Counsellor Education in the Treatment of Sexual Problems: Program Development and Evaluation

by

Lawrence G. McConnell

A thesis submitted to the Faculty of Graduate Studies and Research of McGill University in partial fulfillment of the requirements for the degree of Doctor of Education.

Department of Counsellor Education
McGill University
Montreal, Canada

August 1975

Lawrence G. McConnell
Counsellor Education
McGill University
August, 1975

short title of the thesis: Ed.D.

Counsellor Education in the Treatment of Sexual Problems

ABSTRACT

The present research study was designed to investigate the effects of specific training in sex counselling. A group of thirty-six counsellor trainees served as subjects for this study. The trainees had received practicum training for one semester prior to the start of the present study. Their theoretical background included a minimum one term of studies in counselling psychology. The subjects were divided into four groups: three treatment groups, and one control group. Three training programs in sex counselling were developed specifically for this research project.

Each subject conducted two sex counselling interviews. The first interview was held before treatment, and the second interview was conducted after treatment. Professional actors were hired to play the client roles. All of the sex counselling sessions were videotaped. Competence in sex counselling was operationally defined in terms of empathy, anxiety and sex knowledge. Personality traits of the counsellor trainees were examined to determine the potential such traits have for serving as predictors of positive response to treatment.

The findings demonstrated that the trainees who participated in the training programs experienced gains not realized in the control group. The short-term treatment significantly increased the trainees' knowledge of sex. While the communication of empathy remained constant, the method of treatment resulted in differential anxiety fluctuations. Furthermore, findings supported the claim that personality measures may prove useful in predicting a person's response to specific training in sex counselling.

RESUME EXPLICATIF

Le but de la présente étude a été d'investiguer les effets d'une formation spécifique dans le domaine de la consultation (counselling) sexuelle. Un groupe de trente six consultants en formation ont constitué les sujets de cette étude. Ces consultants avaient reçu une formation pratique pendant un semestre, précédant le début de cette étude. Leur formation théorique comprenait un minimum d'une session d'étude en psychologie du counselling. Les sujets ont été distribués en quatre groupes: trois groupes de traitement, et un groupe de contrôle. Trois programmes de formation en consultation sexuelle ont été développés spécifiquement pour ce projet de recherche.

Chaque subjet a fait deux entrevues de consultation sexuelle. La première entrevue effectuée avant traitement et la seconde, après traitement. Des acteurs professionnels ont été engagés pour jouer le rôle du client. Toutes les sessions de consultation sexuelle ont été enregistrées sur vidéo. La compétence en consultation sexuelle a été définie opérationnellement en terme d'empathie, d'anxiété et de connaissance sexuelle. Les traits de personnalité des consultants en formation ont été examinés pour déterminer le potentiel que ces traits peuvent avoir comme indicateurs de réaction positive au traitement.

Les résultats ont démontré que les consultants en formation qui ont participé aux programmes de formation en ont tiré un profit que n'a pu obtenir le groupe contrôle. Le traitement court terme a accru d'une façon significative la connaissance sexuelle des consultants en formation. Tandis que la manifestation de l'empathie demeurait constante, la méthode de traitement a donné comme résultat différentes fluctuations d'anxiété. De plus les

résultats ont confirmé l'avancé que la mesure de la personnalité peut être utile pour prédire la réaction d'une personne à une formation spécifique en consultation sexuelle.

PREFACE

In recent decades, our culture has undergone considerable social change. Part of this transition has involved matters related to sex. For instance, there has been a gradual removal of the secrecy that surrounded sex in past years. Several myths and taboos that once encompassed sexual behavior are now being challenged by many people. This process has helped to create a more open and objective interest in human sexuality. Some may feel that this new interest in sex has become an obsession within our society. Indeed, there is some truth in this observation when one considers the vast amount of exposure given to sex by most elements of the media. However, a period of overexposure may be a necessary step in the effort to create a society where people approach sexual matters in a positive and well adjusted fashion.

Strictly speaking, the term "sex" refers to a fundamental distinction related to reproduction (Drever, 1964, p.267). That is, sex refers to the male and female distinctions within the species. In its more common usage the term implies overt behavior within or between the sexes. Hence, the expression "having sex." In this manuscript the definition has been expanded to include attitudinal dimensions. In effect, when counselling persons with sexual problems the counsellor is aware of gender differences and overt behaviors, but he is also concerned with his client's value system. This interpretation of the term sex suggests that the manner in which an individual chooses to express himself sexually is related to his sexual value sytem.

A review of the literature revealed the existence of three traditions that could serve as the basis for the development of an individual's sexual belief system. The first chapter of this manuscript reviews the primary works that represent these three schools of thought, insofar as they relate to the psychology of sex: the moralists, who are distinguished through their efforts to interpret sexual behavior in terms of morality; the work of Sigmund Freud; and the scientists who may be identified by the emphasis they place on empiricism and the scientific method. The scientists attempt to remain morally neutral. The various distinctions among the three groups are elaborated upon throughout the first chapter. The implications the systems have for counselling are also discussed.

A review of the literature identified a variety of changes that have occurred in our society. More open attitudes and a new interest in human sexuality have encouraged many people to seek help with their sexual problems. The second chapter discusses the implications these changes have for the helping professions. A rationale has been developed to explain the importance of involving counsellors in this area of human concern. The recognition of this need led to a consideration of the counsellor's ability to function effectively in a sex counselling environment.

Chapter three discusses the research design. This involved four stages. The counsellor's competence was tested prior to his receiving specific training in sex counselling. It was necessary to develop specific training programs in sex counselling. The training programs were then implemented. Finally, these programs were evaluated for their effectiveness in improving a counsellor's sex counselling skills. These training programs contributed to original knowledge by providing a structural

procedure for training counsellors to assist their clients with problems related to sex.

The results reported in the fourth chapter provided a further contribution to original knowledge. Empirical data is presented which suggests that counsellors are not properly trained to function in a counselling setting where the primary concern is sexual matters. The feasibility of changing this situation is demonstrated in the report of positive results achieved through short-term training.

The final chapter discusses the implications these results have for counsellor education and provides suggestions for future research.

ACKNOWLEDGEMENTS

I would like to express my appreciation to the Counsellor Education practicum students who served as the subjects for this study. I would also like to thank Salah Allam and Carmelo Sgro for their co-operation in filming the counselling sessions. I am grateful to the judges who rated the tapes, and the actors who served as clients.

The time and effort Dr. D. Paré devoted to training the raters, and co-ordinating the counselling sessions is appreciated. I would like to thank Dr. J. Harris and Dr. J. Park for the time they devoted to reading and commenting on various sections of this manuscript. A special word of thanks to Susann Allnutt for the excellent job she did in typing the manuscript.

Without the assistance of Dr. Hugh Leard and Dr. Florent Dumont this manuscript would never have become a reality. I am indebted to them for the countless hours they so generously devoted to this project. Their academic excellence, boundless energy, and priceless humor were invaluable to me in the planning and implementation of this research.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF ILLUSTRATIONS

Chapter I

Review of Related Literature

In the past, discussion of sexual matters was not restricted to a single field of inquiry. The subject has been widely dealt with in theology, law, medicine, and psychology. However, the topic of sex has been largely ignored in the field of counsellor education. The present research study evolved from the belief that sexuality is a vital component of the human condition which must not be ignored in the training of counsellors. It was hoped that the research study would provide some direction in overcoming the difficulties associated with training sex counsellors.

The writers who have contributed to the literature on human sexuality represent a wide variety of disciplines. Historically, the Church, through its theologians, and the State, through its legislators, have shown a vast interest in sexual matters. Novelists have written about sexuality. The topic has been given serious consideration in the works of philosophers and anthropologists. The importance of these works should not be dismissed, but most are of minimal use to the counsellor. Relevant material for counsellors may be found in the writings of those whose backgrounds were in medicine or psychology. Primarily, physicians and psychologists have developed the theories and methods presently employed to assist people with sexual problems. Therefore, this review relied heavily on medical and psychological sources.

A review of the literature on human sexuality revealed three major

schools of thought. In the first half of the 20th century most medical doctors and psychologists studied human sexuality within a moralistic or Freudian framework. A third approach to the study of sexuality came with the publication of Alfred Kinsey's major works in 1948 and 1953. This marked a major transition in sex research because emphasis was shifted to scientific analysis. Contemporary society has been influenced by the three traditions. In the present chapter attention is focused upon the contributions made by the major proponents of the three systems of inquiry. The implications of the three traditions for contemporary counsellors are also discussed.

The Moral Analysis of Sexual Behavior

The moralistic approach to sexuality was closely associated with Christian dogma. However, efforts to interpret this dogma resulted in a dichotomy. The Christian debate on sexual behavior was essentially a manifestation of the philosophical differences that existed between the dualists and the naturalists (Cole, 1966, p.9). Cole (1966, pp.4-5) claimed that dualists viewed man's passion as basically evil. Sexual expression required stern restrictions since its only justification was procreation. In contrast, the naturalists claimed that man's sexuality was a divine gift to be enjoyed in a responsible fashion (Cole, 1966, p.3). This dichotomy also surfaced in the writings of those sex theorists who applied moral analysis to sexual behavior (Blackwell, 1902; Ellis, 1938; Van de Velde, 1930). The following section reviews the positions of the dualist and naturalist insofar as they apply to the psychology of sex.

The dualist interpretation of sex. The dualist argument rested

on the premise that procreation was the sole justification for satisfying sexual needs. This meant that intercourse between married couples was the only legitimate form of sexual release. This belief placed strict restraints on other forms of sexual expression. Efforts were made to discourage masturbation, and any other sexual acts among married couples which stood in the way of conception. The dualists also denied the existence of a sexual drive in women.

Richard von Krafft-Ebing (1840-1902), and Elizabeth Blackwell (1821-1910) were major proponents of the dualist position. Their writings provide the reader with an understanding of the moral analysis of sexual behavior from the dualist point of view.

Von Krafft-Ebing (1893) argued that sexual deviants must not be viewed as criminals when he wrote:

> Law and Jurisprudence have thus far given but little attention to the facts resulting from investigations in psychopathology.... scientific investigation shows that a man mentally and sexually degenerate ab origine, and therefore irresponsible, must be removed from society for life, but not as a punishment. (p.379)

It remained for von Krafft-Ebing to define what he viewed as deviant. It was his explanation of deviant behavior that identified him as a dualist.

Von Krafft-Ebing made no effort to deny man's sexual desire, but he interpreted it as a rather vulgar manifestation of human weakness. This attitude was revealed by von Krafft-Ebing (1893) when he suggested that Christianity allowed a person to raise himself spiritually by expecting "a paradise freed from all earthly sensuality, promising the purest of intellectual happiness" (p.5). Therefore, the existence of sexual drives necessitated a strict moral code to govern their overt

expression. Such controls allowed man to distinguish himself from the animal through his recognition that sexual expression had a more noble design than the gratification of lust. As von Krafft-Ebing (1893) wrote:

> With opportunity for the natural satisfaction of the sexual instinct, every expression of it that does not correspond with the purpose of nature - i.e. procreation - must be regarded as perverse. (p.56)

In view of this belief, other forms of sexual expression that were unnecessary for procreation were discouraged. For example, he took great care to admonish married couples against the evil inherent in acts of cunnilinctus and fellatio. Von Krafft-Ebing (1893) stated "these horrible sexual acts seem to be committed only by sensual men who have become satiated or impotent from excessive indulgence in a normal way" (p.382). Masturbation also was considered dangerous. This was made evident with the mass of case histories presented in von Krafft-Ebing's text. In many instances masturbation was listed as a primary etiological factor contributing to the patient's pathology.

The dualism of von Krafft-Ebing's theory was apparent in his analysis of female sexuality. He claimed that the normal woman had little sexual desire (von Krafft-Ebing, 1893, p.13). However, he acknowledged the male's strong sexual appetite. He employed this difference to justify his conclusion that the female should always be punished more severely than the male in the case of infidelity (von Krafft-Ebing, 1893, pp.14-15).

An examination of von Krafft-Ebing's writings in conjunction with Blackwell's (1886, 1902) contributions provides a thorough understanding of the dualist position which they represented. The Blackwell biography (Hays, 1967) was a tribute to the pioneering temperament of the family.

The Blackwells were associated with many noble causes, including women's rights and the abolition of slavery. Elizabeth Blackwell enjoys a unique place in history as the first woman to qualify fully as a physician in either the United States or England. As was common with most physicians of her time, Blackwell discussed human sexuality on the basis of religious principles. Her writings helped to enhance dualism because they emphasized the inferior nature of sexual expression, and the great need for moral guidelines.

