxiety and social desirability (Abramson & Mosher, 1975; Mosher, 1966).

The construct validity of the Mosher forced-choice measure of sex-guilt has been demonstrated in a wide number of investigations. Subjects who score high on the sex-guilt measure have been shown to experience guilt or other negative affects after exposure to erotic literature or explicitly sexual films (Mosher, 1972, 1973; Mosher & Greenberg, 1969), to be less sexually experienced (Langston, 1973; Mosher, 1973; Mosher & Cross, 1971), to have less intimate premarital sexual experiences and less permissive premarital standards (Mosher & Cross, 1971), to have more negative attitudes toward sex (Mosher, 1973), to give fewer sexual associations to double-entendre sexual words
(Galbraith & Mosher, 1968, 1970), to retain less birth control information (Schwartz, 1973), and to report less sexual responsiveness and greater disgust after reading erotic material (Schill, 1972). Along similar lines, Langston (1973) reported positive correlations between sex-guilt and religious activity and negative correlations between religious activity and sexual behavior. In addition, Galbraith (1969) investigated correlates of sex-guilt with Thorne's (1966) Sex Inventory and found sex-guilt positively correlated with Repression of Sexuality, and negatively correlated with Sex Drive and Interest, and Promiscuity and Sociopathy, subscales of the Thorne Inventory. Additionally, Abramson et al. (1977a) found that sex-guilty males showed a preference for affiliative relationships and were less interested in heterosexual contact. Moreover, sex-guilt is related to the content of masturbatory (Abramson & Mosher, 1977) and sexual (Duffy, 1976) fantasies, and, finally, sexual stimuli act as more positive reinforcers for low sex-guilt subjects than for high sex-guilt subjects (Griffitt, 1976).

Thus, a conceptual structure has been articulated to explain the development of guilt (Mosher, 1961), a psychometrically sound measure of guilt has been operationalized (Mosher, 1961, 1966, 1968), and a considerable body of research underscoring the psychological significance of sex-guilt exists. Yet, few attempts have been made to integrate guilt within a broader frame of personality variables (Abramson et al., 1977b) or to employ sex-guilt in sex therapy studies.

The sex-guilt measure, administered at pre, post and followup points, was correlated with each relevant outcome measure, in the
interests of better understanding the empirical relationship between conceptually linked behavioral and attitudinal variables and changes, if any, in subjects' self-reported sex-guilt as a function of time and treatment context.

7. **Self-Consciousness Scale** (1975). Fenigstein, Scheier and Buss (1975) have defined self-consciousness as the "consistent tendency of persons to direct attention inward or outward" (p. 522). The Self-Consciousness Scale (Fenigstein et al., 1975) was constructed from the following categories, in an attempt to sample the domain of self-consciousness: (a) preoccupation with past, present and future behavior; (b) sensitivity to inner feelings; (c) recognition of one's positive and negative attributes; (d) introspective behavior; (e) a tendency to picture or imagine oneself; (f) awareness of one's physical appearance and presentation; and (g) concern over the appraisal of others.

A 38-item scale, drawn from the above categories, was administered to 212 undergraduates. Forty-three percent (43%) of the variance on analysis was accounted for by three factors: private self-consciousness, public self-consciousness and social anxiety. Private self-consciousness captures private, cognitive and affective phenomena (e.g., "I reflect about myself a lot") while public self-consciousness emphasizes an awareness of the self as a social object having impacts on others (e.g., "I'm usually aware of my appearance"). Social anxiety is defined by discomfort in the presence of others (e.g., "I get embarrassed very easily"). Public self-consciousness is viewed as antecedent to social anxiety, but the former is not invariably
followed by the latter (Fenigstein et al., 1975). Theoretically at least, self-focused attention, both public and private, can occur without attendant anxiety.

The present version of the scale consists of 23 items. College norms are provided; the norms appear reliable and the factors stable since replication has been accomplished. Test-retest correlations establish the scale (r = .80) and its subscales ("public," r = .84; "private," r = .79; "anxiety," r = .73) as reasonably reliable (Fenigstein et al., 1975).

Most sex therapy outcome research has employed measures directly relevant to expected behavioral changes. Very few studies have used measures reflecting theoretically stable dispositions of personality. The Self-Consciousness Scale, one such measure in the battery, was administered at pre, post and followup points to assess changes along and among the self-consciousness continua over the course of time and treatment. It is in the nature of the multi-modal therapy format to effect modification simultaneously of public and private self-consciousness and social anxiety, on the assumption that self-knowledge or private self-consciousness will generally be low, while public self-consciousness and social anxiety will generally be high in a clinical population, especially one of men without steady partners. Assessment of changes in self-consciousness was designed to elucidate the relationship between exposure to treatment and the self-focused attention factors.

8. Rotter Internal-External Locus of Control Scale (1966). This scale was originally devised to assess control expectancies in various
reinforcement areas (affiliation, dominance, etc.). Original factor analysis yielded only one general factor. Numerous item analyses produced a 23-item, forced-choice, "homogeneous" scale, adapted from James' 60-item Internal-External Scale (1957), to which 6 filler items were added. Undergraduate norms were developed. Illustrative scale items follow:

I more strongly believe that:

6. a. Without the right breaks one cannot be an effective leader.
   b. Capable people who fail to become leaders have not taken advantage of their opportunities.

9. a. I have often found that what is going to happen will happen.
   b. Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.

23. a. Sometimes I can't understand how teachers arrive at the grades they give.
   b. There is a direct connection between how hard I study and the grades I get.

The subject describes his/her own views by choosing, in a variety of areas, between alternatives which reflect a fatalistic, external control orientation and those indicating a belief in personal control over life events. A number of investigators (Gurin et al., 1969; Kaemmerer & Schwebel, 1976; Lao, 1970; Mirels, 1970) have challenged Rotter's factor analysis, and have isolated additional useful factors. It has been argued that many independent areas of perceived control exist as a function of the particular reinforcement realm and the person about whom attributions are made. Nonetheless, Rotter's scale is still recommended as a measure of generalized I-E expectancy (Robinson & Shaver, 1973).
Scale-based locus of control changes are of interest since they have rarely been used in sex therapy research. Heinrich (1976) used the scale with a female population. The scale has not been used with a male population in any kind of sex therapy research. Increased internal locus of control scores were expected to have theoretically consistent associations with a variety of behavioral outcome measures, such as dating frequency, ejaculatory latency, etc. Individual differences in locus of control at each assessment point were also expected, although it was anticipated that most pretreatment scores would cluster at the external end of the continuum.

The Internal-External Locus of Control Scale, administered at pre, post and followup points, investigated the relationship between exposure to treatment and one's sense of personal or political control. It was also correlated with relevant outcome measures in an effort to generate new information on an unstudied population.

Treatments

**Group Treatment Condition:**

The treatment model used was a variant of that described by Zilbergeld (1978) which includes a series of exercises common to many behaviorally based programs. The eight subjects in this Condition met with the cotherapy team once a week for approximately two (2) hours per session over eight (8) consecutive weeks. Each of the eight sessions included pertinent feedback on each subject's progress, a didactic component, a communications role-playing sequence using the cotherapists as models, some group discussion, a weekly film, occasional handouts, and a detailed set of homework assignments (Appendix A).
The group sessions were designed to provide participants with accurate sexual information and education, lend support and guidance to each participant as he learned about his sexual response and to assign graded behavioral sequences to be practiced at home. The function of the homework steps was to provide systematic desensitization experiences in order to reduce the participants' anxieties tied to their sexuality, bodies and ejaculatory patterns. Additionally, the first half of the program was devoted to a directed masturbation series of successive approximations designed to allow and encourage subjects to learn greater ejaculatory control on their own, and subsequently effect a learning transfer to a partner situation.

During the initial session, the rationale and basic outline of brief group treatment were described. Subjects were told that program features were designed to teach and enhance ejaculatory control and to provide them with guidance as they were developing control skills. Each subject was asked to introduce himself (following instructions by the cotherapists and a general orientation to the goals and policies of the group) and to describe his experience with rapid ejaculation, factors which prompted his decision to seek treatment and his goals. Subjects were introduced to the idea that self-stimulation practice was central in learning control with the use of a film, Sensate Focus II, and to the male sexual response cycle (with specific emphasis on premature ejaculation). In addition, the cotherapists introduced the first control technique (stop-start) and its rationale to the participants. The importance of homework practice was stressed. Subjects were apprised of the obvious fact that the benefits they
derived from the program would be commensurate with the time and energy each devoted to it. They were also told that similar programs at UCLA and elsewhere had yielded very promising results. They were reminded of the fact that, while they shared a common problem, each was unique. This enabled them to proceed at their own pace, discovering preferences for particular practices, exercises and the like.

The first homework assignment consisted of tactile body exploration, and practice of the described control technique in masturbation.

The second (and all subsequent sessions) began with the elicitation of both written and oral homework reports from each subject on reactions to the tactile and control exercises. Following homework review, the male cotherapist provided a brief rationale for and description of the stop-start (or pause) with the use of an appropriate lubricant. Thereafter, Stop and Go I, a film which teaches the use of the control technique, was screened. The female cotherapist focused participants' concerns not only on the technical aspects of the film, but on the importance of communicating with partners about the exercise, establishing a comfortable setting and so forth. Presentation of the rationale for and description of the squeeze, a second major control technique followed. A foam rubber, life-size model of a penis was used for demonstration purposes. While the emphasis was on the man learning the technique in self-stimulation, the minor adjustments necessary for its successful application by a partner were also illustrated. At that point, the rationale for communications homework was given and the male therapist looked into a mirror and role played talking with his partner about sex. Subjects were then asked to
practice for one minute using three different communications suggested by the cotherapists. The homework included reading chapter IV of *Male Sexuality* (1978), "The Fantasy Model Continued: The Process and Goals of Sex" (distributed to all group participants at this point), practicing the stop-start and, if desired, the squeeze techniques in self-stimulation and a communications exercise to be carried out either in vivo, imaginally or both.

In session three, homework reactions were elicited from the subjects with the intention of encouraging their discriminations among the control techniques and the varied practice conditions mandated by the program. The squeeze technique was reviewed next, followed by the film *The Squeeze Technique*. The therapists then discussed partner bridging techniques (e.g., telling partner one has a problem with rapid ejaculation) as a preliminary way of encouraging the transition from solo to partner oriented exercises, and led a group discussion. There followed a role-play, by the cotherapists, of the communications assignment for the week, after which group members engaged in either imaginal or live role-plays with a co-participant. Prior to structuring homework activity, a rationale for the use of fantasy in treatment was given. The homework included reading, the use of the stop-start technique accompanied by erotic fantasy, a continuous stimulation with arousal decreasing variations procedure, teaching the partner (if available) the stop-start technique, and a communications exercise on, for example, discussing general ways of improving sexual activity.

Session four focused emphatically on partner related matters as it represented the treatment midpoint. After the homework review, the
question of partner's satisfaction during the treatment course was broached by the female cotherapist. The issue was addressed through the screening of Sensate Focus III and IV, and handouts culled from Barbach's For Yourself: The Fulfillment of Female Sexuality (1975), namely a chapter on sensate focus exercises for couples (Chapter 12) and one on female sexual anatomy and physiology (Chapter 5). Partner-related sexual and non-sexual discussion ensued. The male cotherapist then turned to the communications role-playing in which, using the mirror, he modeled initiation of the stop-start technique with a partner. Participants subsequently engaged in imaginal rehearsal or role play with a co-participant or both. The cotherapists then demonstrated a live sequence on the same issue. Homework included repetition of prior partner-involved exercises, a solo "directed fantasy I" exercise and a communications exercise.

Session five sustained the partner-oriented thrust insofar as a premium was placed on elicitation of partner responses to the exercises, the female cotherapist described the female sexual response cycle, female variability in orgasmic response and, thereafter, showed the topical film, Sharing Orgasm. Reactions to the film were solicited and the importance of mutual, meaningful sexual communication was underscored. Once again, the male cotherapist role played talking to a partner (using the mirror) followed by partipants practicing imaginally and/or with each other. Then the cotherapists role-played for the group. All role-play involved sharing reactions to the differential aspects of the control techniques. Homework involved a solo "directed fantasy II" exercise, an optional partner-based squeeze
exercise, a partner-based continuous stimulation procedure and a communications exercise.

Session six began with a homework review, followed by the presentation of the film Stop and Go II and discussion subsequent to it. With the use of the mirror, the male cotherapist role-played declining a sexual request. Following this, the subjects rehearsed the same issue imaginarily or with a group co-participant or both. The cotherapists then engaged in a couples role-play using a limits setting situation as their example. Homework included a solo "directed fantasy III," repetition of prior partner-involved exercises, and the addition of a new partner step (sensate focus IV) along with a communications exercise linked to the group session role-plays.

The seventh session followed the homework review with a film, introduced by the male cotherapist, called Overcoming Erectile Dysfunction I. The film was used prophylactically. A discussion on the film and on women's reactions to transient erectile dysfunction followed. Thereafter, the patterned flow of solo and couples communication role-plays was initiated on the question of partners' responses to the vaginal containment of the penis without movement (as prescribed in the Sensate IV exercise). Before the structuring of weekly assignments took place, the cotherapists led a discussion on termination issues, anxieties and the like. Homework included a solo "directed fantasy IV" exercise, repetition of the prior week's partner-based exercises with the addition of a new partner step, limited male intra-vaginal movement, and a communications task.
The last session was devoted to updating partner status and feedback for each subject, discussing ongoing matters relating to the implementation of the treatment regimen, collecting overall reactions to the treatment program, discussing maintenance of gains in both general and specific terms with participants, and reiterating the importance of attending followup meetings and complying with ongoing research demands. Assignments were individually tailored.

Notes on the progress of each participant were made by the co-therapists following each group session. Variation existed in the extent to which participants completed all assigned exercises. The critical variable affecting overall compliance with the regimen and therapeutic adjustments of it was presence of a partner and willingness to involve present partners in the treatment process. Where subjects failed to involve actual or potential partners in the exercises, the chief therapeutic response was repetition of the solo (masturbation) sequence such that increasing degrees of ejaculatory control were reliably achievable, proceeding more slowly or deliberately with the solo sequence, and altering the text of the communications exercises such that a friend or confidante could comfortably engage the subject in the practice of sexual communications.

The post-treatment battery was completed the week after session eight, and subjects were apprised then of the date of the first (Two Month) followup point and the data collection procedures to anticipate immediately prior to and at that time. Appropriate fractions of the contingency deposits were returned at posttest to all subjects. The treatment deposits made by some subjects also were reimbursed
at that time.

The Two Month Followup testing sessions involved all participants in completion of the standard battery of instruments and, pending compliance with the above, return of a specified amount of money as per the incentive deposit agreement. Subsequently, a followup session, lasting one hour, was made available to all group participants. At that time, each subject present was asked to provide a brief description of his progress and any problems he had encountered. Therapists reiterated problem solving suggestions made previously. The Six Month Followup session assumed the same format.

Self-Directed Condition:

The nine subjects in this Condition met with the same male-female cotherapy team in a one-day seminar. The two treatment Conditions were conducted during the same two month period. This Condition closely resembled the Group treatment Condition in that all subjects in both Conditions were exposed to the same didactic materials, films, lecturettes, and handouts and received the same sequence of reading assignments, sexual and communications exercises. The chief differences characterizing the Self-Directed format were: (a) one lengthy session (6 hours); (b) all information and homework steps were thus administered at one time rather than over an eight session format lasting eight weeks; (c) there was no systematic group process and (d) the atmosphere was closer to that of a seminar or college class.

The nonrandomly assigned subject was treated and tested, but the data generated were excluded from all data analyses.
The Self-Directed program began with the cotherapists providing the rationale and overview of treatment as was done in the first session of the Group treatment format, as described above. A presentation on the male sexual response cycle, with special reference to premature ejaculation, and basic anatomy and physiology followed. Copies of Zilbergeld's *Male Sexuality* (1978) were dispensed to all participants. The cotherapists discussed masturbation, its myths, and its centrality and rationale in the treatment program.

Most of the available time was spent on (a) introducing, showing the series of films and answering participants' questions in connection with them; (b) engaging in role-plays and (c) reviewing, in detail, each of the homework assignments. The order of the role-plays was similar to the order in the Group format. The difference was that co-participants were not used in rehearsal. Only imaginal rehearsal was practiced so as to limit group process. The male cotherapist first modeled each communication exercise using the mirror for continuous feedback. Subsequently, each participant was encouraged to undertake an imaginal rehearsal modeled after the cotherapist's example, for a minute or so, with closed eyes. The cotherapy team then modeled the couples communications issue. After the couples modeling sequence, participants were instructed to close their eyes and imaginally rehearse the sequence with a partner, for a few minutes. According to the report of the cotherapists, all of the participants got involved in observing and rehearsing the communications exercises. Some participants expressed some doubt as to whether they would be able to complete these exercises since three of them were in
transition between partners or partnerless at the onset of the program.

Subjects were given a homework manual (Appendix A) which instructed them in a graduated series of solo and partner-based sexual and communications exercises designed to achieve greater ejaculatory control, interpersonal intimacy and satisfaction. The few questions that the participants did raise were in connection with the homework assignments. For example, participants wanted to know whether having intercourse was proscribed, and how often they should do the assigned activities. As part of the homework description and review, and in connection with the film on the squeeze technique, all participants were instructed in the use of the self-administered and partner-applied squeeze. A foam rubber life size model of a penis was passed around to each participant who, in turn, practiced the self and partner-applied variations for the use of the squeeze.

Nothing was done to facilitate group interaction; the participants were not asked to introduce themselves to one another in the seminar setting. During breaks from the seminar there was a minimal amount of exchange among participants. By the end of the day, the subjects had been exposed to all the educational topics included in the Group format. After the formal part of the seminar, each co-therapist met briefly and individually with each participant to confirm their working alliance over the treatment period, to agree on times for weekly telephone contacts, and to answer any lingering program related questions participants had. Each subject was, in fact, contacted weekly by his cotherapist at a pre-arranged mutually convenient time (appropriate for therapeutic discussion) for the purpose
of monitoring progress, troubleshooting, and generally encouraging participants in their regimen. There was no subject attrition from the Self-Directed Condition in either the treatment or followup phases.

The post-treatment battery was completed by the Self-Directed subjects in nine weeks time, as was the case for the Group Condition subjects. Similarly, appointments were made for the Two Month Follow-up and subjects were apprised of the data collection procedures to anticipate at that time. As per the treatment deposit and incentive deposit agreements, monies were returned to each subject at the post-test point.

The Two Month Followup testing session involved the Self-Directed subjects in completing the standard array of dependent measures and, pending proper compliance, refunds were disbursed as per the incentive deposit agreement. Subjects were processed through this phase individually. No group meeting occurred. Instead, cotherapists met with subjects individually to discuss progress, problems and any outstanding personal issues and concerns. The Six Month Followup session assumed the same format.
Chapter III

RESULTS

To determine the existence of any treatment effects, 2 x 5 repeated measures analyses of variance were used, unless otherwise specified. The two factors in these analyses were Condition (Group, Self-Directed) and Period (Pre-pre, Pre, Post, Two Month Followup, Six Month Followup). Where they occurred, Condition x Period interaction effects were examined, since they reflected the differential rate of change in each treatment condition. In those instances where the overall F test revealed a significant Condition x Period interaction, or a significant main effect, a procedure for evaluating pairwise comparisons of means was employed in order to clarify the source of

1 In advance of the data analysis, a decision was made to estimate missing data where, for a given variable, N = 14 or N = 15. The overall mean rather than the particular group mean was used in this procedure so as to avoid, even marginally, advancing the hypothesized group differences. Out of the 881 variables analyzed in this study, 85 met the above articulated criterion. For those 85 variables, 122 missing bits of information were found, 48 for Group Condition subjects and 74 for Self-Directed Condition subjects. These data were subjected to the estimation of missing data (BMDPAM) procedure. The number of affected variables was small, and the extent of the missing data roughly comparable per group. Therefore, it would appear that the impact of this data management factor, in terms of suppressing group differences, is likely quite modest.

The BMDPAM Program was developed at the Health Sciences Computing Facility, UCLA under a Facility Grant sponsored by NIH Special Research Resources Grant RR-3.
the significance. Therefore, when a significant interaction or main effect is reported, the results of the overall analyses of variance are presented first, followed by an evaluation of the pairwise means comparisons using simple t-tests.

The results pertinent to each hypothesis are examined in the original order in which the hypotheses were presented. Thereafter, the results related to the exploratory questions are evaluated in the original order in which those questions were presented. Lastly, additional results of interest, independent of the formal hypotheses advanced in this study, are examined. A summary of the results concludes the chapter.

**Hypotheses**

**Hypothesis I**

It was predicted that significantly greater increases in mean ejaculatory latencies would characterize the post-treatment outcomes in the Group Condition as compared with those in the Self-Directed Condition.

Hypothesis I was tested by separately analyzing the ejaculatory latency data gathered under diverse instructions, from both coital and self-stimulation activity, and in both timed and impressionistic form. The data for the dependent variable were the results of those items on the Sexual Background Inventory and the Ejaculatory Latency Data Form which dealt with ejaculatory latency in the terms described above. A separate 2 x 5 repeated measures analysis of variance for each of the latency items with Condition (Group, Self-Directed) and
Period (Pre-pre, Pre, Post, Two and Six Month Followup) as the independent variables was performed.

**Usual Ejaculatory Latency in Intercourse.** Data for this item were obtained from item 32 of the Sexual Background Inventory (Pre) and the equivalent data on the Post versions. At all observation points, subjects rated their usual length of intercourse, from intromission to ejaculation, on a 12-point scale ranging from "Orgasm Usually Occurs Before Entry" to "More Than 30 Minutes After Entry" (see Appendix C). Support for the hypothesis required a significant Condition x Period interaction. The results did not yield a significant interaction or main effect for Condition, but did manifest a significant main effect for Period, as shown in Table 1.

**Table 1**

Analysis of Variance of Usual Length of Intercourse for all Subjects by Followup

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition (A)</td>
<td>1</td>
<td>0.186</td>
<td>0.02</td>
</tr>
<tr>
<td>Error A</td>
<td>14</td>
<td>9.446</td>
<td></td>
</tr>
<tr>
<td>Period (B)</td>
<td>4</td>
<td>33.731</td>
<td>15.54*</td>
</tr>
<tr>
<td>A x B</td>
<td>4</td>
<td>0.937</td>
<td>0.43</td>
</tr>
<tr>
<td>Error B</td>
<td>56</td>
<td>2.171</td>
<td></td>
</tr>
</tbody>
</table>

*p < .0001

An examination of the Period means in Table 2 reveals that the main effect for Period was an increase in the means from Pre-pre to Followup, with a sharp significant increase, $t(15) = 2.97, p < .01$, from
Pre to Post, indicating an increase in the latency means for all subjects over time.

Table 2
Mean Frequency of Usual Length of Intercourse
for all Subjects by Followup

<table>
<thead>
<tr>
<th>Condition</th>
<th>Pre-pre</th>
<th>Pre</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>5.125</td>
<td>5.500</td>
<td>8.143</td>
<td>8.143</td>
<td>8.125</td>
</tr>
<tr>
<td>Self-Directed</td>
<td>4.875</td>
<td>6.125</td>
<td>7.429</td>
<td>8.000</td>
<td>8.125</td>
</tr>
</tbody>
</table>

Period Means 5.000 5.813 7.786 8.071 8.125

Note: Score increases denote increased estimates of intercourse latency.

Additional comparisons indicated that:

1. Only the Pre to Post comparison of means was significant; there were no significant changes over any other sequential means comparisons. There were no significant control period changes.

2. Any nonsequential comparison of means involving Pre and Post treatment points yielded a significant result (e.g., the Two Month Followup - Pre comparison yielded a \( t(15) = 4.45, p < .001 \). However, comparisons of post-treatment means over the followup period yielded no significant difference between means, \( t(15) = 0.74, p > .05 \). The absence of significant differences between all post-treatment means suggests that gains in ejaculatory latency in intercourse were made during the treatment period and neither
deteriorated nor improved significantly during the six month followup phase.

In view of the absence of timed (objective) latency estimates in intercourse, the impressionistic coital estimates were looked at in light of the three minute screening criterion established for this study. Thus, $2 \times 2$ chi-square analyses\(^2\) were run separately at each observation point to test the independence of Condition and presence of premature ejaculation. At the first testing point (Pre-pre), the frequency table indicated that all sixteen subjects reported lasting less than three minutes in coitus, while at the end of the control period, seven subjects in the Group Condition and six subjects in the Self-Directed Condition reported continued premature ejaculation. Three subjects indicated immediately prior to treatment (Pre), that they were lasting three minutes or longer. In sharp contrast the post-treatment data indicated that eight subjects, equally distributed in each Condition, were reporting achievement and maintenance of the control criterion throughout the followup period.

This is notable in light of the long and continuous histories of premature ejaculatory patterns reported by this sample. It is interesting to note further that, even after treatment half of the sample were not reporting ejaculatory control according to the three

\(^2\)Where appropriate, Yates corrected chi-square and Fisher Exact Tests were applied. There were no significant associations between condition and any of the dependent variables tested.
minute criterion. Looked at in overall terms, the distribution of subjects reporting presence or resolution of the rapid ejaculatory pattern did not depend on the Condition to which subjects were assigned. These outcomes are consonant with those from the above analyses of variance on coital latency.

At the Post and Six Month Followup points, treatment compliance data were collected (Appendix C). Post-treatment interest centered on three issues: (number of) solo exercises done, (number of) partner exercises done, and presence or absence of partner. At Six Month Followup, these questions, along with a host of others, were asked. Six subjects per Condition reported having sexual partners while two subjects per Condition reported not having partners immediately after termination. Five subjects did no partner exercises during the treatment phase while eleven did, five from the Group and six from the Self-Directed Condition. An analysis of variance on the number of partner exercises done at Post, as expected, yielded no significant main effect for Condition, $F(1,14) = 0.31, p > .05$. At Six Month Followup, a frequency table revealed that two Group Condition subjects and four Self-Directed Condition subjects had engaged in partner exercises during followup, whereas six Group Condition subjects and four Self-

---

3This may have been, in whole or in part, an artifact in the study. Subjects were required to endorse a range, namely, "3-5 minutes after entry" (Appendix C). Potentially, subjects who were just meeting the three minute criterion, but were endorsing the prior response choice, "2-3 minutes after entry" were read in as premature ejaculators in the contingency table analyzed above.
Directed Condition subjects had not. An analysis of variance at Six Month Followup indicated no significant effect for Condition $F(1,14) = 1.57, p > .05$.

The suspicion that substantial variation across Condition, in terms of these dimensions at both post-treatment points might help to explain the absence of support for this portion of Hypothesis I, was unfounded. Here as elsewhere, there were no significant differences between the groups in terms of practice or compliance.

In summary, the predicted relationships between Conditions were not reflected in the results. Treated both categorically and continuously, the data indicate a lack of support for this portion of Hypothesis I which proposed differential outcomes for usual intercourse latency as a function of group assignment.

**Usual Ejaculatory Latency in Masturbation.** Data for the analysis of this item were obtained from item 45 of the Sexual Background Inventory (Pre) and the parallel data on the Post versions of the Inventory. At all five measurement periods, subjects rated their usual length of masturbation, from the start of stimulation until ejaculation, along a 10-point scale ranging from "Less Than 5 Seconds" to "More Than 30 Minutes" (see Appendix C). (The intervals on this scale were identical to those on the prior question [coitus] except for the addition, in the latter case, of two pre-intromission scale points.) Support for the hypothesis of differentially increased mean latencies in self-stimulation as a function of treatment Condition required a significant interaction of Condition x Period. The results of the analysis of variance (Table 3) failed to indicate a significant main effect for
Condition, or interaction, but did indicate a significant main effect for Period.

Table 3
Analysis of Variance of Usual Length of Masturbation for all Subjects by Followup

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition (A)</td>
<td>1</td>
<td>1.633</td>
<td>0.60</td>
</tr>
<tr>
<td>Error A</td>
<td>14</td>
<td>2.734</td>
<td></td>
</tr>
<tr>
<td>Period (B)</td>
<td>4</td>
<td>12.070</td>
<td>19.03*</td>
</tr>
<tr>
<td>A x B</td>
<td>4</td>
<td>0.814</td>
<td>1.28</td>
</tr>
<tr>
<td>Error B</td>
<td>56</td>
<td>0.634</td>
<td></td>
</tr>
</tbody>
</table>

*p < .0001

Table 3 indicates that there was a highly significant change over time in all subjects' reports of masturbatory latency. Table 4 below specifies the direction of these changes, indicating that latency means increased sharply and significantly over time. An examination of the Period means in Table 4 indicates that the strong main effect for Period had its source in the increase in the means particularly from Pre to Post, t(15) = 6.58, p < .0001. Additional comparisons indicated that:

1. There were no significant changes for this variable during the control period (Pre-pre - Pre), t(15) = 0.25, p > .05, or the first two followup points (Post - Two Month), t(15) = 0.65, p > .05.
Table 4

Mean Frequency of Usual Length of Masturbation for all Subjects by Followup

<table>
<thead>
<tr>
<th>Condition</th>
<th>Pre-pre</th>
<th>Pre</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>6.000</td>
<td>6.125</td>
<td>8.000</td>
<td>7.750</td>
<td>7.625</td>
</tr>
<tr>
<td>Self-Directed</td>
<td>6.625</td>
<td>6.625</td>
<td>8.250</td>
<td>8.286</td>
<td>7.143</td>
</tr>
</tbody>
</table>

Note: Score increases denote increased estimates of masturbatory latency.

2. As Table 4 reveals, the comparisons of the Two and Six Month Followup means registered a relatively small but significant decline, $t_{(15)} = 2.53, p < .05$.

3. Given the above results, it follows that all comparisons of means involving either pre-treatment point with any post-treatment point would generate significant differences. For example, despite the significant decline between followup points noted above, comparisons between Six Month Followup and Pre-pre or Pre means still revealed significant differences, $t_{(15)} = 2.60, p < .05, t_{(15)} = 3.10, p < .01$, respectively. This indicates that, despite the slump which occurred in the first half of the follow-up phase for this variable, overall treatment gains were substantial, significant and maintained.

The results indicated that the subjects in both treatment conditions significantly changed their assessments of their usual
masturbatory latency in the direction of longer latency to ejaculation in self-stimulation activity. Considering that subjects were actively involved in a treatment regimen which accentuates the therapeutic role and importance of masturbation, and mandates exercises focused on self-stimulation, the significant differences over time appear reasonable.

As was the case with the intercourse latency data, degree of compliance with the self-stimulation sequences was of interest for the additional light which might be reflected on the latency findings. A frequency table drawn on the Followup data indicated that seven subjects in the Group Condition and six in the Self-Directed Condition had done self-stimulation exercises while one in the Group Condition and two in the Self-Directed Condition had not complied with that part of the program. An analysis of variance performed on the number of individual exercises done (Table 5) showed a significant main effect for Condition. Inspection of the Group and Self-Directed means, respectively $X_{GC} = 11.625$, and $X_{SDC} = 19.750$, clearly indicates that the men in the Self-Directed Condition were more compliant with the regimen during the actual treatment phase.

Table 5

Analysis of Variance of Number of
Individual Program Exercises Complied With
by all Subjects at Post-treatment Followup

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition (A)</td>
<td>1</td>
<td>264.063</td>
<td>8.57*</td>
</tr>
<tr>
<td>Error A</td>
<td>14</td>
<td>30.183</td>
<td></td>
</tr>
</tbody>
</table>

* $p < .05$
Their greater compliance during treatment may have been one component suppressing expected group differences in coital and masturbatory latencies. The reasons for these significant practice/compliance differences at Post is open to speculation. At the Six Month Followup point, there was no significant main effect for Condition, $F(1,14) = 1.27, p > .05$, in terms of the number of individual exercises done over the course of followup. An analysis of variance on the Post and Followup data analyzed together indicated no significant main effects for Condition, $F(1,14) = .19, p > .05$, or Period, $F(1,14) = .09, p > .05$, and no significant interaction effects, $F(1,14) = 2.72, p > .05$. Thus, whatever significance attaches to the differences found in the Post compliance data seems relatively circumscribed.

The final subset of masturbation-related latency data emerged out of analyses of the Pre and Post versions of the Ejaculatory Latency Data Forms (Appendix C). The forms asked subjects to time themselves in self-stimulation activities under varying instructions and subsequently, to evaluate their levels of satisfaction and anxiety in connection with each experience. The data were collected at specific points in time and were, therefore, highly particular kinds of measures. The results must be regarded with caution because of their time-bound quality, the existence of missing data and the demand value of timing latency in masturbation. These data were subjected to three separate analyses of variance—"controlled" latency, "uncontrolled" latency and "uncontrolled-controlled" latency. Latency data without the use of control techniques ("uncontrolled") were gathered at four points in time (Pre, Post, Two and Six Months). Table 6 shows the results of
the analysis using Total Scores.

Table 6
Analysis of Variance of "Uncontrolled" Masturbation Latency for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition (A)</td>
<td>1</td>
<td>1073.002</td>
<td>7.94*</td>
</tr>
<tr>
<td>Error A</td>
<td>6</td>
<td>135.140</td>
<td></td>
</tr>
<tr>
<td>Period (B)</td>
<td>3</td>
<td>226.970</td>
<td>7.51**</td>
</tr>
<tr>
<td>A x B</td>
<td>3</td>
<td>44.909</td>
<td>1.49</td>
</tr>
<tr>
<td>Error B</td>
<td>18</td>
<td>30.209</td>
<td></td>
</tr>
</tbody>
</table>

Note: N = 8
*<p < .05
**p < .005

Table 7
Mean Total Scores (in Minutes) of "Uncontrolled" Masturbation Latency for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Period</th>
<th>Condition Group</th>
<th>Means</th>
<th>Pre</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group</td>
<td>13.669</td>
<td>7.750</td>
<td>15.025</td>
<td>16.175</td>
<td>15.725</td>
</tr>
<tr>
<td></td>
<td>Self-Directed</td>
<td>25.250</td>
<td>15.975</td>
<td>32.099</td>
<td>23.250</td>
<td>29.267</td>
</tr>
<tr>
<td>Period Means</td>
<td></td>
<td>11.863</td>
<td>23.536</td>
<td>19.713</td>
<td>22.700</td>
<td></td>
</tr>
</tbody>
</table>

Note: N = 8. The higher the mean score, the greater the timed mean masturbation latency.

As can be seen, the analysis indicates a significant main effect for Condition, $F(1,6) = 7.94$, $p < .05$, and for Period, $F(3,18) = 7.51$, $p < .005$. Appropriate $t$-tests resulted in the findings detailed below:
1. There were no significant differences between the Condition means at Pre, Two Month or Six Month Followup.

2. Thus, the source for the main effect for Condition was the significant difference between group means at Post, \( t(8) = 3.95, p < .005 \). This effect is the result of the differentially increased mean latencies in self-stimulation exercises (without the use of control techniques) immediately following treatment by those in the Self-Directed Condition.

3. Similarly, there were no significant differences between the means over the followup points (Post, Two and Six Month).

4. The source of the significant main effect for Period was located in the Pre-Post means comparison where the trimmed\(^4\) \( t(7) = 3.12, p < .05 \). This effect is the result of the dramatic increase in mean latencies to ejaculation in self-stimulation activity after treatment for all subjects.

   Latency data taken under instructions to use the control techniques learned in treatment ("controlled") were collected at Post, Two and Six Month Followup points only. In light of the fact that no pre-post comparison was possible for this subset, it is not surprising that there were no significant main effects for Condition or Period, and no significant interaction effects. These data suggest that membership in the Group or Self-Directed Condition was largely irrelevant in predicting increased latencies to ejaculation (with use of the control techniques learned in treatment).

---

\(^4\) The trimmed \( t \)-test refers to a robust procedure whereby one case is trimmed from each tail. See Yuen, R. and Dixon, W., The approximate behavior and performance of the two-sample trimmed \( t \). Biometrika, 1973, 60, 369-374.
techniques), and, further, that timed latencies using the control tech­
niques (at the data collection points) did not increase significantly
over the course of followup. In fact, there was a mild trend (Period
x Condition) in the direction of decreased latency scores using the
control techniques during the followup phase, \( F(2,16) = 2.69, p < .10 \).

Moreover, it appears that, over time, a convergence occurred in
subjects' minds between instructions to use or not use the control
techniques and consequent latency outcomes. This can be seen from the
results of the analysis of variance which used difference scores
("uncontrolled" - "controlled") as the basis for study in Table 8
below.

Table 8

<table>
<thead>
<tr>
<th>Condition</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Post</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Group</td>
<td>5.166</td>
</tr>
<tr>
<td>Self-Directed</td>
<td>1.730</td>
</tr>
<tr>
<td>Period Means</td>
<td>3.019</td>
</tr>
</tbody>
</table>

Note: \( N = 8 \). The larger the mean, the greater the mean difference
(in minutes) between latency outcomes under varying instruc­
tions.

The means reveal a steady decline in the differences between latency
measures taken under instructions involving the use of control tech­
niques versus instructions eliciting latency measures without the use
of control strategies. A weak trend reflecting the convergence was found for Period, $F(2,16) = 3.27$, $p < .10$.

In overall terms, Hypothesis I was not supported. While there were significant main effects for Period for all dependent measures involving ejaculatory latency, there were no significant Condition x Period interactions, indicating that outcomes were not differentially affected by group assignment. There were two statistically significant Condition effects in the data relevant to Hypothesis I. Firstly, it was found that Self-Directed subjects completed more exercises during treatment than did Group subjects. Secondly, a significant group difference emerged on timed latency to ejaculation in "uncontrolled" masturbation. This difference, favoring the Self-Directed subjects, was localized at the posttest point.

**Hypothesis II**

It was predicted that, following treatment, the Group Condition subjects would report higher frequency or degree of ejaculatory control in foreplay and coital activities compared with Self-Directed Condition subjects. Hypothesis II was tested by separately analyzing degree of control in foreplay, at intromission or shortly thereafter, in mid-intercourse and in their last five sexual encounters. In each case (except the last) subjects responded, at all five measurement points, along a 6-point interval scale ranging from "Always" to "Never" (Appendix C). Support for the hypothesis of greater degree of control in foreplay and intercourse activities for subjects in the Group Condition required a significant interaction of Condition x Period for each of the dependent variables referred to above.
Frequency of Ejaculatory Control During Foreplay. Data for this analysis were drawn from item 36 of the Sexual Background Inventory (Pre) and its counterpart on the Post Inventory (Appendix C). The results of an analysis of variance on frequency of unintentional ejaculation during foreplay prior to intromission revealed neither significant Condition ($p = .9185$) nor significant Period ($p = .1614$) effects. With respect to degree of ejaculatory control in foreplay, the hypothesis was wholly unsupported.

Degree of Ejaculatory Control at Intromission or Postportally. Data for the analysis were taken from item 37 of the Sexual Background Inventory (Pre) and its counterpart on the Post Inventory (Appendix C). The analysis of variance output on postportal control data appears in Table 9 below.