Blackwell did not morally condemn the pleasurable aspect of sexual expression, but never encouraged her readers to strive for pleasurable experiences. Blackwell (1886) argued:

> There is nothing necessarily evil in physical pleasure. Though inferior in rank to mental pleasure, it is a legitimate part of our nature, involving always some degree of mental action. (p.19)

This theme was further developed when she warned men of the dangers inherent in frequent coitus. She wrote:

> The healthy limitation of physical secretion in men sets free a vast store of nervous force for employment in intellectual and active practical pursuits. The amount of nervous energy expended by the male in the temporary act of sexual congress is very great, out of all apparent proportion to its physical results, and is an act not to be too often repeated. (p.30)

Blackwell's support for the masturbation taboo was congruent with the dualist position. In one of her books (Blackwell, 1886, pp.32-38) an entire chapter was devoted to a discussion of the physical and moral dangers that result from masturbation. She emphasized the mother's responsibility in ensuring her child's avoidance of the evils of masturbation. Blackwell (1886, p.35) stressed the importance of such child rearing procedures by warning that improper guidance could lead to such

drastic results as insanity and suicide.

Blackwell devoted little attention to the sexual behavior of women. Instead, she emphasized the role of women as mothers believing that most women had little interest in sex and rarely felt the need for sexual fulfillment (Blackwell, 1902, p.53). She asked men to understand that women were inclined to prefer tender acts, such as kissing and hugging, to coitus. Blackwell (1902) saw sexual intercourse as "the special act of the male" (p.52).

The writings of von Krafft-Ebing and Blackwell were representative of the dualists' interpretation of human sexuality. However, their position did not remain unchallenged. A second school of thought within the tradition of moral analysis developed a theory in response to dualism.

The naturalist interpretation of sex. The naturalist's position is best represented by the works of Havelock Ellis (1859-1939) and Theodoor Van de Velde (1873-1937). In their writings these authors stressed what they believed to be the moral as well as the normal aspects of sexual behavior. This approach contrasted with the emphasis placed on abnormality by the dualists. The naturalists' interpretation of sexuality also widened the boundaries of normality. This allowed more variations and personal preferences to be realized in sexual behavior.

A tolerance and appreciation for the vast range of normal behavior was evident when Ellis (1938) said:

> All normal persons are a little abnormal in one direction or another, and abnormal persons are still guided by fundamental impulses similar to those felt by normal persons. (p.7)

He thought that sexual expression should be viewed as a private matter. He claimed social intervention was justified only in those instances

where the act was injurious or infringed upon another person's rights (Ellis, 1938, p.158).

In contrast to the dualist viewpoint, an insistence on procreation as the sole justification for sexual intercourse was not present in the writings of Ellis or Van de Velde. However, Ellis (1938) did say, "sexual activities entirely and by preference outside the range in which procreation is possible may fairly be considered abnormal, they are deviations" (p.112). Van de Velde made his position clear with the argument that contraception was a matter where individual choice must be the guideline (Van de Velde, 1930, pp.305-313).

The naturalists wanted to extend the boundaries of permissible behavior between married couples. Ellis (1938) commented:

> Taking sexual relationships in the widest sense, but still on the physical side, it is important always to bear in mind that whatever gives satisfaction and relief to both parties is good and right, and even in the best sense normal, provided no injury is effected. (p.252)

Van de Velde also encouraged his readers to recognize the joy of variation in love play. For instance, he approved of oral-genital sex, although cautioning that "normal" intercourse must terminate with ejaculation of semen into the vagina (Van de Velde, 1930, p.131). This opinion contradicted the dualists' claim that oral-genital sex was pathological.

The masturbation taboo was a consistent theme in dualism. Ellis saw no reason to fear masturbation on moral or physical grounds. He challenged the cause and effect relationship posited between masturbation and insanity. He claimed masturbation was natural, and supported the claim with statistics showing that most people masturbated. Ellis (1938,

p.80) suggested that this fact made it evident that no one was in a position to decide arbitrarily what was natural and what was perverse. The subject of masturbation received only scant attention from Van de Velde. He mentioned the topic in his major work on three occasions, and made no effort to support or refute the taboo (Van de Velde, 1930, pp.23, 54,258).

Implications for contemporary counsellors. The conclusions derived from the moral analysis of sexual behavior survived over the years and influenced various segments of contemporary society. Writing on this theme, Schiller (1973) stated the case succinctly when she said, "For better or worse, the past is very much with us" (p.23). The respected sexologist, Albert Ellis,(1969) related moral analysis to sexual problems when he claimed that "a man or woman may become sexually anesthetic or incompetent because of puritanical fears of sex itself, with concomitant severe feelings of shame and guilt" (p.137). However, not all people who develop a sexual value system which is based on moral analysis find that they have sexual problems. There is no evidence to suggest that people with conservative sexual value systems cannot be happy and effective with their sexual lives (Hartman & Fithian, 1972, p.67). Nevertheless, many people who seek help for sexual problems have a value system that was derived from the moral analysis of sexual behavior. These circumstances make it necessary for the counsellor to comprehend the repercussions this tradition has on the treatment of sexual problems.

Brecher (1971, p.367) claims that our culture is attempting to resolve the conflict created by the notion that procreation is the only

justification for sexual intercourse. The idea that emotional communication and physical pleasure are the primary motives for sexual behavior is not accepted universally. This fact is underlined in the current dispute over contraception. Some churches - and particularly the Roman Catholic Church - have outlawed the use of artificial means of birth control (Pope Paul VI, 1975, p.238). A moral restriction of this nature may have direct clinical implications for the counsellor. Masters and Johnson (1970, p.122) illustrated this point in their case study of a couple who had sexual problems as a result of one partner's refusal to practice birth control on the basis of religious conviction. This type of situation involving as it does, moral standards, is frequently encountered in sex counselling.

Most people who have been brought up in a religious atmosphere have been engendered with a moralistic tradition in respect to sexuality. This is an important fact because Masters and Johnson (1970, pp.229-230) have emphasized that religious orthodoxy remains a major factor in almost every form of sexual inadequacy. Kaplan (1974, p.148) supported this argument when she claimed that many families created serious sexual conflicts in their children. These often resulted in sexual problems later in life. These observations represent a variety of implications for the counsellor. One of the most pertinent problems is concerned with masturbation.

Albert Ellis has observed objections to masturbation in modern writings on sexuality. He said the more common reasons used to discourage the act included claims that it was immature, asocial, frustrating, and could lead to frigidity or impotence (Ellis, 1969, pp.24-26). McCary

(1973) claimed that many people "come to believe that masturbation is an evil, abnormal, or at best, infantile practice" (p.156). In an effort to challenge this attitude, McCary (1973, pp.156-160) devoted a complete section of his text to refuting the arguments against masturbation.

The taboo on masturbation generates anxiety in many people. A recent study conducted by Sarlin (1974) supports this conclusion. She described how New York City recently provided a phone-in service for sex information. Sarlin reported that the majority of questions from male callers related to oral sex and masturbation. She added that most of the inquiries on masturbation sought reassurance regarding its normality. Hartman and Fithian (1972, p.65) discussed this matter in another context. They suggested that our cultural expectations imply that married couples do not masturbate. As a result, many couples who practice self-stimulation often experience guilt feelings that must be handled by the counsellor.

A client's negative attitude towards masturbation may impede the treatment of various sexual dysfunctions. A primary example involves the treatment of orgasmic dysfunction. Hartman and Fithian (1972, p.66) suggested that masturbation was the most direct route to orgasm for the non-orgasmic woman. McCary (1973) supported this contention when he wrote, "learning to masturbate successfully is probably the most important step for the woman in learning to come to orgasm easily and quickly" (p.161). The research results reported by Lo Piccolo and Lobitz (1972) provided experimental evidence that supported McCary's argument. Hastings (1966) also reported positive results when his clients used masturbation to help overcome such problems as premature ejaculation and

vaginismus. In a more general sense, McCary (1973) explained that masturbation was "probably the most successful way of learning to respond to one's full sexual capacity" (p.156). These observations highlighted the need for counsellors to understand their clients' attitudes towards masturbation. Furthermore, they must be aware of the problems that may surface in treatment when a client views masturbation as an immoral act.

The study previously cited (Sarlin, 1974) suggested that questions about oral-genital sex were common. In their clinical work Hartman and Fithian (1972, p.183) encountered many clients with reservations concerning oral-genital sex. This topic is usually viewed with a great deal of caution. Ellis (1969, p.60) suggested that society's taboo on this form of behavior has encouraged many people to view it as wicked and shameful. McCary (1973, p.167) claimed that inhibitions regarding oral-genital sex were essentially derived from the feeling that the genital region was dirty. Whatever the origin, the counsellor must be prepared to understand the individual whose sexual value system does not permit such behavior. The counsellor's understanding and acceptance in this area can be crucial in the treatment of sexual problems. Such acceptance must be present even where reluctance to practice this form of sexual expression may limit the treatment alternatives in certain situations. Ellis (1969, p.63) illustrated how such a conflict can create negative repercussions in terms of intervention strategies. He explained that people who believe such behavior to be immoral will not resort to the kinds of genital stimulation often required for maximum arousal. The client's sexual value system thus becomes an important variable for consideration by the

counsellor when he assigns behaviorally oriented tasks to his clients.

The Contributions of Sigmund Freud

The theories developed by Sigmund Freud (1856-1937) were a major contribution to the literature on human sexuality. The focus of the present study made it impossible to discuss his work in detail. Nevertheless, it was essential to examine portions of his theory in terms of the constructs presently under consideration.

Freud was one of the first personality theorists to propose a theory of sexuality based on personal clinical observations rather than on established moral codes. To understand abnormalities he felt compelled to examine the nature of human sexual development.

In support of tradition. Freud was not identified with either the dualists or the naturalists. However, some of his conclusions were similar to those drawn by the moralists. Krich (1963, p.9) observed that Freud was a victim of abuse because his theory of infantile sexuality ruined the image of "innocence" attached to childhood by Victorian society. Nevertheless, many of Freud's other ideas did not represent a radical departure from the moral standards of his time.

Freud recognized sexual disturbance as a common etiological factor among his patients. As Putnam (1962) pointed out, "Freud's thesis claims that psychoneurotic illnesses never occur with a perfectly normal sexual life" (p.xxiv). This interpretation was accurate since Freud (1953/1905) claimed, "the symptoms constitute the sexual activity of the patient" (p.172). In many instances, Freud's interpretation of sexual abnormality corresponded to the moralists' interpretation.

This harmony with the prevailing norms was evident when Freud (1960/1920) labeled as perverts those people "whose sexual desires aim at the performance of an act which normally is but an introductory or preparatory one" (p.315). He also believed that the use of oral sex as an end in itself was abnormal and disgusting (Freud, 1960/1920, p.314). Although he did not disregard the masturbation taboo, Freud claimed the act was normal during the infantile stage of development. Freud (1953/1905) believed that when masturbation continued until puberty it represented "the first great deviation from the course of development laid down for civilized man", (p.189).

Female sexuality. Freud brought a new interpretation of female sexuality to the psychology of sex. The psychoanalytic explanation did not provide women with an autonomous sexual identity. Their acquisition of individuality was determined by their reactions to "not being a male." Waxenberg (1969) interpreted this notion with his explanation that the woman:

> Was considered to have started life as a deprived, defective travesty on the male prototype. Castrated before genitality entered her life! (sic) And what genitality she was expected to attain, despite all her handicaps - namely, vaginal orgasm. (p.3)

This theoretical position was based on the assumption that all women experienced penis envy. The concept had central importance in the psychoanalytic process. Torok (1970) explained that "in every woman's analysis, there is inevitably a period in which appears a feeling of envy and covetousness for both the male sex organ and its symbolic equivalents" (p.135).

In Freud's theory, the transference of erogenous excitability from the clitoris to the vagina was crucial if the female's sexual

development was to follow a normal pattern (Freud, 1953/1905, pp.220-221). In the female sexual response the absence of vaginal orgasm was symptomatic of neurosis. In effect, Freud recognized a female sexual impulse but argued that for normality to prevail a set pattern must unfold during the satisfaction of these sexual drives.

Implications for contemporary counsellors. In the moral analysis of sexual behavior the female component was frequently ignored, or enveloped in an aura of mythology. This resulted in an abundance of debate, contradiction and bewilderment. The application of scientific analysis helped to clarify much of the confusion surrounding female sexual behavior. Scientific findings generated a change in social attitudes, but some traditional theories remained influential in the psychology of sex. This has been the situation with the psychoanalytic interpretation of female sexuality in terms of penis envy and female orgasm.