Table 9

Analysis of Variance of Ejaculatory Control at Intromission and Postportally for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition (A)</td>
<td>1</td>
<td>5.000</td>
<td>1.54</td>
</tr>
<tr>
<td>Error A</td>
<td>14</td>
<td>3.239</td>
<td></td>
</tr>
<tr>
<td>Period (B)</td>
<td>4</td>
<td>5.219</td>
<td>7.16*</td>
</tr>
<tr>
<td>$A \times B$</td>
<td>4</td>
<td>0.123</td>
<td>0.17</td>
</tr>
<tr>
<td>Error B</td>
<td>56</td>
<td>0.729</td>
<td></td>
</tr>
</tbody>
</table>

$^{*}p < .0005$
The data indicate no significant main effect for Condition, but a highly significant Period effect, $F(4,56) = 7.16, p < .0005$. The pattern and direction of the changes are illustrated in Table 10 below, indicating that ejaculatory control means rose sharply over time.

### Table 10
Mean Frequency of Ejaculatory Control at Intromission and Postportally Across all Subjects by Followup

<table>
<thead>
<tr>
<th>Condition</th>
<th>Pre-pre</th>
<th>Pre</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>4.000</td>
<td>4.000</td>
<td>5.143</td>
<td>4.857</td>
<td>5.125</td>
</tr>
<tr>
<td>Self-Directed</td>
<td>3.625</td>
<td>3.500</td>
<td>4.857</td>
<td>4.143</td>
<td>4.500</td>
</tr>
<tr>
<td>Period Means</td>
<td>3.813</td>
<td>3.750</td>
<td>5.000</td>
<td>4.500</td>
<td>4.813</td>
</tr>
</tbody>
</table>

**Note:** Score increases denote greater ejaculatory control.

T-tests to locate the source(s) of the significant effect yielded:

1. No significant differences between the means taken during the control period (Pre-pre to Pre) or the Two-Six Month Followup periods.

2. The differences between means were significant at both Pre-Post ($t(15) = 3.83, p < .005$) and Post - Two month ($t(15) = 3.28, p < .01$) comparisons. These data appear to indicate a significant increase in control from Pre to Post followed by a lesser, but nonetheless significant decrease in postportal ejaculatory control by the first followup point. Between first and second followup
points, no significant directional changes emerged.

3. Additional a posteriori tests showed, however, that despite the decline in self-reports of control from Post - Two Month Followup, the overall effect of treatment was maintained. For example, comparison of differences for Two Month Followup - Pre means was significant, $t(15) = 2.59, p < .05$, indicating that despite the decline from Post to Two Month Followup, significant effects were sustained throughout the followup phase.

The pattern, as a whole, reveals a significant gain over time for all subjects in terms of ejaculatory control at intromission and post-portally.

**Frequency of Ejaculatory Control in Mid-Intercourse.** Data for analysis of this item were culled from item 38 of the Sexual Background Inventory (Pre) and its analogue on the Post version of the Inventory (Appendix C). At all five testing points, subjects rated their degree of ejaculatory control during intercourse on the aforementioned 6-point scale ranging from "Never" to "Always" (Appendix C). Support for the hypothesis required a significant interaction for Condition x Period. The results yielded a highly significant interaction, in addition to a significant main effect for Period, as shown in Table 11. T-tests indicated that significant differences between means existed at most Pre-post comparisons (Post-Pre-pre, $t(15) = 2.31, p < .05$; Six Month - Pre, $t(15) = 2.56, p < .05$ and Six Month - Pre-pre, $t(15) = 3.01, p < .01$), but not among sequential comparison points in time. The significant interaction, as shown in Table 12, is due to the differential increase in means across time as a function of Condition.
Table 11

Analysis of Variance of Frequency of Ejaculatory Control in Mid-Intercourse for all Subjects by Followup

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition (A)</td>
<td>1</td>
<td>0.006</td>
<td>0.00</td>
</tr>
<tr>
<td>Error A</td>
<td>14</td>
<td>3.020</td>
<td></td>
</tr>
<tr>
<td>Period (B)</td>
<td>4</td>
<td>7.539</td>
<td>5.12*</td>
</tr>
<tr>
<td>A x B</td>
<td>4</td>
<td>6.303</td>
<td>4.28*</td>
</tr>
<tr>
<td>Error B</td>
<td>56</td>
<td>1.472</td>
<td></td>
</tr>
</tbody>
</table>

*P < .005

Note: The Greenhouse-Geisser-Imhof (GGI) statistic for Period was $F(2.32, 32.45) = 5.122, p < .0001$. For A x B, it was $F(2.32, 32.45) = 4.28, p < .05$.

Table 12

Mean Frequency of Ejaculatory Control in Mid-Intercourse for all Subjects Through Followup

<table>
<thead>
<tr>
<th></th>
<th>Pre-pre</th>
<th>Pre</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition Group</td>
<td>1.250</td>
<td>2.250</td>
<td>4.143</td>
<td>3.571</td>
<td>4.250</td>
</tr>
<tr>
<td>Self-Directed</td>
<td>3.125</td>
<td>2.875</td>
<td>3.000</td>
<td>3.000</td>
<td>3.375</td>
</tr>
</tbody>
</table>

Period Means 2.188 2.563 3.571 3.286 3.813

Note: Score increases denote greater ejaculatory control.
Inspection of the means suggests that Group means increased dramatically while Self-Directed means changed very little.

Pairwise means comparisons indicated that a significant baseline difference existed, $t(14) = 3.47, p < .005$. The univariate $F$ statistic, derived from a general analysis of variance, yielded a similar result, $F(1,14) = 12.023, p < .005$. These findings clearly indicate that men in the Group Condition saw themselves as having significantly less ejaculatory control pretreatment than did Self-Directed subjects where mid-intercourse ejaculatory control was concerned. There were no other significant differences between the Conditions at any of the subsequent testing points.

Univariate tests performed to clarify these findings indicated:

1. Where the Condition factor was held constant at Group, the statistics supported the impression of significance given by the means, $F(4,56) = 9.209, p < .0001$ (GGI $p < .0005$).

2. Where Condition was held constant at Self-Directed, no significant Period effect emerged. Thus, men in the Group Condition increased their control scores sharply on this ejaculatory control variable over time whereas Self-Directed subjects reported no significant changes at all.

3. Further tests were performed in order to more precisely specify the source of the significant score changes for Group subjects. Pairwise comparisons for Period on all sequential measurement points yielded no significant differences except from Pre-Post, $F(1,14) = 5.725, p < .05$. The articulated and discrete nature of this effect explains, perhaps, the absence of significant
Figure 1: Mean Frequency of Ejaculatory Control in Mid-Intercourse* Described by Condition and Period

Note: The higher the score, the greater the frequency of control.

*Item 38, Sexual Background Inventory (Pre): "How often do you ejaculate unintentionally in the middle of intercourse, after thrusting is underway?" 1 = "Always"; 6 = "Never."
sequential comparisons for Period discussed above.

The data on frequency of ejaculatory control in mid-intercourse are summarized visually in Figure 1.

In summary, these data lent support to Hypothesis II insofar as the significant interaction effect suggested that subjects in the Group Condition were improving more substantially on a measure of ejaculatory control than subjects in the Self-Directed Condition. However, the presence of baseline differences indicates that men in the two Conditions were significantly different from one another on this variable prior to any intervention (Table 12), with the Self-Directed subjects evidencing superior control means. These baseline data tend to undermine, to some extent, support for the hypothesis.

**Frequency of Ejaculatory Control in Last Five Sexual Encounters.** Data for analysis of this item were drawn from item 34 of the Sexual Background Inventory (Pre) and its equivalents on the Post version of the Inventory (Appendix C). At all five observation points, subjects assessed their degree of ejaculatory control in their last five sexual encounters on a 7-point scale ranging from "Not At Any Time" through "All of The Times" and "Does Not Apply To Me." The latter response choice was provided for those subjects not currently engaging in overt heterosexual behavior. This question focused on subjects' evaluations of control according to their own private and unarticulated criteria, in contrast to the above stage-based variables. Support for Hypothesis II required a significant Condition x Period interaction. The results yielded a significant interaction term as well as a highly significant main effect for Period (Table 13).
Table 13

Analysis of Variance of Ejaculatory Control in

Last Five Sexual Encounters for all Subjects

Through Followup

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition (A)</td>
<td>1</td>
<td>0.800</td>
<td>0.35</td>
</tr>
<tr>
<td>Error A</td>
<td>14</td>
<td>2.311</td>
<td></td>
</tr>
<tr>
<td>Period (B)</td>
<td>4</td>
<td>20.167</td>
<td>16.29*</td>
</tr>
<tr>
<td>A x B</td>
<td>4</td>
<td>4.292</td>
<td>3.47**</td>
</tr>
<tr>
<td>Error B</td>
<td>56</td>
<td>1.238</td>
<td></td>
</tr>
</tbody>
</table>

* *p < .0001
** *p < .05

Appropriate t-tests revealed that the significant Period effect was located at the Pre-Post comparison, \( t(15) = 3.62, p < .005 \). There were no significant differences between the means for any other sequential Period comparisons. Given the potency of this effect, all nonsequential pairwise comparisons involving Pre and Post points were significant at the \( p < .005 \) level or better (e.g., Six Month - Pre, \( t(15) = 5.36, p < .0001 \); Post-Pre-pre, \( t(15) = 3.32, p < .01 \)). The significant interaction, as shown in Table 14, owes its existence to the differential increase in means across Period as a function of Condition. The Group means showed a general, steady increase over time, whereas the Self-Directed means revealed more gradual increases. Appropriate comparisons of the means revealed the following additional results:
Table 14

Mean Frequency of Ejaculatory Control in Last Five Sexual Encounters for all Subjects by Followup

<table>
<thead>
<tr>
<th>Condition</th>
<th>Pre-pre</th>
<th>Pre</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>1.125</td>
<td>1.125</td>
<td>3.571</td>
<td>4.429</td>
<td>4.125</td>
</tr>
<tr>
<td>Self-Directed</td>
<td>1.875</td>
<td>2.125</td>
<td>3.000</td>
<td>3.000</td>
<td>3.375</td>
</tr>
</tbody>
</table>

Period Means: 1.500 1.625 3.286 3.714 3.750

Note: Score increases denote increased mean frequencies of ejaculatory control.

1. Where the Condition factor was held constant at Group, an extremely significant Period effect was obtained, $F(4,56) = 17.102, p < .0001$.

2. Where the Condition factor was held constant at Self-Directed, a substantially less impressive, but nonetheless significant result was obtained, $F(4,56) = 2.655, p < .05$. In sum, Self-Directed subjects reported less dramatic improvement than their Group counterparts across time on this measure.

3. Further tests, looking at Period, to precisely locate the source of significance for both groups, yielded:

   (a) a significant within effect for the Group on the Pre-Post comparison, $F(1,14) = 16.507, p < .005$.

   (b) There were no other significant within effects for the Group on this variable.
(c) Specification of the period for the Self-Directed Condition proved more elusive. None of the within effects were significant. A marginal trend on the Pre-Post comparison probably best reflects the strength and location of the effect, \( F(1,14) = 2.112, p = .1682 \).

4. Finally, pairwise comparisons testing for differences between the Conditions indicated:

(a) a weak trend at Pre-pre, \( F(1,14) = 3.231, p = .10 \).

(b) a significant effect at Pre, \( F(1,14) = 4.766, p < .05 \).

(c) no significant effects or trends at Post or Six Month Followup.

(d) a trend at Two Month Followup, \( F(1,14) = 3.846, p < .10 \).

These data, like those for the previous ejaculatory control variable, support the predictions made in Hypothesis II in that treatment appeared to have had a greater impact on the Group than on the Self-Directed Condition. However, as was the case with the previous variable, the post hoc comparisons also illustrate significant baseline differences between the groups at Pre (Table 14). Paralleling the results on the previous variable, it was the Self-Directed subjects who were reporting higher pretreatment ejaculatory control means on this measure. The baseline differences reduce the significance of these findings with respect to Hypothesis II. These data on frequency of ejaculatory control in last five sexual encounters are the subject of Figure 2.

In overall terms, Hypothesis II, which forecast greater frequency or degree of ejaculatory control in varied sexual activities for subjects in the Group Condition, received partial support. The data on control in foreplay activities lent no support to the hypothesis. The
Figure 2: Mean Frequency of Ejaculatory Control in Last Five Sexual Encounters* Described by Condition and Period

Note: The higher the score, the greater the frequency of control.

*Item 34, Sexual Background Inventory (Pre): "In your last five (5) sexual encounters, how often, if ever, were you able to control the timing of your ejaculation (climax) to your satisfaction?" 1 = Not At Any Time; 6 = All of the Times; 7 = Does Not Apply To Me
results on ejaculatory control at intromission and postportally also
did not support the hypothesis since all subjects improved their con-
trol scores on this variable, without regard to group assignment.
The findings on ejaculatory control in mid-intercourse, which yielded
a highly significant interaction and main effect for Period, indicating
superior gains for subjects in the Group Condition, did support Hypo­
thesis II. The pattern of results was essentially the same for ejacu­
latory control in last five sexual encounters, namely a significant
main effect for Period coupled with a significant Group x Period inter­
action. Subjects in the Group Condition evidenced more marked and
precipitous score increases on this variable as compared with their
Self-Directed cohorts. If baseline differences were not found, these
data would have lent unequivocal support to both the letter and spirit
of Hypothesis II. In view of the significant baseline differences
uncovered for both variables, only the letter of Hypothesis II was
supported by these data.

Hypothesis III

This hypothesis asserted that, subsequent to treatment, the
Group Condition subjects would report greater satisfaction with their
ejaculatory control and other aspects of sexual functioning as compared
with Self-Directed subjects. Hypothesis III was tested by separately
analyzing subjective satisfaction with control in terms of level of
anxiety experienced, subjects' evaluation of their own and partners'
satisfaction with subjects' usual latency, subjects' own appraisal
of satisfaction with and perception of partners' satisfaction with
the overall sexual relationship, and, most importantly, satisfaction
with the ten activities reflected in the Goals for Sexual Therapy-Male Scale (Appendix C). Support for the hypothesis necessitated a significant Group x Condition interaction for each of the dependent variables cited above.

**Usual Level of Anxiety Regarding Ejaculatory Timing.** This variable is obliquely but importantly related to satisfaction. Data for the anxiety-regarding-ejaculatory-control variable were drawn from item 35 of the Sexual Background Inventory (Pre) and the comparable items from the Post Inventory. Subjects rated their usual degree of anxiety along a 5-point scale ranging from "Very Anxious" to "Not At All Anxious" (Appendix C). The results of an analysis of variance on usual level of anxiety are tabulated in Table 15 below. As inspection of the table reveals, there was a highly significant main effect for Period, $F(4,56) = 9.86, p < .0001$.

**Table 15**

Analysis of Variance of Usual Level of Anxiety Regarding Ejaculatory Control for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition (A)</td>
<td>1</td>
<td>7.723</td>
<td>2.86</td>
</tr>
<tr>
<td>Error A</td>
<td>14</td>
<td>2.703</td>
<td></td>
</tr>
<tr>
<td>Period (B)</td>
<td>4</td>
<td>7.160</td>
<td>9.86*</td>
</tr>
<tr>
<td>A x B</td>
<td>4</td>
<td>0.343</td>
<td>0.47</td>
</tr>
<tr>
<td>Error B</td>
<td>56</td>
<td>0.726</td>
<td></td>
</tr>
</tbody>
</table>

*p < .0001
No significant main effect for Condition or interaction term emerged in these data. Inspection of the cell means in Table 16 below further demonstrates the pattern of results for the anxiety variable. Men in both treatment formats reported significant changes in felt anxiety with respect to timing ejaculation. T-tests indicated that:

1. Pairwise comparisons of the means at each Period showed no significant differences for the control period (Pre-pre-Pre), or the followup points (Six Month - Two Month - Post).

2. The source of the significance for the overall Period effect was the Pre-Post means comparison where \( t(15) = 3.03, p < .01 \), which indicated that men in both formats reported less felt anxiety after treatment.

3. Additional nonsequential means contrasts indicated that the overall effect of treatment was maintained through the Six Month Followup. All pre-post-treatment comparisons were significant at the \( p < .005 \) level or better (e.g., Six Month - Pre-pre, \( t(15) = 5.81, p < .001 \); Post - Pre-pre, \( t(15) = 3.88, p < .005 \)), indicating less reported anxiety by men in both Conditions.

Table 16

Mean Frequency of Usual Level of Anxiety Regarding Ejaculatory Control for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Condition</th>
<th>Pre-pre</th>
<th>Pre</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>2.000</td>
<td>2.500</td>
<td>3.429</td>
<td>3.750</td>
<td>3.750</td>
</tr>
<tr>
<td>Self-Directed</td>
<td>1.750</td>
<td>2.000</td>
<td>2.857</td>
<td>2.714</td>
<td>3.000</td>
</tr>
<tr>
<td>Period Means</td>
<td>1.875</td>
<td>2.250</td>
<td>3.143</td>
<td>3.232</td>
<td>3.375</td>
</tr>
</tbody>
</table>

Note: The higher the score, the less the reported anxiety.
The findings on usual level of anxiety regarding ejaculatory control did not lend Hypothesis III support.

Subjects' Evaluation of Their Own and Partners' Satisfaction With Subjects' Usual Latency. These data were only collected at the three post-treatment points, from items 29 and 30 of the Sexual Background Inventory (Post). Subjects rated their degree of satisfaction with their usual latency and their perception of partners' satisfaction with their latency along a 7-point scale ranging from "Very Satisfied" to "Very Dissatisfied" (Appendix C). Not surprisingly, the analysis of variance yielded no significant main or interaction effects, indicating that, over the six month followup phase, subjects neither improved nor deteriorated significantly. Nor did the groups differ from one another markedly. However, as Table 17 illustrates, subjects' sense of satisfaction with their latencies increased over followup.

Table 17
Mean Frequency of Subjects' Latency Satisfaction at all Followup Points for all Subjects

<table>
<thead>
<tr>
<th>Condition</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>4.143</td>
<td>3.571</td>
<td>3.500</td>
</tr>
<tr>
<td>Self-Directed</td>
<td>4.143</td>
<td>4.429</td>
<td>3.500</td>
</tr>
<tr>
<td>Period Means</td>
<td>4.143</td>
<td>4.000</td>
<td>3.500</td>
</tr>
</tbody>
</table>

Note: Score decreases denote reported satisfaction increases.
The analysis of variance (Table 18) on the companion variable, subjects' appraisal of partners' satisfaction with their latencies (assessed at the post-treatment points) revealed a significant main effect for Condition. No Period or interaction effects reached statistical significance. The absence of a Period effect is not surprising in view of the absence of a pretest-posttest comparison in these data.

Table 18

Analysis of Variance of Subjects' Appraisals of Partner Satisfaction with Subjects' Latencies for all Subjects

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition</td>
<td>1</td>
<td>17.007</td>
<td>4.91*</td>
</tr>
<tr>
<td>Error A</td>
<td>14</td>
<td>3.463</td>
<td></td>
</tr>
<tr>
<td>Period (B)</td>
<td>2</td>
<td>0.571</td>
<td>0.54</td>
</tr>
<tr>
<td>A x B</td>
<td>2</td>
<td>0.844</td>
<td>0.79</td>
</tr>
<tr>
<td>Error B</td>
<td>28</td>
<td>1.065</td>
<td></td>
</tr>
</tbody>
</table>

*P < .05

(a) Note: These data reflect post-treatment appraisals only.

Inspection of the means in Table 19, particularly the group marginal means, provides a clearer picture of the main effect for Condition found in Table 18. The results reveal that subjects in the Group Condition thought that their partners were more satisfied with their usual ejaculatory latencies than did Self-Directed subjects. Pairwise comparison of the Condition means reflects this differential conviction: at Two Month Followup, t(14) = 3.54, p < .005. This finding does not conform to any expected pattern. One possible explanation
is that the group process, which embodied discussion on partners' satisfaction, exerted some influence on this variable.

Perceived Satisfaction with Overall Sexual Relationship. Subjects' perceptions of partners' general satisfaction were collected only at the post-treatment observation points and were drawn from item 32 of the Sexual Background Inventory (Post). Subjects rated their perception of partner satisfaction with the sexual relationship along a 7-point scale ranging from "Very Unsatisfactory" to "Very Satisfactory" (Appendix C). Analysis of variance yielded no significant main or interaction effects, indicating that, over the followup course, subjects' perception of partner overall satisfaction neither improved nor deteriorated significantly. Nor did the groups differ significantly from one another.

Table 19

Mean Frequency of Subjects' Appraisals of Partner Satisfaction with Subjects' Latencies for all Subjects

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition Means</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>2.048</td>
<td>2.429</td>
<td>1.714</td>
<td>2.000</td>
</tr>
<tr>
<td>Self-Directed</td>
<td>3.238</td>
<td>3.286</td>
<td>3.429</td>
<td>3.000</td>
</tr>
<tr>
<td>Period Means</td>
<td>2.857</td>
<td>2.571</td>
<td>2.500</td>
<td></td>
</tr>
</tbody>
</table>

Note: Score decreases denote increases in satisfaction ratings.

Along with the specific, but limited, latency satisfaction data, subjects rated, at all five measurement points, their satisfaction with
their overall sexual relationship(s), along a 7-point scale ranging from "Very Unsatisfactory" to "Very Satisfactory" (Sexual Background Inventory [Pre], item 42, see Appendix C). The results of the analysis of variance are presented in Table 20.

Table 20

Analysis of Variance of Subjects' Satisfaction with Overall Sexual Relationship(s) for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition (A)</td>
<td>1</td>
<td>12.013</td>
<td>2.47</td>
</tr>
<tr>
<td>Error A</td>
<td>14</td>
<td>4.870</td>
<td></td>
</tr>
<tr>
<td>Period (B)</td>
<td>4</td>
<td>8.731</td>
<td>5.23*</td>
</tr>
<tr>
<td>A x B</td>
<td>4</td>
<td>0.606</td>
<td>0.36</td>
</tr>
<tr>
<td>Error B</td>
<td>56</td>
<td>1.669</td>
<td></td>
</tr>
</tbody>
</table>

*_{p} < .005

Table 21

Mean Frequency of Subjects' Satisfaction with Overall Sexual Relationship(s) for all Subjects by Followup

<table>
<thead>
<tr>
<th>Condition</th>
<th>Pre-pre</th>
<th>Pre</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>3.500</td>
<td>4.250</td>
<td>5.250</td>
<td>4.750</td>
<td>5.374</td>
</tr>
<tr>
<td>Self-Directed</td>
<td>4.250</td>
<td>5.250</td>
<td>5.375</td>
<td>5.875</td>
<td>6.250</td>
</tr>
</tbody>
</table>

| Period Means  | 3.875 | 4.750| 5.313| 5.313   | 5.813   |

Note: Score increases denote increases in satisfaction ratings.
As can be seen in Tables 20 and 21, a significant main effect for Period was found, $F(4,56) = 5.23$, $p < .005$. Effects for Condition and the interaction term did not reach statistical significance. Regardless of Condition, subjects showed marked increases over time in their appraisals of their sexual relationship(s). Interestingly, post hoc $t$-tests showed the source of the significance to be at the Two Month - Six Month Followup comparison of means, $t(15) = 2.45$, $p < .05$. All possible Pre - Post comparisons were thus significant at the $p < .05$ level or better. These data did not support Hypothesis III; while subjects' sense of satisfaction with their sexual relationship(s) increased sharply and significantly, group of assignment did not differentially affect outcomes on this variable.

**Subjective Satisfaction With Varied Sexual Thoughts, Affects and Behaviors.** Items for this analysis derived from the Goals for Sex Therapy Scale-Male (Appendix C). Administered at each period, the Scale required subjects to evaluate their degree of satisfaction with a variety of current behaviors and feelings along a 7-point scale ranging from "Much Less Than Satisfied" to "Much More Than Satisfied" (Appendix C). Analyses of variance were performed separately for each of the 10 items on the Scale as well as on the Total Scores.

Analyzed by Total Score, the results indicated a highly significant main effect for Period as shown in Table 22 (overleaf). The mean Total Score improved (increased) over time, indicating that treatment had a sharp, significant impact upon subjects' self-reported satisfaction with goal attainment relative to pertinent sexual behaviors and feelings (Table 23).
Table 22

Total Score Analysis of Variance of Satisfaction with Varied Sexual Behaviors and Affects (Goals Scale) for all Subjects by Followup

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition (A)</td>
<td>1</td>
<td>236.083</td>
<td>1.23</td>
</tr>
<tr>
<td>Error A</td>
<td>14</td>
<td>191.430</td>
<td></td>
</tr>
<tr>
<td>Period (B)</td>
<td>4</td>
<td>1747.705</td>
<td>48.97*</td>
</tr>
<tr>
<td>A x B</td>
<td>4</td>
<td>17.953</td>
<td>0.50</td>
</tr>
<tr>
<td>Error B</td>
<td>56</td>
<td>35.687</td>
<td></td>
</tr>
</tbody>
</table>

*P < .0001

Table 23

Mean Total Scores of Goals for Sexual Therapy-Male Scale for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Condition</th>
<th>Pre-pre</th>
<th>Pre</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>29.250</td>
<td>32.500</td>
<td>51.625</td>
<td>50.625</td>
<td>51.250</td>
</tr>
<tr>
<td>Self-Directed</td>
<td>27.625</td>
<td>30.500</td>
<td>44.875</td>
<td>46.321</td>
<td>48.750</td>
</tr>
</tbody>
</table>

Period Means | 28.438 | 31.500| 48.250| 48.473  | 50.000  |

Note: Score increases denote increases in satisfaction ratings.
Appropriate $t$-tests further demonstrated that:

1. The source of the effect, largely, was in the Pre - Post means comparison where $t(15) = 8.20, p < .0001$.

2. There was a significant difference between Pre-pre and Pre means, $t(15) = 2.20, p < .05$.

3. No other sequential pairwise comparison across time reached statistical significance. This suggests that the strong gains made by subjects during the treatment phase were indeed maintained through the Six Month Followup.

4. Thus, all pairwise comparisons involving pre-post-treatment means are significant at the .0001 level.

Total scores analysis did not display significant Condition or Condition x Period effects. Therefore, the results suggested that all subjects improved in their general satisfaction with their sexual affects and behavior related to rapid ejaculation regardless of Condition to which they were assigned. These findings can be clearly seen in Figure 3.

Separate analyses of the items were performed. In each case, results paralleled those found for Total Scores discussed above, in terms of strength and direction of effect and the absence of any significant interaction effect or main effect for Condition. The strongest main effect for Period in the individual item analyses was for the item: "Feeling that I know what to do in order to control my ejaculation," $F(4,56) = 47.33, p < .0001$. In light of their exposure to treatment, subjects' striking change scores appear reasonable.
Figure 3: Mean Total Score of Satisfaction* with Varied Sexual Behaviors and Affects (Goals Scale) Described by Condition and Period.

Note: The higher the score, the greater the satisfaction.

*See Appendix C for full text of Goals Scale. 10 = "Much Less Than Satisfied"; 70 = "Much More Than Satisfied."
In summary, the varied sources of data analyzed in connection with Hypothesis III, which predicted greater subjective satisfaction scores for subjects in the Group Condition (as compared with Self-Directed subjects) over a diverse number of dependent measures, did not support the hypothesis. There was no indication that group membership had any significant impact on usual degree of anxiety with respect to ejaculatory timing, post-treatment appraisals of subjects' satisfaction with their usual latency, perceived satisfaction with overall sexual relationship or satisfaction with varied sexual thoughts, affects and behaviors relevant to prematurity and general sexuality. Only in terms of subjects' appraisals of partner satisfaction with their usual latency did a main effect for Condition emerge. However, the absence of a Condition x Period interaction and the singularity of the result do not constitute a meaningful challenge to the clear trends found in most of the available data.

Hypothesis IV

This hypothesis predicted differential increases in mean amount of time spent in foreplay and mean coital frequency over time as a function of Condition. Subjects in the Group Condition were expected to report greater increases on these variables than Self-Directed subjects. Therefore, support for the hypothesis necessitated a significant Condition x Period interaction effect. Hypothesis IV was tested by separately analyzing mean amount of time spent in foreplay and mean coital frequency.

Mean Amount of Time Spent in Foreplay Activity. Data for analysis of this variable derived from item 29 of the Sexual Background Inventory
(Pre) and corresponding items on the Post version of the Inventory. Subjects rated their usual amount of time spent in foreplay along a 7-point scale ranging from "Less Than One Minute" to "More Than One hour" (Appendix C). The results of a 2 x 5 repeated measures analysis of variance revealed no significant main effects and no significant interaction term, suggesting that this intervention had no real impact on time spent in sexual foreplay, as measured by this scale, for subjects in either Condition.

Mean Intercourse Frequency. Apart from the ejaculatory latency and control data already detailed in prior sections of this chapter, frequency of intercourse suggested itself as a way of looking at time spent in intercourse. An analysis of variance was computed for item 27 of the Sexual Background Inventory (Pre) and its Post Inventory counterparts (Appendix C). Neither the main effects nor the interaction effects were found to be significant, indicating that intercourse frequency, as measured on this scale, was not differentially affected by the treatment conditions. An analysis of variance on a related item, the frequency of desire to have intercourse, yielded a significant main effect for Period, F(4,56) = 2.76, p < .05. Irrespective of Condition, subjects expressed the desire to have intercourse more frequently by the end of followup. An analysis of variance on masturbation frequency showed a trend over time for subjects to decrease their rates of masturbation, F(4,56) = 2.28, p < .10.

As a whole, these data do not support Hypothesis III, which predicted differential increases in mean time spent in various sexual activities as a function of Condition and Period.
Hypothesis V

This hypothesis predicted differential increases in mean dating frequency and satisfaction with frequency and quality as a joint outcome of Condition of assignment and Period. The differential increases were expected to favor subjects in the Group Condition. Hypothesis V was tested by separately analyzing mean dating frequency and subjects' satisfaction with dating frequency and quality.

Mean Dating Frequency. Data for analysis of this variable was taken from item 15 of the Sexual Background Inventory (Pre) and corresponding items on the Post Inventory. Subjects rated their frequency of dating on a 5-point scale ranging from "Less Than Once a Month" to "More Than Twice a Week" (Appendix C). The results of the analysis of variance appear in Table 24 below. It revealed a significant main effect for Period, with the means increasing over time as seen in Table 25. There was no significant main effect for Condition and no significant interaction effect. Post hoc t-tests indicated that the source of the effect was the change in means from Pre to Post, \( t(15) = 2.45, p < .05 \). No other sequential means comparisons were significantly different from one another, suggesting that rates of dating were maintained through the Six Month Followup point. Moreover, several nonsequential pairwise comparisons involving pre-post-treatment comparisons were significant at the .005 level (e.g., 6 Month - Pre-pre, \( t(15) = 3.50, p < .005 \); 2 Month - Pre-pre, \( t(15) = 3.35, p < .005 \); Post - Pre-pre, \( t(15) = 3.53, p < .005 \). Overall, the findings on mean dating frequency did not lend support to Hypothesis V. Regardless of Condition, men increased their dating frequencies over time.
### Table 24

**Analysis of Variance of Mean Dating Frequency**

*for all Subjects Through Followup*

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition (A)</td>
<td>1</td>
<td>0.708</td>
<td>0.24</td>
</tr>
<tr>
<td>Error A</td>
<td>14</td>
<td>2.956</td>
<td></td>
</tr>
<tr>
<td>Period (B)</td>
<td>4</td>
<td>2.944</td>
<td>5.72*</td>
</tr>
<tr>
<td>A x B</td>
<td>4</td>
<td>0.894</td>
<td>1.74</td>
</tr>
<tr>
<td>Error B</td>
<td>56</td>
<td>0.514</td>
<td></td>
</tr>
</tbody>
</table>

*p < .05

### Table 25

**Mean Frequency of Dating Rate for**

*all Subjects Through Followup*

<table>
<thead>
<tr>
<th>Condition</th>
<th>Pre-pre</th>
<th>Pre</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>2.500</td>
<td>2.875</td>
<td>3.250</td>
<td>3.500</td>
<td>2.875</td>
</tr>
<tr>
<td>Self-Directed</td>
<td>2.375</td>
<td>2.875</td>
<td>3.500</td>
<td>3.333</td>
<td>3.857</td>
</tr>
</tbody>
</table>

| Period Means    | 2.438   | 2.875| 3.375| 3.417   | 3.366   |

**Note:** The higher the score, the higher the reported rate of dating.
Satisfaction with Dating Frequency and Quality. Data for these analyses were drawn from items 17 and 18 of the Sexual Background Inventory (Pre) and its counterparts on the Post Inventory. Subjects assessed their relative satisfaction with the frequency and quality of their dating patterns along a 7-point scale ranging from "Very Satisfied" to "Very Dissatisfied" (Appendix C). A repeated measures analysis of variance on satisfaction with dating frequency yielded no significant main or interaction effects. An analysis performed on satisfaction with dating quality revealed a trend over time for men in both formats to increase their ratings of satisfaction with the quality of their dating ($p < .10$).

In sum, subjects significantly increased their dating and tended to regard their dating experiences with greater satisfaction following brief sex therapy, as predicted. However, no differential Condition-based effects were found, and consequently, Hypothesis V was not supported by the data on subjects' dating.

Exploratory Hypotheses

Exploratory Hypothesis I

The results of the communications subset (item 43 on the Pre version of the Sexual Background Inventory) of data were analyzed in order to explore the differential effects of treatment on subjects' frequency of sexually relevant communications to their partners. Subjects rated the relative frequency with which they engaged in each of ten communications (Appendix C) along a 5-point scale ranging from "Almost Always True (90% of Time)" to "Almost Never True (10% of Time)". A repeated
measures analysis of variance performed separately for each item is summarized in Table 26.

As Table 26 clearly displays, there was a significant main effect for Period for each communication item (except item A), with means decreasing over time (Appendix E). The data thus indicated that the mean frequency of communications regarding sexually relevant affects, sensations and behaviors increased over time for all subjects, regardless of their group assignment. Inspection of the post hoc test portion of Table 26 summarizes the source(s) of significance for each of the nine items displaying a significant main effect for Period. In all but one instance (Item D), a significant difference between the means was found in the Pre-Post pairwise comparison at the .05 level or better. These pairwise comparisons yielded a consistent pattern of significant statistics. In addition, there were several significant t-tests at the Post-Two Month Followup means comparisons, indicating continuous increases in the frequency of subjects' communications on sexual issues through the first followup phase. Finally, there were two significant pairwise comparisons for the control period (Items E and H). However, the bulk of the significant changes in frequency of communications on sexual topics occurred at the Pre-Post comparison point and, consequently, for most items, any pairwise comparison involving a pre-post-treatment comparison was significant.

The output summarized in Table 26 further yielded a significant Period x Condition interaction effect for Item D (along with a trend for Item E). The full analysis of variance for this item appears in Table 27 below.
Table 26
Summary of Analysis of Variance for all Communications Items for all Subjects Through Followup\(^{(a),(b)}\)

<table>
<thead>
<tr>
<th>Source</th>
<th>Period (B)</th>
<th>A x B</th>
<th>T-Test by Period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>F</td>
<td>1 - 2</td>
</tr>
<tr>
<td>A. I find it easy to initiate sexual activity</td>
<td>1.44</td>
<td>1.41</td>
<td>--------</td>
</tr>
<tr>
<td>B. I ask my partner(s) to do the sexual which I enjoy</td>
<td>8.92*</td>
<td>0.80</td>
<td>-0.00</td>
</tr>
<tr>
<td>C. I refuse sex with my partner(s) when I don't feel like having it.</td>
<td>10.79*</td>
<td>1.08</td>
<td>1.06</td>
</tr>
<tr>
<td>D. I tell my partner(s) when I've enjoyed our sexual activity(ies)</td>
<td>4.33**</td>
<td>3.33***</td>
<td>0.81</td>
</tr>
<tr>
<td>E. I discuss with my partner(s) ways of improving our sexual activity(ies)</td>
<td>13.67*</td>
<td>2.41</td>
<td>3.16*****</td>
</tr>
<tr>
<td>F. I suggest different position(s) ways of improving our sexual activity(ies)</td>
<td>4.68**</td>
<td>1.38</td>
<td>-0.37</td>
</tr>
<tr>
<td>G. I suggest different sexual activities to my partner(s) during our sexual encounter</td>
<td>6.83*****</td>
<td>1.83</td>
<td>1.58</td>
</tr>
<tr>
<td>H. I tell my partner(s) when I am experiencing negative feelings (anxiety, pressure, etc.) in a sexual situation</td>
<td>15.72*</td>
<td>1.84</td>
<td>2.78***</td>
</tr>
<tr>
<td>I. I tell my partner(s) when I am experiencing negative feelings (anger, resentment, being turned off, etc.) during a sexual experience</td>
<td>9.16*</td>
<td>0.53</td>
<td>0.62</td>
</tr>
<tr>
<td>J. I tell my partner(s) that I have trouble with premature ejaculation</td>
<td>7.75*</td>
<td>0.91</td>
<td>1.57</td>
</tr>
</tbody>
</table>

\( ^{*} P < .0001; \quad ^{**} P < .005 \quad ^{****} P < .05; \quad ^{*****} P < .0005; \quad ^{******} P < .01 \)

\( (a) \) For items B, C, and E through I, full results of the analyses of variance are provided in Appendix E. A full tabular summary for item D appears later in this section.

\( (b) \) Since there were no significant main effects for Condition, Condition F's were excluded from Table 26. They appear in Appendix E. There were also no significant associations between relationship status (questions answered for current or last relationship) and assigned Condition at any test point, as revealed by a series of Fisher Exact Tests.

\( (c) \) This item may not fit the conceptual model proposed for this dataset. Unlike the subsequent nine items which focus on verbal communication, it (a) samples a behavior, or disposition to act and (b) it involves a relative judgment rather than a categorical decision about relevant behavior. These factors may account for the nonsignificant effects obtained.

\( (d) \) In each case, df = 4,56 for the F test and df = 15 for the t statistic.
Table 27

Analysis of Variance of Frequency of Communications on Enjoyment of Sexual Activities for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition (A)</td>
<td>1</td>
<td>1.250</td>
<td>0.41</td>
</tr>
<tr>
<td>Error A</td>
<td>14</td>
<td>3.068</td>
<td></td>
</tr>
<tr>
<td>Period (B)</td>
<td>4</td>
<td>1.300</td>
<td>4.33*</td>
</tr>
<tr>
<td>A x B</td>
<td>4</td>
<td>1.000</td>
<td>3.33**</td>
</tr>
<tr>
<td>Error B</td>
<td>56</td>
<td>0.300</td>
<td></td>
</tr>
</tbody>
</table>

*P < .005
**P < .05

The significant interaction, as shown further in Table 28, is the result of the differential increase in means over time and as a function of Condition. Inspection of the means suggests that, according to prediction, the Group Condition means decreased (improved) sharply, while Self-Directed means changed very little. Appropriate means

Table 28

Mean Frequency of Communications on Enjoyment of Sexual Activities for all Subjects by Followup

<table>
<thead>
<tr>
<th>Condition</th>
<th>Pre-pre</th>
<th>Pre</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>2.375</td>
<td>2.250</td>
<td>1.250</td>
<td>1.500</td>
<td>1.500</td>
</tr>
<tr>
<td>Self-Directed</td>
<td>1.625</td>
<td>1.500</td>
<td>1.500</td>
<td>1.750</td>
<td>1.250</td>
</tr>
</tbody>
</table>

Period Means       | 2.000   | 1.875| 1.375| 1.625   | 1.375   |

Note: Mean decreases denote frequency increases.
comparisons clarified the following:

1. Where the Condition factor was held constant at Group, a significant Period effect was obtained, $F(4, 56) = 6.75, p < .0005$, $(F_{GGI} 2.64, 36.95) = 6.750, p < .005)$. On the other hand, there was no significant overall Period effect when only the Self-Directed Condition data were analyzed. These statistics sharpen and clarify the impression gleaned from inspection of Table 28.