The notion of penis envy as a fundamental aspect of female sexuality has, for the most part, remained unchallenged in the psychoanalytic tradition. Although Karen Horney (1967) disputed many of Freud's theories, she never denied the existence of penis envy. She introduced an original interpretation of the concept, but did not reject it entirely. She argued that a yearning for the male role was motivated by the real social disadvantages experienced by women (Horney, 1967, p.69). She also attempted to balance the ledger with her suggestion that the female's superiority with respect to reproduction resulted in masculine envy (Horney, 1967, pp.61-62).

Following an approach similar to Horney's, Fried (1969) modified Freud's theory on penis envy, but did not reject it. She believed

Freud exaggerated the importance of penis envy in the formation of pathogenic attributes. Instead, she emphasized the importance of penis envy in normal development. Fried (1969) argued that a woman's gradual acceptance of the fact that she had no penis "constitutes an important step in the direction of realism, frustration tolerance, and the ability to develop compromise solutions" (p.53).

Schiller (1973, p.46) claimed that psychoanalysts have stressed to their patients, and the public, the idea that only immature women have clitoral orgasms. This has been a major theory in the traditional psychoanalytic interpretation of female sexuality. Horney (1967) revised the theory but never renounced the basic supposition. Unlike Freud, Horney (1967, p.65) accepted the possibility of vaginal response in youth. However, she never accepted clitoral orgasm as a normal response pattern for adult women.

In recent decades many of the theories advanced by moralists and Freudians have been challenged. This process originated with the scientifically oriented researchers who began to publish their findings after the second world war.

Scientific Analysis of Sexual Behavior

The proponents of scientific analysis introduced a new procedure in the study of sexual behavior. Their intention was to avoid examining sexuality in terms of either a subjectively established moral code or a psychological theory. Instead, they attempted to study sexual behavior from a position that was basically neutral as far as morality was concerned. They replaced moralism with empirical observation and scien-

tific methods. Their system was designed to discover how people expressed themselves sexually and to learn of the problems people encountered with their sexuality. In turn, this led to a search for ways to help those people with sexual problems. The method called for a clear distinction between the subjective and objective forms of inquiry.

The following section discusses the major works in sex research that stemmed from the scientific analysis of sexual behavior. Particular attention has been paid to Kinsey, Masters, and Johnson since their contributions are most relevant for counsellor educators.

The Kinsey era. The work of Alfred Kinsey (1894-1956) represented a clear departure from the moral analysis of sexual behavior. He did not focus attention on moral issues. Instead, his intention was to discover the various forms of sexual behavior practised by the human species. His utilization of quantitative-empirical methods served as a landmark in the movement of sex research from moral discourse to the world of science. Data collection coupled with statistical procedures gained respectability as an instrument of operation in the analysis of human sexual behavior.

In respect to the advancement of sex research, it may be argued that Kinsey's findings were of less importance than the methods he employed to obtain his information. Nevertheless, initially his method was ignored, while his findings received negative reactions in many quarters. Kinsey avoided moralism but, as Bell (1966, p.7) suggested, many people were so threatened by the findings that they were unable to avoid accusing Kinsey of presenting a variety of moral imperatives. This was Zimmerman's (1949, pp.224-225) approach when he demanded that the Kinsey

team provide a plan for the future since they were dissatisfied with the prevailing sex norms. Similar reactions, especially from the dualists, were understandable even though the Kinsey team avoided moralizations in their research reports. The moralists had cause for concern because the findings illuminated the wide discrepancy between attitudes and behavior. They showed that the moral tradition did not have as great an impact on sexual behavior as the moralists believed.

The findings reported by Kinsey and his associates (Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin,& Gebhard, 1953) posed a strong challenge to the moralists' claim that normal sexual behavior was restricted mainly to that which was necessary for procreation. They also questioned the authority of a moral code that advocated as acceptable only sexual behavior that was specifically required for impregnation. This evolved from their discovery that foreplay, with all its variations, was the rule rather than the exception. They found ample evidence for this conclusion in the fact that only 0.2 percent of the women stated that they abstained from foreplay (Kinsey et al., 1953, p.361). These observations suggested that passion consistently overpowered moral judgment. Many people who held to the moralist position probably experienced conflict as a result of their sexual behavior. Kinsey et al. (1953) made no effort to examine the ramifications of such dissonance in terms of sexual function, but they implied that the repercussions might well be negative.

On the basis of his data, Kinsey disputed the moralist and Freudian interpretations of the personalities of people who masturbated. His study revealed that ninety-two percent of the male population masturbated to orgasm. The frequency varied with such factors as age, socio-economic

background and education. Nevertheless, it was clear that the majority of men masturbated (Kinsey, Pomeroy, & Martin, 1948, p.499). His later studies reported similar findings in the case of women. The figure was sixty-two percent for those who had masturbated at least once, while twenty to fifty-eight percent masturbated regularly. The variance in the range was accounted for by the marital status of the subjects and the socio-economic group to which they belonged (Kinsey et al., 1953, p.173).

Kinsey explained that approximately half of those people who masturbated experienced psychological disturbance as a result of their actions. However, he cautioned the reader against interpreting this fact as a sign that masturbation in itself was harmful. He argued that the disturbance was generated by the conflict between the person's moral code and his behavior. He saw the Freudian interpretation as a source of guilt because it viewed the act as infantile. It, therefore, became indicative of a personality defect which required psychiatric attention (Kinsey et al., 1953, p.170). Kinsey rejected this position as unscientific. He stated, "Many adults who are not immature in any realistic sense do masturbate, and there is no science in refusing to recognize this fact" (Kinsey et al., 1953, p.171).

The data compiled on female sexual response reinforced Kinsey's acceptance of a female sex drive. The existence of this sex drive was evident in his reports on women's masturbatory patterns, their capacity for orgasmic response in various forms of sexual behavior, and their potential for multiple orgasms(Kinsey et al., 1953, p.375). Kinsey's research also led him to a definite conclusion on the "clitoral versus

orgasm" dispute. In a direct statement commenting on the Freudian idea of transformation from clitoral to vaginal response Kinsey et al. (1953) wrote, "There are no anatomic data to indicate that such a physical transformation has ever been observed or is possible" (p.582). Kinsey and his associates were leading the way in showing how the scientific method must be employed to test theoretical presumptions.

The work of Masters and Johnson. It was another thirteen years before a comprehensive research program was developed to study human sexuality. This was accomplished by the work of Masters and Johnson. The program started with a scientific explanation of the physiological components of sexual function. The information was obtained through laboratory observation, and resulted in their first joint major publication (Masters & Johnson, 1966). The process was co-ordinated with a detailed exploration of the psychological elements and their relationship to attitudinal sets. The project culminated in a rigorous treatment program which was designed to overcome sexual dysfunction (Masters & Johnson, 1970). In effect, Masters and Johnson were not content with establishing the etiological background for sexual dysfunction. In addition, they were concerned with developing effective methods for treatment.

The treatment procedures designed by Masters and Johnson were not developed on the premise that procreation was the fundamental reason for sexual activities. Instead, they saw pleasure as the basic motivation for these activities. This was evident in their "give-to-get principle" which enjoyed a central place in their treatment program (Masters & Johnson, 1970, pp.72-75). Their lack of concern over procreation was also evident in their clinical definition of premature ejaculation. It

was not classified as a dysfunction when it proved a hindrance to conception. Rather, the diagnosis was based on the frequency of the female's orgasmic response (Masters & Johnson, 1970, p.92).

It is not uncommon for people to seek purposes for behavior. Many people justify their behavior in terms of purpose. In reference to sexual behavior, the moral tradition provided a purpose with its insistence on procreative intentions. Masters and Johnson did not ignore the idea of purpose. However, they stressed the importance of recognizing the desire for pleasure as a valid purpose. They also realized that the belief systems of their clients were frequently influenced by ideas derived from the moral analysis of sexual behavior. In the light of these observations, their treatment program included methods designed to alter self-defeating belief systems. The educational aspect of the program centered on the client's belief system. Masters and Johnson (1970) claimed that positive outcome necessitated an attempt to alter "such timeworn concepts as sex is dirty, nice girls don't involve themselves, or sex is for reproduction only" (p.225). There was no attempt to camouflage the fact that their intentions were to modify sexual value systems as well as patterns of behavior.

Masters and Johnson refused to accept any explanation of sexual behavior that denied the female sex drive. In those instances where orgasmic dysfunction was the presenting symptom, they refused to recognize some innate aversion to sex as the cause. They suggested that women who were unable to express their sex drive still valued sexual stimulation, and desired satisfaction. The problem rested with societal requirements that forced women to repress their sexual feelings (Masters & Johnson,

1970, p.215).

Masters and Johnson discarded the Freudian conclusions on female orgasm. Reporting on their laboratory observations, Masters and Johnson (1965) wrote:

> The analytical literature abounds with descriptions and discussions of vaginal as opposed to clitoral orgasms. From an anatomic point of view, there is absolutely no difference in the responses of the pelvic viscera to effective sexual stimulation, regardless of whether the stimulation occurs as a result of clitoral area manipulation, natural or artificial coition, or, for that matter breast manipulation alone. (p.104)

Therefore, from the physiological point of view the only kind of orgasm is a sexual orgasm (Brecher & Brecher, 1966, p.84).

Implications for counsellors. The empirical findings and treatment procedures that evolved from the scientific analysis of sexual behavior carry important implications for counsellors. The contributions made by Kinsey, Masters, and Johnson provided the foundation for a proper understanding of human sexual behavior. Nevertheless, meaningful contributions were also made by other researchers in the scientific field. The recent emphasis on the scientific analysis of sexual behavior has placed the scientist at centre stage. Reiss (1963) made such an observation when he wrote:

> In the mass of literature and research available on sexual behavior it is a rarity to find an unbiased and scientific approach, but in recent decades one can detect an unmistakeable trend in this direction. In short, the scientific study of sex has come of age. (p.3)

The accuracy of this statement is evident when considered in the context of the past ten years. The recent emphasis on scientific analysis has helped the counsellor in several ways. It is now possible for him to

acquire a better understanding of the vast range of normal sexual behavior. The scientific approach has also been instrumental in exploding a variety of sexual myths. As well, the counsellor now has at his disposal an abundance of material concerned with sexual expression. Such information may serve as a basis for helping the counsellor to master the intervention strategies recently developed in the treatment of people with sexual problems.

The empirical-quantitative method of studying sexual behavior has had a tremendous impact on sex research. It has permitted the counsellor to grasp the variety of sexual experiences open to the individual. In commenting on this method of analysis, Chall (1961) wrote:

> It has created a language describing sexual behavior that is relatively free of "normative" encumbrances and connotations. It perceives sexual behavior as based less on human values traditionally defined and more on frequency and functionality. (p.21)

The counsellor is no longer forced to rely on his own experiences for establishing norms. Awareness of variations also makes acceptance easier. In turn, this helps the counsellor to refrain from imposing his personal value system on the client. This avoids the negative repercussions Hartman and Fithian (1972, p.66) claimed were inherent when a counsellor attempted to force his own sexual value system upon his client.

The proponents of scientific analysis also made a concentrated effort to dispel the various myths surrounding sexual behavior. The work culminated in McCary's (1971) text which was devoted to the presentation of evidence refuting the more popular fallacies surrounding sexuality.

Recent trends in sex research have also stimulated the development of more effective treatment procedures. This is most evident with

the intervention strategies designed by Masters and Johnson (1970), Hartman and Fithian (1972), and Kaplan (1974). In respect to the behavioral components of treatment, all of these methods stress the pleasurable aspect of sexual expression. However, the need for adequate sexual knowledge was deemed an essential prerequisite. Kaplan (1974, p.123) has observed that many couples lack the knowledge necessary for effective sexual treatment. Since such ignorance proves a serious hindrance to positive outcome, the counsellor must be prepared to educate his clients. This role points up the necessity for the counsellor to have a clear knowledge of anatomy and sexual techniques. The authoritative works of Ellis (1969) and Sherfey (1972) have filled any lacuna that may have existed in these areas. Their contributions make it possible for the counsellor to provide his clients with accurate information regarding sexual functioning. In addition, such developments assist counsellors to operationalize such theories as sensate focus (Masters & Johnson, 1970, pp.71-75) in a manner that corresponds with the individual needs of their clients.

The previous sections explained how the sexual value systems of many people were based on conclusions derived from the moral analysis of sexual behavior and psychoanalytic theory. It was argued that the counsellor must understand the moralist and Freudian interpretations of sex because of their public impact. Nevertheless, such understanding is not sufficient. It is also essential that the counsellor familiarize himself with the scientific literature concerned with human sexuality. When this is not done, the most the counsellor may achieve is a partial understanding of the etiological background to sexual dysfunction. He

will certainly lack the skills required in the effective treatment of such problems.

Chapter II

Training Models: Rationale, Variables, and Criterion Measures

The recent emphasis on social change served as a major impetus for this research. The present chapter outlined the experts' interpretation of the social transformation that has occurred in respects to sexual matters. This led to a consideration of the various alternatives available to people who seek assistance with sexual problems. Several shortcomings were found in the services provided for people experiencing problems with their sexuality. These observations drew attention to the role of the counsellor in this area of human concern. An analysis of his role revealed a need for his involvement in sex counselling. It was further argued that adequate training in sex counselling was a prerequisite to effective intervention. In view of this claim, the final section of the chapter concentrated on training procedures. A method was devised to evaluate the proposed training programs in sex counselling. This included a discussion of the selected approaches to treatment, the relevant variables and the criterion measures.

Interpretations of Change

In matters concerned with sexuality, the past decade was frequently characterized as a period of change. However, researchers found it difficult to define the nature of this change. The problem centered on the distinction between attitudes and behavior. Some observers argued

that the change was limited to attitudes. Others suggested that a sexual revolution had occurred and radical changes in sexual behavior were involved.

A focus on attitudes. Reiss (1966) interpreted the change as attitudinal because people showed a new interest and a more open attitude in sexual matters. Gagnon and Simon (1970) supported this interpretation. They suggested that people were more willing to talk about sex and many did so quite openly. Nevertheless, they cautioned against attaching a corollary regarding actual behavior. Freedman (1970) followed this theme when he suggested that people were more likely to accept the behavior of others. Such acceptance did not, however, imply a change in their own behavior. To lend empirical support to the argument, he referred to his own data which reported only a small increase in the incidence of coital experience among college women.

A revolution. Some observers believed that the 1960's witnessed a genuine revolution due to the fact that changes went beyond attitudes. Mazur (1968) argued that the term "revolution" was applicable because it "best expresses the nature of the contemporary changes in patterns of sexual conduct and conviction" (p.5). He suggested that the birth control pill, and the new morality have served as the revolution's catalysts. This, in turn, resulted in the acceptance of sexual contact as a legitimate component of friendship, and placed emphasis on the fun aspect of sexual expression (Mazur, 1968, pp.5-8). The latter claim was similar to an earlier observation made by Foote (1958). He noticed the trend [illegible] earlier when he claimed that the "play" aspect was viewed as the primary purpose of sexual expression rather than procreation.

Sprey (1969) supported this position with his claim that sexuality had acquired autonomy since it no longer suffered restrictions within the institutional framework of reproduction and child rearing. He believed this disassociation was made possible by industrial progress in the form of reliable contraceptives, and extensive leisure time. A further extension of this change was witnessed with the creation of such organizations as the Gay Liberation and Women's Liberation movements. Organizations were also formed to legalize abortions, sterilization, and the sale of pornographic materials. These organizations were concerned with changing modes of behavior as well as attitudes.

Future trends. The argument against simultaneous change in sexual attitudes and behavior did not exclude the possibility of future behavioral changes. In fact, Reiss (1967, p.8) suggested that changes in sexual behavior could quite possibly occur in the near future. McCary (1970) also denied a revolution in terms of behavior but warned that "revolt looms on the horizon" (p.214). In effect, it is reasonable to anticipate changes in overt behavior if the transformation in attitudes is not simply verbal, but corresponds to a shift in deep-seated attitudes.

The dearth of empirical evidence makes it difficult to determine the impact which the forces of change have had on sexual behavior. A study fashioned on the Kinsey et al. (1948, 1953) model is probably required to resolve the debate. Nevertheless, many researchers suggest that the presence of change in itself has important consequences for the helping professions. More specifically, Athanasiou (1973) warned that impending changes have strong implications for professionals in the fields of guidance and counselling. He suggested that ignoring the present trends

would leave the professional unaware of the fact that his personal value system is only one system among many. The implication was that members of the helping professions must not isolate themselves from social change.

The above discussion on change suggested that many people view their sexual relationships in the light of their intrinsic value. It follows that less attention is focused on the procreative aspect of sexuality. It was also noted that more people approach sexual matters with an open attitude. This generates a willingness to talk about sex and sexual behavior. The implication is that people wish to be more comfortable with their own sexuality. However, this does not mean that everyone knows how to achieve this goal even though the intent and desire to do so may be present. In other words, people still encounter sexual problems. This raises a question as to where the responsibility for helping people with these problems rests.

The Contemporary Scene

The work of Masters and Johnson highlighted the fact that many people who are considered part of the so-called "normal population" experience sexual problems. Although Masters and Johnson (1970, p.21) accepted psychoneurotics as clients, they did not work with psychotics. Their clientele was drawn from the mainstream of society.

For most people, travel to a distant foundation for consultation and treatment is not practical. Finding a highly-trained specialist within a community often proves difficult, if not impossible. These observations led to speculation as to where people go when seeking assistance with sexual problems. Elias (1970) provided part of the answer

when he reported on unpublished data acquired from the Institute for Sex Research. He pointed out that seventy-five percent of all university students who were involved in this research project had sought help with their sexual concerns and problems from their peers. The remaining twenty-five percent received assistance from available medical, psychiatric, and psychological counselling services. It is difficult to determine the effects which result from the seeking of peer assistance with sexual problems. Nevertheless, the fact that seventy-five percent of those surveyed had sought such assistance could indicate the lack of alternatives. An examination of the alternatives mentioned did point up important shortcomings.

The physician as a counsellor. Some people seek guidance from their medical doctors about matters related to sex. This may appear to be an enlightened decision but it is worthy of further examination. Is the medical doctor properly trained to function in a counselling setting? When a person's problem centers on the physiological aspects of sexuality, medicine has a role to play. However, beyond this, a physician's training must be questioned. The raison d'être of counsellor education necessarily rests on the principle that professional training, if properly conducted, produces more effective communicators. In most instances, the doctor does not receive such specific professional training. In reference to this issue, White and Watt (1973) argued that "the training of physicians does not generally include a sufficient background in psychology to warrant their meddling in the realm of emotional adjustment" (p.427).

Masters and Johnson pointedly set out the shortcomings of medical counselling as it relates to sexual problems. In an interview with

Belliveau and Richter (1970) they stated, "there are very few physicians practicing medicine today who have ever had a moment's training in human sexual response while they were in medical school" (pp.218-219). As a result, many physicians lack the knowledge required to help people resolve their sexual problems. This argument was supported by Harold I. Lief (1966), a medical doctor who was one of the founders of the Sex Information and Education Council of the United States. He presented research data which showed that members of the medical profession were inadequately trained to meet the demands of sex counselling. His conclusions were reinforced by the findings of Sheppe and Hain (1966). Their project, conducted at the University of Virginia School of Medicine, revealed that the medical student's knowledge of human sexuality increased from his freshman to his senior year. The degree of increase was questioned. They felt that there was cause for concern because the graduating medical student missed, on the average, ten out of the eighty questions on McHugh's (1950) original form of the Sex Knowledge Inventory. Their concern rested on the fact that the test was developed for lay people, and the answers to the questions presented few problems for the sexually sophisticated.

Psychiatric aid. A second alternative which is open to people who are experiencing sexual difficulties is to seek assistance from a psychiatrist. This option does not present the same difficulties encountered when members of the medical profession are consulted but problems do exist. The pragmatic argument that this alternative results in a waste of resources has some legitimate basis. The need for qualified staff to deal with pathological cases indicates that other professionals should assume the responsibility for sex counselling. Some may take ex-

ception to this argument. However, there are other serious reservations associated with this mode of treatment.

The psychiatric model usually implies long-term treatment. In sex counselling, this has led to an emphasis on the remote causes of sexual dysfunction. Kaplan (1974) made this observation when she suggested that "traditional psychiatry has concerned itself with the understanding and resolution of the remote causes, while essentially ignoring the immediate obstacles" (p.118). In contrast, brief treatment procedures necessarily concentrate on the immediate causes, and rely heavily on behavioral oriented techniques. In many instances, the latter approach has proven the most effective. Masters and Johnson (1970, pp.351-391), and Kaplan (1974, pp.435-460) provided outcome reports that indicated the advantages of behavioral methods in the treatment of certain sexual dysfunctions.

The importance attributed to psychoanalytic theory by most psychiatrists may prove a handicap to them in their efforts to help people with sexual problems. Fisher (1973) made this point when he argued:

> While the empirical findings support psychoanalytic theory in its general emphasis on the importance of early socialization, they rarely fit with more specific psychoanalytic formulations. (p.236)

Therefore, psychoanalytic interpretations are often received with negative reactions. An example of this situation was provided by Frankfort's (1972) remarks on female sexuality. She wrote:

> Most psychiatrists would insist that the woman's problems were due to psychic disturbances. And, in many cases, problems women have with their bodies are related to their psychic lives which, in turn, are related to how they feel about their sexual partners and how their partners feel about them, although

> psychiatrists tend to view psyches as existing in a vacuum. (p.181)

The counsellor's role. The above discussion outlined some of the limitations of the existing services available to people experiencing problems with their sexuality. The counsellor must accept some of the responsibility for correcting this situation. In effect, he must be prepared to function effectively in a counselling setting where sexual matters are the primary concern. An analysis of the counsellor's role made it evident that sexual problems cannot be ignored if he is to provide adequate assistance to his clients.

In their effort to define counselling, Brammer and Shostrom (1968, pp.5-6) suggested that this can be achieved by observing that counselling has been historically characterized by terms such as: educational, supportive, situational, problem-solving and conscious awareness with emphasis on "normals." These terms are applicable to the realm of human sexuality. If one is to function within this framework, it would appear that human sexuality must be regarded as one of the content areas to be considered. Therefore, if the counsellor is to deal effectively with the human condition, he must be prepared to be facilitative in a process where sex is the content. Within this context, he may serve as both educator and counsellor. The client may gain from counselling in sexuality when the process is problem-centered and when its basic nature is developmental.

No matter how young their clientele, most counsellors need effective sex counselling skills. This stems from the idea that the process of sexual adjustment has its roots in early childhood. Elias and Gebhard (1970) enunciated this principle when they wrote:

> Adequate sexual adjustment in early childhood is a

> prime factor in later adult sexual adjustment, as healthy attitudes toward self and sexuality are the foundations of adult adjustment. (p.17)

In effect, sexuality is not a phenomenon confined to the world of adults. As it relates to sexual problems, a large part of prevention rests with having children experience an encounter with an adult who is an effective communicator and able to facilitate the child's sexual development.

This principle was further developed when analyzed within the framework provided by Brown and Lynn (1966). They argued that existing facts do not support the idea of an innate, pre-determined, psychologic sexuality. Instead, they suggested that the individual begins life psychosexually plastic and is, therefore, capable of developing in a number of ways. Money's research on psychosexual differentiation led him to a similar conclusion. Money (1965) wrote:

> Psychosexual differentiation is an active process that takes place after birth and needs the stimulus of interaction with a behavioural environment, in much the same manner as does acquisition of a language. (p.20)

These observations help to illuminate the role the competent counsellor can fulfill in assisting a child to come to grips with his sexual being.

As children reach adolescence, problem-centered counselling in the realm of sexuality is more common but the developmental dimension is still present. Blocher's (1966, p.57) model provided a typical example in which the counsellor plays a definite role as the student attempts to develop sex-appropriate behaviors in a range which is flexible and adaptable.

In dealing with the post-high-school adult population, developmental aspects in terms of emphasis are probably replaced by the more

problem-centered components of sex counselling. This form of assistance is not restricted to marriage counselling since sexual problems are not limited to married people.

The observations outlined above suggested that the counsellor has a useful role to perform in sex counselling. He may serve as a catalyst in the development of a person's sexual being. He may assume the role of a helper in correcting the dissonance between a client's attitudinal and behavioral systems. Finally, the counsellor's human relations skills permit him to view sexual problems within the context of social relationships. This ability is crucial when the client's sexual problems are an extension of a more fundamental and larger pattern of maladjustment.