2. To specify precisely the source of significance for the Group subjects on this variable, further $t$-tests were run. These tests showed no significant differences from Pre-pre - Pre (control period), Post-Two Month Followup or Two Month - Six Month Followup. The significance lay in the Pre-Post means comparison, $F(1, 14) = 11.20, p < .005$.

3. Pairwise comparisons testing for differences between Conditions uncovered no significant differences at any of the measurement points.

These data, on frequency of communications on enjoyment of sexual activities, which indicate that the Group subjects were improving more dramatically than their Self-Directed counterparts, strongly support exploratory Hypothesis I. However, even this finding, combined with item E (which showed a trend in the direction of an interaction), does not constitute a meaningful pattern of support for the hypothesis. While these data do not support the prediction of differential impact of treatment formats, they clearly demonstrate strong and sustained treatment effects. A visual summary appears in Figure 4.
Figure 4: Mean Frequency of Communications on Enjoyment of Sexual Activities* Described by Condition and Period

Note: The lower the score, the more frequent the communication of enjoyment of sexual activity.

*Item 43, Sexual Background Inventory (Pre): "I tell my partner(s) when I've enjoyed our sexual activity(ies)."
1 = "Almost Always True (90% of Time); 5 = "Almost Never True (10% of Time)"
Exploratory Hypothesis II

The results of the Self-Consciousness Scale and the Internal-External Locus of Control were reviewed in order to test the hypothesis that differential mean increases in private self-consciousness and internal locus of control would result from Condition of assignment and Period (treatment). The Self-Consciousness Scale, consisting of three factors, required subjects to rate the extent to which a given item described them, along a 5-point scale from "Extremely Uncharacteristic" to "Extremely Characteristic" (Appendix C). A separate repeated measures analysis of variance on the "private" factor revealed no significant main effects for Period or Condition and no significant interaction effects, suggesting that private self-consciousness, as measured by this Scale, is unaffected by brief sex therapy.

A separate repeated measures analysis of variance was performed on the Locus of Control Scale Scores (Appendix C). No significant main or interaction effects emerged, although it appeared that subjects in the Self-Directed Condition reported more internal control at all observation points than did Group subjects. They also did show a trend toward "internality" over time, while the Group subjects showed a slight trend toward "externality" over time. Brief sex therapy advances the notion that persons should take responsibility for their own sexuality. Considering the fact that subjects in the Self-Directed Condition were more singularly and perhaps responsibly involved in their treatment, and could not rely upon therapists or other group members as the Group subjects could, the direction of these trends seems reasonable. Heinrich (1976) reported similar findings; her
"Education Condition" subjects showed the most significant movement in the direction of internal locus of control. The data in the present study indicate that locus of control, as measured by this scale, is not susceptible of manipulation in a brief sex therapy context using male subjects. This finding contrasts sharply with that obtained for pre-orgasmic women exposed to a brief sex therapy intervention (Heinrich, 1976), where highly significant Period effects were obtained.

**Exploratory Hypothesis III**

In order to examine the degree to which predicted differential decreases in mean ratings of public self-consciousness, social anxiety, sex guilt and negative attitudes toward masturbation were found, separate analyses of variance for each measure (with subanalyses as appropriate) were performed.

The predictions on public self-consciousness and social anxiety (factors 2 and 3 of the Self-Consciousness Scale) were not sustained. On neither factor were there significant main or interaction effects.

The Mosher Inventory data were analyzed by Total Score, using the analysis of variance procedure, in order to explore the differential impact, if any, of the therapeutic program on subjects' self-reported sex guilt. Neither significant main effects for Condition or Period nor a significant interaction were found.

Finally, the results of the Negative Attitudes Toward Masturbation Scale were analyzed in order to explore how predicted decreases in mean scores on this measure were related to Period and Condition. Subjects rated the extent to which they agreed with the masturbation items along a 5-point scale ranging from "Strongly Agree" to "Strongly
Disagree" (Appendix C). An analysis of variance on the Total Scores revealed a highly significant main effect for Period, \( F(3,42) = 5.16, p < .005 \).

Table 29

Total Score Analysis of Variance of Negative Attitudes Toward Masturbation Scale for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition (A)</td>
<td>1</td>
<td>78.766</td>
<td>0.18</td>
</tr>
<tr>
<td>Error A</td>
<td>14</td>
<td>436.712</td>
<td></td>
</tr>
<tr>
<td>Period (B)</td>
<td>3</td>
<td>212.057</td>
<td>5.16*</td>
</tr>
<tr>
<td>A x B</td>
<td>3</td>
<td>31.807</td>
<td>0.77</td>
</tr>
<tr>
<td>Error B</td>
<td>42</td>
<td>41.123</td>
<td></td>
</tr>
</tbody>
</table>

*p < .005

Table 30

Mean Total Scores of Negative Attitudes Toward Masturbation Scale for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Condition</th>
<th>Pre</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>124.250</td>
<td>130.625</td>
<td>126.625</td>
<td>127.875</td>
</tr>
<tr>
<td>Self-Directed</td>
<td>118.750</td>
<td>128.500</td>
<td>124.000</td>
<td>129.250</td>
</tr>
</tbody>
</table>

| Period Means  | 121.500 | 129.563 | 125.313 | 125.563 |

Note: Increased scores denote increased acceptance of masturbation.
No other significant effects were obtained. The main effect for Period is clearly visible in Table 30 below where, irrespective of Condition, subjects showed marked decreases in their negative attitudes regarding masturbation as evidenced by their rising mean scores. Appropriate t-tests on the Total Scores indicated that the Pre-Post Comparison was significant, \( t(15) = 3.16, p < .01 \), whereas pairwise comparisons across followup points were not significant. Therefore gains recorded at posttest were maintained throughout followup. In summary, the findings indicated that all subjects increased in their general acceptance of masturbation-related cognitions and affects as measured by this scale.

Individual item analyses were also examined. Eight of the 30 items reached statistical significance. They are summarized in Table 31. Item #8 ("Excessive masturbation is physically impossible, as it is a needless worry.") was the only item for which a significant Condition effect was found, \( F(1,14) = 4.99, p < .05 \). Means comparison revealed that Group subjects had significantly higher scores, indicative of a more accepting attitude on this matter. T-tests revealed that this group difference was manifest at baseline, \( t(14) = 3.36, p < .005 \), but disappeared at all post-treatment comparisons. Throughout the followup phase, the views of Self-Directed subjects were as accepting on this item as those of Group subjects. Six items showed significant main effects for Period and an additional six showed trends toward significance over time (Items 4, 9, 11, 12, 15 and 27). Pairwise a posteriori comparisons, summarized in Table 31, showed that in five of six cases, the chief source of significant change was the
Table 31

Summary of Analysis of Variance for Significant NATM(a) Items

for All Subjects Through Followup

<table>
<thead>
<tr>
<th>Source</th>
<th>Condition (A)</th>
<th>Period (B)</th>
<th>A x B</th>
<th>T-Tests by Period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>F</td>
<td>F</td>
<td>3-2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Post-Pre</td>
</tr>
<tr>
<td>2. People who masturbate will not enjoy sexual intercourse as much as those who refrain from masturbation.</td>
<td>0.24</td>
<td>7.41*</td>
<td>0.46</td>
<td>4.39***</td>
</tr>
<tr>
<td>8. Excessive masturbation is physically impossible, as it is a needless worry.</td>
<td>4.99**</td>
<td>0.43</td>
<td>0.89</td>
<td>NA</td>
</tr>
<tr>
<td>12. I feel guilty about masturbating.</td>
<td>0.10</td>
<td>2.45</td>
<td>3.87**</td>
<td>(See pp. 120-121)</td>
</tr>
<tr>
<td>14. Masturbation can provide an outlet for sex fantasies without harming anyone else or endangering oneself.</td>
<td>0.36</td>
<td>4.13**</td>
<td>0.65</td>
<td>2.42**</td>
</tr>
<tr>
<td>18. Playing with your own genitals is disgusting.</td>
<td>0.27</td>
<td>2.88**</td>
<td>0.32</td>
<td>3.00***</td>
</tr>
<tr>
<td>23. When I masturbate, I am disgusted with myself.</td>
<td>0.00</td>
<td>3.67**</td>
<td>1.39</td>
<td>2.42**</td>
</tr>
<tr>
<td>24. A pattern of frequent masturbation is associated with introversion and withdrawal from social contacts.</td>
<td>0.46</td>
<td>4.17**</td>
<td>2.52</td>
<td>2.61**</td>
</tr>
<tr>
<td>29. Masturbation can teach you to enjoy the sensuousness of your own body.</td>
<td>0.80</td>
<td>2.93**</td>
<td>1.34</td>
<td>2.08</td>
</tr>
</tbody>
</table>

*P < .0005; **P < .05; ***P < .005

(a) Negative Attitudes Toward Masturbation Scale. Appendix F houses the complete analyses of variance on these items (except item 12, which appears later in this section) in tabular form.
Pre-Post Period comparison. In each case, the means increased from Pre to Post (Appendix F) indicating increased acceptance of these sentiments for all subjects throughout followup. Since the directed masturbation component is regarded as the foundation for learning successful ejaculatory control, it is reasonable that items which invoke therapeutic themes or potentials (e.g., item 14, 29) or harsh judgments (e.g., items 12, 18, 23) should have been the most sensitive to change.

As Table 31 indicates, there was one significant interaction effect, $F(3,42) = 3.87, p < .05$, for the item, "I feel guilty about masturbating." The results of the analysis of variance for this item are presented in Table 32 below.

Table 32

Analysis of Variance of Subjects' Self-Reported Masturbation Guilt* for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition (A)</td>
<td>1</td>
<td>0.141</td>
<td>0.10</td>
</tr>
<tr>
<td>Error A</td>
<td>14</td>
<td>1.355</td>
<td></td>
</tr>
<tr>
<td>Period (B)</td>
<td>3</td>
<td>0.432</td>
<td>2.45</td>
</tr>
<tr>
<td>A x B</td>
<td>3</td>
<td>0.682</td>
<td>3.87**</td>
</tr>
<tr>
<td>Error B</td>
<td>42</td>
<td>0.176</td>
<td></td>
</tr>
</tbody>
</table>

*Item 12, Negative Attitudes Toward Masturbation Scale.
**$p < .05$

Inspection of the means in Table 33 indicates the differential changes in mean scores for Condition and Period accounting for this interaction. Whereas Group subjects, across the study period, hardly fluctuated in
their endorsements for this item, Self-Directed subjects changed their scores quite markedly from Pre to Post, but subsequently fluctuated only slightly.

Table 33

Mean Frequency of Subjects' Self-Reported Masturbation

Guilt for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Condition</th>
<th>Pre</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>4.625</td>
<td>4.500</td>
<td>4.625</td>
<td>4.625</td>
</tr>
<tr>
<td>Self-Directed</td>
<td>4.000</td>
<td>4.875</td>
<td>4.625</td>
<td>4.500</td>
</tr>
</tbody>
</table>

Period Means 4.313 4.688 4.625 4.563

Note: Score increases denote decreases in masturbation guilt.

Appropriate comparisons further specified findings as follows:

1. Where the Condition factor was held constant at Group, an insignificant effect was obtained.

2. Where the Condition factor was held constant at Self-Directed, a highly significant overall Period effect was found, $F(3,42) = 6.143, p < .005$. In sum, Self-Directed subjects reported more substantial change than their Group peers across time on this variable.

3. To locate more precisely the source of the significance in time, further tests showed:
   
   (a) a significant within effect for the Self-Directed Group on the Pre-Post contrast, $F(1,14) = 8.795, p < .05$. 
(b) no significant contrast effects for the remaining sequential followup points.

(c) that pairwise comparisons testing for differences between the Conditions were not significant.

These data are the subject of Figure 5.

In conclusion, the Negative Attitudes Toward Masturbation Scale proved one of the most fruitful instruments used in this research. While not supporting the hypothesis proposing differential decreases as a joint outcome of Period and Condition, the Scale seems responsive, as a measure, to therapeutic interventions of this kind. Subjects reduced their negative scores over time, particularly during the treatment period.

As an additional test of the dependent measure, item 46 of the Pre Background Inventory (and its correlates on the Post form) was analyzed. Subjects were asked to rate their relative degree of satisfaction with masturbation along a 7-point scale ranging from "Very Satisfying" to "Very Dissatisfying" (Appendix C). The analysis of variance is presented in Table 34 below.

As the Table makes clear, no significant main effect for Condition or interaction effect emerged, but a significant main effect for Period manifested itself. Inspection of the means in Table 35 provides a summary of the trends over time in the direction of significantly improved masturbation satisfaction ratings.

Appropriate t-tests indicated:

1. a trend toward significant increases in satisfaction scores during the control period from Pre-pre to Pre, t(15) = 2.09,
Figure 5: Mean Frequency of Subjects' Masturbation Guilt* Described by Condition and Period.

Note: The lower the score, the greater the negative expression.

*Item 12, Negative Attitudes Toward Masturbation Scale: "I feel guilty about masturbating." 1 = "Strongly Agree"; 5 = "Strongly Disagree."
Table 34

Analysis of Variance of Subjects' Relative Satisfaction with Masturbation (for all Subjects) Through Followup

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition (A)</td>
<td>1</td>
<td>0.717</td>
<td>0.22</td>
</tr>
<tr>
<td>Error A</td>
<td>14</td>
<td>3.186</td>
<td></td>
</tr>
<tr>
<td>Period (B)</td>
<td>4</td>
<td>1.979</td>
<td>3.15*</td>
</tr>
<tr>
<td>A x B</td>
<td>4</td>
<td>0.085</td>
<td>0.13</td>
</tr>
<tr>
<td>Error B</td>
<td>56</td>
<td>0.627</td>
<td></td>
</tr>
</tbody>
</table>

*p < .05

p < .06.

2. no other significant comparisons for any subsequent sequential contrasts.

3. maintenance of gains throughout followup on this variable as all comparisons involving Pre-pre and post-treatment points were significant (Six Month - Pre-pre, t(15) = 2.87, p < .05; Two Month - Pre-pre, t(15) = 2.88, p < .05; Post - Pre-pre, t(15) = 2.36, p < .05).

Decreased negative attitudes toward masturbation and increased masturbation satisfaction scores form a coherent pattern of results suggesting that attitudinal and behavioral variables tied to masturbation can be meaningfully modified and/or maintained in the context of a brief sex therapy regimen.

Overall, Exploratory Hypothesis III was not supported by the available data. Three of the measures for which significant interactions were predicted, public self-consciousness, social anxiety and
Table 35

Mean Frequency of Subjects' Relative Satisfaction with Masturbation (for all Subjects) Through Followup

<table>
<thead>
<tr>
<th>Condition</th>
<th>Pre-pre</th>
<th>Pre</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>2.875</td>
<td>2.375</td>
<td>2.125</td>
<td>2.125</td>
<td>2.000</td>
</tr>
<tr>
<td>Self-Directed</td>
<td>3.000</td>
<td>2.750</td>
<td>2.125</td>
<td>2.286</td>
<td>2.286</td>
</tr>
</tbody>
</table>

Period Means 2.938 2.563 2.1255 2.205 2.143

Note: Score decreases indicate increased satisfaction ratings.

sex guilt appeared to be nonresponsive to the intervention. The fourth, negative attitudes toward masturbation, substantiated the directional but not the group differential aspect of the prediction. Post hoc tests showed the directional aspect (reduced negative attitudes) was treatment related. The data on masturbation satisfaction may be viewed as a companion measure; they showed the same directional, but not differential support for the hypothesis.

Exploratory Hypothesis IV

In order to explore the extent, if any, to which, measures of increased ejaculatory latency/control were related to predicted attitude changes, a correlation matrix was examined. In view of the hypothesis statement, change scores (reflecting Six Month - Pre values) on each of seven attitude variables and twelve ejaculatory control variables were correlated. The control variables entered into the matrix included coital latency, masturbation latency, control in last
five encounters, in mid-intercourse, in foreplay, etc. Significant correlated variables are presented in Table 36 (overleaf).

The most prominent correlation coefficient ($r = .8187$) was obtained for the timed latency/sexual relationship satisfaction item, indicating that, for this sample, a strong positive relationship between latency and sexual satisfaction ratings exists. This relationship supports Exploratory Hypothesis IV. The correlations on coital length or latency correlate highly and positively with other measures of ejaculatory control and, interestingly, with anxiety levels. The latter relationship lends support to the theoretical claim and clinical impression that rapid ejaculation is tied to felt anxiety and perhaps "spectatoring"—given the correlation with public self-consciousness. The positive correlations involving goal statements and ejaculatory behaviors and affect (anxiety) conform to the hypothesis, suggesting that satisfaction with various sexual behaviors and sentiments is associated with degree of behavioral control. By the same token, the direct, positive relationship between sex guilt (Mosher Scale) and mid-coital ejaculatory control conforms to prediction.

Six variables revealed significant negative correlations. The bulk of these supported prediction: negative attitudes toward masturbation inversely related to masturbatory satisfaction and ejaculatory control in last five sexual encounters, social anxiety and public self-consciousness strongly inversely associated with communicating ejaculatory difficulty to partner. In the postportal control items, the minus signs were artifacts of coding and transformation of the
Table 36

Summary of Significant Correlations Between Ejaculatory Control and Attitude Inventory Variables\(^{(a)}\)

<table>
<thead>
<tr>
<th>Transformed Variable</th>
<th>Correlation Coefficient (r)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mosher(^{(b)})/Ejaculation Mid-Coitus</td>
<td>.5289*</td>
</tr>
<tr>
<td>NATM(^{(c)})/Control in Last Five Encounters</td>
<td>-.6371***</td>
</tr>
<tr>
<td>NATM/Masturbation Satisfaction</td>
<td>-.7446***</td>
</tr>
<tr>
<td>Goals(^{(d)})/Coital Length</td>
<td>.7311***</td>
</tr>
<tr>
<td>Goals/Control in Last Five Encounters</td>
<td>.5317*</td>
</tr>
<tr>
<td>Goals/Control in Postportal Ejaculation</td>
<td>.5121*</td>
</tr>
<tr>
<td>Goals/Anxiety Regarding Ejaculatory Control</td>
<td>.6203**</td>
</tr>
<tr>
<td>CAINSOC(^{(e)})/Communicating Rapid Ejaculation Problem</td>
<td>-.6917***</td>
</tr>
<tr>
<td>CAINPUB(^{(f)})/Coital Length</td>
<td>.4986*</td>
</tr>
<tr>
<td>CAINPUB/Communicating Rapid Ejaculation Problem</td>
<td>-.5177*</td>
</tr>
<tr>
<td>Coital Length/Control in Last Five Encounters</td>
<td>.6753***</td>
</tr>
<tr>
<td>Coital Length/Control in Postportal Ejaculation</td>
<td>.6123**</td>
</tr>
<tr>
<td>Coital Length/Anxiety Regarding Ejaculatory Control</td>
<td>.5410**</td>
</tr>
<tr>
<td>Postportal Control/Communicating Rapid Ejaculation Problem</td>
<td>-.5138*</td>
</tr>
<tr>
<td>Postportal Control/Coital Frequency</td>
<td>-.5330*</td>
</tr>
<tr>
<td>Sexual Relationship Satisfaction/Timed Masturbation Latency</td>
<td>.8187***</td>
</tr>
<tr>
<td>Subjective Masturbation Latency/Communicating Rapid Ejaculation Problem</td>
<td>-.5048*</td>
</tr>
</tbody>
</table>

\(^{a}\) Approximately 8.5 of the overall number (171) would be significant on the basis of chance.

\(^{(b)}\) Mosher Sex Guilt Scale.

\(^{(c)}\) Negative Attitudes Toward Masturbation Scale.

\(^{(d)}\) Goals for Sexual Therapy-Male Scale.

\(^{(e)}\) California Inventory (Self-Consciousness Scale), Social Anxiety factor.

\(^{(f)}\) California Inventory (Self-Consciousness Scale), Public Self-Consciousness factor.
variables. A positive correlation existed between postportal ejaculatory control and coital frequency and communication of ejaculatory difficulty. In sum, all of the relationships found were in the direction predicted by Exploratory Hypothesis IV. However, a relatively small number of items is represented; not all of the possible predicted relationships (e.g., private self-consciousness and any of the coital latency or satisfaction items) emerged significantly.

Additional Data of Clinical Significance. Items 33 and 34 of the Sexual Background Inventory (Post) were analyzed to learn how subjects ranked the various control techniques and exercises the program provided (Appendix C). Separate Friedman two-way analyses of variance and Kendall tests of concordance were performed for the two questions at each of the three posttest points, yielding six measures overall. The summary of these data appears in Table 37 below.

As Table 37 indicates, subjects' perceptions of the most effective techniques used in learning, at all points in time, were (1) stop-start; (2) arousal decreasing variations in stimulation; (3) changes in the amount of verbal communication; and (4) position variations in intercourse. Thereafter, the order differed slightly at the different periods, but inspection of the means resulted in the following order: (5) alterations in body tension; (6) frequency of sexual interaction and/or intercourse; (7) squeeze; (8) changes in the amount of foreplay/touching; and (9) changes in fantasy.

Means over time of those techniques used in subjects' maintenance programs revealed the following order: (1) stop-start; (2) arousal decreasing variations in stimulation; (3) changes in amount of verbal
Table 37

Subjects' Rankings* of Control Techniques (Program Components) for Learning and Maintenance Purposes for all Subjects at Post and Followup

<table>
<thead>
<tr>
<th>Variable Name**</th>
<th>Followup Observation Point</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Post</td>
<td>Post</td>
<td>2 Month</td>
<td>2 Month</td>
<td>6 Month</td>
<td>6 Month</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Learning</td>
<td>Maintenance</td>
<td>Learning</td>
<td>Maintenance</td>
<td>Learning</td>
<td>Maintenance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rank Sums</td>
<td>Rank Sums</td>
<td>Rank Sums</td>
<td>Rank Sums</td>
<td>Rank Sums</td>
<td>Rank Sums</td>
</tr>
<tr>
<td>Stop-Start</td>
<td></td>
<td>25.5</td>
<td>23.0</td>
<td>30.0</td>
<td>34.0</td>
<td>19.0</td>
<td>22.0</td>
</tr>
<tr>
<td>Squeeze</td>
<td></td>
<td>89.5</td>
<td>94.0</td>
<td>96.5</td>
<td>100.0</td>
<td>102.0</td>
<td>126.0</td>
</tr>
<tr>
<td>Variations</td>
<td></td>
<td>56.5</td>
<td>38.0</td>
<td>60.0</td>
<td>32.0</td>
<td>64.0</td>
<td>70.0</td>
</tr>
<tr>
<td>Fantasy</td>
<td></td>
<td>113.5</td>
<td>96.0</td>
<td>106.5</td>
<td>76.0</td>
<td>98.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Positioning</td>
<td></td>
<td>78.5</td>
<td>50.0</td>
<td>77.0</td>
<td>44.0</td>
<td>75.0</td>
<td>70.0</td>
</tr>
<tr>
<td>Body Tension</td>
<td></td>
<td>89.5</td>
<td>66.0</td>
<td>93.0</td>
<td>65.0</td>
<td>90.0</td>
<td>72.0</td>
</tr>
<tr>
<td>Foreplay</td>
<td></td>
<td>99.5</td>
<td>69.0</td>
<td>100.0</td>
<td>64.0</td>
<td>108.0</td>
<td>101.0</td>
</tr>
<tr>
<td>Coital Frequency</td>
<td></td>
<td>96.5</td>
<td>65.0</td>
<td>85.0</td>
<td>72.0</td>
<td>98.0</td>
<td>96.0</td>
</tr>
<tr>
<td>Communication</td>
<td></td>
<td>71.5</td>
<td>39.0</td>
<td>72.0</td>
<td>53.0</td>
<td>66.0</td>
<td>63.0</td>
</tr>
</tbody>
</table>

Friedman Test Statistic  
43.342*** 55.422*** 37.846*** 42.289*** 51.783*** 59.417***

Kendall Coefficient  
.362 .577 .296 .441 .405 .464

*The lower the rank sum on a given item, the greater subjects' regard for that item as an effective learning or maintenance tool.

**See Appendix C for full names.

***p < .0001
communication; (4) position variations in intercourse; (5) alterations in body tension; (6) frequency of sexual interaction; (7) changes in the amount of foreplay/touching; (8) changes in fantasy, and (9) squeeze.

It is clear, from the stability of the ranks over testing periods, the stability of the rank order comparing learning and maintenance conditions, and the statistics, that subjects' concurred strongly on their appraisals of the relative value of each of the control strategies presented to them in therapy. The stop-start technique was highly prized by this sample as were its cognates, arousal decreasing and position variations in intercourse, whereas the squeeze technique was regarded as less effective or popular. These data echo an earlier theme: change in amount of foreplay was regarded as a relatively ineffective management technique. This appraisal may be related to the finding that mean amount of time spent in foreplay did not increase significantly. Frequency of sexual activity, which, prior to therapy, was a prominent control strategy for most subjects, was assigned moderate importance post-treatment. Verbal communication maintained a place of importance in all evaluations following therapy. Not a single subject mentioned it prior to treatment. Particularly in the maintenance context, fantasy was far less effective in subjects' relative appraisals than therapists might think. Additionally, subjects mentioned relaxation, masturbation, sensory awareness and appropriate scene setting as means of enhancing ejaculatory control. Overall, these rankings suggest some directions for the design of treatment formats.
Summary

The first hypothesis posited differential increases in mean ejaculatory latency as a function of Period and Condition. The data on usual ejaculatory latency in intercourse, compliance with partner exercise component, rapid ejaculation at baseline, presence of partner, usual latency in masturbation, number of masturbation exercises done at followup, and timed masturbation sequences using control techniques did not reveal significant main effects for Condition or interaction effects. In all the latency measures, only two significant main effects for Condition were manifest, as can be seen in Table 38 below. On the other hand, significant main effects for Period were found for each dependent measure, indicating that treatment had substantial impacts on mean ejaculatory latency for all subjects, however measured.

The second hypothesis predicted differential outcomes favoring Group subjects on frequency or degree of ejaculatory control in foreplay and coital activities over time. The data on control in foreplay, control at intromission and shortly thereafter, and erectile control failed to confirm the hypothesized outcome. Indeed the foreplay and erectile control variables indicated no significant effects of any kind. The control variable showed only a highly significant Period effect, indicating improvement for all subjects. The findings in mid-intercourse ejaculatory control and control in last five sexual encounters revealed significant interaction terms and main effects for Period (but not Condition). However, the existence of baseline
Table 38

Summary of Significant Main Effects for Condition (A) and Interaction Effects (A x B) for all Hypotheses

<table>
<thead>
<tr>
<th>Variable</th>
<th>Relevant To:</th>
<th>Found In:</th>
<th>Effect:</th>
<th>Outcome Favored:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Number of Masturbation Exercises Done at Post</td>
<td>Hypothesis I</td>
<td>Table 5</td>
<td>Main (A)</td>
<td>Self-Directed Subjects*</td>
</tr>
<tr>
<td>B. Timed &quot;Uncontrolled&quot; Masturbation Sequences</td>
<td>Hypothesis I</td>
<td>Table 6</td>
<td>Main (A)</td>
<td>Self-Directed Subjects*</td>
</tr>
<tr>
<td>C. Ejaculatory Control in Mid-Intercourse</td>
<td>Hypothesis II</td>
<td>Table 11</td>
<td>Interaction (A x B)</td>
<td>Men's Group**</td>
</tr>
<tr>
<td>D. Ejaculatory Control in Last Five Sexual Encounters</td>
<td>Hypothesis II</td>
<td>Table 13</td>
<td>Interaction (A x B)</td>
<td>Men's Group**</td>
</tr>
<tr>
<td>E. Subjects' Appraisal of Partner Satisfaction with Latency</td>
<td>Hypothesis III</td>
<td>Table 18</td>
<td>Main (A)</td>
<td>Men's Group***</td>
</tr>
<tr>
<td>F. Frequency of Subjects' Communication on Enjoyment of Sexual Activity(ies)</td>
<td>Exploratory</td>
<td>Tables 26-28</td>
<td>Interaction (A x B)</td>
<td>Men's Group****</td>
</tr>
<tr>
<td>G. Item number 8, Negative Attitudes Toward Masturbation Scale, &quot;Excessive masturbation is physically impossible, as it is a needless worry.&quot;</td>
<td>Exploratory</td>
<td>Hypothesis I</td>
<td>Table 31</td>
<td>Main (A)</td>
</tr>
</tbody>
</table>

*contrary to prediction
**presence of baseline differences
***absence of baseline differences
****according to prediction
differences in each case diminishes the support implied for Hypothesis II. Group differences predated rather than postdated therapeutic intervention. On the other hand, all ejaculatory control variables were responsive to treatment as indicated by universal Period effects.

The third hypothesis asserted differential increases in reported satisfaction with ejaculatory control and other facets of sexual functioning as a joint outcome of Period and Condition influences. The data on usual level of anxiety regarding ejaculatory timing, subjects' latency satisfaction, subjects' perception of partners' satisfaction with overall sexual relationship, and satisfaction with varied sexual thoughts, affects and behaviors (Goals Scale) did not reveal any significant main effects for group or interaction effects. In all these satisfaction measures, only one significant main effect for Condition (Table 38) was uncovered. In itself, it is a rather indirect and isolated measure of satisfaction. On the other hand, several significant Period effects were found for the more central measures of satisfaction (e.g., Goal Scale variables, subjects' anxiety levels, subjects' own overall satisfaction). These effects indicated that treatment had significant impacts on measures of ejaculatory and general sexual satisfaction for all subjects.

The fourth hypothesis proposed differential increases in mean amount of time spent in foreplay and coital activities as a function of Condition and Period. The data on mean amount of time spent in foreplay and intercourse showed no significant effects, contrary to prediction. A related variable, frequency of desire for coitus, revealed only a significant Period effect, while masturbation frequency revealed a
trend indicating decreased frequency over time. These data failed to support the hypothesis.

The fifth hypothesis predicted differential increases in mean dating frequency, and quality and satisfaction with both, as a joint outcome of Condition and Period. The data on mean dating frequency, satisfaction with dating frequency, and quality revealed no significant main effect for Condition or interaction effect. All subjects increased their dating frequency over time and tended to regard their dating experiences as more satisfactory over time.

The first exploratory hypothesis asserted that Group subjects would increase their frequency of sexually relevant communications at a greater rate than Self-Directed subjects. The data on all nine significant communication items showed Period rather than Condition-based effects (Table 26), while one showed a significant interaction effect, in line with the hypothesis (Table 38). Treatment, therefore, significantly increased the frequency of sexually relevant communications for all subjects in this study.

The second exploratory hypothesis proposed differential increases in private self-consciousness and internal locus of control as a function of Condition and Period. No significant main or interaction effects emerged, thereby denying support to the hypothesis. These data further suggest that these dimensions of interest, at least as measured by these Scales, are unaffected by brief sex therapy with single males.

The third exploratory hypothesis posited differential decreases in mean public self-consciousness, social anxiety, sex guilt and
negative attitudes toward masturbation appraisals. On the first three variables, no significant main or interaction effects were found. The implications parallel those for exploratory hypothesis II described above. Only a significant Period effect was obtained for the fourth variable, suggesting that all subjects increased their acceptance of masturbation as measured by this Scale. (One of the thirty items showed a significant main effect for Condition, but no interaction.) In sum, none of the four variables lent the overall hypothesis any support.

The final, exploratory hypothesis was supported by the significant correlations obtained.
CHAPTER IV

Discussion

This research was designed to ascertain the relative efficacy of two behavioral-educational treatment formats in the management of premature (rapid) ejaculation in males without steady partners. The Group treatment format involved participants in weekly meetings with a male-female cotherapy team for group discussion, graded behavioral homework tailored to ejaculatory dyscontrol, and sex education and information. Self-Directed format participants met once in an all-day seminar and received the same educational and homework components, but did not have the benefit of therapist-led group process. Instead, they had weekly phone contact.

Prior to treatment onset, each subject acted as his own control for a period generally equal to the treatment period (two months) or longer. At intake, at the conclusion of the control period, at post-treatment, and at Two and Six Month Followups, a test battery was administered to each participant. The chief hypothesis, suggested by prior research in the area, was that the Group Condition would be more effective than the Self-Directed Condition in promoting behavior change on all outcome variables, while both forms of treatment would be more effective than no treatment (control).
A variety of dependent variables were assembled in order to test the prediction of differential treatment effects. They included: ejaculatory latency in self-stimulation and coitus, ejaculatory control in various activities, satisfaction with ejaculatory pattern and broader aspects of sexual functioning, amount of time spent in foreplay and coitus, frequency of dating and satisfaction with frequency and quality of dating. Generally, the hypotheses advanced in this study were not confirmed.

The findings, summarized at the conclusion of the last chapter (pp. 130-134), are discussed below along with their implications for further research. Finally, a critique of the research and overall conclusions are presented.

**Major Findings**

**Ejaculatory Latency**

In view of the fact that this treatment was designed with the management of rapid, uncontrolled ejaculation in mind, a chief outcome concern was ejaculatory latency.

An attempt was made to gather a broad spectrum of impressionistic/timed and masturbatory/coital latency data. This strategy was not entirely successful. For instance, the quantity and pattern of missing data on timed measures of coital latency yielded the conclusion that statistical treatment would be problematic. Therefore, these data were not analyzed for this report. Apart from this subset of the latency data, the broadly angled strategy generally worked well to yield useful information on this critical dimension of sexual
functioning for this sample.

Regardless of format, subjects significantly improved their coital ejaculatory latency estimates in response to treatment. Over the entire study phase, however, predicted format differences did not materialize. Post-treatment, 50% of the subjects were able to control their usual ejaculation for three minutes or longer in coitus, the criterion used here. It is worth reiterating that a conservative decision was made vis a vis the definition of premature ejaculation. Several subjects who may have been meeting the criterion at posttest but who endorsed the prior response choice "2-3 minutes after entry," were regarded as rapid ejaculators.

The results on subjective masturbatory latency yielded a similar pattern. Subjects markedly increased their usual latency estimates and sustained those gains over the entire followup phase. Although there were no format differences, Self-Directed subjects were more compliant than Group subjects in terms of the number of self-stimulation exercises they reported having done at treatment termination. Not only did the timed masturbation latency data indicate that treatment was successful in promoting longer latencies to ejaculation, but the treatment experience also appeared to teach subjects to absorb control strategies into their "normal" or routine sexual practice as well.

Ejaculatory Control

The attainment of a sense of voluntary control over the timing of ejaculation, a concern articulated by many rapid ejaculators, was considered a central outcome dimension. Hence, a number of diverse measures of
control were collected and analyzed: control during foreplay, control at intromission, control in mid-intercourse and control in last five sexual encounters. With respect to control exercised during foreplay, none of the subjects reported difficulty prior to treatment and their self-assessments in this regard did not change post-treatment. However, the pattern of results for ejaculatory control at intromission, in mid-intercourse and in subjects' last five sexual encounters, indicated significant treatment effects (and in the case of the latter two variables, significant interaction effects marked by baseline differences). These data indicate that control estimates improved dramatically for subjects, irrespective of format. Though the type of intervention made little difference, treatment itself substantially improved performance.

In addition, questions relating to erectile difficulty were germane here. The results indicated that subjects had no difficulty in experiencing or maintaining erections prior to treatment, and their self-appraisals were not altered measurably by treatment. The absence of significant effects is noteworthy for clinical and theoretical reasons. First, they are consistent with a theoretical claim made by adherents of the "new sex therapy" (Kaplan, 1974), namely that erectile and ejaculatory dysfunctions are conceptually and functionally discrete and ought not, therefore, be construed in terms such as "impotence." Clinically, they suggest that prophylactic program components centering on erectile dyscontrol may be superfluous for like populations in like circumstances.
Sexual Satisfaction

Typically, measures of satisfaction tied to reported changes in behavior, are regarded as important variables in sex therapy outcome research. A wide variety of variables were, therefore, used. In general, strong treatment effects were obtained for measures dealing with subjects' overall satisfaction with their sexual relationship(s), and with varied, specific sexual thoughts, affects and behaviors. These kinds of positive satisfaction outcomes may promote greater confidence and self-esteem in clients. In turn, clients may approach sexual interaction with enhanced control and pleasure.

Frequency of Sexual Interaction

Prior studies dealing with mixed sex dysfunctions and primary anorgasmia (Golden et al., 1978; Heinrich, 1976) have reported increases in mean amount of time spent in coitus and foreplay. Analyses on these variables in this study failed to yield any significant effects, suggesting that this treatment for a sample of single, premature ejaculators, had no effect on this sort of time-oriented dimension, and further suggesting that ejaculatory dyscontrol was unrelated to foreplay behavior for this sample. Despite the establishment of greater confidence, satisfaction and control regarding ejaculation, along with longer usual ejaculatory latencies in masturbation and in intercourse, treatment did not seem to alter usual frequency of coitus or foreplay. This outcome is surprising since, one would expect that given the reinforcement value of sexual interaction (Griffit, 1976), as control and confidence rose, subjects would approach such experiences more frequently and extend their length.
Prior to treatment, ejaculatory frequency was an important control technique articulated by many subjects. In terms of learning and maintaining ejaculatory control post-treatment, subjects, in consistent fashion with the above data, rated ejaculatory frequency (in terms of its relative control value) in the lowest third of a ranked series of control techniques offered in this program. Moreover, there was a trend in the direction of decreased masturbatory frequency over time for these subjects, contributing further to the finding that ejaculatory frequency neither seemed to be an important treatment outcome nor a valued mediator of outcome. The impression the findings generate is that as clients learned an array of effective control strategies, their need for masturbation as a tactic to prolong subsequent ejaculation(s) decreased.

It appears that the outcomes on desired frequency of intercourse, which indicated that subjects increased their desired frequency rates, ought to be taken seriously for this sample. While the self-report measures discussed above were based on subjects' current behavior(s), these data refer to future aspirations. It appears that the confidence and skills gained in the treatment context may increase clients' desire for coitus and promote increases in actual intercourse frequency. It is also possible that this outcome is an expression of clients' desire for prophylactic and/or therapeutic sexual opportunities.