It is important to recognize that the present discussion relates to the counsellor's potential rather than to his existing ability. An examination of university calendars from across the country revealed that counsellor education programs provide little, if any, specific attention to training in sex counselling. However, competence in this field requires having the counsellor undergo training in the area of human sexuality. The next section outlines a procedure designed to assist counsellor trainees to realize their potential for effective sex counselling.

Training Sex Counsellors

The helping professions need to improve the services provided for people who are experiencing problems related to sex. The aim is to have easily accessible professionals who are trained to be facilitative in short-term counselling with the normal population. In addition, they require specific training that will prepare them to function effectively in

a counselling setting where sexual matters are the primary concern. The counsellor's overall training was designed to provide him with the skills required to be effective in short-term counselling with the normal population. In most instances the counsellor's working milieu allows him easy access to the public. The present study was developed in view of the final requirement, namely, the provision for specific training in sex counselling.

Three steps were involved in the creation of a framework that provided for the proper development and evaluation of a training program in sex counselling. First, attention was focused on those aspects of counsellor behavior that were to be altered through training. Secondly, the three training programs employed to change behavior were discussed. Finally, appropriate criterion measures were selected to evaluate the effectiveness of the treatment programs. The following discussion concentrated on these three areas of concern.

The variables. The primary purpose for the present research was to design and evaluate three methods of treatment geared to facilitate the development of competent sex counsellors. This generated a need for an operational definition of the term competence. In an effort to meet this requirement, the notion of competence was associated with specific counselling behaviors. This involved the isolation of particular variables that were amenable to objective measurement. In effect, a structure was provided which would recognize the distinctions between competent and incompetent counsellors. The objective was reached through the analysis of four crucial variables which were operating during sex counselling. The affective component of sex counselling was examined in terms of empathy.

The presence of anxiety in clinical interactions was considered within the context of sex counselling. The cognitive aspect was related to the counsellor's knowledge of sexual matters. Finally, the counsellor's personality traits were considered for their possible implications on the counselling process. These variables were discussed separately to point up their importance in the counselling process.

Stotland, Sherman, and Shaver (1971) defined empathy as "an observer reacting emotionally because he perceives that another is experiencing or is about to experience an emotion" (p.1). This definition is incomplete. The term empathy also implies the ability to communicate content and affect. The counsellor must be able to communicate his understanding to the client (Truax and Mitchell, 1971, p.319). Rogers (1961) suggested that empathy was present:

> When the therapist is sensing the feelings and personal meanings which the client is experiencing in each movement, when he can perceive these from "inside" as they seem to the client, and when he can successfully communicate something of that understanding to his client. (p.62)

The importance of empathy as a basic ingredient of the counselling process has been stressed by many researchers (Carkhuff & Berenson, 1967, p.4; Rogers, 1969, p.38; Truax & Carkhuff, 1967). The significance attached to empathy was justified by research results. Several studies (Dickenson & Truax, 1966; Rogers, 1961, chap.3; Truax, 1963; Truax, Carkhuff, & Kodman, 1965) presented evidence indicating that the depth and accuracy of a counsellor's empathic responses were related to his client's improvement. It was these results that led Stotland et al. (1971) to conclude that the counsellor's ability to empathize allowed him to

"understand his client better, to communicate with him better, and to establish better rapport with him" (p.14).

Empathy continues to be an important factor in the field of sex counselling. It was reported earlier (Elias, 1970) that peer assistance was sought by many people who faced sexual problems. This may have indicated the difficulty they experienced in approaching strangers for assistance with their problems. The sensitivities of many who experience sexual problems emphasize the necessity for high levels of empathy if the counsellor is to establish good counselling relationships. Perez (1968, pp.3-9) listed rapport, security, acceptance, freedom, and identification as factors which contribute to such relationships.

A further reason for attaching added significance to empathy rests in the fact that it allows the counsellor to reach out beyond his personal experience. Bernard expressed the principle that reliance on one's personal experience in the field of sex counselling resulted in counselling inadequacies. She claimed "the person who depends exclusively on his own experience knows only his own sexuality" (Bernard, 1968, p.125). Probably higher levels of empathy assist the counsellor to understand better his client's sexual being. Therefore, counsellors functioning at a facilitative level must be trained to maintain this level in the more threatening environment of sex counselling.

Anxiety was the second variable considered in this research. Spielberger, Gorsuch, and Lushene (1968, pp.1-2) set out properties which contribute to feelings of anxiety. These involved tension, nervousness, worry and apprehension. An individual's sexual life is an intimate and sensitive part of his total experience. It is, therefore, not uncommon

for a client to experience this form of anxiety when seeking related help. However, during training the counsellor must learn to control any heightened anxiety he may experience in order to control it in his clinical work.

The counsellor's level of anxiety has an important influence on his client's affective responses. Truax and Mitchell (1971) stated, "in S-R terminology an affective stimulus serves as an unconditioned stimulus in automatically eliciting an affect response, which is in kind and proportion to the stimulus" (pp.322-323). In effect, where the counsellor's feeling of anxiety is low, the feeling may be internalized by the client. Referring specifically to sex counselling, Belliveau and Richter (1970, p.78) pointed out the importance of counsellors being trained so that they are at ease when discussing sexual matters with clients. The practical implications of apprehension were made clear by Burnap and Golden (1967) who reported that the physician's comfort with the subject of sex was positively correlated with the frequency with which sexual problems were brought to him. It is a reasonable assumption that similar results would be experienced in the case of counsellors.

One of the most significant results of reduced anxiety rests in the premise that it permits the counsellor to be an effective "sex-talker." He is able to function without hindering what Rychlak (1972) referred to as long-range cognitive projections. That is, any psychological discomfort the counsellor may experience does not interfere with his effort to establish client-oriented goals and positive interaction.

Low anxiety is also conducive to the employment of fewer defense mechanisms on the part of the counsellor. It results in his avoidance of "double-bind" messages. As Brenton (1972, pp.108-109) explained, this

entails the conveyance of one meaning by the use of words and the conveyance of an opposite meaning by the use of tone, look, stance, or other non-verbal signs. When the counsellor has control over his feelings of anxiety there is no conflict between his verbal and non-verbal behavior. The client will recognize this and will respond better. Sexual double-talk confuses the one to whom it is directed, and probably increases the counsellor's anxiety levels.

The counsellor's knowledge of sexual matters is another relevant factor in sex counselling. Regardless of the age level of his clientele, the sex counsellor frequently finds himself in the position of an educator. In many instances, his knowledge of sex provides the foundation for problem resolution. He must, therefore, be in a position to provide accurate information when the need arises. There is no reason to assume that counsellors possess the requisite knowledge to do an adequate job in this specialized area. As both Masters and Johnson pointed out in an interview with Belliveau and Richter (1970, pp.66-67), their experiences with professional and non-professional groups indicated clearly that neither group had accurate information about sexual functioning.

The importance of counsellors acquiring a thorough knowledge of sexual matters was supported by Kaplan's (1974) observations. She explained that "many couples do not know very much about sexuality and are too guilty and frightened to explore and experiment" (p.123). The clinical experiences of Masters and Johnson (1970) had led them to a similar conclusion. They claimed that the etiological background for most sexual dysfunction rested in "sociocultural deprivation and ignorance of sexual physiology rather than psychiatric or medical illness" (p.21). Thus,

their approach to the treatment of sexual inadequacy combines a short-term educational program with supportive counselling. Earlier research findings had indicated the value of an educational component in treatment procedures. Both Wright (1953, pp.159-160) and Kleegman (1959) reported considerable improvement in a number of women who had experienced sexual problems. They suggested that positive outcomes resulted from a combination of simple explanations of female sexual physiology and adequate sex instruction. Dominian (1968, p.81) also stressed the necessity for sex education in the treatment of sexual problems.

In sex counselling, the didactic aspect of the process is not limited to the adult population. Many couples encounter difficulties in marital communication when sex is the topic but, as Bernard (1968, pp.260-262) argued, one of the main reasons for this is inadequate education during childhood - especially amongst males. It was also pointed out that the situation was complicated by the fact that the major source of sex education for wives was their husbands. The Paonessas' (1971) research on contemporary youth supported this viewpoint. They concluded that young people lacked adequate instruction concerning sexual maturation. Using a sample of three hundred and sixty-five male and five hundred and eighty-two female university and education students, Juhasz (1969) reported similar findings. She concluded that, regardless of background factors, two-thirds of the subjects lacked adequate knowledge of the physiology of sex. These studies pointed up the need for knowledgeable counsellors in this field.

The counsellor's personality characteristics constituted the final variable selected for this study. In the past, there was a tendency to

assume that homogeneity prevailed in terms of counsellor and client personality factors (Carson, 1967). However, research results failed to support these "uniformity myths" (Kiesler, 1966). As a result, most researchers now agree with Heller's (1971) claim that "the psychotherapeutic interaction is influenced by a number of factors, primary among which are patient and therapist personality characteristics" (p.139).

Betz (1962, pp.50-51) found certain personal qualities in physicians to be crucial determinants of therapeutic outcome in the treatment of schizophrenic patients. McNair, Callahan, and Lorr (1962) provided immediate support for this position when they presented similar findings for the treatment of neurotics. Allen (1967) was unable to develop personality "types" related to counselling outcome. His research did indicate that more general factors such as the counsellor's degree of self-awareness and openness might help to identify competent counsellors. Bare's (1967) research led her to conclude:

> Counsellor personality characteristics of high original thinking, high vigor, low ascendancy, low achievement needs, and low order needs seemed to be related to counsellor helpfulness, empathy, and the facilitation of a close therapeutic relationship. (p.421)

More recent studies (Donnan, Harlan, & Thompson, 1969; Wogan, 1970) have provided additional evidence which bears on the relationship between counsellor personality traits and counselling outcomes.

In terms of sex counselling, the research in this area has important implications. One of the more significant points relates to the possibility that, given certain personality profiles, some counsellors may prove more effective than others in this particular milieu. As well, a close examination of counsellor personality factors may provide the basis

for adequate selection procedures.

Empathy, anxiety, sex knowledge, and personality traits are not the only variables existing in the sex counselling milieu. Nevertheless, they are important factors which influence the outcome of a given sex counselling session. This means that the counsellor trainee must be provided with the opportunity to develop in these areas in a fashion that will prove beneficial to his clients. This leads to a consideration of the methods to be employed in the effort to realize this goal.

Three methods of treatment. The treatments or training programs were developed to assist counsellor trainees in their efforts to attain competence in the field of sex counselling. The concept of competence was operationally defined in terms of the counsellor's behavior. There were three primary factors included in the definition. They involved the ability to be empathic, the degree of control exercised over anxiety, and the counsellor's knowledge of sexual matters. The personality dimension was incorporated for its predictive potential. It was not viewed as an area of behavior to be changed through treatment. After the behavioral objectives were established it was necessary to select a method of treatment. An analysis of this requirement revealed the need to avoid a restrictive approach. Therefore, the limitations inherent in the use of a single treatment procedure were eliminated through the utilization of three separate methods for training sex counsellors. The conjoint, experiential, and didactic methods were used in this study.

The conjoint method was distinguished by the presence of both experiential and didactic components. This model, which incorporates the experiential and didactic elements of teaching, was proven effective by

Carkhuff, Douds, and Truax (1964), and Carkhuff and Truax (1965). The approach was also applied effectively in a project concerned with training college students in counselling (Berenson, Carkhuff, & Myrus, 1966).

The positive results achieved with this approach led to the development of a more refined and inclusive training program for counsellor trainees (Truax & Carkhuff, 1967). Essentially the program involved specific didactic input on the part of the supervisor. This was coupled with a quasi-group experience (Truax & Carkhuff, 1967, p.242). The quasi-group experience allowed the trainees to explore the personal difficulties they encountered as counsellors (Truax & Carkhuff, 1967, pp.273-284). Carkhuff (1969, pp.200-201) also emphasized the intellectual dimension in the form of didactic input by the counsellor supervisor.

In terms of the present research, this model was revised only as far as was necessary to provide specific training in sex counselling. In effect, the experiential component stressed the difficulties experienced in sex counselling. Through the use of role playing the trainees were also provided with the opportunity to practice sex counselling. The didactic component centered on material related to human sexuality.

The second approach to treatment was based on an experiential model. The method concentrated on the reduction of anxiety experienced by the trainees when they were sex counselling. Thus, the process was directed towards helping the participants to feel comfortable when discussing sexual matters. This method was similar to Scheffler's (1967, pp.124-129) "insight model" in that self-exploration was made possible through a group experience. Within this framework the trainees were encouraged to verbalize their concerns regarding sex counselling. Role playing techniques

were used to provide the trainees with an opportunity to practice sex counselling under supervision. It was felt that this particular approach would eventually allow the benefits of overall training to surface in the sex counselling milieu.

The experiential approach to training was closely associated with the client-centered tradition. Rogers and his collaborators (Blocksma & Porter, 1947) made the first attempt to develop and evaluate a short-term training program. The initial project evolved into Rogers' (1951) more elaborate training program. In it, considerably more emphasis was placed on experiential learning. The final result was a method of training involving the techniques of role playing, modeling, and group experiences (Rogers, 1957). These experiential elements were easily manipulated to fit the more specific requirements of training in sex counselling. The adjustment simply involved placing emphasis on counselling situations concerned with the resolution of sexual problems.

The final method of treatment was restricted to the intellectual dimension. The trainees in the didactic group concentrated all their efforts on obtaining a thorough academic knowledge of sexual matters. This process made it possible to determine if such instruction, coupled with the trainees' overall training, was sufficient to produce competent sex counsellors.

The didactic treatment was similar to Scheffler's (1967) "impression model" which he characterized as a method that allowed the learner to acquire the basic elements of a given subject "fed in from without, organized and processed in standard ways, but, in any event, not generated by the learner himself" (p.121). The supervisor adopted the role of an in-

structor in contrast to the experiential model in which he functioned as a facilitator (Dearden, 1967, pp.135-138). The concept of instruction did not imply a need for rote learning. The objective was to teach "methods" related to sex counselling. In this context the term has a specific meaning which Ryle (1967) provided when he interpreted method "as a learnable way of doing something, where the word 'way' connotes more than mere rote or routine" (p.114). In effect, the treatment procedure was geared to what Peters (1966, pp.31-32) referred to as the cognitive perspective. That is, the trainee was not taught isolated facts, but was helped to integrate the material in terms of his sex counselling behaviors. The method involved a lecture format designed after the fashion proposed by Hyman (1970, pp.151-155). His procedure stressed the importance of student involvement through open discussion and the asking and answering of questions.

The criterion measures. In the present study the dependent variables examined were levels of empathic response, anxiety fluctuations resulting from sex counselling, and degree of sex knowledge. The trainees' personality traits also came under scrutiny, especially for their potential to serve as a predictor of performance on the three dependent variables. The treatment was comprised of three methods: didactic, experiential, and conjoint. The present section provided an explanation of the instruments employed to measure the effects the various methods of treatment had on the selected dependent variables.

The level of empathy expressed by the counsellor trainee in any given counselling session was evaluated according to the Accurate Empathy Scale. The scale was developed in 1961 by C.B. Truax (Traux & Carkhuff, 1967, pp.43-58). It was designed to determine the counsellor's level of

empathy within a range comprised of nine stages. Truax and Carkhuff (1967) explained that "accurate empathy involves both the therapist's sensitivity to current feelings and his verbal facility to communicate this understanding in a language attuned to the client's feelings" (p. 46). The scale provided for a wide range of responses. The lowest stage indicated that the counsellor was virtually unaware of the most obvious feelings of the client. At the opposite extreme, the ninth stage indicated the counsellor's unerring ability to respond accurately to the deepest feelings of the client (Truax & Carkhuff, 1967, pp.47-58).

The empathy scale has been used in a variety of research studies. It has proven useful in studies designed to examine the relationship between the counsellor's empathy skills, and the outcome of treatment. A variety of studies (Dickenson & Truax, 1966; Truax & Carkhuff, 1967, pp. 83-89; Truax, Carkhuff, & Kodman, 1965; Truax, Wargo, & Silber, 1966) have indicated a positive correlation between therapeutic outcome and the degree of empathy expressed by the counsellor. The scale has also proven effective when used to measure the improvement in empathy skills of the students in counselling training programs (Carkhuff, Douds, & Truax, 1964; Carkhuff & Truax, 1965).

Truax and Carkhuff (1967, p.45) presented results from a group of studies that provided reliability reports on the empathy scale. The reliability coefficients ranged from .43 to .95. On the basis of twenty-eight studies, they concluded, "most often a moderate to high degree of reliability is obtained with the scales whether measurement is of counselling or therapy, group or individual" (p.44). They presented no data on the validity of the scale but argued that on the basis of their research

it was evident that the scale was significantly related to therapeutic outcome. They proceeded to devote an entire chapter to an outline of research studies which supported their argument (Truax & Carkhuff, 1967, chap.3).

The level of anxiety exhibited by the trainee while sex counselling was determined by the State-Trait Anxiety Inventory (Spielberger, Gorsuch, & Lushene, 1968). The inventory has two forms. Only the A-State scale or Form X-1 (reproduced in Appendix A) was used in the present research. It was pointed out by Spielberger et al. (1968) that "the essential qualities evaluated by the A-State scale involve feelings of tension, nervousness, worry, and apprehension" (p.1). The test was particularly appropriate because it was designed to measure anxiety states induced by experimental conditions. In fact, Spielberger et al. (1968, p.4) recommended its use as a means of measuring the level of anxiety created by a counselling session. It was reasonable to use a self-report inventory since the objective was to measure what Cattell (1965) referred to as "overt anxiety." He defined it as "that part of anxiety of which the individual is aware and ready to speak" (p.372).

A variety of samples was used to compile the norms for the test. They included college students, general medical patients, prisoners, and neuropsychiatric patients (Spielberger et al., 1968, p.8). The test-retest reliability coefficients reported for the A-State scale ranged from .16 to .54. These results were consistent with the purpose of the test which is to evaluate fluctuating states of anxiety influenced by experimental conditions. In terms of reliability, the alpha coefficients which measured internal consistency were more meaningful. They were reported

for six groups, and had a range from .83 to .92 (Spielberger et al., 1968, p.18). The researchers also presented data on the construct validity of the scale. They conducted two projects, one where the test was administered under relaxed conditions, and one where stress inducing conditions were present. In both instances, significant differences were found between the two states (Spielberger et al., 1968, pp.21-27). A study conducted by O'Neil, Spielberger, and Hansen (1969) found that A-State scores increased while students worked on difficult learning tasks, and decreased when the tasks were easier. Allen (1970) also found that varying conditions effected the level of anxiety reported by the subjects. As well, the authors of the test reviewed several doctoral studies where the inventory proved effective as a means of measuring anxiety (Spielberger et al., 1968, pp.37-44).

The counsellor trainee's knowledge of sexual matters was evaluated by the Sex Knowledge Inventory: Form X (McHugh, 1967). The inventory was comprised of eighty multiple choice questions. The test covered a wide range of topics including masturbation, sex-act techniques, birth control, pregnancy, and venereal diseases. Not much technical information was required to answer the questions correctly. Sheppe and Hain (1966) explained that "the SKI is not a test of highly technical sexual knowledge. It was developed for lay individuals, and most of its questions are fairly easy for sexually sophisticated individuals" (p.461).

The inventory was not intended to evaluate sex counselling skills. Instead, it tested the minimal amount of sex knowledge required by a trainee before he attempted to master sex counselling techniques. In fact, McHugh (1968a, p.2) suggested that one reason for developing the test was to allow

counsellor trainees to discover those aspects of human sexuality about which they lacked information.

The author has not completed the compilation of normative data. Because of this, a report on the reliability and validity of the test is not available. However, he has established percentile ranks obtained from four hundred and eighty-three pre-marital counsellees (McHugh, 1968b). Furthermore, the inventory was particularly noteworthy because the author avoided any attempt to evaluate beliefs. As Adams (1965, pp.935-936) pointed out, McHugh has managed to develop a test based on factual knowledge. The questions do not generate emotionally laden responses. They simply seek factual answers.

The Sixteen Personality Factor Questionnaire: Form A (Cattell, 1968) was used to examine the personality characteristics of the trainees. The questionnaire was comprised of one hundred and eighty-seven questions which required approximately forty-five minutes to answer. The essential feature of the 16PF is that it "insures initial item coverage for all the behavior that commonly enters ratings and the dictionary descriptions of personality" (Cattell, Eber, & Tatsuoka, 1970, p.6). In effect, the 16PF "consists of scales carefully oriented and groomed to basic concepts in human personality structure research" (p.13). The primary and secondary source traits covered by the test were outlined in the Handbook (Cattell et al., 1970, pp.16-17).

The test-retest reliability coefficients were influenced by the length of the interval between administrations. The reliability data were calculated separately for each factor. The coefficients ranged from .58 to .83 when the delay between administrations was one week or less. When

the interval was over two months, certain traits were more liable to fluctuation. In these instances, the reported range was .35 to .85 (Cattell et al., 1970, pp.30-34). Tests for construct validity revealed a range of .35 to .92. The authors concluded that the validity reports were "at least as high as have been reached for any attempted primary factor-pure measures" (Cattell et al., 1970, p.37).

Cattell's questionnaire has been employed with positive results in an effort to establish a relationship between personality types and therapeutic outcomes. In McClain's (1968) study, the Sixteen Personality Factor Questionnaire proved useful in distinguishing different characteristics for men and women which are relevant to successful counselling. De Blassie (1968) viewed Cattell's test as a meaningful instrument to be used in the matching of counsellors' preferences with clients' problems. He claimed that differentiations established by the test proved useful in assigning clients to counsellors. The procedure improved the counsellor's performance. The test has also shown potential as an instrument of aid in the making of marriage counselling decisions (Cattell et al., 1970, pp.291-295). The test could serve a similar role in the present research through identifying those most likely to respond to training in sex counselling.

In addition to the measures outlined above, two research questionnaires were developed specifically for the present study. The questionnaire reprinted in Appendix B was devised to provide a method whereby the subjects' perceptions of their own behavior, and their evaluations of their skills as sex counsellors could be discovered. The questionnaire presented in Appendix C was incorporated into the study to gain some insight into the

trainees' attitudes and feelings regarding their training program in sex counselling.

Chapter III

Method

The previous chapter demonstrated the need for clinicians who are competent when sex counselling. Competence was operationally defined in terms of empathy, anxiety and knowledge of matters related to sex. The research design which was developed for the present study incorporated the above factors as the dependent variables. In effect, the counsellor's level of proficiency was evaluated with reference to empathy, anxiety, and sexual knowledge. Furthermore, the design was extended to include personality measures. The personality dimension was explored in terms of its potential to serve as a predictor of competence in sex counselling.

The primary purpose of the present research was to discover the effects of specific training in sex counselling. That is, would such training produce counsellors who were more effective in their attempt to assist people with sexual problems? A process involving several stages was designed to answer this question. First, it was necessary to phrase this global question in a more specific form. This resulted in a series of research questions that could be answered by using objective measures. The second stage involved the development of three treatment programs. This process was followed by the actual experiment which involved the collection of pre-and postmeasures, and the implementation of the treatment programs. The final stage involved the selection of the statistical procedures required to evaluate the effects of treatment. The present chapter discusses each of the stages in detail.

Research Questions

In the previous chapter competence was given a more specific meaning through the introduction of the dependent variables. The selection of the criterion measures indicated how these specific variables could be measured objectively. The presence of the dependent variables and criterion measures made it possible to formulate specific research questions concerned with the counsellor's level of performance. The first series of questions relates to those counsellors who have received no specific training in sex counselling. The second series is concerned with counselling skills following specific training.

The untrained counsellor. The initial stage of the research was concerned with evaluating the level of proficiency exhibited by an untrained counsellor while sex counselling. The clinical behavior of the untrained subjects when sex counselling was examined in light of these research questions:

1. Is the untrained sex counsellor unable to express empathic responses that are at least minimally facilitative?

2. Does the counsellor trainee exhibit a level of anxiety that is detrimental to his efforts as an effective sex counsellor?

3. Do individual differences in sex knowledge exist to the extent that some trainees do not possess the amount of sex knowledge necessary for positive therapeutic outcome?

The trained counsellor. The trainees were provided with specific training in sex counselling. The training programs were implemented after the required data were collected from the untrained counsellors. The effects of treatment were examined in terms of the following research

questions:

1. Are trained counsellors more effective than those who are untrained in expressing facilitative empathic responses while counselling clients with sexual problems?

2. During sex counselling, are the anxiety levels of the trained counsellors lower than the anxiety levels displayed by the untrained counsellors?

3. Do trained counsellors show a significant increase in their knowledge of human sexuality that is not evident with the untrained counsellors?

In terms of the research questions, it was predicted that the treatments would have a positive outcome. Since the predicted outcome was directional, it was deemed preferable to use a one-tailed test (Blalock, 1960, p.127).