**Dating Frequency and Satisfaction**

The final major hypothesis, which predicted increases in mean dating frequency and satisfaction with its frequency and quality, was
partly confirmed. Specifically, treatment tended to increase subjects' reported satisfaction with dating quality and sharply improved their reported dating frequencies. Since dating frequency and relationship status typically have implications for subjects' overall mental health status, the improvement in subjects' dating frequency, as a function of exposure to treatment, is a salient outcome. It also seems reasonable to suppose that the trend in the direction of greater satisfaction with dating quality may incorporate elements such as greater verbal and/or sexual intimacy, incipient indicators of progression along a continuum whose extreme might be anchored at heterosexual intercourse.

Future studies involving samples of males without steady partners might consider additional followup points. The suggestion here is that, for some subjects in this sample, significant changes in dating and intercourse frequency (which fall along a recognizable continuum of relationship progress) may only be manifest after a longer follow-up period. Using the present study as a guide, the argument might be made that if the significant increases in reported dating frequency, which were maintained throughout the followup phase, were sustained over another measurement period (two months), it is possible that significantly elevated intercourse frequencies would also emerge. Elevated intercourse frequencies, in turn, might further enhance ejaculatory latency and control outcomes.

In sum, the outcomes for both formats indicated that where ejaculatory latency and control, sexual satisfaction, and dating frequency were concerned, treatment produced significant improvements
Additional Findings

Sexual Communications

The communications data, which derived from the 10-item subscale of the Sexual Background Inventory and which focused on frequency of specific communications with partner on therapeutically pertinent matters, generally revealed strong treatment effects. Subjects markedly increased the frequency of their communications about sexual topics. This increase may have been tied to other significant, positive outcomes reported here. Since communications exercises on various sexually relevant topics were an integral part of the treatment program, it appears reasonable that strong treatment effects resulted. Perhaps the relevance of the communications components to the psycho-social circumstances of the sample was the crucial factor in the production of the effects.

More difficult to explain is the absence of significant interaction effects in the predicted direction for 8 of 9 communications variables. Whereas both treatment formats received written, weekly communications exercises (Appendix A) and received modeling and guidance in connection with them, only subjects in the Group context were able to observe deliberate, weekly exercise modeling, practice and group discussion. Thus, they were expected to exceed their Self-Directed counterparts on sexually relevant communications. The data, however, suggest that whether subjects in such treatment contexts receive their therapeutic information in one sitting or several, and

for a sample of single males without steady sexual partners.
whether they have group discussion and in-group practice elements or not, has no measurable impact on their ability to absorb and act on such information in their lives. One explanation is that the graded element in the communications exercises may have assisted Self-Directed subjects in staying with the pace (recommended in the manual's introduction) rather than racing ahead or approaching the exercises haphazardly. Whether or not subjects actually observed the order in and of the exercises, both sexual and communicational, is not known. In either case, different presentation modes and, potentially, subjects' differing styles of managing self-relevant therapeutic information had no differential outcome effects.

**Self-Consciousness**

The data analysis suggested that the apparently relevant scale factors (private and public self-consciousness and social anxiety), as measured by this instrument, were unaffected by brief sex therapy. This finding is consistent with results of studies recently done at the Human Sexuality Program, UCLA on group management of secondary erectile dysfunction. Additional research is warranted to investigate the theorized relationships between Self-Consciousness factors and the process of treatment, perhaps using other treatment formats and other symptom constellations as well.

**Sex Guilt**

Contrary to expectation, the results on the Mosher Sex Guilt Scale yielded no significant effects. The lack of significant effects may
have reflected a poor instrument choice for this sample. The pre-
treatment appraisals of sex guilt were very low and remained so 
throughout followup, suggesting a possible ceiling on any further 
improvement. In retrospect, it seems dated and unsophisticated to 
subjects presenting themselves voluntarily for brief sex therapy.

While the Mosher Sex-Guilt Scale reflected no significant treat-
ment effects, clinical impression and the data on decreased negative 
attitudes regarding masturbation (as measured by the Negative Atti-
tudes Toward Masturbation Scale), suggested a reduction in some as-
pects of subjects' sex guilt. The latter scale appears to be concep-
tually related to the construct underlying the Sex-Guilt Scale, but 
it is of more recent vintage. An overall sex-guilt measure, which 
would be better able to detect the relationship(s) between sex-guilt 
and behavioral variables characteristic of and relevant to brief sex 
therapy, seems to be worth developing, though it is possible that 
there is, in fact, no relation between sex guilt and sexual dysfunc-
tion for subjects like those involved in this sample.

One way a new sex-guilt scale might be useful is in the detection 
of sex-guilt differences between volunteers and non-volunteers for 
human sexuality studies. Several investigators (Diamant, 1970; 
Farkas, Sine, & Evans, 1978; Kaats & Davis, 1971; Siegman, 1956), in 
laboratory, questionnaire and interview studies have found that 
volunteers were less guilty, less sexually fearful, more sexually 
permissive and experienced and more "masculine" than non-volunteers. 
These and other data using the Sex-Guilt Scale (Clark, 1952; Mosher, 
1973; Mosher & Cross, 1971), argue that greater sexual experience and
permissiveness would be negatively correlated with sex guilt, thus suggesting that volunteers in the area of sex investigations may be less guilty than their non-volunteer cohorts. These data on volunteers are consistent with the sex-guilt findings in this study and perhaps suggest a line for further research, namely an investigation of the extent to which applicants who complete treatment ("volunteers") for sex therapy studies differ from applicants who drop out prior to treatment onset ("non-volunteers") and the extent to which they differ from patients in general, along these and/or other sexual and personality lines.

**Locus of Control**

There were no significant findings in the data generated from the Rotter Internal-External Locus of Control Scale. Self-Directed subjects (whose baseline scores were more external) showed a trend toward heightened internal locus of control whereas subjects in the Group format showed a trend toward heightened external locus of control. Inspection of pretest means may help to explain these results. A median split procedure (using the standard scale) indicated that all subjects were classifiable as "internals" at pretest, suggesting that a ceiling effect may have been operative. Their status as "internals" may have been a function of their educational and occupational levels and/or the subject selection procedure which drew a sample free of major psychopathology.

These results were surprising in light of the large body of prior psychotherapy outcome research which suggests that locus of control scores are amenable to change secondary to therapeutic manipulation(s) (Phares, 1976). For example, both Dua's (1970) "action-oriented" and
re-educative therapy formats led to increased internal scores in clients, particularly among those in the "action-oriented" group. Heinrich's (1976) sex therapy research demonstrated significant treatment-related increases in internal locus of control for her female sample, especially for those in the "education" (self-directed) group.

While there were no salient changes on the locus of control scale in the present study, there were significant changes or improvements on behavioral measures relevant to locus of control. For example, in the goals data relative to Hypothesis III, the strongest effect among a series of like items showing significant treatment effects was for the statement "Feeling like I know what to do in order to control my ejaculation." In a sexually relevant sphere, this kind of statement appears to represent a translation of the locus of control construct into terms which reflect behavior. The strategy of coupling items sampling from both reports of attitudinal and behavioral locus of control domains (Lefcourt, 1976) allows for the possibility of such discrepant outcomes. The utility of the Rotter Internal-External Locus of Control Scale in this context is, thus, open to question.

Attitudes Toward Masturbation

The Negative Attitudes Toward Masturbation Scale revealed highly significant treatment effects, indicating that the interventions had strong impacts on subjects' masturbatory attitudes and sentiments. This result seems to be a joint function of the stress placed upon masturbation as a therapeutic instrumentality in the management of rapid ejaculation, and the often fluctuating relationship status of
these subjects. Their status as single males may have made reliance on masturbation exercises necessary, and, if so, this pragmatic necessity may well have influenced outcomes on this measure. However, the sustained nature of the effect over the entire followup suggests that subjects' more positive outlook on masturbation transcended its merely instrumental role in treatment.

Among the standard measures, the Negative Attitudes Toward Masturbation Scale seemed to be the most responsive to treatment intervention and useful in outcome research, particularly when considered in conjunction with increased masturbation satisfaction ratings. The clear and positive findings suggest the scale's appropriateness and relevance to a sex therapy patient population like this one. Further, the apparent association between attitudinal (Negative Attitudes Toward Masturbation) and behavioral self-reports above increases the confidence with which these scale findings may be regarded.

Future researchers in the area are urged to consider using both the Sex-Guilt and Negative Attitudes Toward Masturbation Scales to further elucidate the relationship between the two as well as the relationship between the constructs they involve. Further, their role in the process and outcome of brief sex therapy deserves further investigation.

**Subjects' Appraisals of Program Components**

Most published reports in the area have not reported subjects' evaluations of specific components used in treatment. In this study, subjects' evaluations of program features and components were thought to be important, especially in consideration of future
designs for group and self-directed interventions. These data, which showed clear preferences for the pause technique and selected others (continuous stimulation with arousal decreasing variations, coital position variations), and for the communications component, suggest that some control techniques offered in the course of the program might be discontinued in future program designs. If those features regarded as most helpful by clients could receive greater emphasis, greater improvements on outcome variables might result. These ranked data also suggest an area for future research, namely a component analysis study in which one experimental group receives the exercise manual and the communications component while the other group receives the manual alone. Given its information value, researchers in the area are encouraged to include and/or report subjects' component feedback, where appropriate.

The Present Study in Perspective

Treatment and Research Design Issues

The strong broadly-based treatment effects substantiate the claims made by many adherents of the "new sex therapy" that brief behaviorally-based treatment is an effective and efficient technology for the management of the common sex dysfunctions, including premature ejaculation. The treatment appears robust enough to accommodate variations in the number of therapists, the length of the format, the unit of intervention (couple, couples group, group, self-directed), and the relationship status of the client.
Few studies in sexual dysfunction have been done under controlled conditions. The present study amended an original plan to include a simultaneous control group (for lack of sufficient applicants who met study criteria) to one in which each subject acted as his own control, an admittedly weaker solution. Nonetheless, inclusion of a control period helped to clarify the effects of applying for treatment, acceptance, initial testing and the intake procedure to some extent.

One of the problems with each subject being his own control is that control data are lost over the treatment and followup phases, including the repeated measurement points. Moreover, each subject knew as he passed through the initial interview and testing phase that he was being accepted for one or the other form of treatment; assignment to a control group was not a possibility. This knowledge may have affected evaluations made by subjects in unknown ways. Despite these constraints, perusal of the control period data suggests that expectancies (and any other factors) appear not to have significantly affected the dependent variables. In general, subjects' scores and assessments shifted very little over the course of the control period.

The question of control groups is salient in terms of placing the present findings into the broader sex therapy outcome literature. Major uncontrolled clinical trials (Kaplan, 1974; Masters & Johnson, 1970; Semans, 1956) consistently reported success rates between 97% and 100%. Where control groups have been employed (Heinrich, 1976; Zeiss et al., 1978), outcomes have been less clearcut and outstanding,
suggesting an imperative to employ control groups (or control periods).

Furthermore, the Masters and Johnson (1970) treatment model emphasizes intensive, brief, dual-sex therapist-directed and couples-oriented treatment in the management of all of the common sex dysfunctions. The literature indicates that the more radical the departure from the treatment model, procedurally or substantively, the greater the differences in outcomes. This has been the case where self-directed treatment formats were investigated (Heinrich, 1976; Lowe & Mikulas, 1975; Zeiss et al., 1978) or where single persons were the unit of intervention (Zilbergeld, 1975). In this context, the expectation was that success rates would be lower than those reported in connection with uncontrolled studies and therapist-directed, couples-oriented formats since this study tested an intervention on men who had no guarantee of partners with whom to practice the management techniques and, further, half of them had only limited professional intervention.

Changing times seem to be having an impact on the practice and investigation of sex therapy. It appears that the populations seeking formal sex therapy in 1979-1980 may be increasingly different from those who sought treatment in the early part of the last decade, when sex therapy was just establishing itself as a new speciality and before the commercial market exploded with self-help manuals and a broader public debate about brief directive sex therapy. Nowadays, clients seem to be more experienced with the sex therapy philosophy and treatment modality(ies), are more likely to have tried at least a self-administered bibliotherapeutic approach, and therefore,
seem likelier to be more difficult and complex cases when they present
themselves for sex therapy.

Moreover, a sex-based socialization factor may also be operating
to produce the newer, relatively depressed outcomes. Reference has
already been made to the finding that volunteers for interview
studies on human sexuality are more "masculine" than non-volunteers
for such studies (Diamant, 1970; Kaats & Davis, 1971; Siegman, 1956).
This fact would tend to heighten the salience of an oft made observa-
tion that help seeking behavior is incongruent with the general model
of male sex role socialization, while it is congruent with the general
socialization model for females. Like the factor discussed above,
this factor, if valid, may promote greater self-selection among men.
Since men would have to overcome the informal prohibition on help-
seeking, this factor would tend to concentrate, in clinic applicant
pools, clients with the more severe, intractable symptom pictures.
Assuming equal difficulty of dysfunctions and their resolution from a
sex therapy standpoint, one would expect such a sex-based self selec-
tion factor to depress outcomes for men's sex therapy formats such
that they would generally be inferior to those for women. Where this
comparison may now be meaningfully made (the Heinrich (1976) study
versus the present one), this situation in fact obtains.

The cross-sex study comparison is less important, perhaps, than
same sex study comparisons. In that sense, the present research is
best evaluated against the work of Zeiss et al. (1978). In their
controlled, couples-based comparison of standard and self-directed
treatment, strong treatment effects (increases) on timed and
estimated coital latency and quality of sexual relationship scores were obtained at posttest. There were no significant differences between the groups on any of these outcome measures, as was the case in the present study. Also, as in the Zeiss et al. (1978) study, strong treatment effects were found at posttest. However, whereas Zeiss et al. (1978) found a sharp decline in maintenance of treatment gains at followup, particularly for self-directed couples, the present study revealed no such deterioration effects for subjects in either treatment context. For a variety of reasons, one would have expected maintenance of gains for the couples to exceed those for single men. Two possible explanations for these discrepancies come to mind. First, the absence of partner data in this study allows for the possibility that subjects inflated their reports regarding maintenance of gains for approval-related reasons. Another possibility is that couples in Zeiss' study returned to pretreatment levels of patterned interpersonal conflict which, in turn, affected sexual function.

Sex Role Issues

Evidence now exists to document the model's efficacy and utility with three populations: single women (Heinrich, 1976), couples (Zeiss et al., 1978) and the present study using single men. It is interesting to note that whereas Heinrich (1976) found format differences (favoring the Group over the Self-Directed format) in her research on the reversal of primary orgasmic dysfunction in women, both in couples and singles contexts, research on males with rapid ejaculation yielded no format distinctions.
One might speculate that socialization imperatives for men, which urge an active, self-reliant and instrumental orientation as the key to problem-solving and success in life, might have acted to level format differences in these studies. On the other hand, given customary female sex role socialization, which urges an other-directed, expressive orientation, one might expect enhancement of format effects in comparative treatment contexts which pivot, in a sense, on sex role relevant dimensions like internal-external locus of control. If, indeed, such a socialization imperative operates in the manner theorized, one would expect male sex research subjects to display it, given their greater "masculinity" (Diamant, 1970; Kaats & Davis, 1971). Implicit in these conjectures is the notion that the therapist-directed Group format may, paradoxically, have diminished the putative socialization advantage men bring to problem-solving contexts, while the Self-Directed format may have capitalized upon it, thus diminishing format effects and helping to explain the outcome differences when men's and women's groups are compared.

The phenomenology of the treatment formats may also have played a role in these outcomes. While it appears to be the case that the Group model motivated subjects to report weekly on their homework, it does not necessarily mean that they were complying with the structured assignment. Weekly therapist progress notes corroborated the fact that most subjects were behind schedule to varying degrees. In fact, it is possible to argue that more than completing the weekly complement of exercises, furnishing homework reports became the task of first priority. On the other hand, the Self-Directed model may promote the realization that the structured exercises are the essence of the program.
and, in the absence of other relevant tasks and tangents, Self-Directed subjects may have devoted themselves to the exercises in a more purposeful and self-reliant way. Their significantly greater compliance, at posttest, with the treatment regimen may reflect this conjecture. This line of analysis implies the relative lack of importance of the group process as compared with the structured exercises in producing good clinical outcomes, a position contrary to much pre-existing clinical research.

Available empirical evidence (Zeiss et al., 1978), however, indicates that self-reliance has its limits in the therapeutic sphere. Zeiss et al. (1978), in their comparative study involving couples who received either standard couples-based sex therapy, self-directed treatment in conjunction with minimal phone contact with a therapist or entirely self-directed treatment (no therapist phone contact), found that whereas 11 of 12 couples in the first two conditions were regarded as successfully treated at posttest, none of the six couples in the no contact condition were successful. A clear majority of them, in fact, dropped out of treatment early. If couples in committed relationships did not sustain themselves in a purely self-directed treatment process, it seems probable that the attrition/failure risk would be even greater for essentially unattached males. Apart from the ethical obligation to provide continuity of care under experimental as well as clinical conditions, an additional ethical question is raised by the Zeiss et al. results. The question is whether it is permissible to expose experimental subjects to a treatment format associated with a high attrition rate, possible financial expense and potentially
deleterious sequelae tied to the overall experimental experience—a context in which the risks clearly outweigh the benefits—when evidence exists to demonstrate the inefficacy of such a treatment design.

Looking at these studies in conjunction with the present research, a useful modification of the original Masters and Johnson treatment model emerges. The results point to the efficacy of a brief (approximately 8 week) format, where, for males with this symptom picture, both group and self-directed formats may be employed with the expectation of equal efficacy and great cost-effectiveness. The present research makes possible the treatment of a heretofore hapahzardly handled population, namely men without steady partners. Instead of referring them to surrogate partners or encouraging them to re-apply for treatment when they have steady partners (an often paradoxical and unrealistic suggestion), some empirical basis now exists to offer this population two alternate formats tailored to their status. This would appear to be an important development of the treatment model insofar as the single male population, owing to diverse social forces, is a large one.

Format Issues

It seems clear, from the results achieved on most major dependent variables, that the treatment model is remarkably potent. This is particularly so when one considers the historically lengthy, intensive non-behavioral treatments heretofore employed and, even in the behavioral context, when the departures from the Masters and Johnson model entertained here are considered.

The question arises as to why the hypothesized differences between treatments failed to materialize across most dependent variables.
Several possible explanations may be offered, some of which refer to specific data, while others are broader in focus.

The fact that Self-Directed subjects did more masturbation exercises during the treatment phase may have enabled them to overcome any potentially disabling effects in connection with the Self-Directed treatment format. Perhaps their early adherence to the directed masturbation sequence gave them a "headstart" such that they did as well as Group format subjects on most subsequent measures.

Another way of explaining these results is to argue that the group process variable was imperfectly operationalized. In terms of the Group format, perhaps the schedule was overprogrammed. (The fact that participants were generally behind schedule might be an indication of this.) In this context, however, what overprogramming might mean is that the operation of an unfettered group process was rendered improbable by a task orientation on the part of the therapists, which in turn was dictated by overall program demands. It also might be said that it was not possible to separate the formats categorically in terms of group process and therapist contact. While every effort was made to observe these distinctions between formats, the therapists were obliged to behave in clinically responsible and responsive ways. As planned, those in the Self-Directed Condition had minimal contact with one another (at the one-day seminar and at post-treatment data collection points) and their "therapists" (usually weekly phone contact). Although contacts were generally brief and largely pro forma, some phone contacts were more substantial in their informational and problem-solving value. While interviews with therapists suggested
that these kinds of peer and "therapist" contacts were unlikely to have had much impact on outcome, the possibility cannot be ruled out.

Perhaps the brevity of the treatment (or followup) period itself disallowed the emergence of format differences. Significant improvement in ejaculatory latency and control (along with increases in satisfaction and dating frequency and satisfaction) were recorded for all subjects over the eight week treatment course. In general, the followup phase indicated that there was neither significant improvement nor significant deterioration, but rather steady maintenance of treatment gains.

The insufficiency of partner latency data, however, probably reflects the fact that since many subjects were behind treatment schedule, at Post, they were not comfortable enough to initiate timed coital experiences with their partners. This suggests that the transition from solo to partner exercises was more difficult for subjects than anticipated in the design, and that the amount of time and practice needed to transfer the new response pattern to a partner context may be longer than eight weeks. This may especially be the case for this target population at this historical moment for reasons already detailed. For a sample of single males without steady partners, perhaps the criterion of whether or not the program has been sufficient in length should be full reporting of timed coital latency measures. A longer treatment (or followup) period, it appears, would be necessary to produce such data.

This is not to suggest that none of the clients successfully transferred new response patterns to the partner context, nor that there was no partner-oriented latency and control discussion in the latter part of the program. There were indeed, subjects who completed
all aspects of the regimen essentially on schedule and who provided anecdotal and timed information on their coital experiences during and after treatment. It is only to suggest that, perhaps if more men had managed the partner transfer sooner in the existing format, the group process would have had a more beneficial impact in terms of performance and outcome expectancies (Mahoney, 1977a), ongoing technical instruction and correction, coaching and constructive interpersonal feedback (Kaplan, 1974; Lazarus, 1961, 1968) delivered by a variety of live peer models with varying interpersonal styles. In this sense, the opportunity for reciprocal helping (Reissman, 1965) in groups is presumably diminished when exaggerated differences in members' progress through the program exist.

The eight week format used in this research was inspired by prior experience with group treatment formats at the Human Sexuality Program, UCLA and by published sex therapy outcome research (Clarke & Parry, 1973; Golden et al., 1978; Heinrich, 1976; Zeiss et al., 1978). In most cases, the unit of intervention has been the couple. Where it has been the individual (e.g., Heinrich, 1976), the task has been more discrete (attainment of orgasm under any stimulating conditions) and partners were present though untreated. Given the experience with men without steady partners, perhaps the format should be expanded in length.

Finally, the small overall number of subjects may have contributed to the lack of detected format effects. On balance, it would appear that whereas small differences between the formats, if any, may have been obscured by the sample size, they would not likely be
powerful differences. Replication of the present study using a larger sample is, nevertheless, recommended in order to further verify the absence of format effects.

In sum, it seems that the treatment formats compared in the present study are substantially equivalent in their impacts on a variety of self-report behavioral and attitudinal outcome variables, although further replications are warranted. The heart of the treatment program appears to be the sexual and communications exercises, embodied in a semi-automated manual, which are economical and beneficial in the management of rapid ejaculation. Although the format variable recommends itself as a target of study for understandable practical reasons, more powerful variables (e.g., age) may exist by which to meaningfully analyze outcome data in future sex therapy research. In a similar vein, certain constellations of personality variables and attitudes, e.g., negative attitudes toward masturbation, may be more useful as future sources for hypothesis generation.

Weaknesses of the Present Study

Methodological weaknesses in this study include the weak control used, which did not allow for the testing of extra-treatment variables (e.g., testing, acceptance) over the entire study phase. A further weakness was the small number of subjects in this study. As suggested earlier, the small n itself may have exerted distorting effects on outcomes in various ways, most notably in terms of detection of format differences. A third factor involves the nature of the data itself. Since major dependent variable changes, latency in and voluntary control over ejaculation were not directly observable for
practical and ethical reasons, and since partner relationships were too tenuous to involve partners in treatment-related testing, pure reliance on subjects' self-reports was necessary. With this population, it was not possible to have corroborative status reports from female partners.

An additional weakness in this study was the unexpectedly odd and significant association between length of control period and group of assignment. Despite random assignment, men assigned to the Self-Directed format waited significantly longer for treatment than did Group participants. Since this variable was uncontrolled, its impact on outcomes, if any, remains unknown. The probabilities for a recurrence of this kind in a future study are extremely low.

Strengths of the Present Study

The strengths of this research include an experimental design using two treatment variations to which subjects were randomly assigned following a variable length control period. This design prompted the evaluation of the relative merits of the two treatment formats, especially the role of the group process. The existence of an initial control phase for all subjects made it possible to evaluate, in part, the effects of variables which are not formal aspects of the treatment, as well as treatment itself. Other strengths include:

(a) the lengthy followup phase, comparable to that used by Zeiss et al. (1978), but not commonly seen in sex therapy research;
(b) the separation of therapist and investigator roles;
(c) the use of multiple, well-defined measures of treatment outcome, including timed coital and masturbation latency measures
and heretofore unemployed personality measures. The strength of the results in connection with the communications subset of the revised Background Inventory suggest that its development as a separate scale is warranted. Published inventories in the area deal with self-reports of sexual behavior, knowledge and attitudes exclusively. An outcome measure dealing with subjects' reports of their sexually relevant communications with partners would represent a useful addition to many inventory batteries.

(d) the fact that it is clinical research with direct and immediate applications to the current practice of sex therapy. While the study enabled 17 men to receive treatment for their ejaculatory dyscontrol, it, more importantly, opens the door for others.

Summary of Suggestions for Future Research

Various suggestions for future research have been made throughout this report, including replication of the present design with the simultaneous use of a control group and a larger sample, investigating the varied ways in which the Negative Attitudes Toward Masturbation Scale can become more useful in sex therapy research, and component analysis studies. In addition, suggestions were made to (a) increase the length of either (or both) treatment and followup periods; (b) test other major relevant variables, e.g., age, for their value in organizing and generating new information; (c) employ alternatives to the Mosher Sex-Guilt, Self-Consciousness and Locus of Control Scales where appropriate; and (d) develop the communications subscale used in this research as a separate instrument for future use in outcome studies.
Overall Conclusions

The major findings of this study clearly demonstrated the effectiveness of the behavioral-educational approach in the management of premature ejaculation. On most major dependent variables, including coital latency estimates, masturbatory latency estimates, ejaculatory control in intercourse stages, and satisfaction with both specific and general aspects of sexual functioning, along with dating frequency, subjects showed dramatic improvement over the brief treatment course and maintained their treatment gains throughout the Six Month Followup. Moreover, the formats appear to be equally successful since no coherent superiority of either therapeutic format emerged over the large number of variables evaluated. These findings, which are consistent with those reported by Zeiss et al. (1978), must be regarded with some reservation since subjects were used as their own controls. However, in a controlled, couples context, Zeiss et al. (1978) also found no differential effects to suggest the superiority of standard, therapist-directed treatment over experimental, self-directed treatment at posttest. Thus, it appears from this data that Group and Self-Directed therapy formats are equally effective in promoting ejaculatory control, longer latencies and increased sexual satisfaction. However, further replications, with the use of simultaneous control groups, would increase the confidence of this assertion.

The exploratory questions studied here provided further useful information. Additional evidence for the efficacy of the treatment
were the findings that the men in this study decreased their negative attitudes toward masturbation and reported increased communications with partners on immediately sexually relevant issues. Further, there were 17 high correlations between ejaculatory control variables and attitudinal variables. The most important of these were the high positive correlation between sexual relationship satisfaction and timed masturbation latency and the high negative correlation between the Negative Attitudes Toward Masturbation Scale and masturbatory satisfaction. Finally, sex guilt, self-consciousness and locus of control were analyzed as dependent variables in order to explore a wider range of treatment effects. While none of them displayed significant treatment effects, further useful information was provided on the sex guilt and locus of control measures regarding their appropriateness for use in sex therapy outcome studies involving males. More specifically, it was discussed why research is needed to clarify the relationship(s) between sex guilt, locus of control, and sex therapy outcome variables.

In conclusion, this research successfully demonstrated and clarified a low-cost, effective, efficient, widely accessible alternative to standard couples or group treatment for rapid ejaculation in the form of self-directed treatment with minimal therapist contact. As more research using this population and these formats is reported, the confidence with which the self-directed treatment will be offered as the peer of group treatment is sure to grow. These data suggest that sexual and communications exercises can be incorporated in several different kinds of packages without reducing efficacy.
Variation in packaging means increased versatility in matching clients with formats which are maximally appealing and realistic and most likely to fit their life circumstances.


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APPENDIX A

Homework Exercise Manual
AN EIGHT WEEK TREATMENT PROGRAM FOR THE MANAGEMENT OF RAPID
EJACULATION IN SINGLE MALE MALES

Developed by Doreen Seidler-Feller
in consultation with Susan Price, Ph.D.,
and based upon the work of Bernard Zilbergeld, Ph.D., author of Mala Sexuality.

1979
Introduction:

The following exercises are aimed at helping you to gain greater control over your ejaculation. It is important that you follow the program in the proper, prescribed sequence. Each week, do the exercises assigned for that week. DO NOT move ahead to the next week's assignments, and try not to fall behind. If you complete one week's assignments satisfactorily, and you have extra practice time, you might want to repeat those same exercises. Learning to control your ejaculations is a process and skill which benefits greatly by practice. The more practice you get, the more you learn about your body's responses to various forms of stimulation and the more you learn about when and how to delay ejaculation. So, it's wise to remember that practice is a good teacher!

People learn in small steps, so don't expect to develop instantaneous ejaculatory control at the outset of the program. Each step and each exercise may teach you something helpful which you can use in later steps and, eventually, with partners. It is a great help if you can remain motivated and patient and willing to work diligently on the problem. It must be a priority in your life: you should set aside up to 3 hours per week for assignments and practice.

How To Use These Exercises:

The exercises in this program are very similar to those we use in other programs in our clinic. They are effective in teaching ejaculatory control, provided that you follow the instructions carefully and completely. Read the exercises thoroughly before beginning the assigned activity. Do exactly what the exercise directs you to do. Do not go beyond the explicit instructions of the assignment. Each exercise has its overall place in treatment and the program probably will not work unless you do all that is assigned in the presented sequence. Do each assignment whether you think it applies to you or not. If you run into problems with a particular assignment and need to repeat it, simply delay the start of the new exercises a few days (if necessary), or return to the prior exercise to gain greater control and confidence. Probably each of you will need to repeat a few of the assignments because you ran into one kind of problem or another. Don't let it get you down. Try again. If problems with a particular exercise persist, you can always take them up when you have contact with your therapist.

Some people find it helpful to schedule their exercises in advance—it helps them pace themselves. We think it's a good idea to have regular times set aside for assigned activities. It is not a good idea to wait until the night before you have contact with your therapist to complete your week's assignments. What if you had an unavoidable interruption or needed to repeat the assigned activity? You should give yourself ample time and a lot of practice. Don't short change yourself!

The setting you establish for yourself is also important. Set aside enough time so you can relax. If music, low lights or a glass of wine helps you set the scene, by all means include them in your activity in moderation. Treat yourself in the way you most want to be treated! Apart from making provision for ample time and a relaxing scene, privacy and freedom from distraction are important elements to consider. The question of establishing a relaxing scene and taking time for yourself
In self-stimulation is important not only for your progress in the program, but is important for your sexual activity in the future. It's a good habit to develop.

The exercises themselves are both sexual and non-sexual in nature. The sexual exercises involve masturbation in various ways in order to begin learning ejaculatory control. Masturbation activities are used first because it is easier to learn the fundamental control techniques without the presence of a partner. Later on in the program, you will have partner-oriented assignments to help you apply what you've learned to actual heterosexual situations. Initially, try not to worry about ejaculating too soon. If this happens, practice stopping stimulation sooner the next time. The following guidelines apply to all the sexual exercises which follow, except where otherwise noted:

1. Each exercise requires 15 minutes. This time period (15 minutes) is used because it has produced good clinical results, not because it is the right or ideal amount of time for intercourse to last. The 15 minute period refers to the time actually spent in various self-stimulation exercises—not to any time spent in preparation for the exercise or after.

2. After you have completed the exercise, you may ejaculate if you wish. Pay attention to the sensations you're feeling as your excitement increases and during the process of ejaculation, and go slowly. In this way, ejaculation will not only be pleasant, it will be part of your learning as well.

3. It is helpful to be consistent in your masturbatory practices. Once you begin the program, stay with the new ways you are learning rather than alternating with your old ways of masturbating. Making these suggested ways of self-stimulation your pattern should accelerate your progress in learning control.

4. Each sexual exercise should be done at least 3 or 4 times a week. Even if you meet the 15 minute time goal successfully after doing an exercise once or twice, repeat it again, as time permits, for further practice and confidence.

5. Just as you may, at first, ejaculate quickly in the course of an exercise, you may also find at times that it is difficult to attain or maintain your erection. Don't be alarmed if this should occur. Your arousal level might be increased if you use fantasy or whatever else you know works best for you. If you still do not experience an erection, return to the exercise later on. There is always another time to practice, so don't put undue pressure on yourself. The same holds true if you ejaculate before you want to or before the 15 minute time period is up. Return to the exercise later on and repeat it.

6. As suggested earlier, do the exercises in the sequence in which they appear. Before proceeding to the next exercise, you should be able to delay ejaculation for 15 minutes with a maximum of 2 or 3 stops or other adjustments to maintain control, and you should feel relatively comfortable doing the exercise knowing that you can delay your ejaculation.

7. For those of you with regular sexual partners, the question naturally arises as to what to do about sexual activity with a partner. Several choices exist. It is important in making choices that you remember that you are involved in a process of learning and relearning, and that you wouldn't want to do anything which might slow or undermine altogether your progress. Just as masturbating in your old pattern may prevent you from enhancing your learning in the program, having sex with a partner according to your previous pattern may have the same effect. So, taking this into account, choose among the following options the one that seems best for you. One op-
tion is simply not to have sex with anyone until you have completed the first half of the program (the first 4 weeks); in the second half of the program, you will be strongly encouraged to apply your learning in various intercourse situations. A second choice consists of engaging in sexual activities with your partner that do not include intercourse. This is suggested because for most men, especially at the beginning of the program, maintaining control in intercourse is the most difficult thing. In our experience, not having intercourse until you have good ejaculatory control works best. If you feel you must continue to have intercourse with a partner, even in the initial stages of the program, incorporate the techniques you're learning in your solo exercises as far as possible. If you decide on either the second or third options, several other suggestions are in order. First, you will need to choose among partners, if you have more than one, the one(s) with whom you feel most comfortable and who are likely to be most cooperative because you may be doing things differently and may need to discuss what you're doing, and how and why with your partner(s). Second, you may discover that continuing to have intercourse with your partner(s) is either slowing or interfering with your progress in the program—perhaps because you're unwilling to discuss the changes you're making in intercourse situations, or because you find maintaining the sexual relationship too distracting or time consuming in the initial stages of the program, etc. If this is the case, you can always decide to discontinue intercourse and/or other sexual activities until you have developed good ejaculatory control in the solo exercises.

Don't persist in maintaining the sexual part of your relationship(s) in the initial stages if you find it's unwise. Finally, you should understand that if you choose to maintain ongoing sexual relations with a partner(s), you will still need to do each and every solo exercise as prescribed.

Remember: Don't expect immediate results. You will be learning new skills and techniques—and that always takes practice, care and time. Be sure to read everything carefully and completely before beginning, set the scene to your liking, do everything that is assigned, do not do what is not assigned, and keep at it. You are going to be learning new things about your body and doing some pleasurable activities. Have fun and enjoy yourself!
| Activity: Spend 30 minutes touching and stroking all the parts of your body except for your genital. Identify particular locations that feel pleasurable and types of touching (e.g. speed, direction, pressure, etc.) that feel pleasant or unpleasant. Do not concern yourself with arousal per se. Focus instead on what feels good, where and how. Under the "Activity" column, record the parts of your body you were touching and under "Comments", note the types of touching you found pleasant or unpleasant. Record the amount of pleasure by putting a score from 1-10 in the column titled "Pleasure". For example, "stroked inner thigh and outer thigh. Pleasure: 6; Comments: Long slow strokes were most pleasurable. Light touch tickled inner thigh."

Rationale: The purpose of this exercise is not to get "turned on" but instead to become more knowledgeable about your body and how and where you like to be touched. Learning about your likes and dislikes in this way will be helpful in the near future when you are asked to share this information with your partner, and also to ask her what kinds of caress she finds pleasurable.
<table>
<thead>
<tr>
<th>ACTIVITY</th>
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<th>COMMENTS (Positive &amp; negative reactions, thoughts, problems, etc.)</th>
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<tbody>
<tr>
<td>Activity: Self-Stimulation to Identify the &quot;Point of No Return&quot;;</td>
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<tr>
<td>Masturbate in the way you have typically done in the past. Do not try to last longer. Instead, try to focus on the sensations, particularly the sensations that occur right before and at the &quot;point of no return&quot;. After you ejaculate, try to describe in your own words what the sensations at the &quot;point of no return&quot; feel like. If you had any trouble identifying the &quot;point of no return&quot;, repeat this exercise until you are able to do so. In the &quot;Comments&quot; section, write a brief description of the feelings and sensations that you experienced right before and at the &quot;point of no return&quot;.</td>
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**Rationale**: The purpose of this exercise is to practice focusing on sensations during masturbation & especially, on those sensations that occur before reaching the "point of no return".
**Activity:** Self-Stimulation with Stop-Start

Stimulate yourself with a dry hand (no lubricant) for 15 minutes without ejaculating. Focus on the sensations in your penis to help you monitor your arousal level. When you feel highly aroused and close to the "point of no return", stop the stimulation and do nothing but focus on the sensations in your penis. Within 30 seconds or a few minutes, the urge to ejaculate will diminish. Then resume stimulation. It is common to experience a partial or complete loss of erection when you stop stimulation. It is nothing to be concerned about. When you begin this exercise, you will probably need to stop a number of times in order to last the full 15 minutes. (Stop time, the time you stop stimulation in order to let your excitement subside, is included in the 15 minutes). As you continue doing the exercise, you will find that you will learn when to stop, how long to wait, and the number of times you need to stop will gradually decline. When you feel comfortable and only need to stop 2 or 3 times to last 15 minutes, you are ready for the next step. Write a brief description of each self-stimulation experience. Include the approximate number of times you stopped and any problems you encountered.

**Rationale:** To practice experiencing high levels of arousal and then, using the stop-start technique, to prolong the period of arousal before reaching ejaculation. Practicing alone in self-stimulation allows a man to focus on sensations without being distracted or concerned about his partner.

**Possible Problems:**

a. You need to stop stimulation soon after you resume masturbation. Probably you are not allowing enough time for the ejaculatory urge to subside. Take longer pauses.

b. You are stopping at the "point of no return". This is a poor habit to establish. Not only can waiting until the last moment increase anxiety, it can produce unnecessary ejaculations.

### Table

<table>
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<tr>
<th>Activity</th>
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<th>COMMENTS (Positive &amp; negative reactions; thoughts, problems, etc.)</th>
</tr>
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(over)
ACTIVITY: SELF-STIMULATION WITH A LUBRICANT

This exercise is done in the same way as the previous exercise except you now use a lubricant on your hand when you stimulate your penis. The lubricant is used because it heightens the sensation and also tends to feel like the sensations you will experience when you have intercourse with a partner. By using a lubricant in your self-stimulation, you can practice the stop-start when you are highly aroused but not distracted by or worried about your partner. Some commonly used lubricants include: Vaseline Intensive Care or Jergens Lotion, K-Y Jelly, Abolene or massage oil. You may need to try a few before you find one you prefer. Since lubricants feel cold, you might want to rub the lubricant or oil on your hand before applying it to your penis. Then you can stimulate yourself for 15 seconds with a lubricant and need to stop only 2 to 3 times, you are ready for the next step.

Briefly describe each self-stimulation experience using the categories on this form. In the "Comments" section, be sure to include your assessments of the experiences, include the approximate number of times you stopped (for each trial), and any problems you may have encountered.