These research questions center on the attempt to determine the differences between trained and untrained sex counsellors. However, the design allowed for comparisons among the three treatment groups and between the control group and each treatment group. It was then possible to determine if a particular method of treatment was superior to other methods. The combinations involved are shown in Figure 1. It may be observed that each treatment group (T_1, T_2, T_3) was compared with the control group (C), and the differences between treatment groups were also considered. There was no prediction for the interaction effects of the three treatment groups. Therefore, two-tailed tests were used with the level of significance fixed at .05.

The research design included consideration of personality factors.

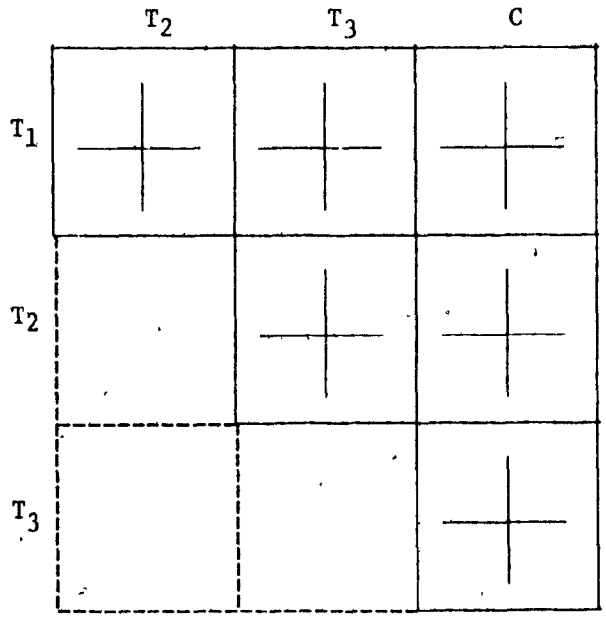

Figure 1. The groups compared in the study. Each cross indicates the pair of groups examined.

In the case of the untrained subjects, the goal was to determine whether or not a relationship existed between their personality profiles and their sex counselling skills. Attention also was focused on the potential which personality trait measures may have for predicting positive response to training. The .05 level of significance was used in the examination of the personality dimension.

The Treatment Programs

The second stage of the research involved consideration of the treatment programs that were to be used in the training of sex counsellors. Three programs were developed specifically for the present study. The first was a didactic treatment. The second was experiential. The third was conjoint. There was also a control group.

The development of the treatment programs involved utilization of

the more recent findings in the areas of human sexuality and sex counselling. The presumption was that specific training improved the knowledge of counsellors regarding sexual behavior and functioning. The training was also intended to reduce anxiety and to increase the trainee's level of empathy during sex counselling. Emphasis was placed on having a training program that could be integrated into the overall training program at the master's level.

Appropriate consideration was given to such factors as didactic and experiential input, texts and number of sessions. All of the programs were designed so that it was possible for them to be incorporated into the trainee's practicum course. Each one involved five two-hour sessions. This duration corresponded to the time designated for a similar program at the Howard University Health Service (Schiller, 1973, p.173). Tyler, too, has instituted a one week program in sexuality for social workers (Schiller, 1973, pp.177-178). This short time span also permitted examination of the feasibility of providing such training as a module of a regular practicum course. The curriculum for the three programs is outlined below.

The didactic method. The didactic treatment was conducted strictly within an intellectual framework. This meant that the approach was confined to a lecture and question-answer period. Each session involved a different area of human sexuality.

The first session examined the verbal aspects of sex communication. Attention was given to the technical terminology, as well as to the more common usages employed in verbal sex communication. The discussion also considered the implications of sex talk for counsellors.

The language theme was placed in a realistic context by selecting sexual anatomy as the subject matter for the lecture. The rationale for this choice of material came from McCary (1973) who stated:

> Any truly informed inquiry into sexuality must encompass a thorough understanding of the "givens" of sexual functioning. For sexuality is greatly determined by our physiology, as well as by our psychology and our socio-cultural conditioning. (p.37)

The session began with a talk on the differentiation and functioning of the male and female sexual systems. The student was not expected to become an expert in physiology, but it was deemed essential for him to acquire a basic understanding of human sexual anatomy. The trainee was also made aware of the sources available for consultation if he required additional information. Van de Velde's (1930, pp.3-127) text proved particularly useful in reaching these limited goals because the book was written for the layman. Naturally, certain revisions were necessary as a result of more recent research findings.

Several other topics were introduced and related to the verbal aspects of sexuality. These included such topics as the union of sperm and ovum, male secretions before orgasm, and the determination of pregnancy by test and heart beat. It was believed that this material would help to familiarize the students with the language of human sexuality. In addition, they received a general explanation of the human reproductive system.

The next session in the didactic program was designed to refute the more popular falsehoods surrounding human sexuality. The impact the moral tradition has had on contemporary society was outlined in Chapter I of this thesis. This tradition has perpetuated any number of myths regarding human sexuality. It is necessary for the sex counsellor to have

confidence in his ability to discriminate between mythology and reality. The importance of this exercise was evident in the fact that a leading sexologist, McCary (1971), devoted an entire textbook to the topic of sexual myths. His work and that of Salzman (1970) were used as major sources of information necessary to the discarding of myths surrounding such topics as masturbation, female orgasm, homosexuality and sex drive in the aged. The discussion had particular significance for those who were not familiar with the sex research findings of the past thirty years. Results were presented from a variety of research projects concerned with these subjects.

The topic for the third lecture was sexual behavior. In order to make the subject matter manageable, discussion was restricted to masturbation, petting, and intercourse. Frequently, counsellors are approached by clients encountering problems with genital behavior. The client's lack of knowledge is often partially responsible for his sexual dysfunction. Under any circumstances a "blind leading the blind" approach to therapy is detrimental. If the counsellor is to have a meaningful part in the therapeutic process, he must be capable of adopting the role of instructor when the need arises. This entails a sophisticated understanding of the various modes of sexual expression.

The opening discussion centered on the need for counsellors to develop a framework within which to view sexual behavior. The theme stressed the importance of recognizing that which lies beyond one's own sexuality. The shortcomings of viewing sexual behavior in a normal-abnormal dichotomy became apparent through an analysis of Ellis' (1972) work in this area.

The act of masturbation was considered as it relates to both the male and the female. A further extension involved analysis of the act from the standpoints of solitude and sociability. The cultural implications of masturbation were also reviewed.

Petting was discussed with reference to three different groups: the young, the engaged, and the married. An explanation of the physiological changes that result from petting was provided. The discussion included an examination of the various social attitudes regarding the act of petting.

The final section of the lecture concentrated on sexual intercourse. The physiological changes were considered within the context of the "four phases response cycle" elucidated by Masters and Johnson (1970, pp.220-221). The notion that sexual response patterns are closely associated with social rules and regulations was discussed.

The last two sessions were concerned with sexual dysfunction. The first lecture concentrated on the etiological background of sexual dysfunction while the second focused on treatment. The work of Rachman and Teasdale (1969), Wolpe (1969, chap.6), and Hartman and Fithian (1972) made it apparent that several approaches were available in the training of subjects in the diagnosis and treatment of sexual dysfunction. However, the most thorough investigation of sexual dysfunction was conducted by Masters and Johnson (1970). Their work concentrated on etiological analysis and treatment procedures. In view of the time factor, it was deemed more beneficial to provide the trainees with a thorough introduction to the work of these experts rather than to a survey approach that included several methods. Therefore, both classes relied on the work of Masters and Johnson. Parti-

cular attention was given to the more common forms of sexual dysfunction such as premature ejaculation and orgasmic dysfunction.

The principle aim of the first lecture on sexual dysfunction was to acquaint the students with a variety of problems that are encountered in sex counselling. At this point no effort was made to discuss modes of treatment. The discussion was strictly descriptive in terms of dysfunction. Specific attention was focused on the problems of premature ejaculation, ejaculatory incompetence, penis phobia, primary and secondary impotence, and orgasmic dysfunction. Vaginismus, dyspareunia, and sexual inadequacy in the aged were also briefly discussed. All of the above topics were clearly defined, and the etiological background was explained.

Sexual dysfunction was considered from the point of view of a symptom and as a problem in itself. An explanation was given which showed that a poor relationship between a couple can result in sexual inadequacy. This included an examination of the ways in which poor communication can create sexual problems. Attention was also paid to behavioral problems that can arise even when a couple is experiencing a sound relationship. In effect, the model accepted the idea that a sexual problem can be part of a larger problem, but it can also be a problem in itself.

The final lecture in the series was concerned with treatment. An attempt was made to expose the students to the treatment modes presently employed to help people with sexual problems. The content areas were the same as those in the previous lecture, but they were discussed within the treatment framework developed by Masters and Johnson (1970).

The experiential method. The content area for the experiential model was principally the same as that of the didactic. However, the ex-

periential method was distinguished by the absence of structured didactic input from the instructor. Instead, the focus was on the participant. The trainees were given an opportunity to experience as many aspects of sex counselling as possible. Inherent in the program's design was a desensitization process. This involved a group process where sexual material was the primary topic of discussion. The program was structured in such a way that the subjects were encouraged to become more aware of their sexual attitudes and, where necessary, to re-evaluate their approach to sexuality. This endeavor prepared them to better understand the diverse content of sexual material encountered in sex counselling. They also acquired counselling experience under supervision. This involved the role playing of various situations encountered by the sex counsellor. The five sessions have been outlined below.

The primary goal of the first session was desensitization to sex language. The session began with a short group meeting where attitudes and feelings toward sex language were discussed. The participants were encouraged to overcome inhibitions related to the use of sex language. Attention was focused on technical language and common sex terminology. Two exercises were employed to facilitate this process.

The "graffiti board" (Schiller, 1973, p.99) was used to assist the group to gain familiarity with common sex terminology. The exercise was designed to help people overcome embarrassment when using sex language in a group. The group members were also encouraged to provide feedback regarding perceived non-verbal behavior. The second exercise involved a more formal task. The group members were placed in dyads. The task involved taking the sex history of a client by following an abridged form

of the technique used by Masters and Johnson (1970, pp.34-51). The exercise presented the trainee with an opportunity to discuss sexual behavior using formal language in a one-to-one relationship. Role playing in this situation reduced the inhibition which initially accompanies such an encounter.

The second class brought the students together for a two hour group session. A life line was drawn on the board covering the ages of four months, four years, fourteen years, twenty-four years, forty-four years, and sixty-four years. The following topics were considered in relation to these stages of life: masturbation, homosexuality, nudity, petting, and sexual intercourse. This "life line approach" (Schiller, 1973, p.97) was used to generate participation by the group members in their attempt to separate fact from myth.

The third class was concerned with sexual behavior. During the first hour the participants remained in a group setting. In the group session the trainees were encouraged to become more aware of their own attitudes regarding various forms of sexual expression. They also were encouraged to share their fears concerning sex counselling. Emphasis was placed on minimizing the shock element often associated with sex counselling.

The trainees were arranged in dyads for the second hour of the class. They were provided with areas of sexual behavior to discuss. The process was designed to help prepare the counsellor to maintain his acceptance of the client even when the sexual behavior discussed was alien to the personal life style of the counsellor. This was exampled by a heterosexual counselling a homosexual.

The fourth session exposed the trainees to various problems encountered in sex counselling. At this stage, emphasis was on the etiological background of sexual dysfunction. This approach helped the trainees to distinguish the various symptoms associated with the dysfunctions. It also provided an opportunity for them to discuss these problems without the added pressure of the need for treatment. The process involved a variety of role playing situations. The subjects were given the opportunity to play the role of a client as well as the counsellor. The one-to-one encounters were videotaped so that discussion could follow. During the playback, the students considered the various causes that may have resulted in the existing dysfunction.

The final session was devoted to role playing with all of the participants functioning in the clinical setting. Emphasis was placed on the treatment of sexual dysfunction. Each student was given the opportunity of experiencing the role of both counsellor and counsellee. Selected case histories were used to provide the content for these practice sessions. The complete process was videotaped so that the group was able to provide feedback on the technique used by each counsellor trainee.

The conjoint method. The third training program does not require extensive elaboration. The conjoint approach was based on the possibility that both the didactic and experiential methods for training effective sex counsellors were necessary. That is, both were necessary, but neither was sufficient by itself. Therefore, this conjoint approach was a combination of the other two treatments in that it was comprised of both didactic and experiential components. Again, the structure involved five two-hour meetings. The first hour of each session involved an abridged form of the corre-

sponding session in the didactic treatment. The second hour followed the approach outlined for the experiential treatment. The same methods were employed, but for half the time required for the experiential treatment. Thus, five hours of the conjoint program were didactic, and five hours were experiential.