Rationale: Inserting the penis into the vagina is the point at which many men have the most difficulty maintaining control. Self-stimulation with a lubricant simulates the sensations associated with vaginal containment, helping to build skill and confidence.

Possible Problems: These are the same as for the previous exercise namely:

a. You need to stop stimulation soon after you resume masturbation. Allow more time for the ejaculatory urge to diminish. Take longer pauses.

b. You are stopping split seconds before the point of ejaculatory inevitability, becoming anxious and possibly ejaculating. Stop sooner.

c. You don't seem to be making progress despite
**Activity:** The Squeeze Technique

You might begin this exercise by sitting on your bed with your back against the headboard of the bed, supported with pillows. Stimulate your penis until you have a full erection. Continue stimulation until you reach the point right before ejaculation seems inevitable. Then apply the squeeze by placing the thumb on the frenulum, located below the coronal ridge on the side of the penis nearest to your body. At the same time, put your first and second fingers directly above and below the coronal ridge on the side of the penis farthest from your body. Apply the squeeze in this way for 3 to 4 seconds. Don't be afraid to apply rather strong pressure. With the squeeze, you will immediately lose the urge to ejaculate. You may also partially lose your erection. Allow 15 to 30 seconds to pass before resuming stimulation of your penis. Again, when you are highly aroused and feel the urge to ejaculate soon, apply the squeeze. Continue applying the squeeze followed by rest and resumption of stimulation until you can last without ejaculating for 15 minutes. You will find that if the squeeze is properly applied to the erect penis, it should not be painful in any way. Experimenting with the squeeze will help you learn how much pressure is necessary to decrease the ejaculatory urge and later you'll be able to share this information with a partner.

**Rationale:** To practice experiencing high levels of arousal and then, using the squeeze technique, to prolong the period of arousal before reaching ejaculation. Also, to provide you with another technique (which you may prefer) for diminishing the ejaculatory urge and maintaining control.

**Possible problems:**

a. You need to stop stimulation soon after resuming masturbation. Allow the ejaculatory urge to diminish fully by taking longer slopes.

b. You are applying the squeeze split seconds before ejaculating. Practice stopping earlier.

c. Despite practice, you don't seem to be learning when to squeeze and the number of times you need to squeeze doesn't decrease. This could well mean that you are not sufficiently relaxed. Set the scene to promote a relaxed mood.

| ACTIVITY Duration Pleasure (1-10) COMMENTS (Positive & negative reactions, thoughts, problems, etc.) |
|-------------------------------------------------|-----------------------------------------------|
| **Activity:** The Squeeze Technique             |                                               |
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| bed with your back against the headboard of the  |                                               |
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| in any way. Experimenting with the squeeze      |                                               |
| will help you learn how much pressure is        |                                               |
| necessary to decrease the ejaculatory urge      |                                               |
| and later you'll be able to share this           |                                               |
| information with a partner.                     |                                               |
| **Rationale:** To practice experiencing high    |                                               |
| levels of arousal and then, using the squeeze   |                                               |
| technique, to prolong the period of arousal     |                                               |
| before reaching ejaculation. Also, to provide    |                                               |
| you with another technique (which you may      |                                               |
| prefer) for diminishing the ejaculatory urge    |                                               |
| and maintaining control.                        |                                               |
| **Possible problems:**                          |                                               |
| a. You need to stop stimulation soon after      |                                               |
| resuming masturbation. Allow the ejaculatory    |                                               |
| urge to diminish fully by taking longer slopes.  |                                               |
| b. You are applying the squeeze split seconds   |                                               |
| before ejaculating. Practice stopping earlier.   |                                               |
| c. Despite practice, you don't seem to be      |                                               |
| learning when to squeeze and the number of      |                                               |
| times you need to squeeze doesn't decrease.     |                                               |
| This could well mean that you are not           |                                               |
| sufficiently relaxed. Set the scene to          |                                               |
| promote a relaxed mood.                         |                                               |
Don't be afraid to apply rather strong pressure. With the squeeze, you will immediately lose the urge to ejaculate. You may also partially lose your erection. Allow 15 to 30 seconds to pass before resuming stimulation of your penis. Again, when you are highly aroused and feel the urge to ejaculate soon, apply the squeeze. Continue applying the squeeze followed by rest and resumption of stimulation until you can last without ejaculating for 15 minutes. You will find that if the squeeze is properly applied to the erect penis, it should not be painful in any way. Experimenting with the squeeze will help you learn how much pressure is necessary to decrease the ejaculatory urge and later you'll be able to share this information with a partner.

Rationale: To practice experiencing high levels of arousal and then, using the squeeze technique, to prolong the period of arousal before reaching ejaculation. Also, to provide you with another technique (which you may prefer) for diminishing the ejaculatory urge and maintaining control.

Possible problems:
1. You need to stop stimulation soon after resuming masturbation. Allow the ejaculatory urge to diminish fully by taking longer stops.
2. You are applying the squeeze under seconds before ejaculating. Practice stopping earlier.
3. Despite practice, you don't seem to be learning when to squeeze and the number of times you need to squeeze doesn't decrease. This could well mean that you are not sufficiently relaxed. Set the scene to promote a relaxed mood.
4. You are applying the squeeze as you begin ejaculating. This can be painful. Never apply the squeeze once you have passed the "point of no return".

Begin the squeeze sequences using a dry hand. Even if you can last for 15 minutes with only 2-3 squeezes the first time you try the exercise, repeat it at least one more time before going on to the second phase, namely, the squeeze with a lubricated hand. Once again, even if you are able to last for 15 minutes with only 2-3 squeezes on the first try you try the exercise, repeat it at least one more time before going on to the next exercise.
Interpersonal communication is a vital part of our general well-being. Establishing and maintaining open lines of communication with sexual partners promotes a feeling of competence and well-being, and tends to enhance sexual response and satisfaction. The area in which many people are reluctant to communicate verbally is the area of sexual interaction. It is for this reason that we include a series of communication exercises as part and parcel of our treatment programs. It is always difficult to change habits and patterns. Try to avoid procrastinating or excusing yourself altogether from these exercises. In the long run, having the ability to communicate freely about sexual issues should enhance your relationships appreciably.

Begin by role-playing in front of a mirror: telling your "mirror partner" you have enjoyed a recent sexual or non-sexual activity. Share your reactions as fully as possible, and remember to be as specific as possible. For example, tell her how good it feels when she does X, how much you enjoy her sexual pleasure, how much you enjoy being able to confide in her, etc.

Then repeat this positive feedback sequence, except this time, tell your real life partner (or a friend or confidante) about a sexual or non-sexual activity you have recently enjoyed with her. Try to be complete and specific in your sharing. If you first choose to share your positive reaction with her regarding a sexual experience, repeat the exercise using a non-sexual example, and vice versa.

In the spaces provided at right, share with us your comments regarding these communication experiences.
Activity: Continuous Self-Stimulation with variations to decrease arousal

Stimulate yourself with a lubricant for 15 minutes without stopping and without ejaculating. Focus on the sensations, and when you reach a high level of arousal, change the stimulation in a way that decreases your arousal. You will need to experiment to discover what changes will decrease your arousal. Try changing the way you stroke your penis by using shorter strokes or circular motions, or stroking more slowly. Try moving your hand from a highly stimulating area of your penis, such as the glans or tip, to a less stimulating area, such as the shaft or base of the penis. You will also need to experiment to discover when to change the stimulation. You may need to make these changes even sooner than you needed to stop in the previous exercises. If you make a change and it doesn't decrease your arousal, you can always stop stimulation. After the urge to ejaculate subsides, you can resume stimulation. Try one arousal-decreasing variation at a time. When you have mastered it, then go on to try another, until you are able to discover which variations work best for you. In the "Comments" section, briefly describe each self-stimulation session including the variation(s) you tried, your reactions, any problems you found, etc.

Rationale: To prolong intercourse many men naturally stop and start or change from highly arousing positions or types of thrusting. This exercise is designed to aid in identifying which types of stimulation tend to heighten arousal and which tend to reduce it, and then provide an opportunity for varying the intensity of stimulation in order to prolong the period before ejaculation.

Possible Problems: It is to be expected that progress will be more difficult with continuous stimulation than it was with the stop-start exercises. Discovering which changes work well and when to apply them takes time and practice. Don't hesitate to introduce the arousal-decreasing variations early.

This exercise should be done at least 4 times, using the 15 minute time period as your goal. Even if you are able to last the full 15 minutes with continuous stimulation and variations to decrease arousal on the first try, repeat the exercise at least 3 more times before going ahead to the next exercise.

<table>
<thead>
<tr>
<th>ACTIVITY</th>
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<th>Pleasure (1-10)</th>
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<td></td>
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<td>1=low;10=high</td>
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SOCIAL SECURITY #: __________________

DATE: ____________________________

DAILY RECORDED

188
ACTIVITY Duration Pleasure (1-10) 1=low;10=high COMMENTS (Positive & negative reactions, thoughts, problems, etc.)

Activity: Self-Stimulation with Stop-Start & Fantasy
Stimulate yourself using the stop-start technique for 15 minutes while fantasizing that your partner is stroking your penis in the ways you find highly arousing. Start the fantasy by imagining that you are kissing and hugging and proceed through all the sequences which might occur in this fantasized sexual encounter. As part of the fantasy, imagine yourself needing to stop with your partner, and stopping stimulation. Thus, when you and your partner stop in the fantasy, stop stimulating yourself. When the urge to ejaculate decreases, begin the self-stimulation and resume the fantasy. Be sure to include these scenes of needing to stop, so you can practice in fantasy the use of the stop-start technique with a partner. Stop either when you actually need to stop to prevent ejaculation or at points in your fantasy where you feel you might need to stop (if and when you put that fantasy into practice).

In this exercise, it is important to stop stimulating yourself at the same time you pause in your fantasy. Some fantasy scenes are very arousing and many men have difficulty maintaining control with particular scenes. Since what gives you trouble in fantasy probably is difficult in reality, work directly with the difficult fantasy scenes, rather than avoid them. In the "Comments" section, describe your experience with this exercise.

Rationale: Practicing in fantasy can be as effective as practicing in real life. If you can identify situations which pose problems and then practice handling them in fantasy, you will be much better prepared to use the stop-start technique with a real partner.

Possible Problems:
a. You find it difficult to stay tuned to your fantasy, perhaps because you are becoming distracted by other thoughts. If this happens, simply return to the scene you were imagining; put yourself back on track.

b. You don't stop early enough to prevent ejaculation.
urge to ejaculate decreases, begin the self-stimulation and resume the fantasy. Be sure to include these scenes of needing to stop, so you can practice in fantasy the use of the stop-start technique with a partner. Stop either when you actually need to stop or when you put that fantasy into practice. In this exercise, it is important to stop stimulating yourself at the same time you pause in your fantasy. Some fantasy scenes are very arousing and many men have difficulty maintaining control with particular scenes. Since what gives you trouble in fantasy probably is difficult in reality, work directly with the difficult fantasy scenes, rather than avoid them. In the "Comments" section, describe your experience with this exercise.

Rationale: Practicing in fantasy can be as effective as practicing in real life. If you can identify situations which pose problems and then practice handling them in fantasy, you will be much better prepared to use the stop-start technique with a real partner.

Possible Problems:

a. You find it difficult to stay tuned to your fantasy, perhaps because you are becoming distracted by other thoughts. If this happens, simply return to the scene you were imagining; put yourself back on track.

b. You don't stop early enough to prevent ejaculation because you forget about your arousal level. It is important that you maintain an awareness of your excitement level so that you can stop in time. It means that you must focus on both the fantasy and your actual arousal level. One suggestion is to try keeping most of your concentration on your arousal level, even if this makes the fantasy less distinct or powerful. Another idea is to tape record the fantasy and then play it while you are doing this exercise. In this way, you can keep your attention largely on your excitement level while listening simultaneously to the fantasy recording.

c. Don't rush through the difficult scenes. Speeding through the difficult scenes in fantasy sidesteps the purpose of this exercise and may hinder your progress.

This exercise should be done at least twice, and before you engage in assigned partner exercises. After you have done your assigned partner exercises, you should repeat this exercise at least once, if time permits.
By now, you should feel reasonably confident regarding your ability to exercise ejaculatory control. You probably can last quite a long time and are now ready to use your newly acquired control with a partner(s). Our approach encourages you to work with a partner(s) on a series of exercises. This series has been widely employed by many sex therapists over a considerable period of time, and with good outcomes. It requires, of course, a cooperative partner with whom to do the sequence of assignments, but it does not necessarily bind you to your partner forever! As far as we're concerned, it would be ideal to have a comfortable, cooperative relationship(s) for the duration of the treatment program.

It is important, since the partner exercises involve two people, that you go slowly and follow all the rules. As your comfort level in this novel situation increases, your awareness about following the rules will diminish because they will become automatic. You will, firstly, need to discuss with your partner your involvement in our treatment program and in explaining it to her, solicit her cooperation. You will probably want to tell her how you became interested in treatment, how treatment works, and what you have already learned and accomplished for yourself. You will also need to describe to her what you are asking of her, so it might be helpful to read some of the partner-oriented exercises in anticipation of your discussion with her. She may want to read them too. Discuss your feelings and her feelings about the program of exercises, and try to work out any differences or misunderstandings before beginning.

Clear communication and mutual understanding is vitally important. Your partner needs to know that the exercises are part of a training program and won't be required of you indefinitely. Another important matter, discussed in the introduction to the treatment exercises, is that of scheduling time to do the exercises, as often as necessary or desired, and in the most comfortable setting. Therefore, you might want to reach an agreement with your partner regarding frequency, and/or any other scheduling issues which might arise in mutual discussion. It's worth mentioning too, that you shouldn't limit your physical activities with your partner to these exercise sequences. Build in other time for hugging, kissing, showering together, massage, etc. Another important issue is the sexual satisfaction of your partner. You might want to let her know that you are prepared to satisfy her manually or orally before or after completing an exercise, and that it's important to you that she receives enjoyment from the exercises themselves. Some of you might not yet be prepared to engage in partner exercises, despite our strong urgings to do so at this time in the program. In that case, read through these anyway (they might just inspire you to take the plunge!), continue with the solo exercises and, possibly, adapt some of the partner-oriented exercises to your situation.

The guidelines below apply to all partner exercises, unless otherwise indicated:

A. Both of you should read, understand and discuss each exercise before engaging in it.
B. Set a relaxing scene and mood before starting an exercise. Do what works well for the two of you.
C. You might start a session with some hugging, general pleasing or massage, and then go on to the exercise itself.
D. The stop-start technique runs through many of the exercises and your partner needs to understand the importance of stopping immediately upon your request. You must tell her when to stop, by saying "stop" or "now", etc. Don't rely on nonverbal means of conveying your message.
E. During the exercise itself, keep your attention focused on your arousal level,
The goal in each partner exercise, as in each solo exercise, is to last for about 15 minutes, stops, squeezes or other adjustments included, without ejaculating. After you have lasted for 15 minutes, you can ejaculate if you wish, but go slowly, focus on your arousal level and the point of inevitability, and enjoy yourself!

C. Lasting 15 minutes with 2-3 stops (or other adjustments) should be your goal in each exercise. Then, go on to the next exercise. If you have a lot of difficulty with the subsequent one, and it doesn’t seem to get any easier with repetition and practice, return to the exercise before and repeat it further to develop your skills.

D. As with the solo exercises, the more frequently you do the exercises, the better. You should try to do them three times a week.

E. After completing the exercise, you can stimulate your partner to orgasm either manually or orally, or otherwise provide her with physical pleasuring, as she desires. Ask her how you can increase her pleasure and enjoyment of the exercises.
FIGURE A: Position for Teaching Partner Control Techniques

FIGURE B: Application of the "Squeeze" Technique by Partner

FIGURE C: The Woman-Above, Face-to-Face Position for Developing Ejaculatory Control
<table>
<thead>
<tr>
<th>ACTIVITY</th>
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<tbody>
<tr>
<td><strong>Activity:</strong> Assigned Reading</td>
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This week, in addition to the sexual and communication exercises, you should read chapter 12, *Dealing with a Partner*, in Zilbergeld's *Male Sexuality*. When you have read the chapter, share with us your reactions in the spaces provided at right in the "Comments" section.
**Activity:** Teaching Partner the Stop-Start II

This exercise is done in the same way as the previous exercise, except that you now have your partner use a lubricant (K-Y Jelly, massage oil, etc.) on her hand when she stimulates your penis. The lubricant heightens sensations and is like those you will have when intercourse is resumed. As you prepare for this exercise, it might be a good idea to remind your partner to rub the cold lotion in her hands before beginning stimulation of your penis. As in the previous exercise, set a relaxing scene, assume comfortable positions, and begin. When you can be stimulated by your partner’s lubricated hand for 15 minutes and need to tell her to stop only 2-3 times, you are ready for the next step. Briefly describe each experience with this exercise on this form. Include the approximate number of times you stopped (for each trial), your and your partner’s reactions to the exercise, etc.

**Rationale:** Partner stimulation with a lubricant more closely approximates the sensations associated with containment of the penis in the vagina. In so doing, it helps a man build self-confidence and ejaculatory control in a gradual, systematic way. Exercises which involve your partner should heighten their relevance for you and, importantly, provide the opportunity for explicit sex-related discussion and feedback.

**Possible Problems:** These are the same kinds of possible problems described throughout the training program:

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<tbody>
<tr>
<td>a.</td>
<td>You find that you need to instruct your partner to stop stimulation soon after it has been resumed, allow more time for the ejaculatory urge to diminish, and take longer stops.</td>
</tr>
<tr>
<td>b.</td>
<td>You are stopping too late in the cycle and are becoming anxious, or ejaculating, or both. With a lubricant, you will probably need to stop sooner and communicate this clearly to your partner.</td>
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**Remember:** Focus on your penile sensations and monitor your arousal level.

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<tr>
<th>Activity</th>
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<tr>
<td>Teaching Partner the Stop-Start II</td>
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</table>

**COMMENTS (Positive & negative reactions, thoughts, problems, etc.):**
### Activity: Communication Exercise

Begin by role-playing in front of a mirror:

1. The expectations you have which are relevant to sexual activity. Be complete and specific in your sharing, trying to imagine a partner or potential partner in the mirror. For example, focus on the things you like and those you dislike in sexual encounters, or sources of comfort and discomfort (physical, psychological or both), or the things you like to do to set the scene well.

Then, try to share with your partner, as best you can, the expectations you have relevant to sexual activity, likes and dislikes, etc. If you have no current partner, share with a friend or confidante some specific sexual preferences, dislikes, expectations.

2. Role play with your "mirror partner":
   - Telling your partner that you’re having some sexual difficulty, without making her feel responsible.
   - Then, try to share with your partner, as best you can, your perception(s) of your sexual difficulty.
   - If you have no current partner, choose a friend or confidante to share with. In either case, be as complete and specific in your disclosures as you can.

In each case when you actually share with a partner be sure to allow her to respond to you, in turn.

In the spaces provided at the right, share with us your comments and reactions to these communication exercises.
### Daily Record

<table>
<thead>
<tr>
<th>Activity: Self-Stimulation with Stop-Start and Directed Fantasy: 1</th>
<th>Duration</th>
<th>Pleasure (1-10) 1=low; 10=high</th>
<th>Comments (Positive &amp; negative reactions, thoughts, problems, etc.)</th>
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- **Activity:** Stimulate yourself in the same way as in the previous exercise only this time imagine that the woman (your partner) stimulates your penis with her hand and her mouth in the ways that you find highly arousing. When you feel close to the point of ejaculatory inevitability, or before this point, imagine that the woman stops the manual and oral stimulation. When you can last 15 minutes stopping 2 to 3 times, you are ready for the next step. If you are not aroused by this fantasy, omit this exercise and repeat the previous exercise instead, possibly introducing some variations in it, or repeating parts of the fantasy which give you trouble. Be sure you are relaxed before beginning this exercise. In the "Comments" section, describe your experience with this exercise. Be sure to be as specific as possible in describing your activities and reactions.

- **Rationale:** Some men find oral sex highly arousing and this exercise can provide an opportunity to practice, in fantasy, the stop-start technique in a manner which will likely transfer to real life oral sex situations. If oral sex does not arouse you in fantasy or reality or if you find that it goes against your personal values, omit this exercise.

- **Possible problems:**
  a. You find yourself drifting from the fantasy. Bring yourself back to the scene this fantasy directs you to imagine.
  b. Keep up an awareness of your actual arousal level, or you may not stop in time to delay ejaculation. Again, taping the fantasy can assist you.
(your partner) stimulates your penis with her hand and her mouth in the ways that you find highly arousing. When you feel close to the point of ejaculatory inevitability, or before this point, imagine that the woman stops the manual and oral stimulation. When you can last 15 minutes stopping 2 to 3 times, you are ready for the next step. If you are not aroused by this fantasy, omit this exercise and repeat the previous exercise instead, possibly introducing some variations in it, or repeating parts of the fantasy which give you trouble. Be sure you are relaxed before beginning this exercise. In the "Comments" section, describe your experience with this exercise. Be sure to be as specific as possible in describing your activities and reactions.

Possible problems:

a. You find yourself drifting from the fantasy. Bring yourself back to the scene this fantasy directs you to imagine.

b. Keep an awareness of your actual arousal level, or you may not stop in time to delay ejaculation. Again, taping the fantasy can assist you to both concentrate on your excitement level and participate in the oral sex fantasy.

c. Don't rush the fantasy, especially at the difficult points. Relax and proceed slowly through it. This exercise should be done at least twice, and before you engage in assigned partner exercises. After you have done your partner assigned exercises, you should repeat this exercise at least once, if time permits.
Activity: **Teaching Partner the Stop-Start Technique**

Lie comfortably on your back and have your partner also find a comfortable position in which she will be able to stimulate you for 15 minutes or so. The position we suggest is illustrated in Fig. A. When you have set the scene to your liking and found comfortable positions, have your partner begin to stimulate your penis (with her dry hand) in the ways you find most arousing. As she is stimulating you, share with her and teach her how and where you like to be touched. Focus on the sensations in your penis to help you monitor your arousal level. When you are highly aroused and close to the point of inevitability, tell her to stop the stimulation. Then, do nothing but focus on the sensations in your penis. Allow enough time for the ejaculatory urge to subside (30 seconds to 2 minutes or so) before asking your partner to resume stimulation. If you find that you need to stop again as soon as stimulation begins anew, try taking longer steps. When you feel comfortable and only need to stop 2 or 3 times to last 15 minutes, you are ready for the next step. Write a brief description of each experience with this exercise. Include the approximate number of times you stopped and any problems you encountered, partner reactions and discussion, etc.

**Rationale:** To practice experiencing high levels of arousal with a partner present by using the stop-start technique to prolong the period of arousal & orgasmic delay. In addition, this exercise helps you establish a pattern of communicating and sharing with your partner your sexual likes and dislikes.

**Possible Problem:** You are instructing your partner to stop too late in the cycle for you to delay your ejaculation. This can have the effect of making you more anxious the next time you try this exercise. You will maintain a relaxed state if you stop in time, by focusing your attention on your excitement level, rather than thinking of your partner. Commonly, men wonder whether partners are becoming bored, tired or aroused by the exercise. These important concerns should be discussed, if they are relevant to you, once the exercise is completed. Return to focusing on your sensations if you find yourself thinking about these things during the exercise itself.

Even if you are able to last for 15 minutes with only 2-3 stops on the first time you try the exercise, repeat it at least one more time before.

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<th>COMMENTS (POSITIVE &amp; NEGATIVE REACTIONS, THOUGHTS, PROBLEMS, ETC.)</th>
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Rationale: To practice experiencing high levels of arousal with a partner present by using the stop-start technique to prolong the period of arousal & orgasmic delay. In addition, this exercise helps you establish a pattern of communicating and sharing with your partner your sexual likes and dislikes.

Possible Problem: You are instructing your partner to stop too late in the cycle for you to delay your ejaculation. This can have the effect of making you more anxious the next time you try this exercise. You will maintain a relaxed state if you stop in time, by focusing your attention on your excitement level, rather than thinking of your partner. Commonly, men wonder whether partners are becoming bored, tired or aroused by the exercise. These important concerns should be discussed, if relevant to you, once the exercise is complete.

Return to focusing on your sensations if you find yourself thinking about these things during the exercise itself.

Even if you are able to last for 15 minutes with only 2-3 stops on the first time you try this exercise, repeat it at least one more time before going on to the next partner exercise.
Activity: Communication Exercise

Once again, begin by role playing, to your "mirror partner", general ways of improving your sexual activity together. As you go along, you might want to get more specific about suggestions. For example, you might share the fact that you are involved in a brief treatment program, and that you want to try something new sexually with your partner, like the stop-start technique. Try to relax as you share this new information and your feelings surrounding it, with your "mirror partner". When you feel comfortable and relaxed in front of a mirror, you are ready to share with a real life partner (or friend or confidante) general ways of improving your joint sexual activity. When comfortable, go on to raising specific suggestions like the stop-start technique. If you're sharing with a friend or confidante, the exercise will go somewhat differently, of course, but try to be specific anyway about your feelings and suggestions. Whether you share with a friend or real life sexual partner, be sure to allow her a chance to respond to you.

If you have the time, you might want to share another specific suggestion designed to improve your joint sexual activity with a partner.

In the comments section at the right, share with us your reactions to these communication sequences.
**Activity:** Self-Stimulation with Stop-Start and Directed Fantasy: II

Using a lubricant, stimulate yourself using the stop-start technique for 15 minutes. During this time, repeatedly imagine that you insert your penis in your partner's vagina and then stop the stimulation to let your arousal decrease. Many men find this the most difficult point because the feelings of vaginal insertion and containment are highly arousing. You may need to repeat this exercise a number of times before feeling comfortable and confident in the degree of control you have established. In the "Comments" section, record your experience with this exercise, including how many times you paused in each session, and how many times you did the exercise.

**Rationale:** Since vaginal insertion is a difficult point for many men, this exercise provides repeated opportunities to practice this step.

**Possible Problems:**

a. You find yourself distracted from the fantasy. Try to relax and return to the scene you were imagining.

b. You lose track of your level of arousal, and possibly don't stop in time to prevent ejaculation. Next time you do the exercise, keep your attention on your excitement level, even if the fantasy dims somewhat. Alternatively, tape record the fantasy and listen to it as you are doing this exercise.

c. Don't rush the fantasy to get over the difficult scenes. Relax and proceed through it slowly, so that you can maximize the benefit of the exercise.

This exercise should be done at least twice, and before you engage in partner exercises. After you have done your partner assigned exercises, you should repeat this exercise at least once, if time permits.

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**DAILY RECORD**

**SOCIAL SECURITY #:**

**DATE:**
**Activity:** Teaching Partner the Squeeze Technique

For this exercise, assume the position illustrated in Fig. A. This position allows the female comfortable and easy access to the male's genitals. Both partners should be nude for this and all joint exercises. When teaching your partner the squeeze, it is important that pressure be applied in the same way as when you applied it to yourself (refer to Fig. B for a review of the squeeze). It is also important that firm pressure be applied. In the position we suggest, most women find it easiest to place the thumb on the frenulum (on the underside of the penis) and the forefinger and middle finger of the same hand on either side of the corona ridge. The fingers of the other hand may be placed over those, if necessary, for increased pressure. Many women are reluctant to use the squeeze technique and will need encouragement from the partner that the squeeze is not painful if properly applied in an otherwise healthy man. Once comfortably positioned, have your partner begin stimulation with a dry or lubricated hand, as desired. As soon as you have a full erection, you should apply the squeeze for 5 seconds or so. Pant or 10-30 seconds. Then your partner should practice placing her fingers for the squeeze. After placement has been learned, stimulation is resumed by you. As soon as you experience a full erection, you might want to demonstrate the squeeze once again, to have your partner apply it. In the latter case, you may want to place your fingers over hers to guide her application of pressure. Once the squeeze has been practiced in this way, stimulation should be resumed, but, this time, the focus should be on applying the squeeze a few seconds before ejaculation. If fullness is reached, at that point, you should tell her to "squeeze" and she should apply it. After a short period, signal your partner to begin stimulation again until you are close to inevitability, either when to squeeze (for 5-30 seconds), rest, and repeat again. Again, ejaculation after the session through manual means (not intercourse) is fine, if desired.

**Rationale:** To provide you and your partner with experiences using an additional control technique and to compare experience with the squeeze to that with the stop-start in terms of personal preferences and effectiveness.

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**AUXILIARY & ADDITIONAL ACTIVITY:**

**SOCIAL SECURITY #**

**DATE:**

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**PEACE (1-10)**

**COMMENTS (Positive & negative reactions, thoughts, problems, etc.)**

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**200**
and the forefinger and middle finger of the same hand on either side of the coronal ridge. The fingers of the other hand may be placed over these, if necessary, for increased pressure. Many women are reluctant to use the squeeze technique and will need encouragement from the outset that the squeeze is not painful if properly applied in an otherwise healthy man. Once comfortably positioned, have your partner begin stimulation with a dry or lubricated hand, as desired. As soon as you have a full erection, you should apply the squeeze for 5 seconds or so. Rest for 10-30 seconds. Then your partner should practice placing her fingers for the squeeze. After placement has been learned, stimulation is resumed by her. As soon as you experience a full erection, you might want to demonstrate the squeeze once again, or have your partner apply it. In the latter case, you may want to place your fingers over hers to guide her application of pressure. Once the squeeze has been practiced in this way, stimulation should be resumed, but, this time, the focus should be on applying the squeeze a few seconds before ejaculatory inevitability is reached. At that point, you should tell her to "squeeze" and she should apply it. After a rest period, signal your partner to begin stimulation again until you are close to inevitability, then to squeeze (for 5-10 seconds), rest, and repeat again. Again, ejaculation after the session through sexual means (not intercourse) is fine, if desired.

Problems: To provide you and your partner with experiences using an additional control technique and to compare these experiences with the squeeze technique in terms of personal preference and efficacy.

Briefly describe your experience with this exercise in the "Comments" section (overleaf). Be sure to include your and your partner’s reactions.

Possible Problems:

a. Your partner doesn’t apply the squeeze with enough pressure, and you ejaculate before you are ready. Show her how much pressure is necessary by placing your fingers in position over hers and squeezing, once the penis is erect.
b. You need to stop stimulation soon after resuming it. Allow the ejaculatory urge to diminish fully by resting longer than 10-30 seconds, if necessary.
c. You are signaling your partner to apply the squeeze split seconds prior to ejaculation. Practice signaling to your partner earlier.
d. You are having your partner apply the squeeze as you begin ejaculating. This can be painful. Never have your partner apply the squeeze once you have passed the "point of no return".

Experiment with the use of both dry and lubricated hand (in that order), time permitting.

Remember: The more practice you get, the greater should be your gain.
**Activity:** Partner Applied Continuous Stimulation with Variations to Decrease Arousal

Both of you should be nude and comfortably positioned for this exercise. Have your partner stimulate you manually in the ways you enjoy for 15 minutes without ejaculating and without stopping stimulation.

Focus on the sensations, and when you reach a high level of arousal, change the stimulation in a way that decreases your arousal. Feel free to suggest changes in her behavior or make changes in your own. You will need to experiment to find what works best with your partner. You might try changing the way she strokes your penis by using shorter strokes or circular motions, or stroking more slowly. Try moving her hand from a highly stimulating area of your penis (such as the glans or tip), to a less stimulating area, such as the shaft or base of the penis. You will also need to discover when to change the stimulation. You may need to make these changes even sooner than you needed to in the solo exercises. If you make a change and it doesn't decrease your arousal, you can always stop stimulation. (When you urge to ejaculate subsides, you can have her resume stimulation). Try one arousal-decreasing variation at a time. When you and your partner have mastered it, go on to another, until you are able to discover which variations work best for you. With time devoted to practice, you will learn both how and when to use the adjustments you are learning. The first few times you do the exercise, your partner should not lubricate her hand. When you have established some control, she can then begin using a lubricant. In the "Comments" section, briefly describe each session, including the variation(s) you tried, your reactions, any problems encountered, etc.

**Rationale:** This exercise is designed to aid in identifying which types of partner applied stimulation tend to heighten arousal and which tend to reduce it, and then provides an opportunity for varying the intensity of stimulation in order to promote ejaculatory delay.

**Possible Problems:** It is to be anticipated that progress will be more difficult with continuous partner applied stimulation than it was with the step-start, squeeze or solo exercises. Discovering which changes work well with a partner and then to apply them requires time and practice. Don't hesitate to suggest the arousal-decreasing variations to your partner early. This exercise should be
her hand from a highly stimulating area of your penis (such as the glans or tip), to a less stimulating area, such as the shaft or base of the penis. You will also need to discover when to change the stimulation. You may need to make these changes even sooner than you needed to in the solo exercises. If you make a change and it doesn’t decrease your arousal, you can always stop stimulation. (When the urge to ejaculate subsides, you can have her resume stimulation.) Try one arousal-decreasing variation at a time. When you and your partner have mastered it, go on to another, until you are able to discover which variations work best for you. With time devoted to practice, you will learn both how and when to use the adjustments you are learning. The first few times you do the exercise, your partner should not lubricate her hand. When you have established some control, she can then begin using a lubricant. In the “Comments” section, briefly describe each session, including the variations you tried, your reactions, any problems encountered, etc.

**Notes:** This exercise is designed to aid in identifying which types of partner applied stimulation tend to heighten arousal and which tend to reduce it, and then provides an opportunity for varying the intensity of stimulation in order to promote ejaculatory delay.

**Possible Problems:**
It is to be anticipated that progress will be more difficult with continuous partner applied stimulation than it was with the stop-start, squeeze or solo exercise. Discovering which changes work well with a partner and when to apply them taken time and practice. Don’t hesitate to suggest the arousal-decreasing variations to your partner early. This exercise should be done at least twice, using the 15 minute time period as your goal. If you have difficulty with this exercise which persists, consider returning to the exercise which involves continuous self-stimulation with variations to decrease arousal. Even if you are able to last the full 15 minutes with continuous partner applied stimulation and variations to decrease arousal on the first try, repeat the exercise at least once more before going on to the next partner oriented assignment.
Activity: Communication Exercise

In this exercise, you have the opportunity to share your reactions with your partner to the dry and lubricated stop-start exercises. Hopefully, you have been practicing all of the assigned exercises, and it makes sense to discuss your reactions to them. Begin with your "mirror partner" until you feel comfortable and confident about what you want to say and how you want to say it. When comfortable, turn to a real-life partner, friend or confidante. Try to stay relaxed as you initiate the discussion. As you become more relaxed, it will probably get easier for you to get more specific in your reactions. That's all to the good—the more specific you can get, the more useful the mutual communication is likely to be. Also, try to maintain a "problem-solving" outlook—avoid blaming yourself or your partner if the exercise didn't go all that smoothly. A positive approach toward problem solving will go a long way toward keeping your partner interested and involved in your efforts to change. Be sure also to allow her a chance to disclose her reactions. If you learn, through this process, some useful pointers for next time you try the exercise, that's great!

If each of you feels satisfied with the way this sharing activity went, you might want to try asking your partner to do the things which you're learning that help you last longer (other activities, pacing, scene setting, foreplay, etc.)

In the spaces provided at right, share with us your reactions to these communication experiences.

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<td>Self-Stimulation with Stop-Start and Directed Fantasy: III</td>
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<td>When you are able to use the stop-start technique for 15 minutes without ejaculating while imaging your penis inserting your partner's vagina, you are ready for the next step. Stimulate yourself in the same ways you have done in the past but this time imagine that after you insert your penis, you begin thrusting slowly. When you feel very aroused, either stop the stimulation or stimulate yourself in a way that decreases your arousal. When your arousal goes down, resume the stimulation until you need to stop again. In the &quot;Comments&quot; section, record your experience with this exercise, including the approximate number of times you stopped, how often you did the exercise, any problems you found, and anything new you learned about yourself.</td>
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**Rationale:** This fantasy represents another difficult point for many men in real life intercourse. The exercise provides an opportunity to practice without the distraction or concern for a partner.

**Possible Problems:**

a. Straying from the fantasy. As before, bring yourself back to the scene you were imagining.

b. Losing track of your excitement level. Keep your attention on your actual arousal level or you may not be able to delay or prevent ejaculation before you have gone through the fantasy. Use the tape recording if you are finding that it works well for you. Otherwise, keep more of your attention on your actual arousal level.

c. Don't rush the fantasy to get through the hard parts. Relax and proceed as slowly as necessary. Use the exercise for your own gain.

This exercise should be done at least twice, and before you engage in assigned partner exercises. After you have done your partner exercises, you should repeat this exercise once, if time permits.
**ACTIVITY**

*Squeeze Focus III: "Vaginal"

Your practice with the stop-start and squeeze techniques has probably, by now, made it possible for you to delay ejaculation effectively with two different methods. This probably means your sexual activities with partners are much more diverse & expanded over what they used to be. In this exercise, you should make no effort to stimulate your partner, or you should have no performance demands placed upon you. Begin by lying on your back & have your partner sit astride your legs (as in Fig A). Be sure you are both comfortable so that you will both be able to last in that position for 15 minutes. When comfortably positioned, your partner should begin stimulating your penis until you have an erection. Have her rub your penis gently around the outer rim of her vagina and in her pubic hair. Become accustomed to the sensations, focus on your arousal level & note any desired adjustments (pause, squeeze, movement or pressure variations, etc.) Take your time in acclimatizing to the idea of having your penis around her vagina. When you are comfortable in this regard, feel in control of your ejaculatory process, then she should gently insert your penis into her vagina. Do not have her insert your penis until you are comfortable & confident about your control—even if it means repeating the first step. In this exercise, once inserted, focus on the sensations; your partner should not move except as necessary to maintain your erection. (Tell her, if desired, that you feel your erection diminishing, to either contract your pelvic muscles a few times, or to move gently so as to keep your erection firm.) Retain in this position for 15 minutes. Stay focused on your pelvic sensations & the vaginal environment (texture, lubricity, temperature, etc.) Concentrate on being squirited & becoming comfortable. If your sense of control is threatened, you can also ask your partner to lift off your penis, apply the squeeze, or you can try relaxing or tensing your pelvic muscles. If your ejaculation is desired, after the 15 minutes have elapsed, but go slowly & focus as you pass through the point of inevitability. In the "Concrete" section, briefly describe each experience with this exercise, including personal reactions, any difficulties found, etc.

Possible Problems:

**ACTIVITY**

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Once inserted, focus on the sensations; your partner should not move except as necessary to maintain your erection. Tell her, if she feels your erection diminishing, to either contract her pelvic muscles a few times, or to move gently back and forth to keep your erection firm. Remain in this position for 15 minutes. Stay focused on your pelvic sensations and the vaginal environment (texture, lubricity, temperature, etc.) Concentrate on being inserted and becoming comfortable. If your sense of control is threatened, you can either ask your partner to lift off your penis, apply the squeeze, or you can try relaxing or tensing your pelvic muscles to help maintain your erection. If desired, after the 15 minutes have elapsed, but go slowly & firmly as you pass through the point of inevitability. In the "Concentrate" section, briefly describe each experience with this exercise, including personal reactions, any difficulties found, etc.

Possible Problems:

a. Since you probably haven't had intercourse for a while, you may become very aroused the first time you do this exercise, & you may ejaculate quickly. This is not a problem unless it persists. If so, there are several things you can do and should try:

One option is for your partner to return to stimulating you with her lubricated hand (using the squeeze, squeeze, or around-decreasing variations as per earlier exercises) until you get more comfortable & confident with that. A second option is to do a masturbation exercise accompanied by a fantasy involving vaginal penetration or vaginal containment. A third option is to repeat the partner-applied-continuous-stimulation-with-variations-decreasing-arousal exercise, adding a penetration fantasy or containment fantasy while your partner is stimulating you. A fourth option is to spend several sessions without ever testing the vagina completely. You might rub your penis around the vaginal rim until that is comfortable & then insert your penis only a little bit. Gradually you can then increase the depth of penetration as you gain confidence.

b. Your partner finds it hard to control her movements in the way the exercise requires; she may even experience orgasm during this sequence. This tends to heighten the arousal level & make it more dramatic. Discuss with your partner the need to carefully control stimulation during these sessions. Indicate to her that this is a temporary state of affairs. Additionally, it is fine for you (or your partner) to bring her to orgasm through manual or oral means either before or after the exercise, if desired.

c. A problem some people report is that the exercise is difficult because the woman is not aroused at all or enough to produce vaginal lubrication. In this case, use a non-irritating lubricant (e.g., K-Y Jelly) to make penetration comfortable.
Activity: Communication Exercise

As with the previous communication exercises, begin this one with your "mirror partner":

a. If you have been practicing the partner-applied dry and lubricated squeeze technique this week, begin by sharing your reactions, as specifically as possible, to the squeeze. Direct your attention to your actual experience with the squeeze, and then, possibly, you might want to share your reactions about the squeeze in relation to the stop-start technique.

b. If you chose not to practice the squeeze, but went on to the other partner-oriented exercise for this week (continuous stimulation with arousal-decreasing variations), share your reactions and experiences with this exercise as fully as possible with your "mirror partner".

When you feel comfortable with the way you've roleplayed these communication sequences, approach your actual partner (or friend). Remember to try to be specific and complete and to give your partner the chance to reciprocate with her reactions.

c. The next sequence, which should first be practiced with your "mirror partner", and then your actual partner (or friend) involves setting limits in sexual situations. Setting limits can involve many different issues: from limiting the amount of contact with a partner to limiting the amount or type of sexual contact. Begin by practicing, as best you can, saying no to a sexual or non-sexual request made by your partner. Role-play both kinds of situations and when comfortable, enact both kinds in real life situations.

d. Sometimes, the concern is expansion of limits, saying yes in sexual (and non-sexual) situations. For example, you may want to initiate sexual contact more frequently, or be more receptive to sexual advances made by your partner, or respond positively to a sexual activity you've rarely experienced. Bring to mind a situation or activity which fits the bill for you and this part of the assignment and go ahead! Once you've practiced with your "mirror partner", try, as best you can, to practice similarly with your real life partner or friend. Be sure to allow her to share her reaction with you too.

e. Finally, practice first with your "mirror partner" and then with your actual partner (or friend), asking her precisely what her likes and preferences are in certain situations. Try to elicit from her the exact

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this work (continuous stimulation with unusual decreasing variations), share your reactions and experiences with this exercise as fully as possible with your "mirror partner".

When you feel comfortable with the way you've role played these communication sequences, approach your actual partner (or friend). Remember to try to be specific and complete and to give your partner the chance to reciprocate with her reactions.

c. The next sequence, which should first be practiced with your "mirror partner", and then your actual partner (or friend) involves setting limits in sexual situations. Setting limits can involve many different issues: from limiting the amount of contact with a partner to limiting the amount or type of sexual contact. Begin by practicing, as best you can, saying no to a sexual or non-sexual request made by your partner. Role-play both kinds of situations and when comfortable, enact both kinds in real life situations.

d. Sometimes, the concern is expansion of limits, or saying yes in sexual (and non-sexual) situations. For example, you may want to initiate sexual contact more frequently, or be more receptive to sexual advances made by your partner, or respond positively to a sexual activity you've rarely experienced. Bring to mind a situation or activity which fits the bill for you and this part of the assignment and go ahead! Once you've practiced with your "mirror partner", try as best you can, to practice similarly with your real life partner or friend. Be sure to allow her the chance to share her reaction with you too.

e. Finally, practice, first with your "mirror partner" and then with your actual partner (or friend), ask her precisely what her likes and preferences are in sexual situations. Try to elicit from her the most specific kinds of information you can. If you don't understand something she says, ask her to clarify verbally what she means. Be sure to allow her the time to give you a full response to both her and your satisfaction.

In the comments section on the overleaf, share with us your reactions to these various communications exercises.
**Activity: Communication Exercise**

You should begin by sharing, with your "mirror partner" your reactions to this week's partner-oriented assignments (partner-applied control technique, continuous stimulation and "quiet vagina" exercises). Give yourself the opportunity to react individually to each experience associated with each exercise. When relaxed and comfortable, approach a partner (or friend) and share your reactions similarly. Try to be complete and specific in your disclosures and allow your partner a chance to share her reactions too.

Then, with your "mirror partner", try, as best you can, to share some negative feeling relevant to a sexual situation, trying not to make your partner feel defensive. For example, share with your partner the fact that you don't like it when she strokes you in a certain way, or perhaps that when she brings up everyday subjects in the middle of a sexual encounter, you feel annoyed or angry. These are only examples, which may not be relevant to you. In that case, choose examples which are drawn from your life that are relevant.

Once you feel comfortable and confident about the way you're going about this role-play, approach your partner (or friend), try to relax, and share your negative reaction to the best of your ability.

As in each of the other communication exercises, try to be specific and complete in sharing your reactions, and allow your partner the opportunity to respond to you too.

In the comments section, share with us your experience with this exercise.

<table>
<thead>
<tr>
<th>ACTIVITY</th>
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<th>Pleasure (1-10)</th>
<th>COMMENTS (Positive &amp; negative reactions, thoughts, problems, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication Exercise</td>
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</tbody>
</table>
Stimulate yourself for 15 minutes using a lubricant. Imagine inserting your penis in your partner's vagina and having sex with her in various positions such as the woman on top, or side-to-side position. When you feel highly aroused, use a type of stimulation you know will decrease your arousal. When your arousal subsides, imagine having intercourse and resume stimulating yourself in a more arousing manner, and so on until you can last 15 minutes with continuous stimulation and fantasy. Remember, if at first it is difficult to continue the stimulation throughout the 15 minutes, you can include stopping and letting your arousal decrease. In the "Comments" section, record your experiences with this exercise as specifically and completely as possible.

Rationale: This exercise simulates what you and other men typically will do to prolong intercourse. It provides an opportunity to practice, in fantasy, stop and start sequences, along with changing positions as a natural and comfortable way to prolong stimulation before ejaculation.

Possible Problems:

- You leave your fantasy behind and become distracted along other lines. As before, bring yourself back to the scene you were imagining.
- You lose track of your arousal level, possibly ejaculating, before you get through the fantasy. Next time, keep your attention focused more closely on your arousal level so that you can practice the fantasy in all its parts. You may want to continue using the tape recording if that's been working for you.
- Don't rush through the fantasy to sidestep the difficult points, positions, etc. Stay with it. Relax and go slowly.

This exercise should be done at least twice, and BEFORE you engage in PARTNER exercises.

After you have done the partner assigned exercises, you should repeat this exercise at least once, if time permits.

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>Duration</th>
<th>Pleasure (1-10)</th>
<th>COMMENTS (Positive &amp; negative reactions, thoughts, problems, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity: Self-Stimulation with Stop-Start and Directed Fantasy: IV</td>
<td>l-15 minutes</td>
<td>1-low;10-high</td>
<td></td>
</tr>
</tbody>
</table>
Activity: Limited Female Intravaginal Movement

This exercise is similar to the previous one (Quiet Vagina). Begin by setting the scene to your liking and taking comfortable positions. Make no effort to stimulate your partner during the course of the exercise itself. Lie on your back and have your partner sit astride your legs. Your partner should begin stimulating your penis until you have an erection. Become accustomed to having your erect penis around her vagina; focus on the sensations. When you feel comfortable and in control of your ejaculatory process, have her slowly insert your penis into her vagina. Do not have her insert your penis until you are confident about your control—even if it means repeating the first step in this exercise. Once inserted, relax a moment, and focus on the sensations of intravaginal containment. Your partner should be in the Female Abdominal position as you progress to the point of insertion. She should then begin to move and thrust slowly. You need to instruct her as to how much and how fast the movements are. Use the subtle adjustments you have learned so far (stops & squeezes) to make it possible for you to last the full 15 minute period without ejaculating. Again, it is important that your partner take her cues from you; you must be in control of what kind, and how much and how fast the movements are. Before you allow the pace or depth of thrusting to increase, be sure you are comfortable at each step along the way. If you use the stop-start technique, you may want to try having your partner lift off your penis altogether, or simply stop movement while you remain inserted. If you try the first approach, be sure to have her stop and lift off sooner in the arousal process, because actual withdrawal may be arousing enough to promote ejaculation. If you use the squeeze, you may want to have your partner lift off your penis altogether & apply the squeeze in the usual way, or apply the squeeze while you remain inserted. If you choose the latter approach, you should know that the squeeze may be effectively applied anywhere along the shaft of the penis provided firm pressure is used. Feel free to experiment with the control techniques.

**Rationale:** This exercise provides a closer approximation to regular intercourse in that controlled movement is included.

**Possible Problems:**

a. You may become very quickly aroused with this exercise.
the subtle adjustments you have learned so far (or 
stops & squeezes) to make it possible for you to 
last the full 15 minute period without ejaculating.
Again, it is important that your partner take her 
(as you do) to make it possible for you to 
last the full 15 minute period without ejaculating. 
Before you allow the pace or depth of thrusting to increase, 
be sure you are comfortable at each step along the 
way. If you use the stop-start technique, you may 
want to try having your partner lift off your penis 
altogether, or simply stop movement while you remain 
inserted. If you try the first approach, be sure to 
leave her stop and lift off sooner in the arousal pro-
cess, because actual withdrawal may be arousal 
and should not promote ejaculation. If you use the squeeze, 
you may want your partner lift off your penis 
altogether & apply the squeeze in the usual way, 
or apply the squeeze while you remain inserted.

If you choose the latter approach, you should 
know that the squeeze may be effectively applied any-
where along the shaft of the penis provided firm 
pressure is used. Feel free to experiment with the 
control techniques. 

Rationale: This exercise provides a closer approxi-
mation to regular intercourse in that controlled 
movement is included. 

Possible Problems: 

A. You may become very quickly aroused with this ex-
ercise, & you may ejaculate sooner than you intended. 
This is not a problem unless it persists. If it does, 
there are several things you can try: 
One option is to return to the "Quiet Vagina" exercise 
where you experience insertion but limit movement to 
that which is necessary for continued erection. Anot-
her option is for your partner to return to stimula-
ting you with her lubricated hand using arousal-de-
creasing variations until your comfort and confidence 
increases. Thirdly, you might repeat a masturbat-
ion exercise in which you simultaneously fantasize con-
tainment, penetration and partner movement. Another 
option is to have your partner stimulate you orally 
(with stops or variations as needed) while you accom-
pny her stimulation with a fantasy involving pen-
etration, containment or thrusting. Once comfortable 
with these latter options, you might then return to 
"quiet vagina" being sure to go slowly at first, and 
getting used to having your penis in and around the 
vagina. 

B. Your partner finds it difficult to control her 
movements in the way required in this exercise. Dis-
cuss with her the need to control & limit her stimu-
lation of you. Remind her that limiting movement is 
temporary. Before or after the exercise, it is fine 
to facilitate her orgasm, if mutually desired, by 
either manual or oral means. 
C. If your partner has difficulty becoming aroused 
prior to insertion, by all means use a lubricant to 
ease penetration and increase her comfort. 

Even if you are able to last the full 15 minutes on 
the first time you try this exercise, repeat it at 
least once more before going on to the next partner 
oriented exercise. 

You may wish to refer to Figure C for an illus-
tration of the woman-above position.
ACTIVITY: Limited Male Intravaginal Movement

This exercise is similar to the preceding one. Set the scene and get comfortable. Begin by lying nude on your back and have your partner begin stimulating your penis until you experience an erection. You may want to have her rub your penis gently around the pubic & vaginal areas first, as you relax and focus on the sensations you're experiencing. When you are feeling confident regarding ejaculatory control, have her sit astride you and slowly insert your penis into her vagina. Once inserted, you will probably want to take a few motionless moments to accustom yourself to containment. When you are ready, you should begin to move and thrust slowly. Monitor your arousal level as you move and, as necessary, use the subtle adjustments (or stops &/or squeezes) which decrease your arousal level and make it possible for you to last 15 minutes without ejaculating. It is important that you attend to your excitement level so that you can control the kind, pace & depth of thrusting. Be sure that you feel comfortable & confident at each step along the path. If you use the control techniques, feel free to experiment with them, as you may have done in the previous exercise.

RATIONALE: This exercise is designed to promote comfort & prolonged intravaginal containment experience with movement but without rapid ejaculation. Like the prior partner exercise, it provides a close approximation to regular intercourse.

POSSIBLE PROBLEMS:

- Again, you may become very quickly aroused with this exercise, and you may ejaculate rapidly. This is not problematic, unless it persists. If it does, return to one of the earlier partner-oriented sequences. One option is to return to the exercise involving limited female intravaginal movement. Another is to repeat the "quiet vagina" exercise, limiting movement to that necessary to maintain erection, then your comfort and confidence with these.

INCREASE: Return to the present exercise. Other options include partner applied manual or oral continuous stimulation (with arousal decreasing variations) with a lubricated hand, while you accompany the stimulation with penetration or containment or thrusting fantasy; or you might repeat a masturbation exercise, accompanying it with fantasy as above. As always, when you return to the newer exercise sequences, go slowly & focus on your sensations and arousal level.
level as you move and, as necessary, use the subtle adjustments (or stops &/or squeezes) which decrease your arousal level and make it possible for you to last 15 minutes without ejaculating. It is important that you attend to your excitement level so that you can control the kind, pace & depth of thrusting. Be sure that you feel comfortable & confident at each step along the path. If you use the control techniques, feel free to experiment with them, as you may have done in the previous exercise.

Rationale: This exercise is designed to promote comfort & prolonged intravaginal containment experience with movement but without rapid ejaculation. Like the prior partner exercise, it provides a clone approximation to regular intercourse.

Possible Problems:
- Again, you may become very quickly aroused with this exercise, and you may ejaculate rapidly. This is not problematic, unless it persists. If it does, return to some of the earlier partner-oriented sequences. One option is to return to the exercise involving limited female intravaginal movement. Another is to repeat the "quiet vagina" exercise, limiting movement to that necessary to maintain erection. When your comfort and confidence are

Increase, return to the present exercise. Other options include partner applied manual or oral continuous stimulation (with arousal decreasing variations) with a lubricated hand, while you accompany the stimulation with penetration or containment or thrusting fantasy; or you might repeat a masturbation exercise, accompanying it with fantasy as above. As always, when you return to the new exercise sequences, go slowly & focus on your sensations and arousal level.

b. In the event that your partner finds that she is not sufficiently aroused to experience insertion comfortably, use a lubricant to ease penetration and promote her relaxation.

c. As before, if your partner finds it hard to limit her movements in this exercise, discuss with her your continuing need to have stimulation limited. Be sure though, to remind her that movement will not forever and always be limited. As in the past, you may want to facilitate her orgasm, if she so desires, through manual or oral means, before or after the exercise.

Even if you are able to last the full 15 minutes on the first time you try this exercise, repeat it at least once more before going on to the next partner-oriented exercise.

You may wish to refer to Figure C for an illustration of the woman-above position.
Activity: Communication Exercise

In this final set of exercises, a range of present and future issues lie before you as topics for mutual discussion and disclosure of feelings. You may want to begin by role-playing in front of a mirror, or go directly to your partner or friend. Begin by discussing your reactions to the exercises you and your partner did this week. Try to describe your reactions fully and specifically; include your feelings along with your thoughts. Allow your partner to do the same.

1. Initiate a discussion focusing on your progress in, and your reactions to this training program as a whole. Review the gains you have made, the things you have learned about yourself and your sexual functioning, and those areas which might still benefit more practice. Discuss specifics, like your satisfaction with your ejaculatory control, your partner's satisfaction with your usual control, preferred positions for intercourse, the things you can do for your partner on those occasions when you ejaculate more rapidly than you or she wish, or what you don't feel like having intercourse as much, etc. Allow your partner a chance to respond to the issues you raise, and to add any additional impressions, if desired.

2. Finally, depending on the nature of your relationship with your partner, you might find a mutual discussion which focuses on your immediate future together useful. For example, matters like desired sexual frequency and the role of exercises in maintaining and enhancing your treatment gains are two important issues for mutual exchange of thoughts and feelings.

In the spaces provided at right, share with us your reactions to the communications exercises you've engaged in with your partner (or confidante).

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>Duration</th>
<th>Pleasure (1-10)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Activity: Communication Exercise</td>
<td></td>
<td></td>
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</tbody>
</table>
Activity: Position Experimentation

After having established an intravaginal containment and movement pattern in the woman-above position, which has enabled you to last 15 minutes or so, you have the opportunity to experiment with different positions. The best new position to begin with is the lateral (side-to-side) position. One way to get into this face-to-face position is to begin in the female above position and then both partners slowly roll to one side. Once on your sides in the lateral position, you may need to rearrange your arms and legs to get comfortable. You may also need to reinsert your penis. Go slowly, concentrate on your sensations and general arousal level, and make adjustments as needed. Have your partner begin the movement and give her cues. Then you might move slowly too, if you're maintaining good control. If not, repeat the stepwise process as in the last two exercises (in the lateral position, begin with limited female movement only, then limited male movement only). Gradually return to mutual movement, slowly increasing speed and depth of thrusting. Whenever trying a novel position, you may feel some awkwardness and loss of control. Go slowly and use the adjustments you've learned when you get highly aroused.

When you are regularly able to last 15 minutes or so in the lateral position, you may want to try other positions. Most men find the male above, face-to-face position the most difficult one in which to maintain good control. So, we suggest that you experiment with other positions first.

Rationale: The female above position is the foundation for learning the techniques and process of good ejaculatory control with a partner. Once the pattern of increased, regular ejaculatory control has been established, there is every reason to experiment with other positions for intercourse using your acquired learning.

Possible Problem: Since you are experimenting with novel positions, you may ejaculate rapidly at first. Don't despair! Again, this is not problematic unless it persists. Take a few moments after the sexual encounter is over, to analyze the situation. You have the principles and techniques to take your next encounter just longer. Return to the earlier exercise with which you feel confident and comfortable. Or perhaps, be more active in providing movement and stimulation cues to your partner. Go slowly, monitor your arousal...
sations and general arousal level, and make adjustments as needed. Have your partner begin the movement and give her cues. Then you might move slowly too, if you're maintaining good control. If not, repeat the stepwise process as in the last two exercises (in the lateral position, begin with limited female movement only, then limited male movement only). Gradually return to mutual movement, slowly increasing speed and depth of thrusting. Whenever trying a novel position, you may feel some awkwardness and loss of control. Go slowly and use the adjustments you've learned when you get highly aroused. When you are regularly able to last 15 minutes or so in the lateral position, you may want to try other positions. Most men find the male above, face-to-face position the most difficult one in which to maintain good control. So, we suggest that you experiment with other positions first.

**Rationale:** The female above position is the foundation for learning the techniques and process of good ejaculatory control with a partner. Once the pattern of increased, regular ejaculatory control has been established, there is every reason to experiment with other positions for intercourse using your acquired learning.

**Possible Problem:** Since you are experimenting with novel positions, you may ejaculate rapidly at first. Don't despair! Again, this is not problematic unless it persists. Take a few moments after the sexual encounter to analyze the situation. You have the principles and techniques to make your next encounter last longer. Return to an earlier exercise with which you feel confident and comfortable. Or perhaps, be more active in providing movement and stimulation cues to your partner. Go slowly, monitor your arousal level and make adjustments as necessary. It is useful to remember that you don't have to prolong your ejaculation during each and every sexual encounter. Sometimes you will want to ejaculate quickly. So, relax! The point is that you now know what to do when your goal is to delay ejaculation. And the more practice you get systematically experimenting with different positions, or with other exercises in this series, the more habitual ejaculatory control will become.

Once you have completed this series of exercises to your satisfaction, and in accordance with the general guidelines set forth by your therapists, you should spend some time thinking about a maintenance program for yourself. Your therapists will help you in this regard.
APPENDIX B

Sequence of Films Used

in Treatment
Sensate Focus II
Stop and Go I
The Squeeze Technique
Sensate Focus III
Sensate Focus IV
Sharing Orgasm
Stop and Go II
Overcoming Erectile Dysfunction I

All films used in this treatment program are distributed by Multimedia, Inc., San Francisco, California.
APPENDIX C

Inventories and Measures
NAME ____________________________ BIRTHDATE _____ / _____ / _____
ADDRESS ____________________________ SOCIAL SECURITY NUMBER ____________________
PHON(E(S) ____________________________ TODAY'S DATE _____ / _____ / _____

SEXUAL BACKGROUND INVENTORY (PRE)

Please write or PRINT clearly as you answer each of the questions below.

1. Age: _____ 2. Sex: _____

3. Type of Referral to the UCLA Sexuality Clinic:
   A. Family  F. Private Professional
   B. Friend  G. UCLA Hospital
   C. School  H. UCLA Clinic
   D. Self  I. Other, specify:
   E. Court

5. Religion at birth: ____________________________
   Current religion: ____________________________

6. Religious activity in childhood: 
   _______ devout
   _______ moderately active
   _______ occasionally active
   _______ inactive, did not attend

7. Current religious activity: 
   _______ devout
   _______ moderately active
   _______ occasionally active
   _______ inactive, do not attend

8. Current Occupational Status:
   A. Professional/Technical
   B. Managerial/Proprietor
   C. Artist (Actor, Musician, etc)
   D. Salesperson/Clerical
   E. Crafts/Trades (Plumber, Mechanic, etc)
   F. Service Worker (Police, Barber, etc)
   G. Laborer
   H. Homemaker
   I. Student
   J. Other, specify:
   Current Status: _____ Employed _____ Unemployed _____ Retired

9. Mother's occupation ____________________________ Father's occupation ____________________________

10. Ethnic Origin:
   A. White  E. Asian
   B. Black  F. Mixed, specify:
   C. Spanish/Mexican
   D. American Indian
   G. Other, specify

11. Current Marital Status:
   A. Separated
   B. Divorced
   C. Widowed
   D. Single, never married
   E. Single, engaged to be married
   F. Other, specify,
12. a) If previously married, for how long?_________________ / __________ months
    b) If children, how many? __________
    c) How long have you been single?_________________ / __________ months

13. Current Living Situation. Are You:
   A. Living Alone
   B. Living with male roommate(s)
   C. Living with female sexual partner
   D. Living at home with parent(s)
   E. Living in a collective
   F. Sometimes at my place, sometimes at my
   G. Other, specify: ____________________________

14. Are you currently dating? __________ yes __________ no

15. If yes, how often do you date?
   A. less than once a month
   B. 2-3 times a month
   C. 4-6 times a month
   D. more than once a week
   E. more than twice a week

16. Are you dating one person steadily? __________ yes __________ no

17. In general, how satisfied are you with the frequency of your dating? (Check one)
    ___ very satisfied
    ___ moderately satisfied
    ___ slightly satisfied
    ___ neither satisfied or dissatisfied

18. In general, how satisfied are you with the quality of your dating experiences? (Check one)
    ___ very satisfied
    ___ moderately satisfied
    ___ slightly satisfied
    ___ neither satisfied or dissatisfied

19. Current health problems and treatments (medications, etc.) ____________________________

20. At what age did you begin having sexual intercourse? ____________________________

21. How many years have you had a problem with premature ejaculation? ____

22. Since you began having intercourse, have you consistently experienced premature
    ejaculation? __________ yes __________ no

23. If no, what do you think accounts for the times when you were able to last longer
    in intercourse? ____________________________
23. In the last few months, has the problem:
   ___gotten worse  ___stayed about the same  ___gotten better

24. How do you define premature ejaculation?

25. What techniques have you tried, if any, to overcome the premature ejaculation problem? Check all which apply to you.

   ___thinking distracting thoughts before or during intercourse
   ___avoiding sexual or social encounters
   ___masturbating before having or anticipating sex
   ___causing pain to yourself during intercourse (biting yourself, pulling your hair, etc.)
   ___applying an anesthetic ointment to the penis before intercourse
   ___taking tranquilizers; specify:
   ___taking other drugs, medications, alcohol; specify:
   ___reading marriage or sex manuals
   ___undergoing minor surgery
   ___consulting a physician, Name:
   ___going to a prostitute
   ___going to a surrogate sex partner
   ___consulting a psychologist, psychiatrist, or other therapist
   ___using the "squeeze" or "stop-start" techniques during intercourse
   ___using the Masters and Johnson program on your own
   ___other sex therapy program
   ___other; specify:

26. In your longest previous relationship, how long did you have intercourse?
   ___less than a month
   ___1 to 3 months
   ___4 to 6 months
   ___7 to 10 months
   ___10 to 12 months
   ___more than a year

27. How frequently do you have sexual intercourse?

28. How frequently would you like to have intercourse?

29. For how long do you and your partner usually engage in sexual foreplay (kissing, petting, etc.) before having intercourse?

   ___less than one (1) minute
   ___1 to 5 minutes
   ___6 to 10 minutes
   ___11 to 15 minutes
   ___15 to 30 minutes
   ___30 minutes to one (1) hour
30. Do you have any trouble keeping an erection before intercourse begins?

never
rarely, 10 to 25% of the time
occasionally, less than 50% of the time
usually, more than 50% of the time
nearly always, 75 to 90% of the time
always

31. Do you have any trouble keeping an erection once intercourse has begun?

never
rarely, 10 to 25% of the time
occasionally, less than 50% of the time
usually, more than 50% of the time
nearly always, 75 to 90% of the time
always

32. How long does intercourse usually last, from entry of the penis until you reach orgasm (climax)? Estimate as accurately as possible.

orgasm usually occurs before entry
orgasm usually occurs during entry
less than 5 seconds after entry
less than 30 seconds after entry
30 seconds to one (1) minute after entry
1 to 2 minutes after entry
more than 30 minutes after entry

33. Ideally, how long would you like to be able to delay orgasm, from the time of entry until orgasm (climax)?

less than 5 seconds
less than 30 seconds
30 seconds to one (1) minute
1 to 2 minutes
more than 30 minutes

34. In your last five (5) sexual encounters, how often, if ever, were you able to control the timing of your ejaculation (climax) to your satisfaction?

not at any time
1 of the 5 times
2 of the 5 times
3 of the 5 times
4 of the 5 times
all of the times
does not apply to me

35. How anxious do you usually feel about your ability to control the timing of your ejaculation?

very anxious
moderately anxious
somewhat anxious
a little anxious
not at all anxious

36. How often do you ejaculate unintentionally during foreplay (ejaculate while kissing, hugging, petting, etc.) before intercourse begins?

always
nearly always, 75 to 90% of the time
usually, more than 50% of the time
occasionally, less than 50% of the time
rarely, 10 to 25% of the time
never

37. How often do you ejaculate unintentionally just when intercourse begins, or after only a few thrusts or movements?

always
nearly always, 75 to 90% of the time
usually, more than 50% of the time
occasionally, less than 50% of the time
rarely, 10 to 25% of the time
never

38. How often do you ejaculate unintentionally in the middle of intercourse after thrusting is underway?

always
nearly always, 75 to 90% of the time
usually, more than 50% of the time
occasionally, less than 50% of the time
rarely, 10 to 25% of the time
never
39. Women can respond in many different ways when a man ejaculates too soon. In your experience, when it seemed to you that the woman responded in a positive or supportive way, what did she say and/or do?

40. In those situations where you perceived a negative response when you ejaculated too soon, what did your partner(s) say and/or do?

41. Any other things partners have said and/or done after you ejaculated too soon?

42. Overall, how satisfactory do you think your sexual relationship(s) have been with your partner(s)?

<table>
<thead>
<tr>
<th>Very unsatisfactory</th>
<th>Slightly unsatisfactory</th>
<th>Slightly satisfactory</th>
<th>Moderately satisfactory</th>
<th>Very satisfactory</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Please answer the following series of questions in terms of your current dating relationship(s). If you have no present partner(s), answer in terms of your last dating relationship(s). Circle the number for each item below which most accurately reflects your experience with each question.

<table>
<thead>
<tr>
<th>Item</th>
<th>Almost always true (90% of time)</th>
<th>Sometimes true (50%)</th>
<th>Almost never true (10% of time)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I find it easy to initiate sexual activity with a partner(s)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>B. I ask my partner(s) to do the sexual activities which I enjoy</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>C. I refuse sex with my partner(s) when I don’t feel like having it</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>D. I tell my partner(s) when I’ve enjoyed our sexual activity(ies)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>E. I discuss with my partner(s) ways of improving our sexual activity(ies)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>F. I suggest different position(s) for having intercourse with my partner(s)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>G. I suggest different sexual activities to my partner(s) during our sexual encounter</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>H. I tell my partner(s) when I am experiencing negative feelings (anxiety, pressure, etc.) in a sexual situation</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I. I tell my partner(s) when I am experiencing negative feelings (anger, resentment, being turned off, etc.) during a sexual experience</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
2. Pre

<table>
<thead>
<tr>
<th>Item</th>
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<th>Almost never true (10% of time)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I tell my partner(s) that I have trouble with premature ejaculation</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Have you responded to the 10 items above in terms of a current relationship(s) or in terms of your last relationship(s)? Place a checkmark (✓) in either space.

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44. How often do you masturbate?
- more than once a day
- once a day
- 3 to 4 times a week
- twice a week
- once a month
- less than once a month
- not at all

45. How long does masturbation usually last, from the start of stimulation until ejaculation?
- less than 5 seconds
- less than 30 seconds
- 30 seconds to one (1) minute
- 1 to 2 minutes
- 2 to 3 minutes
- 3 to 5 minutes
- 5 to 10 minutes
- 10 to 20 minutes
- 20 to 30 minutes
- more than 30 minutes

46. How do you regard your experience with masturbation?
- very satisfying
- moderately satisfying
- slightly satisfying
- neither satisfying nor dissatisfying

47. When engaging in sexual intercourse, what form(s) of birth control have you used? Check all which apply to you.

<table>
<thead>
<tr>
<th>Form of Birth Control</th>
<th>Used in the past</th>
<th>Am using now</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nothing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Withdrawal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rhythm method</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condom</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vasectomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female uses birth control pills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female uses intrauterine device (I.U.D.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female uses spermicidal foam or jelly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female uses &quot;morning after&quot; pill</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abortion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other; Specify</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

48. Do your birth control practice have any negative effect(s) on your sexual functioning or enjoyment?
- yes
- no

If yes, please explain below:
49. List three (3) things about your own sexual behavior that you would most like to change:
1.
2.
3.

50. What do you think the result of participating in this treatment will be?
Will your problem with premature ejaculation:
- get much worse
- get somewhat worse
- stay about the same
- get much better
SEXUAL BACKGROUND INVENTORY (POST)

Please write or PRINT clearly as you answer each of the questions below.

1. Age: ______  2. Sex: ______

4. Current religious identification: ____________________________

5. Current religious activity:
   - devout
   - moderately active
   - occasionally active
   - inactive, do not attend

6. Current Occupational Status:
   - A. Professional/Technical
   - B. Managerial/Proprietor
   - C. Artist (Actor, Writer, Musician, etc.)
   - D. Salesperson/Clerical
   - E. Crafts/Trades (Plumber, Mechanic, etc.)
   - F. Service Worker (Police, Barber, etc.)
   - G. Laborer
   - H. Homemaker
   - I. Student
   - J. Other: ______

   Current Status: ______ Employed ______ Unemployed ______ Retired

7. Ethnic Origin:
   - A. White
   - B. Black
   - C. Spanish/Mexican American
   - D. American Indian
   - E. Mixed, specify: ______
   - F. Other, specify: ______

8. Marital Status:
   - A. Separated
   - B. Divorced
   - C. Widowed
   - D. Single, never married
   - E. Single, engaged to be
   - F. Single, married
   - G. Other, specify: ______

9. Current Living Situation. Are you:
   - A. Living alone
   - B. Living with male roommate(s)
   - C. Living with female sexual partner
   - D. Living at home with parent(s)
   - E. Living in a collective
   - F. Sometimes at my place, sometimes at my female partner’s place
   - G. Other, specify: ______

10. Are you currently dating? ______ yes ______ no

II. If yes, how often do you date?

   - A. Less than once a month
   - B. 2 – 3 times a month
   - C. 4 – 8 times a month
   - D. More than once a week
   - E. More than twice a week
   - F. Other, specify: ______
2 Sexual Background Inventory (Post)

12. Are you dating one person steadily? __yes __no

13. In general, how satisfied are you with the frequency of your dating? (Check one)

- very satisfied __slightly dissatisfied
- moderately satisfied __moderately dissatisfied
- slightly satisfied __very dissatisfied
- neither satisfied nor dissatisfied

14. In general, how satisfied are you with the quality of your dating experiences? (Check one)

- very satisfied __slightly dissatisfied
- moderately satisfied __very dissatisfied
- slightly satisfied __slightly dissatisfied
- neither satisfied nor dissatisfied

15. Current health problems and treatments (medications, etc.)

Following are a series of questions on sexual behavior, attitudes and feelings. Please respond to each question as carefully and accurately as possible. Answer each in terms of a current dating relationship. If you have no present partner(s), answer in terms of your most recent dating relationship.

16. How frequently do you have sexual intercourse?

- more than once a day __once every two weeks
- once a day __once a month
- 3 or 4 times a week __less than once a month
- twice a week __not at all
- once a week

17. How frequently would you like to have intercourse?

- more than once a day __once every two weeks
- once a day __once a month
- 3 or 4 times a week __less than once a month
- twice a week __not at all
- once a week

18. For how long do you and your partner usually engage in sexual foreplay (kissing, petting, etc.) before having intercourse?

- less than one (1) minute __15-30 minutes
- 1 to 5 minutes __30 minutes to one (1) hour
- 6 to 10 minutes __more than one (1) hour
- 11 to 15 minutes
19. Do you have any trouble keeping an erection before intercourse begins?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Never</th>
<th>Rarely, 10 to 25% of the time</th>
<th>Occasionally, less than 50% of the time</th>
<th>Usually, more than 50% of the time</th>
<th>Nearly always, 75 to 90% of the time</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Occurrence</strong></td>
<td>never</td>
<td>rarely, 10 to 25% of the time</td>
<td>occasionally, less than 50% of the time</td>
<td>usually, more than 50% of the time</td>
<td>nearly always, 75 to 90% of the time</td>
<td>always</td>
</tr>
</tbody>
</table>

20. Do you have any trouble keeping an erection once intercourse has begun?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Never</th>
<th>Rarely, 10 to 25% of the time</th>
<th>Occasionally, less than 50% of the time</th>
<th>Usually, more than 50% of the time</th>
<th>Nearly always, 75 to 90% of the time</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Occurrence</strong></td>
<td>never</td>
<td>rarely, 10 to 25% of the time</td>
<td>occasionally, less than 50% of the time</td>
<td>usually, more than 50% of the time</td>
<td>nearly always, 75 to 90% of the time</td>
<td>always</td>
</tr>
</tbody>
</table>

21. How long does intercourse usually last, from entry of the penis until you reach orgasm (climax)? Estimate as accurately as possible.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>2 to 3 minutes after entry</th>
<th>3 to 5 minutes after entry</th>
<th>5 to 10 minutes after entry</th>
<th>10 to 20 minutes after entry</th>
<th>20 to 30 minutes after entry</th>
<th>More than 30 minutes after entry</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Occurrence</strong></td>
<td>2 to 3 minutes after entry</td>
<td>3 to 5 minutes after entry</td>
<td>5 to 10 minutes after entry</td>
<td>10 to 20 minutes after entry</td>
<td>20 to 30 minutes after entry</td>
<td>More than 30 minutes after entry</td>
</tr>
</tbody>
</table>

22. Ideally, how long would you like to be able to delay orgasm, from the time of entry until orgasm (climax)?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>3 to 5 minutes</th>
<th>5 to 10 minutes</th>
<th>10 to 20 minutes</th>
<th>20 to 30 minutes</th>
<th>More than 30 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Occurrence</strong></td>
<td>3 to 5 minutes</td>
<td>5 to 10 minutes</td>
<td>10 to 20 minutes</td>
<td>20 to 30 minutes</td>
<td>More than 30 minutes</td>
</tr>
</tbody>
</table>

23. In your last five (5) sexual encounters, how often, if ever, were you able to control the timing of your ejaculation (climax) to your satisfaction?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Not at any time</th>
<th>1 of the 5 times</th>
<th>2 of the 5 times</th>
<th>3 of the 5 times</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Occurrence</strong></td>
<td>Not at any time</td>
<td>1 of the 5 times</td>
<td>2 of the 5 times</td>
<td>3 of the 5 times</td>
</tr>
</tbody>
</table>

24. How anxious do you usually feel about your ability to control the timing of your ejaculation?

<table>
<thead>
<tr>
<th>Anxiety level</th>
<th>Very anxious</th>
<th>Moderately anxious</th>
<th>Slightly anxious</th>
<th>Not at all anxious</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Occurrence</strong></td>
<td>Very anxious</td>
<td>Moderately anxious</td>
<td>Slightly anxious</td>
<td>Not at all anxious</td>
</tr>
</tbody>
</table>

25. How often do you ejaculate unintentionally during foreplay (ejaculate while kissing, hugging, petting, etc.) before intercourse begins?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Always</th>
<th>Nearly always, 75 to 90% of the time</th>
<th>Usually, more than 50% of the time</th>
<th>Rarely, 10 to 25% of the time</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Occurrence</strong></td>
<td>Always</td>
<td>nearly always, 75 to 90% of the time</td>
<td>usually, more than 50% of the time</td>
<td>rarely, 10 to 25% of the time</td>
<td>never</td>
</tr>
</tbody>
</table>

26. How often do you ejaculate unintentionally just when intercourse begins, or after only a few thrusts or movements?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Always</th>
<th>Nearly always, 75 to 90% of the time</th>
<th>Usually, more than 50% of the time</th>
<th>Rarely, 10 to 25% of the time</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Occurrence</strong></td>
<td>Always</td>
<td>nearly always, 75 to 90% of the time</td>
<td>usually, more than 50% of the time</td>
<td>rarely, 10 to 25% of the time</td>
<td>never</td>
</tr>
</tbody>
</table>
4 Sexual Background Inventory (Post)

27. How often do you ejaculate unintentionally in the middle of intercourse, after thrusting is underway?

- always
- occasionally, less than 50% of the time
- nearly always, 75 to 90% of the time
- rarely, 10 to 25% of the time
- usually, more than 50% of the time
- never

28. Women can respond in many different ways when a man ejaculates too soon. Drawing on your recent sexual experience, please comment on any things partner(s) have said or done when you ejaculated too soon. Use the other side of the page if necessary.

29. How satisfied are you with your usual ejaculatory latency (length of time from entry of the penis into the vagina until ejaculation)?

- very satisfied
- slightly dissatisfied
- moderately satisfied
- moderately dissatisfied
- slightly satisfied
- very dissatisfied
- neither satisfied nor dissatisfied

30. How satisfied do you think your partner is with your usual ejaculatory latency?

- very satisfied
- slightly dissatisfied
- moderately satisfied
- moderately dissatisfied
- slightly satisfied
- very dissatisfied
- neither satisfied nor dissatisfied

31. Overall, how satisfactory to you is your sexual relationship with your partner(s)?

- very unsatisfactory
- slightly satisfactory
- moderately unsatisfactory
- moderately satisfactory
- slightly unsatisfactory
- very satisfactory
- neither unsatisfactory nor satisfactory

32. Overall, how satisfactory to your partner do you think your sexual relationship is?

- very unsatisfactory
- slightly satisfactory
- moderately unsatisfactory
- moderately satisfactory
- slightly unsatisfactory
- very satisfactory
- neither unsatisfactory nor satisfactory
5 Sexual Background Inventory (Post)

33. Which techniques were most effective for you in helping you to learn more control over your ejaculation? Rank order the techniques in terms of effectiveness, e.g. 1 = most effective, 2 = next most effective ... 9 = least effective:

- stop-start
- squeeze
- arousal decreasing variations in stimulation
- changes in fantasy
- position variations in intercourse
- alterations in body tension (in genitals or whole body)
- changes in the amount of foreplay/touching
- frequency of sexual interaction and/or intercourse
- changes in the amount of verbal communication with partner/communication exercises

34. Among the procedures or techniques described above, which do you use now in your ongoing partner-oriented sexual activities? Rank order the techniques in terms of the frequency with which you use them currently, e.g. 1 = most often used, 2 = next most often used ... 9 = least often used:

- stop-start
- squeeze
- arousal decreasing variations in stimulation
- changes in fantasy
- position variations in intercourse
- alterations in body tension (in genitals or whole body)
- changes in the amount of foreplay/touching
- frequency of sexual interaction and/or intercourse
- changes in the amount of verbal communication with partner/communication exercises

35. Is there anything else that you found useful in learning or maintaining ejaculatory control?

36. How has(ve) your partner(s) reacted to the use of the stop-start technique before or during intercourse?

37. How has(ve) your partner(s) reacted to the use of the squeeze technique before or during intercourse?
6. Sexual Background Inventory (Post)

Please answer the following series of questions in terms of your current dating relationship(s). If you have no present partner(s), answer in terms of your last dating relationship(s). Circle the number for each item below which most accurately reflects your experience with each question.

<table>
<thead>
<tr>
<th>Item</th>
<th>Almost always true (90% of time)</th>
<th>Sometimes true (50%)</th>
<th>Almost never true (10% of time)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. I find it easy to initiate sexual activity with a partner(s).</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>B. I ask my partner(s) to do the sexual activities which I enjoy.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>C. I refuse sex with my partner(s) when I don't feel like having it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>D. I tell my partner(s) when I've enjoyed our sexual activity(ies).</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>E. I discuss with my partner(s) ways of improving our sexual activity(ies).</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>F. I suggest different position(s) for having intercourse to my partner(s).</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>G. I suggest different sexual activities to my partner(s) during our sexual encounter.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>H. I tell my partner(s) when I am experiencing negative feelings (anxiety, pressure, etc.) in a sexual situation.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I. I tell my partner(s) when I am experiencing negative feelings (anger, resentment, being turned off, etc.) during a sexual experience.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>J. I tell my partner(s) that I have trouble with premature ejaculation.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Have you responded to the 10 items above in terms of a current relationship(s), or in terms of your last relationship(s)? Place a checkmark (✓) in either space.

39. How often do you masturbate?

- more than once a day
- once a day
- 3 to 4 times a week
- twice a week
- once a week
- once every two weeks
- once a month
- less than once a month
- not at all
40. How long does masturbation usually last, from the start of stimulation until ejaculation?

- less than 5 seconds
- less than 5 seconds
- 30 seconds to one (1) minute
- 1 to 2 minutes
- 2 to 3 minutes
- more than 30 minutes

3 to 5 minutes
5 to 10 minutes
10 to 20 minutes
20 to 30 minutes
more than 30 minutes

41. How do you regard your experience with masturbation?

- very satisfying
- slightly dissatisfying
- moderately satisfying
- moderately dissatisfying
- slightly satisfying
- very dissatisfying
- neither satisfying nor dissatisfying

42. Which form(s) of birth control are you currently using? Check all which apply to you.

- nothing
- female uses diaphragm
- withdrawal
- female uses intrauterine device (I. U. D.)
- rhythm method
- female uses spermicidal foam or jelly
- condom
- female uses "morning after" pill
- vasectomy
- abortion
- female uses birth control pills
- other, specify: _______________________

43. Do your current birth control practices have any negative effect(s) on your sexual functioning or enjoyment?

- yes
- no

If yes, please explain below:

44. What has been the result of participating in this program? Has your ability to control the timing of your ejaculation:

- gotten much worse
- gotten somewhat worse
- stayed about the same
- gotten somewhat better
- gotten much better

45. How has this program affected your satisfaction with social relationship(s) and dating?

- the program prevented any satisfaction with my dating and relationship(s)
- the program interfered slightly with my satisfaction with my dating and relationship(s)
- the program had no effect on my satisfaction with my dating and relationship(s)
- the program contributed slightly to my satisfaction with my dating and relationship(s)
- the program contributed greatly to my satisfaction with my dating and relationship(s)

46. The directors of this program would appreciate any comments or criticisms you have about the project. Use the back of this page if necessary. Thank you.
GOALS FOR SEXUAL THERAPY - Male

Please rate how satisfied you are with your current behavior or feelings in the areas described below.

Use the following guide which describes the meaning of each number.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Much less than satisfied</td>
<td>Less than satisfied</td>
<td>Somewhat satisfied</td>
<td>Satisfied</td>
<td>Somewhat more than satisfied</td>
<td>More than satisfied</td>
<td>Much more than satisfied</td>
</tr>
</tbody>
</table>

Now circle the number that describes how satisfied you are currently on each of the ten items. If any item describes a behavior that you have never tried, please write "never tried" next to that item.

1 2 3 4 5 6 7 1. Being able to anticipate having intercourse without fear, anxiety, or resentment.

1 2 3 4 5 6 7 2. Being able to caress and touch my partner during foreplay without ejaculating.

1 2 3 4 5 6 7 3. Being able to have my partner caress and touch me during foreplay without ejaculating.

1 2 3 4 5 6 7 4. Being able to insert my penis without ejaculating almost immediately.

1 2 3 4 5 6 7 5. Being able to experience thrusting during intercourse without ejaculating very quickly.

1 2 3 4 5 6 7 6. Being able to engage in intercourse for as long as I desire before ejaculating.

1 2 3 4 5 6 7 7. Feeling that I know what to do in order to control my ejaculation.

1 2 3 4 5 6 7 8. Being able to engage in intercourse long enough to bring my partner to orgasm. (This includes with or without manual stimulation)

1 2 3 4 5 6 7 9. Feeling like I am desirable to my partner.

1 2 3 4 5 6 7 10. Feeling comfortable about my own sexuality.
In addition to the behaviors and feelings described above, you may have some other goals for yourself and your partner in sex therapy. In the spaces provided below write down as clearly and specifically as you can the behaviors or feelings that you want to include in your goals for yourself. Then do the same for any goals that you have for your partner. Your therapist will help you complete this part. After you have done this, go back over these items and rate them as to how satisfied you are currently with the activity or feeling described in the item. Using the guide from the first page, circle the number that best describes your answer.

A. Goals for yourself

1 2 3 4 5 6 7  

1. __________________________

2. __________________________

3. __________________________
ETACULATORY LATENCY DATA FORM (PRE-MS)

SOCIAL SECURITY #: __________________________

Directions: This form is for the recording of the length of time from the start of stimulation until ejaculation (climax or orgasm) during regular masturbation. You are asked to record this information during two (2) self-stimulation experiences in the next few days. Data should be taken as follows: Hold a standard stopwatch, start it with the onset of stimulation (fantasy, body caress, penile stroking, etc.), and stop it when you ejaculate. After you ejaculate, you can put the stopwatch aside and the time can be recorded on this sheet later, after the sexual experience is over. With the exception of the stopwatch, the session should be a normal masturbation experience, typical of what you usually do.

Session 1

Date __/____/____

Elapsed Time _________ Min. _________ Sec.

1. How anxious were you during this experience?

___ very anxious  ___ a little anxious  ___ not at all anxious
___ moderately anxious  ___ not at all anxious
___ somewhat anxious

2. How satisfying was this masturbation session for you?

___ very satisfying  ___ slightly dissatisfying
___ moderately satisfying  ___ moderately dissatisfying
___ slightly satisfying  ___ very dissatisfying
___ neither satisfying  ___ not satisfying
___ nor dissatisfying

Session 2

Date __/____/____

Elapsed Time _________ Min. _________ Sec.

3. How anxious were you during this experience?

___ very anxious  ___ a little anxious  ___ not at all anxious
___ moderately anxious  ___ not at all anxious
___ somewhat anxious

4. How satisfying was this masturbation session for you?

___ very satisfying  ___ slightly dissatisfying
___ moderately satisfying  ___ moderately dissatisfying
___ slightly satisfying  ___ very dissatisfying
___ neither satisfying  ___ not satisfying
___ nor dissatisfying

Comments: __________________________

__________________________

EJACULATORY LATENCY DATA FORM (POST-I/S)

SOCIAL SECURITY #: ______________________

Directions: This form is for the recording of the length of time from the start of stimulation until ejaculation (climax or orgasm) during regular masturbation. You are asked to record this information during two (2) self-stimulation experiences in the next few days. Data should be taken as follows: Hold a standard stopwatch, start it with the onset of stimulation (fantasy, body caress, penile stroking, etc.), and stop it when you ejaculate. After you ejaculate, you can put the stopwatch aside and the time can be recorded on this sheet later, after the sexual experience is over. With the exception of the stopwatch, the session should be a normal masturbation experience, typical of what you usually do.

**Session 1**

Elapsed Time ____________

Date __/____/____

Min. Sec.

1. How many times did you use the Squeeze or Pause before ejaculation, when masturbating with a dry hand?
   - ________ Squeezes
   - ________ Pauses

2. How many times did you use the Squeeze or Pause before ejaculation, when masturbating with a lubricated hand?
   - ________ Squeezes
   - ________ Pauses

3. How anxious were you during this experience?
   - very anxious
   - moderately anxious
   - somewhat anxious
   - a little anxious
   - not at all anxious
   - ____________

4. How satisfying was this masturbation session for you?
   - very satisfying
   - moderately satisfying
   - slightly satisfying
   - neither satisfying
   - very dissatisfying
   - moderately dissatisfying
   - slightly dissatisfying
   - neither satisfying
   - not at all satisfying

**Session 2**

Elapsed Time ____________

Date __/____/____

Min. Sec.

5. How many times did you use the Squeeze or Pause before ejaculation, when masturbating with a dry hand?
   - ________ Squeezes
   - ________ Pauses

6. How many times did you use the Squeeze or Pause before ejaculation, when masturbating with a lubricated hand?
   - ________ Squeezes
   - ________ Pauses
7. How anxious were you during this experience?

- very anxious
- moderately anxious
- somewhat anxious
- a little anxious
- not at all anxious
- somewhat anxious

8. How satisfying was this masturbation session for you?

- very satisfying
- moderately satisfying
- slightly satisfying
- neither satisfying nor dissatisfying
- slightly dissatisfying
- moderately dissatisfying
- very dissatisfying

Directions for Sessions 3 and 4: You are now asked to record the same information twice more, but during self-stimulation sessions in which you do not use the Squeeze or Pause. Thank you.

Session 3

9. How anxious were you during this experience?

- very anxious
- moderately anxious
- somewhat anxious
- a little anxious
- not at all anxious

10. How satisfying was this masturbation session for you?

- very satisfying
- moderately satisfying
- slightly satisfying
- neither satisfying nor dissatisfying
- slightly dissatisfying
- moderately dissatisfying
- very dissatisfying

Session 4

11. How anxious were you during this experience?

- very anxious
- moderately anxious
- somewhat anxious
- a little anxious
- not at all anxious

12. How satisfying was this masturbation session for you?

- very satisfying
- moderately satisfying
- slightly satisfying
- neither satisfying nor dissatisfying
- slightly dissatisfying
- moderately dissatisfying
- very dissatisfying

Comments:
ETACULATORY LATENCY DATA FORM (POST-PT)

SOCIAL SECURITY #:____________________

DIRECTIONS: This form is to be filled out by you and your partner, if you're both willing to do so at this time. The information requested on this form would be very useful to the directors of this study. If you would try these exercises and record the information requested on this form, we would appreciate it very much. Thank you.

This form is for the recording of the length of time from intromission (when the erect penis enters the vagina) to ejaculation (orgasm or climax) during normal intercourse. You are asked to record this information during two sexual encounters in the next few days. Data should be taken as follows: The female should hold a standard stopwatch, start it when the male enters her, and stop it when he ejaculates. The male should signal to the female at the point of ejaculation. After the male ejaculates, the female can put the stopwatch aside and the time can be recorded on this sheet after the sexual encounter is over. With the exception of the stopwatch, the session should be a normal sexual encounter, typical of what is usually done between the two of you.

Date. _____/_____/_____
Seconds ______

1. How many times did you use the Squeeze or Pause before intromission?
   Squeezes ______
   Pauses ______

2. How many times did you use the Squeeze or Pause during intercourse?
   Squeezes ______
   Pauses ______

3. How anxious were you (the male) during intercourse?
   __very anxious
   __moderately anxious
   __somewhat anxious
   __a little anxious
   __not at all anxious

4. How satisfying was this intercourse session for you (the male)?
   __very satisfying
   __moderately satisfying
   __slightly satisfying
   __slightly dissatisfying
   __moderately dissatisfying
   __very dissatisfying
   __neither satisfying nor dissatisfying

5. How satisfying was this intercourse session for you (the female)?
   __very satisfying
   __moderately satisfying
   __slightly satisfying
   __slightly dissatisfying
   __moderately dissatisfying
   __very dissatisfying
   __neither satisfying nor dissatisfying

6. Did you (the female) reach orgasm during vaginal containment and thrusting of the penis, either with or without direct clitoral stimulation?
   yes
   no
   not sure
Session 2

Date

Elapsed Time

Min. Sec.

7. How many times did you use the Squeeze or Pause before intromission?

______Squeezes ______Pauses

8. How many times did you use the Squeeze or Pause during intercourse?

______Squeezes ______Pauses

9. How anxious were you (the male) during intercourse?

____ very anxious _______a little anxious
____ moderately anxious ______ not at all anxious
____ somewhat anxious

10. How satisfying was this intercourse session for you (the male)?

____ very satisfying _______slightly dissatisfying
____ moderately satisfying _______moderately dissatisfying
____ slightly satisfying _______very dissatisfying
____ neither satisfying nor dissatisfying

11. How satisfying was this intercourse session for you (the female)?

____ very satisfying _______slightly dissatisfying
____ moderately satisfying _______moderately dissatisfying
____ slightly satisfying _______very dissatisfying
____ neither satisfying nor dissatisfying

12. Did you (the female) reach orgasm during vaginal containment and thrusting of the penis, either with or without direct clitoral stimulation?

____ yes _______no _______not sure

Directions for Sessions 3 and 4: You are now asked to record the same information twice more, but during sexual encounters in which you do not use the Squeeze or Pause. Thank you.

Session 3

Date

Elapsed Time

Min. Sec.

13. How anxious were you (the male) during intercourse?

____ very anxious _______a little anxious
____ moderately anxious ______ not at all anxious
____ somewhat anxious

14. How satisfying was this intercourse session for you (the male)?

____ very satisfying _______slightly dissatisfying
____ moderately satisfying _______moderately dissatisfying
____ slightly satisfying _______very dissatisfying
____ neither satisfying nor dissatisfying
15. How satisfying was this intercourse session for you (the female)?

very satisfying __ slightly dissatisfying
moderately satisfying __ moderately dissatisfying
slightly satisfying __ very dissatisfying
neither satisfying nor dissatisfying

16. Did you (the female) reach orgasm during vaginal containment and thrusting of the penis, either with or without direct clitoral stimulation?

yes ______ no ______ not sure

Session 4

17. How anxious were you (the male) during intercourse?

very anxious __ a little anxious
moderately anxious __ not at all anxious
somewhat anxious __

18. How satisfying was this intercourse session for you (the male)?

very satisfying __ slightly dissatisfying
moderately satisfying __ moderately dissatisfying
slightly satisfying __ very dissatisfying
neither satisfying nor dissatisfying

19. How satisfying was this intercourse session for you (the female)?

very satisfying __ slightly dissatisfying
moderately satisfying __ moderately dissatisfying
slightly satisfying __ very dissatisfying
neither satisfying nor dissatisfying

20. Did you (the female) reach orgasm during vaginal containment and thrusting of the penis, either with or without direct clitoral stimulation?

yes ______ no ______ not sure

Comments:
Attitudes Towards Masturbation

The following 30 items sample diverse opinions and attitudes about masturbation. Masturbation means stimulating your own genitals to enjoy the pleasurable sensations or experience orgasm. Answers are to be marked on the separate answer sheet.
Marking 1 means you STRONGLY AGREE; marking 2 means you AGREE; marking 3 means you are UNDECIDED marking 4 means you DISAGREE; and marking 5 means you STRONGLY DISAGREE.

1. People masturbate to escape from feelings of tension and anxiety.
2. People who masturbate will not enjoy sexual intercourse as much as those who refrain from masturbation.
3. Masturbation is a private matter which neither harms nor concerns anyone else.
4. Masturbation is a sin against yourself.
5. Masturbation in childhood can help a person develop a natural, healthy attitude toward sex.
6. Masturbation in an adult is juvenile and immature.
7. Masturbation can lead to homosexuality.
8. Excessive masturbation is physically impossible, as it is a needless worry.
9. If you enjoy masturbating too much, you may never learn to relate to the opposite sex.
10. After masturbating, a person feels degraded.
11. Experience with masturbation can potentially help a woman become orgasmic in sexual intercourse.
12. I feel guilty about masturbating.
13. Masturbation can be a "friend in need" when there is no "friend in deed."
14. Masturbation can provide an outlet for sex fantasies without harming anyone else or endangering oneself.
15. Excessive masturbation can lead to problems of impotence in men and frigidity in women.
16. Masturbation is an escape mechanism which prevents a person from developing a mature sexual outlook.
17. Masturbation can provide harmless relief from sexual tensions.
18. Playing with your own genitals is disgusting.
19. Excessive masturbation is associated with neurosis, depression, and behavioral problems.
20. Any masturbation is too much.
Attitudes Towards Masturbation (Continued)

21. Masturbation is a compulsive, addictive habit which once begun is almost impossible to stop.

22. Masturbation is fun.

23. When I masturbate, I am disgusted with myself.

24. A pattern of frequent masturbation is associated with introversion and withdrawal from social contacts.

25. I would be ashamed to admit publicly that I have masturbated.

26. Excessive masturbation leads to mental dullness and fatigue.

27. Masturbation is a normal sexual outlet.

28. Masturbation is caused by an excessive preoccupation with thoughts about sex.

29. Masturbation can teach you to enjoy the sensuousness of your own body.

30. After I masturbate, I am disgusted with myself for losing control of my body.
In line with the cognitive-behavioral approach to the treatment of premature ejaculation, a number of measures tapping cognitive dimensions of current functioning and change were used in this study. One of the most obvious areas in which sexual learning and cognition is both haphazard and erroneous is masturbation. Myths regarding masturbation and its alleged, negative consequences have been extremely widespread, and they die hard. Yet, the practice of masturbation is rather prevalent (Kinsey et al., 1948, 1953). Over twenty years ago, the Kinsey data revealed that 94% of American men had, at some time, masturbated to orgasm.

Generally, sex therapists are concerned with eliminating myths about masturbation, reducing associated guilt, anxiety and fear, and altering the social meanings usually attached to it. Further, many therapy formats incorporate masturbation steps into the structured exercise sequence for the treatment of female anorgasmia (Lobitz & LoPiccolo, 1972) and premature ejaculation (Kaplan, 1974). In fact, for a population of men without steady partners, one could argue that exercises involving masturbation and its associated affects and cognitions form the cornerstone of treatment. Masturbation, after all, represents the most probable way in which a man can initially learn the internal sensations premonitory to orgasm and the techniques and other external circumstances which promote or diminish ejaculatory control. A sequence of graded, in vivo steps leads, hypothetically, from control established under masturbatory conditions with increasing approximations to the vaginal environment, to control achieved with genital manipulation by a partner, to control under coital conditions with increasing approximations to "normal" intercourse.

Negative attitudes toward masturbation, regardless of their source, present an obstacle in the treatment path of rapid ejaculators, especially those without steady partners. For these reasons, masturbatory attitudes and behavior occupy a central role in conceptualization and treatment of premature ejaculation, and sexual behavior in general.
This questionnaire consists of a number of pairs of statements or opinions which have been given by college men and women in response to the "Kosher Incomplete Sentences Test". These men and women were asked to complete phrases such as "When I tell a lie..." and "To kill in war..." to make a sentence which expressed their real feelings about the stem. This questionnaire consists of the stems to which they responded and a pair of responses which are lettered A and B. This particular form of the inventory consists of all the items which pertain to sexual behavior.

You are to read the stem and the pair of completions and decide which you most agree with or which is most characteristic of you. Your choice, in each instance, should be in terms of what you believe, feel, or respond. This is not a test. There are no right or wrong answers. Your choices should be a description of your own personal beliefs, feelings, or reactions.

In some instances you may discover that you believe both completions or neither completion to be characteristic of you. In such cases select the one you more strongly believe to be the case as far as you are concerned. Be sure to find an answer for every choice. Do not omit an item even though it is very difficult for you to decide, just select the more characteristic member of the pair. Encircle the letter, A or B, which you most agree with.

1. If in the future I committed adultery...
   A. I won't feel bad about it.
   B. it would be sinful.

2. "Dirty" jokes in mixed company...
   A. are common in our town.
   B. should be avoided.

3. As a child, sex play...
   A. never entered my mind.
   B. is quite widespread.

4. Sex relations before marriage...
   A. ruin many a happy couple.
   B. are good in my opinion.

5. If in the future I committed adultery...
   A. I wouldn't tell anyone.
   B. I would probably feel bad about it.
6. When I have sexual desires...
   A. I usually try to curb them.
   B. I generally satisfy them.

7. Unusual sex practices...
   A. might be interesting.
   B. don't interest me.

8. Prostitution...
   A. is a must.
   B. breeds only evil.

9. As a child, sex play...
   A. is not good for mental and emotional well being.
   B. is natural and innocent.

10. As a child, sex play...
    A. was a big taboo and I was deathly afraid of it.
    B. was common without guilt feelings.

11. "Dirty" jokes in mixed company...
    A. are not proper.
    B. are exciting and amusing.

12. Unusual sex practices...
    A. are awful and unthinkable.
    B. are not so unusual to me.

13. When I have sex dreams...
    A. I cannot remember them in the morning.
    B. I wake up happy.

14. "Dirty" jokes in mixed company...
    A. are lots of fun.
    B. are coarse to say the least.

15. Petting...
    A. is something that should be controlled.
    B. is a form of education.

16. Unusual sex practices...
    A. are O.K. as long as they're heterosexual.
    B. usually aren't pleasureable because you have preconceived feelings about their being wrong.

17. Sex relations before marriage...
    A. are practiced too much to be wrong.
    B. in my opinion, should not be practiced.

18. As a child, sex play...
    A. was indulged in.
    B. is not harmful but does create sexual pleasure.
19. As a child, sex play...
   A. was indulged in.
   B. is immature and ridiculous.

20. When I have sexual desires...
   A. they are quite strong.
   B. I attempt to repress them.

21. Sex relations before marriage...
   A. help people to adjust.
   B. should not be recommended.

22. Masturbation...
   A. is a habit that should be controlled.
   B. is very common.

23. If I committed a homosexual act...
   A. it would be my business.
   B. it would show weakness in me.

24. Sex relations before marriage...
   A. are O.K. if both partners are in agreement.
   B. are dangerous.

25. Masturbation...
   A. is all right.
   B. should not be practiced.

26. Sex...
   A. is a beautiful gift of God not to be cheapened.
   B. is good and enjoyable.

27. Prostitution...
   A. should be legalized.
   B. cannot really afford enjoyment.
Mosher Sex-Guilt Scale: 
Relevance to the Present Study

Sex guilt has long been regarded as a useful construct in the investigation of human sexual behavior. Mosher and Cross (1971) suggest that sex guilt is a personality disposition acquired or learned in a series of situations related to sex and conscience and development and that it constitutes a:

generalized expectancy for self-mediated punishment for violating or for anticipating violating standards of proper sexual conduct. (p. 27)

This disposition presumably develops in the course of socialization to parental and cultural standards of behavioral control, and is a function of past reinforcement history. Sex guilt may influence the way in which situations are perceived and/or the response patterns of individuals to specific stimulus situations. More specifically, sex guilt is viewed, by most theorists in the area, as a stable, indwelling tendency to inhibit sexual motives and/or avoid sexual behavior. Mosher and Cross (1971) well represent such disposition-oriented theorizing:

Such a disposition might be manifested by resistance to sexual temptation, by inhibited sexual behavior, or by the disruption of cognitive processes in sex-related situations. (p. 27)

Another means of conceptualizing sex guilt, however, is to propose that it is related more to expectations of external reinforcement contingencies than to internalized standards or dispositions (Langston, 1973). Several studies, including work by Mosher, (Clark, 1952; Galbraith & Mosher, 1968; Mosher & Greenberg, 1969) support the latter theoretical view.

Previous research on the influence of sex guilt upon sexual behavior has stressed an approach-avoidance model to interpret the inverse relationship between sex-guilt and sexual behavior or arousal (Clark, 1952). While guilt is viewed as an inhibiting force, it is unclear whether the inhibition affects arousal, expression or both (Galbraith, 1968; Langston, 1973; Schill, 1972).

Although major difficulties exist in the measurement of sexual stimulation, arousal and behavior, both in the laboratory and in the clinic, measurement of sex guilt is much more straightforward.
The sex-guilt measure is one of several personality measures used in this study, in an effort to extend knowledge on the associations between relevant attitudinal and behavioral variables and the impact of treatment on pertinent attitudinal domains. It is viewed as a companion measure to the Negative Attitudes Toward Masturbation Scale (Abramson & Mosher, 1975). Both measures assess clinically relevant dimensions of psychological functioning; both are considered central in conceptualizations of sexual behavior and sex dysfunction and neither has been used before in outcome studies of brief sex therapy formats. Sex therapy-based clinical observation suggests that sex-guilt can be lessened by the behavioral retraining, sex information dissemination and general attitude restructuring which typically occur in sex therapy.

The notion that guilt is a relevant mediator of sexual affects, attitudes, beliefs, values and practices has been widely promulgated. The Sex-Guilt Scale recommends itself as a good indicator of the theoretical construct involved, and is relevant to certain hypotheses advanced in this study. The forced-choice (male) form of the scale is the most adequate and refined sex-guilt measure available. Much of the construct validational work was done on a college population, making the scale relevant to the present college-based, target population.

Where it has existed, clinical attention to the sex-guilt variable has been informal, unsystematic and inferential. Several background inventories used in screening prospective clients request information on client level of religious observance. It is speculated that this information is understood as a rough index of sex guilt by practitioners. Clinicians also seem to informally agree that religiously active persons represent a more difficult class of clients (as compared with religiously inactive persons) in sex therapy procedures. The difficulty they pose is due, in part, to the presumed power of their religious convictions, their potential to inhibit sexual behavior(s) and to override the essentially contrary, secular thrust of sex therapy.

It remains possible, as some studies have indicated, that sex-guilt is susceptible to changing expectations regarding reinforcement contingencies. The therapeutic content and process components in this research may be construed as an 'environment' in which such changes are likely. Sex therapy strives to normalize sexual fantasy and practice, to give permission and therapeutic license to practices (e.g., masturbation) often considered taboo, to ameliorate associated guilt, and generally to counsel approach rather than avoidant sexual and social behavior while simultaneously providing skills and techniques necessary to achieve specific sexual goals. These aspects of treatment were expected to depress sex-guilt and in turn, to be negatively correlated with a variety of outcome measures, such as intercourse frequency, masturbatory frequency, sexual satisfaction, ejaculatory latency and so forth.
From the literature reviewed above, it would appear important to assess individual differences in self-reported sex-guilt. Such assessments, though important, are beyond the purview of the present study. Future work might reveal the extent to which individual differences along these and other personality dimensions used in this study may have important implications for both therapeutic outcome and process(es). Outcomes which vary as a function of individual differences in sex-guilt may promote refinements in screening criteria and candidate selection. They may also foster analysis of the effectiveness of individual treatment components in brief formats. It would seem that low sex-guilt subjects would show less avoidance and inhibition in regard to their structured homework exercises, find sexual and social stimuli more positively reinforcing, consider heterosexual contact more important, and therefore, differ from high sex-guilt subjects in various relevant ways (dating experience, range of sexual repertoire, etc.). By contrast, the literature suggests that high sex-guilt males are more likely to be socially anxious, display social skills deficits, possess impoverished sexual repertoires and more prohibitive conduct standards, and display less heterosexual interest. These and related factors might make the low sex-guilt group more rapid and/or more successful learners as compared with the high sex-guilt males. For similar reasons, low sex-guilt males may maintain treatment gains better than their high sex-guilt counterparts. The profiles for high and low sex-guilt subjects, drawn from the literature, are theoretically consistent with the profiles of high scorers in the domains of social anxiety and negative attitudes toward masturbation.

Since the sex-guilt measure has not been used in any sex therapy outcome investigations, it appears to be a matter of priority to first ascertain whether and to what extent the predicted relationship between sex-guilt and exposure to treatment exists and whether the correlational data bear fruit. If the measure is inert, further attention to correlational analyses on individual differences in sex-guilt and outcome, screening or format variables is unwarranted.
California Inventory

Circle the number that best expresses the extent to which the behavior described in the following items is characteristic of your typical behavior.

<table>
<thead>
<tr>
<th>Item</th>
<th>Extremely uncharacteristic</th>
<th>Extremely characteristic</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I'm always trying to figure myself out.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>2. I'm concerned about my style of doing things.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>3. Generally, I'm not very aware of myself.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>4. It takes me time to overcome my shyness in new situations.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>5. I reflect about myself a lot.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>6. I'm concerned about the way I present myself.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>7. I'm often the subject of my own fantasies.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>8. I have trouble working when someone is watching me.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>9. I never scrutinize myself.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>10. I get embarrassed very easily.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>11. I'm self-conscious about the way I look.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>12. I don't find it hard to talk to strangers.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>13. I'm generally attentive to my inner feelings.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>14. I usually worry about making a good impression.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>15. I'm constantly examining my motives.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>16. I feel anxious when I speak in front of a group.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>17. One of the last things I do before I leave my house is look in the mirror.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>18. I sometimes have the feeling that I'm off somewhere watching myself.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>19. I'm concerned about what other people think of me.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>20. I'm alert to changes in my mood.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>21. I'm usually aware of my appearance.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>22. I'm aware of the way my mind works when I work through a problem.</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>23. Large groups make me nervous.</td>
<td>1 2 3 4 5</td>
<td></td>
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</tbody>
</table>
Fenigstein (1974) demonstrated that women high in public self-consciousness (as evidenced by pretest scores on the scale), were more sensitive to rejection by a peer group. Having been excluded from a group, they were less attracted to it and less willing to affiliate with it than low public self-conscious women. Turner (1976) found that persons high in public self-consciousness had better social skills in public contexts since they were more attuned to the external social setting. In a comedy monologue task (Turner, 1976), high public self-conscious subjects told more jokes and received higher ratings on the task from blind raters. In the present context, it was expected that public self-consciousness scores, usually elevated in clinical populations (Turner, 1976), would decrease as a function of treatment, since one might argue generalized performance concerns and "spectatoring," (in which the person compares himself to others and is preoccupied with his self-presentation), fall under the rubric of public self-consciousness.

Other research reported by Fenigstein et al. (1975) suggests that subjects high in private self-consciousness appear to be more responsive to their transient affective states as compared with subjects low in private self-consciousness. Still other research reports correlate manipulated self-consciousness with the accuracy of self-reports (Carver, 1974; Pryor, Gibbons, & Wicklund, cited in Wicklund, 1975). In a series of investigations, Turner (1976) found that persons high in private self-consciousness gave more lengthy and more accurate self-descriptions, which were more powerfully correlated with their behavior (as observed by blind raters) when compared with low private self-conscious subjects. In this connection, Fenigstein et al. (1975, p. 526) note:

...moving from situational self-awareness to dispositional self-consciousness, the trait may act as a moderator variable between self-report and behavior. Self-conscious persons closely examine their beliefs and feelings, and so their reported dispositions may have greater predictive validity than the reports of non-self-conscious persons. (p. 526)

These treatment interventions endeavored to increase private self-consciousness even as they attempted to moderate public self-consciousness. Relaxation training, assertion training and the structured exercises can be viewed as instruments to increase private self-consciousness, as well as social effectiveness and ejaculatory control. Use of this subscale permitted correlations between changes
on private self-consciousness scores and various outcome measures, as well as any increments in private self-consciousness attributable to the treatment intervention.

Many theorists hold that anxiety disrupts adequate ejaculatory control by directing attention away from the self and the sexual experience (Kaplan, 1974; Masters & Johnson, 1970), or by potentiating the ejaculatory reflex (Wolpe, 1973). While it is generally true that clinical populations manifest elevated levels of social anxiety (Turner, 1976), and equally true that theorists place special emphasis on anxiety in the psychogenesis of premature ejaculation, no published study to date has sought to assess subjects' pre and post treatment levels of social anxiety. In research on self-focused attention using the Self-Consciousness Scale, Turner (1976) found that highly socially anxious persons were slower in processing self-relevant information as compared with subjects low in social anxiety. This was particularly true where socially undesirable traits were concerned. The various components designed to deal with social anxiety (communications skills training, assertion training, etc.) were intended to decrease subjects' social anxiety and, presumably, speed their learning.
SOCIAL REACTION INVENTORY

This is a questionnaire to find out the way in which certain important events in our society affect different people. Each item consists of a pair of alternatives lettered A or B. Please select the one statement of each pair (and only one) which you more strongly believe to be the case as far as you're concerned. Be sure to select the one you actually believe to be more true rather than the one you think you should choose or the one you would like to be true. This is a measure of personal belief; obviously there are no right or wrong answers.

Your answer, either A or B to each question on this Inventory, is to be reported on the attached answer sheet. Do not place any stray marks on this form.

Please answer these items carefully but do not spend too much time on any one item. Be sure to find an answer for every choice. For each numbered question make an X on the line beside either A or B on the Answer Sheet, whichever you choose as the statement most true.

In some instances you may discover that you believe both statements or neither one. In such cases, be sure to select the one you more strongly believe to be the case as far as you're concerned. Also try to respond to each item independently when making your choice; do not be influenced by your previous choices.

Remember

Select the alternative which you personally believe to be more true.

I more strongly believe that:

1. ___A. Children get into trouble because their parents punish them too much.
   ___B. The trouble with most children nowadays is that their parents are too easy with them.

2. ___A. Many of the unhappy things in people's lives are partly due to bad luck.
   ___B. People's misfortunes result from the mistakes they make.

3. ___A. One of the major reasons why we have wars is because people don't take enough interest in politics.
   ___B. There will always be wars, no matter how hard people try to prevent them.

4. ___A. In the long run people get the respect they deserve in this world.
   ___B. Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.

5. ___A. The idea that teachers are unfair to students is nonsense.
   ___B. Most students don't realize the extent to which their grades are influenced by accidental happenings.

6. ___A. Without the right breaks one cannot be an effective leader.
   ___B. Capable people who fail to become leaders have not taken advantage of their opportunities.
2 Social Reaction Inventory

7. A. No matter how hard you try some people just don't like you.
   B. People who can't get others to like them don't understand how to get along
   with others.

8. A. Heredity plays the major role in determining one's personality.
    B. It is one's experiences in life which determine what they're like.

9. A. I have often found that what is going to happen will happen.
    B. Trusting to fate has never turned out as well for me as making a decision
to take a definite course of action.

10. A. In the case of the well prepared student there is rarely if ever such a
    thing as an unfair test.
    B. Many times exam questions tend to be so unrelated to course work that
    studying is really useless.

11. A. Becoming a success is a matter of hard work, luck has little or nothing
to do with it.
    B. Getting a good job depends mainly on being in the right place at the right
time.

12. A. The average citizen can have an influence in government decisions.
    B. This world is run by the few people in power, and there is not much the
    little guy can do about it.

13. A. When I make plans, I am almost certain that I can make them work.
    B. It is not always wise to plan too far ahead because many things turn out
to be a matter of good or bad fortune anyhow.

14. A. There are certain people who are just no good.
    B. There is some good in everybody.

15. A. In my case getting what I want has little or nothing to do with luck.
    B. Many times we might just as well decide what to do by flipping a coin.

16. A. Who gets to be the boss often depends on who was lucky enough to be
    in the right place first.
    B. Getting people to do the right thing depends upon ability; luck has little
    or nothing to do with it.

17. A. As far as world affairs are concerned, most of us are the victims of forces
    we can neither understand, nor control.
    B. By taking an active part in political and social affairs the people can con-
    trol world events.
18. **A.** Most people can't realize the extent to which their lives are controlled by accidental happenings.
   **B.** There really is no such thing as "luck".

19. **A.** One should always be willing to admit his mistakes.
   **B.** It is usually best to cover up one's mistakes.

20. **A.** It is hard to know whether or not a person really likes you.
    **B.** How many friends you have depends upon how nice a person you are.

21. **A.** In the long run the bad things that happen to us are balanced by the good ones.
    **B.** Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.

22. **A.** With enough effort we can wipe out political corruption.
    **B.** It is difficult for people to have much control over the things politicians do in office.

23. **A.** Sometimes I can't understand how teachers arrive at the grades they give.
    **B.** There is a direct connection between how hard I study and the grades I get.

24. **A.** A good leader expects people to decide for themselves what they should do.
    **B.** A good leader makes it clear to everybody what their jobs are.

25. **A.** Many times I feel that I have little influence over the things that happen to me.
    **B.** It is impossible for me to believe that chance or luck plays an important role in my life.

26. **A.** People are lonely because they don't try to be friendly.
    **B.** There's not much use in trying too hard to please people, if they like you, they like you.

27. **A.** There is too much emphasis on athletics in high school.
    **B.** Team sports are an excellent way to build character.

28. **A.** What happens to me is my own doing.
    **B.** Sometimes I feel that I don't have enough control over the direction my life is taking.

29. **A.** Most of the time I can't understand why politicians behave the way they do.
    **B.** In the long run the people are responsible for bad government on a national as well as on a local level.
Locus of control is a construct designed to tap individual differences in the perception of contingencies between personal behavior and consequent environmental events. Literature reviews (Lefcourt, 1976) emphasize the notion that locus of control is to be understood as a limited category of self-appraisals regarding the degree to which persons view themselves as having some causal role in determining specified outcomes. Causal attributions of events along the internal-external dimension are significant components of self-assessment and are, moreover, relevant to clinical problems and settings.

The locus of control construct is conceptualized as a moderator variable in Rotter's (1966) social learning formulation regarding prediction of actions. Rotter regards values (strength of reinforcement for particular behaviors), situational variables and expectation of reinforcement (locus of control) as equal contributors to any behavioral outcome. A general expectation of success or failure is built upon specific value-expectation-behavior-outcome sequences. Thus, the perception of control constitutes an abstraction based upon causal analysis of personal success and failure and causal attribution to internal or external sources of control. Those research findings relevant to the present study are briefly reviewed below.

The maintenance of control expectancies, or beliefs in causation, regarded as a correlate of cognitive activity, has generated considerable research on cognitive functioning and locus of control. Internal control expectancies are associated with resistance to coercion (presumably useful in sexual/social encounters requiring self-assertion); with better retention of task and situation relevant information (Seeman, 1963), which ought to enhance learning in therapeutic (and other) milieus; with greater attention to cues relevant to goal attainment, and more attention given to decisions involving skill (Rotter & Mulry, 1965); with greater perceptiveness and orientedness to learning about the environment, greater curiosity, and more efficient information processing (Davis & Phares, 1967; Phares, 1968); with being more knowledgeable about a disease from which the "internals" suffered (Seeman & Evans, 1962); with greater verbal fluency (Brecher & Denmark, 1969); with shorter latencies in extracting cues leading to accurate judgments, better recall of performances, greater likelihood of using information for estimating subsequent performances (DuCette & Wolk, 1973) and better performance on intentional and incidental learning measures (Wolk & DuCette, 1974) than are external control expectancies. In sum, the research on cognitive functioning and locus of control suggests that significant differences exist between persons holding internal versus external control expectancies with respect to acquisition, organization and retention of information, particularly the self-relevant kind. These
data on cognitive functioning and internal locus of control have obvious implications for therapeutic environments.

Another area of research relevant to the present study consists of correlational work associating locus of control with various indicators of psychopathology. Kilpatrick et al. (1974) found that "internals" showed fewer self-reported mood disturbances than "externals," facilitating instrumental behavior under stress among medical students. Melges and Weisz (1971) reported that an external locus of control orientation was associated with a preponderance of negative affective experiences in a study on suicide. Lefcourt (1976) found that "externality" was positively correlated with debilitative anxiety, while Platt and Eisenman (1968) and Powell and Vega (1972) found correlations with depression and general dysphoria. Phares (1971) has shown, moreover, that clinical groups tend to discount personal responsibility and espouse an external control orientation to a greater degree than non-clinical groups (Palmer, 1971). Furthermore, a relationship has been demonstrated between "externality" and the severity of psychopathology (Shybut, 1968; Smith, Pryer, & Distefano, 1971). It is hypothesized by many researchers that the sense of helplessness which accompanies an external control orientation leads to dissatisfying social interactions, which are perceived as aversive events, and which result in social withdrawal.

Both stability and change exist in the causal construction of events. Lefcourt (1976) and others have argued that locus of control is neither trait or typology (as often misconstrued), but rather a process. Thus, it is not surprising that many researchers report behavioral and scalar (self-report) changes in perception of control as a function of naturally occurring or manipulated laboratory events. Cause for interest in the processes which are capable of altering locus of control are self-evident.

Based upon the foregoing review of cognitive and affective phenomena and their relation to locus of control, shifts in perception of control present themselves as plausible, therapeutically desirable ends and means. As Lefcourt (1976) notes:

Patients are encouraged to shift attributions of cause, sometimes to external, sometimes to internal sources...These reattributions are most often of a singular nature--the reconstrual of a drug effect, a symptom or a reaction. In each case, the misattribution has left the patient believing that he is incapable of dealing with his problems. Therapy, while at the same time encouraging a specific external attribution, can oddly enough serve to reinstate the general
sense of being able to act. In social learning terms, shifts in specific expectancies from internal to external can be said to at times encourage the return of confidence or generalized expectancies of internal control. (p. 94) (Underscore added)

Lefcourt, above, suggests perhaps the operation of a paradoxical effect. Presumably the direct encouragement to shift to internal sources of control, typical of psychotherapy contexts, also increases internal control orientation.

Various studies make clear that within many educational, change-oriented formats, internal states can be created by environmental events such that individuals will shift in their expressions of the perception of control. Smith et al. (1971) assessed the locus of control scores of clients before and after treatment at a crisis center and reported significant increases in clients' "internality" at post-treatment assessment. Similarly, Foulds (1971) found significant shifts toward "internality" among a group of college students in a quasi-group therapy setting, and Foulds et al. (1974) reported similar shifts after an experiential marathon group. Levenson (1974), working with an institutionalized population, and Diamond and Shapiro (1973), after an encounter group experience, also reported scale assessed increases in internal locus of control among their subjects. Harrow and Ferrante (1969) reassessed patients on locus of control after six weeks at a clinic and found that shifts in control were a function of disorder. Schizophrenics showed no scale changes, depressives shifted significantly in the internal direction, others less significantly in the internal direction, while manic patients shifted in the external direction.

Perhaps most significant for present purposes, Dua (1970) reported that women subjects receiving "action-oriented" treatment showed increased "internality" scores post-treatment, and that their scores were significantly more internal than those of either the re-educational treatment or control subjects. Women in the re-educational group shifted toward "internality," but not to a significantly different degree from controls. In its similarity of design and intention, Dua's (1970) study seems particularly relevant to the present one. It was speculated that the "action-oriented" treatment produced the greatest scale changes because of the opportunity for cognitive rehearsal provided, the contingent social reinforcement intended to promote "internality," and the consideration of alternative approaches for interacting with others (Dua's target behavior) through what Lefcourt terms "active exercises." Finally, Riessman (1962), Harvey (1971) and others have suggested that helping others heightens one's sense of personal effectiveness and increases one's self-reported control orientation (elsewhere referred to as the helper therapy principle).
The reactivity associated with the use of scales as outcome measures limits their usefulness unless scale score changes are accompanied by behavioral changes from which locus of control shifts can be inferred. Examples of this approach are provided by Reimanis (1971) and Masters (1970). Masters (1970) focused an individual therapy course specifically on redefining control issues and reconstructing causal attributions in an adolescent in crisis with his family. Reimanis (1971) induced "internality" among college students in both individual and group counseling sessions by asking questions such as: "What could you have done about it?", "What do you want to do about it?", and by promoting the use of "I statements" throughout the course of therapy. More important than the scale shifts toward "internality":

...it was noted from the counseling records that most of the experimental group subjects began to model after the counselor's style of questioning and to talk more about their own responsibility for continuing with their education and solving interpersonal problems. (Lefcourt, 1976, p. 118)

In addition, behavioral indices of "internality" were also noted. Along similar lines, deCharms (1972) has demonstrated that behavioral indicators of locus of control are modifiable by training programs stressing personal causation. The results of many of these investigations suggest that therapies which are action-oriented, which stress concrete learning of and effecting of contingencies in the service of realistic, defined goals seem optimal for altering clients' causal attributions. However, the permanence of these effects, with the single exception of deCharms' (1972) study, has not been satisfactorily addressed in the literature.

In summary, research with both naturally occurring and manipulated events reveals that locus of control scale scores and behavioral indices are mutable. Given demand characteristics and other potential contaminants, a research strategy employing both behavioral indices of locus of control and scalar indices was indicated. The predictions offered in the present study are consistent both with the research on individual differences in locus of control and cognitive and affective functioning, and earlier therapy/education outcome investigations.

As previously suggested, causal attributions and the contingencies which mediate them are frequently the basis for therapeutic interventions. The readiness to perceive such relationships is an essential element in behavior therapies. In the realm of functionally based premature ejaculation, it is fundamentally sound and realistic to induce an internal control orientation and to expect its maintenance once therapy is terminated. Ejaculatory control is more controllable by the individual, after all, than are remote or large
scale social system events. The appeal to common sense, the apparently successful techniques used to treat premature ejaculation as suggested by the available outcome data, and the overwhelming evidence that specific control expectancies are experimentally manipulable, made it likely that subjects' internal control orientations would be enhanced as a function of treatment. Both the self-directed and group treatment formats were designed to teach control and a variety of coping mechanisms including relaxation and assertion training. To have such instrumental responses at one's disposal was expected to increase personal sense of control, tolerance for failure and for aversive events, self-reliance, sense of effectiveness and achievement-facilitating behavior. Moreover, the brief, contract-based program arrangement was expected to contribute to an internal control orientation. Perhaps the self-directed format most clearly conveys this modus operandi and goal.
UPDATE QUESTIONNAIRE

Please answer the following questions based on your experience since July, 1979, the last followup point. If, for the period from July to November, 1979, the questions don’t apply to you, write or check “not applicable” (n/a) and indicate why.

1. We would like to know something about your relationship status. During this period have you:
   A. continued a relationship you had during the treatment program or first followup period? yes no n/a
   B. ended a relationship you had during the treatment program or first followup period? yes no n/a
   C. initiated one or more new relationships since the first followup period? yes no n/a
   D. anything else about your current relationship status that we should know?

2. During this period, did you ever ask, or suggest to a partner to do an exercise(s) from the treatment program with you? yes no n/a

3. If yes, please check off, from the list below those exercises which you and a partner did during this period:
   - partner applied manual stimulation using the stop-start technique and a dry hand
   - partner applied manual stimulation using the stop-start technique with a lubricated hand
   - partner applied manual stimulation using the squeeze technique and a dry hand
   - partner applied manual stimulation using the squeeze technique and a lubricated hand
   - partner applied manual continuous stimulation with variations to decrease arousal
   - the quiet vagina exercise in which intravaginal containment is practiced
   - exercises in which the female is on top of the male or on his side and limited movement by the female is practiced
   - exercises in which the female is on top of the male or on his side and limited movement by the male is practiced
   - exercises using unlimited movement and variations to decrease arousal, position variations, other adjustments, etc.
   - individual maintenance program (describe: __________________)

4. Approximately how often did you and your partner intentionally engage in partner-exercises during this followup period? (Please provide a number, even if it's a guesstimate) __________________

5. During this period, have you engaged in intercourse with a partner(s) without intentionally engaging in any of the partner-oriented exercise(s)? yes no n/a
UPDATE QUESTIONNAIRE CONTINUED:

6. During this period, have you engaged in kissing, petting and/or massage without engaging in intercourse?  yes  no  n/a

7. For each of the activities listed below, endorse the category which best reflects your level of activity during the followup period:

<table>
<thead>
<tr>
<th>Activity Type</th>
<th>Never</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. self-stimulation activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. self-stimulation activities along with partner-oriented sexual activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. partner activities limited to kissing, massage or petting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. partner activities limited to foreplay and intercourse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. partner activities involving foreplay, 'regular' intercourse and treatment program exercises</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. other: please describe:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. During the followup period, how many different partners have you had?

9. Since July, have you practiced any of the solo exercises which are part of the treatment program?  yes  no  n/a

10. If yes, check off those exercises you have practiced during the followup:

- 30 minute body caress excluding your genitals
- self-stimulation to the 'point of no return'
- self-stimulation with a dry hand using the stop-start
- self-stimulation with a lubricated hand using the stop-start
- self-stimulation with a dry hand using the squeeze technique
- self-stimulation with a lubricated hand using the squeeze technique
- continuous self-stimulation with variations to decrease arousal
- self-stimulation with the stop-start technique and use of fantasy
- self-stimulation with the stop-start technique and directed fantasy I
- self-stimulation with the stop-start technique and directed fantasy II
- self-stimulation with the stop-start technique and directed fantasy III
- self-stimulation with the stop-start technique and directed fantasy IV

11. Approximately how often did you engage in solo exercises during this period? (Please provide a number, guesstimate)

12. During the followup period, has there been any source of social contact and support (other than your partner) whom you felt contributed to your progress or success in meeting your goals in this program? Please describe:

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APPENDIX D

Informed Consent Form, Incentive Deposit Agreement,
"Subject's Bill of Rights"
CONSENT FORM

I, ________________________, hereby consent to participate in a research program conducted by the Human Sexuality Program, UCLA for men with the problem of premature ejaculation who do not have steady partners. I understand that my participation is entirely voluntary and I will be asked to do the following: (a) answer five questionnaires related to my sexual functioning before and after participation in the program, and (b) attend group meetings in which I will receive sex information and suggestions for resolving my sexual problems and concerns, and view films related to the resolution of these problems, ("group format"), or (c) attend a one day intensive group meeting in which the same materials and information described in (b) above will be conveyed to me, ("self-directed format"). I realize that the questionnaires used in this program gather general personal information as well as specific information related to my sexual functioning, attitudes and activities. I understand that I need not answer any question that I do not wish to answer. I am aware that these groups are for males only. I understand that I may be regularly contacted by phone by a therapist during the 8 week treatment period to discuss my progress in the program. I realize that I may be assigned for treatment or asked to wait four months and then be treated. I understand that this assignment, like the assignment to treatment format, will be purely by chance (random). I am aware that if I do not wish to participate in this program, I will not be denied treatment in other programs of the Human Sexuality Program because of my refusal. I realize that no harm is expected to result from my participation. I am aware that I may withdraw my consent and discontinue participation in the project at any time without prejudice. I understand that any questions I have will be answered at any time.

Should any unforeseen psychological or physical problem arise, Susan Price, Ph.D., will be available for referral for appropriate care. I realize that while it is possible that there may be no specific benefit for me, a benefit of this research program may be to gather information that may aid in developing effective sex therapy programs for men in treatment without regular sexual partners. I understand that if the study design or use of the information is to be changed, I will be so informed and my consent re-obtained.

I know that my identity will not be revealed in any publication of the results of this study unless I give my separate specific consent or unless as
required by law. I understand that the co-therapists will strongly request that group members not divulge information shared in the group to persons outside the group. I realize that the co-therapists have no way to control group members in this regard.

I understand that the group treatment formats will be conducted by Susan Price, Ph.D. and Barry Reynolds, Ph.D., clinical psychologists on the staff of the Human Sexuality Program. I am aware that the group format participants will meet with the co-therapists eight times over a two month period for approximately two hours per session. I understand that self-directed format participants will meet with the co-therapists for a one-day intensive group meeting for approximately 8 hours followed by regular weekly telephone contact with a therapist over the two month treatment period. I am aware that there will be eight men in each treatment format.

I understand that if I have any questions, comments, or concerns about the study or the informed consent process, I may address them to the Associate Vice Chancellor-Research, Room 3134, Murphy Hall, UCLA Los Angeles, CA 90024, (213) 825-8714.

Date: ____________________ Signature: ______________________

Witnessed by: ______________________

On signing this consent form, I acknowledge receiving a copy of the form, as well as a copy of the "Subjects Bill of Rights".

I understand that the University will provide free medical care and hospital treatment which I may require for physical illness or injury directly resulting from my participation in this research project. I also understand, that without proof of negligence, the University will not provide any other form of compensation to me as a result of any illness or injury I suffer as a result of my participation.

Date: ____________________ Signature: ______________________

Witnessed by: ______________________

Principal Investigator:
Susan Price, Ph.D.
UCLA Department of Psychiatry
Human Sexuality Program
924 Westwood Boulevard, Suite 335
Los Angeles, California

Form prepared: January, 1979
INCENTIVE DEPOSIT SYSTEM

Participants in the group treatment programs of the Human Sexuality Program are required to pay a $40.00 incentive deposit. This deposit is paid in advance of treatment and is used to insure that people participating in our programs are really serious about wanting treatment and to provide us with necessary information about the effectiveness of our programs.

It is clearly possible to get the entire deposit back if you complete all of the questionnaires at the end of the treatment and at the followup points and return them to us on schedule. Your incentive deposit will be returned according to the following schedule:

<table>
<thead>
<tr>
<th>Amount</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10.00</td>
<td>Immediately Post Treatment Period</td>
</tr>
<tr>
<td>$10.00</td>
<td>At Two Month Followup</td>
</tr>
<tr>
<td>$20.00</td>
<td>At Six Month Followup</td>
</tr>
</tbody>
</table>

In order to have things go smoothly, we ask that you inform us if you change your address, so that during the course of the treatment program and afterwards, the questionnaires will reach you without delay. With your cooperation, we will be able to return to you all of the $40.00 deposit.

I have read and understand the rules of the incentive deposit system and agree to them in full.

__________________________  ________________
Client Signature  Date

__________________________  ________________
Witness Signature  Date

__________________________
Client Social Security Number

Deposit Received:

__________________________  ________________
Therapist  Date
RIGHTS OF HUMAN SUBJECTS
IN MEDICAL EXPERIMENTS

Any person who is requested to consent to participate as a subject in a research study involving a medical experiment or who is requested to consent on behalf of another has the right to:

1. Be informed of the nature and purpose of the experiment.
2. Be given an explanation of the procedures to be followed in the medical experiment, and any drug or device to be utilized.
3. Be given a description of any attendant discomforts and risks reasonably to be expected from the experiment.
4. Be given an explanation of any benefits to the subject reasonably to be expected from the experiment, if applicable.
5. Be given a disclosure of any appropriate alternative procedures, drugs or devices that might be advantageous to the subject, and their relative risks and benefits.
6. Be informed of the avenues of medical treatment, if any, available to the subject after the experiment if complications should arise.
7. Be given an opportunity to ask any questions concerning the experiment or the procedure involved.
8. Be instructed that consent to participate in the medical experiment may be withdrawn at any time and the subject may discontinue participation in the medical experiment without prejudice.
9. Be given a copy of any signed and dated written consent form used in relation to the experiment.
10. Be given the opportunity to decide to consent or not to consent to a medical experiment without the intervention of any element of force, fraud, deceit, duress, coercion, or undue influence on the subject's decision.
APPENDIX E

Supplementary Analyses of Variance

on Communications Variables
TABLE 39

Analysis of Variance of Frequency of Requests to Engage in Sexually Pleasurable Activities for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition (A)</td>
<td>1</td>
<td>1.25</td>
<td>0.74</td>
</tr>
<tr>
<td>Error A</td>
<td>14</td>
<td>1.682</td>
<td></td>
</tr>
<tr>
<td>Period (B)</td>
<td>4</td>
<td>4.175</td>
<td>8.92*</td>
</tr>
<tr>
<td>A x B</td>
<td>4</td>
<td>0.375</td>
<td>0.80</td>
</tr>
<tr>
<td>Error B</td>
<td>56</td>
<td>0.468</td>
<td></td>
</tr>
</tbody>
</table>

*P < .0001

TABLE 40

Mean Frequency of Requests to Engage in Sexually Pleasurable Activities for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Condition</th>
<th>Pre-pre</th>
<th>Pre</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>3.125</td>
<td>3.250</td>
<td>2.500</td>
<td>2.125</td>
<td>2.625</td>
</tr>
<tr>
<td>Self-Directed</td>
<td>3.125</td>
<td>3.000</td>
<td>2.500</td>
<td>1.875</td>
<td>1.875</td>
</tr>
<tr>
<td>Period Means</td>
<td>3.125</td>
<td>3.125</td>
<td>2.500</td>
<td>2.000</td>
<td>2.250</td>
</tr>
</tbody>
</table>

Note: Decreases in means indicate increases in frequencies.
TABLE 41
Analysis of Variance of Frequency of Refusal to Engage in Sex When Not Desired for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition (A)</td>
<td>1</td>
<td>6.531</td>
<td>1.66</td>
</tr>
<tr>
<td>Error A</td>
<td>14</td>
<td>3.935</td>
<td></td>
</tr>
<tr>
<td>Period (B)</td>
<td>4</td>
<td>6.027</td>
<td>10.79*</td>
</tr>
<tr>
<td>A x B</td>
<td>4</td>
<td>0.602</td>
<td>1.08</td>
</tr>
<tr>
<td>Error B</td>
<td>56</td>
<td>0.558</td>
<td></td>
</tr>
</tbody>
</table>

*R < .0001

TABLE 42
Mean Frequency of Refusal to Engage in Sex When Not Desired for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Period</th>
<th>Condition</th>
<th>Pre-pre</th>
<th>Pre</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group</td>
<td>4.143</td>
<td>3.625</td>
<td>2.500</td>
<td>2.500</td>
<td>2.375</td>
</tr>
<tr>
<td></td>
<td>Self-Directed</td>
<td>4.125</td>
<td>4.000</td>
<td>3.250</td>
<td>3.375</td>
<td>3.250</td>
</tr>
<tr>
<td></td>
<td>Period Means</td>
<td>4.134</td>
<td>3.813</td>
<td>2.875</td>
<td>2.938</td>
<td>2.813</td>
</tr>
</tbody>
</table>

Note: Decreases in means denote increases in frequencies.
### TABLE 43

Analysis of Variance of Frequency of Discussions of Ways to Improve Sexual Activity for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition (A)</td>
<td>1</td>
<td>0.113</td>
<td>0.05</td>
</tr>
<tr>
<td>Error A</td>
<td>14</td>
<td>2.463</td>
<td></td>
</tr>
<tr>
<td>Period (B)</td>
<td>4</td>
<td>7.363</td>
<td>13.67*</td>
</tr>
<tr>
<td>A x B</td>
<td>4</td>
<td>1.300</td>
<td>2.41</td>
</tr>
<tr>
<td>Error B</td>
<td>56</td>
<td>0.538</td>
<td></td>
</tr>
</tbody>
</table>

*p < .0001

### TABLE 44

Mean Frequency of Discussions on Ways to Improve Sexual Activity for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Condition</th>
<th>Pre-pre</th>
<th>Pre</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>4.000</td>
<td>3.375</td>
<td>1.750</td>
<td>2.250</td>
<td>2.375</td>
</tr>
<tr>
<td>Self-Directed</td>
<td>3.500</td>
<td>3.125</td>
<td>2.750</td>
<td>2.250</td>
<td>2.500</td>
</tr>
<tr>
<td>Period Means</td>
<td>3.750</td>
<td>3.250</td>
<td>2.250</td>
<td>2.250</td>
<td>2.438</td>
</tr>
</tbody>
</table>

**Note:** As the means suggest, an A x B trend is indicated at the .06 level. Mean decreases denote frequency increases.
TABLE 45
Analysis of Variance of Frequency of Suggestions on Different Coital Positions for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition (A)</td>
<td>1</td>
<td>0.123</td>
<td>0.04</td>
</tr>
<tr>
<td>Error A</td>
<td>14</td>
<td>2.874</td>
<td></td>
</tr>
<tr>
<td>Period (B)</td>
<td>4</td>
<td>3.164</td>
<td>4.68*</td>
</tr>
<tr>
<td>A x B</td>
<td>4</td>
<td>0.932</td>
<td>1.38</td>
</tr>
<tr>
<td>Error B</td>
<td>56</td>
<td>0.676</td>
<td></td>
</tr>
</tbody>
</table>

*p < .005

TABLE 46
Mean Frequency of Suggestions on Different Coital Positions for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Condition</th>
<th>Pre-pre</th>
<th>Pre</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>2.875</td>
<td>3.000</td>
<td>1.625</td>
<td>2.125</td>
<td>2.375</td>
</tr>
<tr>
<td>Self-Directed</td>
<td>2.750</td>
<td>2.750</td>
<td>2.375</td>
<td>1.857</td>
<td>1.875</td>
</tr>
<tr>
<td>Period Means</td>
<td>2.813</td>
<td>2.875</td>
<td>2.000</td>
<td>1.991</td>
<td>2.125</td>
</tr>
</tbody>
</table>

Note: Decreases in means indicate increased frequencies.
**TABLE 47**

Analysis of Variance of Frequency of Suggestions on Different Sexual Activities for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition (A)</td>
<td>1</td>
<td>0.013</td>
<td>0.00</td>
</tr>
<tr>
<td>Error A</td>
<td>14</td>
<td>2.984</td>
<td></td>
</tr>
<tr>
<td>Period (B)</td>
<td>4</td>
<td>4.250</td>
<td>6.83 *</td>
</tr>
<tr>
<td>A x B</td>
<td>4</td>
<td>1.138</td>
<td>1.83</td>
</tr>
<tr>
<td>Error B</td>
<td>56</td>
<td>0.622</td>
<td></td>
</tr>
</tbody>
</table>

*P < .0005

**TABLE 48**

Mean Frequency of Suggestions on Different Sexual Activities During Encounter for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Period</th>
<th>Pre-pre</th>
<th>Pre</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>3.250</td>
<td>3.500</td>
<td>2.375</td>
<td>2.500</td>
<td>2.500</td>
</tr>
<tr>
<td>Self-Directed</td>
<td>3.750</td>
<td>2.875</td>
<td>2.875</td>
<td>2.000</td>
<td>2.500</td>
</tr>
<tr>
<td>Period Means</td>
<td>3.500</td>
<td>3.188</td>
<td>2.625</td>
<td>2.250</td>
<td>2.500</td>
</tr>
</tbody>
</table>

*Note: Score decreases indicate frequency increases.*
TABLE 49
Analysis of Variance of Frequency of Communications Regarding Anxiety and Pressure in Sex for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition (A)</td>
<td>1</td>
<td>2.113</td>
<td>1.13</td>
</tr>
<tr>
<td>Error A</td>
<td>14</td>
<td>1.877</td>
<td></td>
</tr>
<tr>
<td>Period (B)</td>
<td>4</td>
<td>8.169</td>
<td>15.72*</td>
</tr>
<tr>
<td>A x B</td>
<td>4</td>
<td>0.956</td>
<td>1.84</td>
</tr>
<tr>
<td>Error B</td>
<td>56</td>
<td>0.520</td>
<td></td>
</tr>
</tbody>
</table>

*p < .0001

TABLE 50
Mean Frequency of Communications Regarding Anxiety and Pressure in Sex for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Condition</th>
<th>Pre-pre</th>
<th>Pre</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>4.375</td>
<td>4.125</td>
<td>2.625</td>
<td>3.250</td>
<td>2.250</td>
</tr>
<tr>
<td>Self-Directed</td>
<td>4.500</td>
<td>3.875</td>
<td>3.250</td>
<td>3.375</td>
<td>3.250</td>
</tr>
<tr>
<td>Period Means</td>
<td>4.438</td>
<td>4.000</td>
<td>2.938</td>
<td>3.313</td>
<td>2.750</td>
</tr>
</tbody>
</table>

Note: Declines in mean scores indicate increases in frequencies.
TABLE 51

Analysis of Variance of Frequency of Communications Regarding Anger in Sex for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition (A)</td>
<td>1</td>
<td>0.013</td>
<td>0.01</td>
</tr>
<tr>
<td>Error A</td>
<td>14</td>
<td>2.377</td>
<td></td>
</tr>
<tr>
<td>Period (B)</td>
<td>4</td>
<td>3.981</td>
<td>9.16*</td>
</tr>
<tr>
<td>A x B</td>
<td>4</td>
<td>0.231</td>
<td>0.53</td>
</tr>
<tr>
<td>Error B</td>
<td>56</td>
<td>0.435</td>
<td></td>
</tr>
</tbody>
</table>

*P ≤ .0001

TABLE 52

Mean Frequency of Communications Regarding Anger and Resentment in Sex for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Period</th>
<th>Condition</th>
<th>Pre-pre</th>
<th>Pre</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group</td>
<td>4.375</td>
<td>4.125</td>
<td>3.375</td>
<td>4.000</td>
<td>2.875</td>
</tr>
</tbody>
</table>

Note: Score decreases indicate frequency increases.
TABLE 53

Analysis of Variance of Frequency of Communications Regarding Ejaculatory Dyscontrol for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition (A)</td>
<td></td>
<td>0.800</td>
<td>0.14</td>
</tr>
<tr>
<td>Error A</td>
<td>14</td>
<td>5.739</td>
<td></td>
</tr>
<tr>
<td>Period (B)</td>
<td>4</td>
<td>7.081</td>
<td>7.75 *</td>
</tr>
<tr>
<td>A x B</td>
<td>4</td>
<td>0.831</td>
<td>0.91</td>
</tr>
<tr>
<td>Error B</td>
<td>56</td>
<td>0.913</td>
<td></td>
</tr>
</tbody>
</table>

*p ≤ .0001

TABLE 54

Mean Frequency of Communications Regarding Ejaculatory Dyscontrol for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Condition</th>
<th>Pre-pre</th>
<th>Pre</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>3.625</td>
<td>3.500</td>
<td>2.000</td>
<td>2.000</td>
<td>2.000</td>
</tr>
<tr>
<td>Self-Directed</td>
<td>3.625</td>
<td>3.000</td>
<td>2.375</td>
<td>2.500</td>
<td>2.625</td>
</tr>
<tr>
<td>Period Means</td>
<td>3.625</td>
<td>3.250</td>
<td>2.188</td>
<td>2.250</td>
<td>2.313</td>
</tr>
</tbody>
</table>

Note: Decreases in means denote increases in frequencies.
APPENDIX F

Supplementary Analyses of Variance on Negative Attitudes Toward Masturbation Variables
### TABLE 55

**Analysis of Variance of NATM Item #2**
for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition (A)</td>
<td>1</td>
<td>0.141</td>
<td>0.24</td>
</tr>
<tr>
<td>Error A</td>
<td>14</td>
<td>0.596</td>
<td></td>
</tr>
<tr>
<td>Period (B)</td>
<td>3</td>
<td>0.932</td>
<td>7.41 **</td>
</tr>
<tr>
<td>A x B</td>
<td>3</td>
<td>0.057</td>
<td>0.46</td>
</tr>
<tr>
<td>Error B</td>
<td>42</td>
<td>0.126</td>
<td></td>
</tr>
</tbody>
</table>

**"People who masturbate will not enjoy sexual intercourse as much as those who refrain from masturbation."**

**P < .0005**

### TABLE 56

**Mean Frequency of Scores for NATM Item #2**
for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Period</th>
<th>Pre</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Condition</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>4.375</td>
<td>5.000</td>
<td>4.625</td>
<td>4.750</td>
</tr>
<tr>
<td>Self-Directed</td>
<td>4.250</td>
<td>4.750</td>
<td>4.625</td>
<td>4.750</td>
</tr>
<tr>
<td><strong>Period Means</strong></td>
<td>4.313</td>
<td>4.875</td>
<td>4.625</td>
<td>4.750</td>
</tr>
</tbody>
</table>

*"People who masturbate will not enjoy sexual intercourse as much as those who refrain from masturbation."

**Note:** Score increases indicate increased positive attitudes.
TABLE 57
Analysis of Variance of NATM Item #8*
for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition (A)</td>
<td>1</td>
<td>9.000</td>
<td>4.99**</td>
</tr>
<tr>
<td>Error A</td>
<td>14</td>
<td>1.804</td>
<td></td>
</tr>
<tr>
<td>Period (B)</td>
<td>3</td>
<td>0.458</td>
<td>0.43</td>
</tr>
<tr>
<td>A x B</td>
<td>3</td>
<td>0.958</td>
<td>0.89</td>
</tr>
<tr>
<td>Error B</td>
<td>42</td>
<td>1.077</td>
<td></td>
</tr>
</tbody>
</table>

*"Excessive masturbation is physically impossible, as it is a needless worry."

**p<.05

TABLE 58
Mean Frequency of Scores for NATM Item #8*
for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Period</th>
<th>Condition</th>
<th>Group Means</th>
<th>Pre</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Self-Directed</td>
<td></td>
<td>2.813</td>
<td>2.250</td>
<td>3.125</td>
<td>3.000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Period Means</td>
<td></td>
<td>2.938</td>
<td>3.250</td>
<td>3.250</td>
<td>3.313</td>
</tr>
</tbody>
</table>

*"Excessive masturbation is physically impossible, as it is a needless worry."

Note: Score increases indicate increased positive attitudes.
TABLE 59
Analysis of Variance of NATM Item #14*
for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition (A)</td>
<td>1</td>
<td>0.250</td>
<td>0.36</td>
</tr>
<tr>
<td>Error A</td>
<td>14</td>
<td>0.692</td>
<td></td>
</tr>
<tr>
<td>Period (B)</td>
<td>3</td>
<td>1.063</td>
<td>4.13**</td>
</tr>
<tr>
<td>A x B</td>
<td>3</td>
<td>0.167</td>
<td>0.65</td>
</tr>
<tr>
<td>Error B</td>
<td>42</td>
<td>0.257</td>
<td></td>
</tr>
</tbody>
</table>

* "Masturbation can provide an outlet for sex fantasies without harming anyone else or endangering oneself."
** $P \leq .05$

TABLE 60
Mean Frequency of Scores for NATM Item #14*
for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Period</th>
<th>Condition</th>
<th>Pre</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group</td>
<td>4.250</td>
<td>4.625</td>
<td>4.250</td>
<td>4.500</td>
</tr>
<tr>
<td></td>
<td>Self-Directed</td>
<td>4.125</td>
<td>4.500</td>
<td>3.875</td>
<td>4.625</td>
</tr>
<tr>
<td>Period Means</td>
<td></td>
<td>4.188</td>
<td>4.563</td>
<td>4.063</td>
<td>4.563</td>
</tr>
</tbody>
</table>

* "Masturbation can provide an outlet for sex fantasies without harming anyone else or endangering oneself."

Note: Score increases indicate increased positive attitudes.
TABLE 61

Analysis of Variance of NATM Item #18* for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition (A)</td>
<td>1</td>
<td>0.141</td>
<td>0.27</td>
</tr>
<tr>
<td>Error A</td>
<td>14</td>
<td>0.525</td>
<td></td>
</tr>
<tr>
<td>Period (B)</td>
<td>3</td>
<td>0.516</td>
<td>2.88**</td>
</tr>
<tr>
<td>A x B</td>
<td>3</td>
<td>0.057</td>
<td>0.32</td>
</tr>
<tr>
<td>Error B</td>
<td>42</td>
<td>0.179</td>
<td></td>
</tr>
</tbody>
</table>

* "Playing with your own genitals is disgusting."
** p < .05.

TABLE 62

Mean Frequency of Scores for NATM Item #18* for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Period</th>
<th>Pre</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Condition</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>4.375</td>
<td>4.750</td>
<td>4.750</td>
<td>4.875</td>
</tr>
<tr>
<td>Self-Directed</td>
<td>4.375</td>
<td>4.750</td>
<td>4.625</td>
<td>4.625</td>
</tr>
<tr>
<td>Period Means</td>
<td>4.375</td>
<td>4.750</td>
<td>4.688</td>
<td>4.750</td>
</tr>
</tbody>
</table>

* "Playing with your own genitals is disgusting."

Note: Score increases indicate increased positive attitudes.
TABLE 63
Analysis of Variance of NATM Item #23* for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition (A)</td>
<td>1</td>
<td>0.000</td>
<td>0.00</td>
</tr>
<tr>
<td>Error A</td>
<td>14</td>
<td>1.138</td>
<td></td>
</tr>
<tr>
<td>Period (B)</td>
<td>3</td>
<td>0.771</td>
<td>3.67**</td>
</tr>
<tr>
<td>A x B</td>
<td>3</td>
<td>0.292</td>
<td></td>
</tr>
<tr>
<td>Error B</td>
<td>42</td>
<td>0.210</td>
<td></td>
</tr>
</tbody>
</table>

* "When I masturbate, I am disgusted with myself."
** $P < .05$

TABLE 64
Mean Frequency of Scores for NATM Item #23* for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Period</th>
<th>Condition</th>
<th>Pre</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group</td>
<td>4.375</td>
<td>4.625</td>
<td>4.500</td>
<td>4.625</td>
</tr>
<tr>
<td></td>
<td>Self-Directed</td>
<td>4.375</td>
<td>4.875</td>
<td>4.125</td>
<td>4.750</td>
</tr>
<tr>
<td>Period Means</td>
<td></td>
<td>4.375</td>
<td>4.750</td>
<td>4.313</td>
<td>4.688</td>
</tr>
</tbody>
</table>

* "When I masturbate, I am disgusted with myself."

Note: Score increases indicate increased positive attitudes.
### TABLE 65
Analysis of Variance of NATM Item #24* for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition (A)</td>
<td>1</td>
<td>1.266</td>
<td>0.46</td>
</tr>
<tr>
<td>Error A</td>
<td>14</td>
<td>2.766</td>
<td></td>
</tr>
<tr>
<td>Period (B)</td>
<td>3</td>
<td>1.057</td>
<td>4.17 **</td>
</tr>
<tr>
<td>A x B</td>
<td>3</td>
<td>0.641</td>
<td>2.52</td>
</tr>
<tr>
<td>Error B</td>
<td>42</td>
<td>0.254</td>
<td></td>
</tr>
</tbody>
</table>

* "A pattern of frequent masturbation is associated with introversion and withdrawal from social contacts."

** $p < .05$

### TABLE 66
Mean Frequency of Scores for NATM Item #24* for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Condition</th>
<th>Pre</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>3.875</td>
<td>4.125</td>
<td>4.125</td>
<td>3.875</td>
</tr>
<tr>
<td>Self-Directed</td>
<td>3.250</td>
<td>4.250</td>
<td>3.500</td>
<td>3.875</td>
</tr>
<tr>
<td>Period Means</td>
<td>3.563</td>
<td>4.188</td>
<td>3.813</td>
<td>3.875</td>
</tr>
</tbody>
</table>

* "A pattern of frequent masturbation is associated with introversion and withdrawal from social contacts."

Note: Score increases indicate increased positive attitudes.
### TABLE 67
Analysis of Variance of NATM Item #29*
for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition (A)</td>
<td>1</td>
<td>0.766</td>
<td>0.80</td>
</tr>
<tr>
<td>Error A</td>
<td>14</td>
<td>0.962</td>
<td></td>
</tr>
<tr>
<td>Period (B)</td>
<td>3</td>
<td>0.307</td>
<td>2.93 **</td>
</tr>
<tr>
<td>A x B</td>
<td>3</td>
<td>0.141</td>
<td>1.34</td>
</tr>
<tr>
<td>Error B</td>
<td>42</td>
<td>0.105</td>
<td></td>
</tr>
</tbody>
</table>

* "Masturbation can teach you to enjoy the sensuousness of your own body."
** $p < .05$

### TABLE 68
Mean Frequency of Scores for NATM Item #29*
for all Subjects Through Followup

<table>
<thead>
<tr>
<th>Period</th>
<th>Condition</th>
<th>Pre</th>
<th>Post</th>
<th>2 Month</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group</td>
<td>4.250</td>
<td>4.625</td>
<td>4.250</td>
<td>4.375</td>
</tr>
<tr>
<td></td>
<td>Self-Directed</td>
<td>4.375</td>
<td>4.625</td>
<td>4.625</td>
<td>4.750</td>
</tr>
<tr>
<td>Period Means</td>
<td></td>
<td>4.313</td>
<td>4.625</td>
<td>4.438</td>
<td>4.563</td>
</tr>
</tbody>
</table>

* "Masturbation can teach you to enjoy the sensuousness of your own body."

Note: Score increases indicate increased positive attitudes.