The previous sections focused on the formulation of specific research questions and the development of the treatment programs. The following section will explain the procedure that was implemented to examine the effects of specific training in sex counselling.

Procedure

The procedure followed for the present study involved five major stages. A clear description of the process necessitates a separate explanation for each step. The five stages included the selection of the sample, the training of actors, the collection of premeasures, the counselling sessions, and the collection of the post data.

Population and sample. The sample of thirty-six subjects was selected from a population of counsellor trainees at the master's level in counsellor education. The sample consisted of the entire practicum group. There were eight males and twenty-eight females in the sample. The age range of the subjects was twenty-one to forty-seven, with a mean age of thirty-two. Prior to this research all of the subjects had completed at least one full semester of theoretical courses and the first half of their practicum training.

At the time of this study the counsellor education program offered three principal options: elementary, secondary, and college level. Coun-

sellor trainees from all options were used as subjects. The trainee's choice of one of these options indicated his perference for a given clientele. The inclusion of trainees from all three options was consistent with the argument put forth earlier which suggested that human sexuality is an area in which all counsellors should be trained.

The sample was divided into four groups. There were ten subjects in the control group. The didactic and conjoint groups each had nine subjects, and there were eight subjects in the experiential group. For treatment purposes the subjects remained in the groups to which they had been assigned at the beginning of the year. As a further precaution, the premeasures obtained on the dependent variables were subjected to a one-way analysis of variance. As indicated in Table 1, this revealed no significant differences between the groups on any of the dimensions under scrutiny in this research.

Table 1

One-Way Analysis of Variance with the Premeasures for the Four Groups (N=36). Criteria: Empathy, Anxiety, Sex Knowledge.

Source	MS	df	F	P
	Analysis of Empathy			
Total	0.59	35		
Between	0.09	3	0.14	n.s.
Error	0.63	32		
	Analysis of Anxiety			
Total	92.24	35		
Between	102.24	3	1.12	n.s.
Error	91.30	32		
	Analysis of Sex Knowledge			
Total	108.43	35		
Between	50.25	3	0.44	n.s.
Error	113.88	32		

The three treatments were assigned randomly to the four groups. The remaining group served as the control group. During the treatment period they participated in their usual practicum program. Provision was made to train them in sex counselling when the research was completed.

Training actors as clients. Since the competence of the counsellor trainee was under scrutiny, it was deemed unethical to use actual clients. As a result, three actors and two actresses were hired to portray the roles of clients. All of these coached clients had previously performed professionally in the theatre. They were paid for their work in this research.

The coached clients first met with the researcher and received an explanation of the part they were to have in the study. Each actor was then presented with an individual case history. All of the problems were concerned with sexual matters. Those problems most frequently encountered in sex counselling were selected. Four distinct sexual problems served as the nuclei in the development of the case histories. Premature ejaculation and orgasmic dysfunction were used because they are two of the most common sexual dysfunctions (Kinsey et al., 1953, p.532; Masters & Johnson, 1970, pp. 359-360; Schiller, 1973, p.61). A problem related to oral-genital sex was selected since long existing cultural taboos frequently cause couples to experience problems in this area of sexuality (Schiller, 1973, p.61). A problem based on the need for sex information also was included since Masters and Johnson (1970, p.21) have argued that ignorance is a major factor contributing to sexual problems.

The actors were given several days to rehearse their roles. A week later, the actors met with the researcher to discuss their case histories. During this two hour session, the coached clients had their roles clarified,

and all questions concerned with technicalities were answered. They were then instructed to master their roles before the next meeting which was to be a week later.

When the actors felt that their performance was standardized they were exposed to a mock counselling session with the researcher acting as the counsellor. The experimental conditions they were to work under were present so that the practice sessions were as realistic as possible. During the first practice session all of the actors were present. This enabled them to criticize each other's performances. The second session was conducted individually a few days before the actual experiment.

Collection of premeasures. The research began with a briefing session for the subjects. The subjects' practicum supervisors solicited their co-operation and participation in a study to be conducted by a doctoral candidate. They were assured that the experience would be worthwhile in that a training period was involved. The professors had agreed that the training would be presented as a module of their practicum course. It was explained that for standardization purposes information was necessarily vague. However, the subjects were promised a debriefing session by the researcher upon completion of the study. All of the students who were approached agreed to participate in the research.

All the subjects wrote two tests during the week which followed the briefing session. The Sixteen Personality Factor Questionnaire (Cattell, 1968) was administered first. The participants received a short rest period and then answered McHugh's (1967) Sex Knowledge Inventory. This process was followed on two consecutive days. The experiential and conjoint groups wrote the tests together on the first day. The didactic and control groups

followed the same procedure the next day. Each testing session lasted for approximately one and one-half hours.

The counselling sessions. All the subjects conducted two counselling interviews. Each subject's first interview was held during the week between the collection of the above data and the implementation of the treatment programs. The second series of counselling sessions was conducted during the week following the conclusion of the treatment programs. In both instances, three days were required to complete the thirty-six counselling interviews.

The same procedure was utilized for both series of interviews. That is, each male subject saw a female client, and each female subject saw a male client. In addition, no subject saw the same coached client for both of his interviews. In the second interview, each subject was presented with a problem that was different from the one he had encountered during his first sex counselling session.

The problems were stratified on the basis of the sex to which they pertained since all the interviews involved opposite sex dyads. When this stratification was completed, the problems were then randomly assigned to the subjects in the various groups. The distribution of the four problem areas amongst the groups has been shown in Figure 2.

The interviews were conducted at the counsellor training facilities in the Education Building at McGill University. All of the sessions were videotaped by an inconspicuous microphone and camera. The subjects were familiar with the counselling rooms as they had used them frequently during their practicum training. The coached clients had conducted their practice sessions in the same rooms and were, therefore, also familiar with the

surroundings.

Problem Areas	Groups			
	Didactic	Experiential	Conjoint	Control
Premature Ejaculation	2 4	2 0	2 3	4 2
Oral-genital Sex	2 4	1 1	5 1	2 4
Orgasmic Dysfunction	0 0	2 2	1 1	1 1
Sex Information	5 1	3 .5	1 4	3 3

Figure 2. The top numeral in each cell indicates the frequency distribution of the problems for the first series of interviews. The bottom numeral refers to the frequency distribution of the problems for the second series of interviews.

The trainees were provided with a limited amount of briefing. They were simply asked to conduct an initial interview lasting anywhere from thirty to forty-five minutes. They were handed a card before they entered the counselling office. The card, which is reproduced in Appendix D, informed the subjects that their client was coached.

Immediately following each interview the subject remained in the counselling booth. After the client departed, a professor entered the office and administered Form X-1 (Appendix A) of the State-Trait Anxiety Inventory (Spielberger, 1968). This procedure was standardized by providing the professor with an instruction sheet to follow when administering the test. This completed the collection of the premeasures.

Collection of postmeasures. The treatment programs began the week following the completion of the first series of interviews. The treatment

involved weekly two hour sessions for five consecutive weeks. The post-measures were obtained the week which immediately followed completion of the treatment programs. Again, the subjects were required to counsel a coached client who had sought their help with a sex problem. The bottom numeral in each cell of Figure 2 has indicated the random distribution of the four problems among the groups. No subject was presented with the same problem or coached client that he had encountered in his first experience. The subject's level of anxiety was measured in the same way that it was measured before treatment.

The final phase of the research was carried out during the same week. The personality questionnaire (Cattell, 1968) was not administered a second time. However, the subjects were required to answer the Sex Knowledge Inventory (McHugh, 1967) a second time. The participants were requested to respond to the questionnaire entitled "My Approach to Sex Counselling" which has been reproduced in Appendix B. Finally, they were asked to give their opinions on the program by answering the questions which appear in Appendix C.

As was the case with the premeasures, two days were required to collect the above data. On the first day the subjects in the experiential and conjoint groups wrote the tests. The remaining two groups wrote them on the following day. The members in the control group commenced their training in sex counselling following the conclusion of this study. When all the data were collected, individual and group meetings were arranged with the subjects to explain the research.

Data Analysis

A variety of techniques was employed to analyze the data collected in this research. In some instances, independent raters were required for proper analysis. In other cases, results were obtained through the use of the computer. The present section describes the methods used to obtain the results reported in the following chapter.

Training raters. All counselling sessions of the subjects were videotaped. Later these tapes were used by independent judges who rated the level of empathy expressed by the subjects. The subject's level of empathy was determined by the guidelines Truax set down in his Accurate Empathy Scale (Truax & Carkhuff, 1967, pp.46-56).

Two undergraduate students, one male and one female, were paid to undergo training and to rate the tapes. The two judges were trained in empathy discrimination by Dr. D. Paré, Associate Professor in the Education Faculty at McGill University. The judges' training program followed well accepted procedures (Kiesler, Mathieu, & Klein, 1967, pp.141-147; Rogers, Gendlin, & Moursund, 1967, pp.55-57). The raters were trained on the scale until an inter-rater correlation (Pearson) of .69 was reached. This compared favourably with the .60 correlation accepted by Rogers and his associates (Kiesler et al., 1967, p.141). It also surpassed the minimum inter-rater reliability of .50 which Truax and Carkhuff (1967, p.85) require their judges to reach before assigning them to the actual research material. When this acceptable inter-rater correlation (.69) was achieved the raters proceeded to the research material.

The judges met on two separate occasions to rate the research material. Two three-minute excerpts were selected from each counselling session for evaluation. The first segment included the ninth to the twelfth minutes

of the interview. The second segment contained the eighteenth to the twenty-first minutes of the session. The same time periods were used for all subjects.

The segments were re-recorded randomly before presentation to the raters. Each rater was assigned one hundred and forty-four segments. This comprised a total of four three-minute segments for each subject. Two excerpts were obtained from each subject's interview before treatment, and the second pair was selected from the interview conducted after the treatment programs. With each segment the judges indicated their rating on the standard form reproduced in Appendix E. This form, which was used by the raters in their training, provides a schematic breakdown of the various levels of empathy.

Statistical analysis. Premeasures were collected to furnish the basis for a description of the counsellor in training. Furthermore, the data provided an empirically based rationale for the development and implementation of the sex counselling training programs. The research questions raised in reference to the untrained counsellor were answered through the use of basic statistical procedures. The required information was obtained from the standard deviations, the mean scores, and the frequency and range of scores. In the case of empathy, the mean provided a sound indication of the counsellors' skills in regard to this dimension. The anxiety and sex knowledge factors were compared to the norms of the various sample populations. Multiple regression was employed to determine the feasibility of using personality traits for predictive purposes.

An analysis of covariance was the primary procedure utilized to evaluate the effects of specific training in sex counselling. The data

on empathy, anxiety, and sex knowledge were analyzed using an analysis of covariance with the pretreatment measures as the covariant. Multiple regression was used to examine the relationship between the personality data and the subjects' responses to treatment. An item analysis was employed to interpret the questionnaires (Appendices B & C) given to the subjects after treatment.

Chapter IV

Results

This research project addressed itself to the counsellor trainee's behavior in a clinical setting. Attention was focused on behaviors related to sex counselling. Empathy, anxiety and sex knowledge were the dependent variables. The research design also called for an exploratory analysis of the subjects' personality characteristics. There were three independent treatment variables each of which consisted of a distinct five week training program in sex counselling. The design called for the collection of pre- and post-data.

The present chapter reports the results obtained in this study. In reporting these results, the research questions put forth in the previous chapter served as the primary frame of reference. These questions were concerned with the performance of untrained and trained sex counsellors. Therefore, in the present chapter separate attention is focused on each group. The results for the untrained counsellors are reported first. Then the various effects of treatment are examined in terms of the dependent variables.

Performance Prior to Treatment

The premeasures provided useful information. These data permitted a descriptive analysis of the untrained counsellor in terms of the dependent variables. The data were gathered by means of one counselling inter-

view and three written tests. At the start of the research all subjects were administered the Sixteen Personality Factor Questionnaire (Cattell, 1968), and the Sex Knowledge Inventory (McHugh, 1967). During the following week all the subjects were required to conduct a sex counselling interview. Immediately following the departure of his client, each counsellor trainee responded to the State-Anxiety Scale (Appendix A). The trainee's level of communication of empathy was established through an objective rating of two excerpts selected from his counselling session. The written tests were hand scored. The related results have been reported separately for each variable.

Empathy levels. As a group, the untrained sex counsellors were unable to express empathic responses that were at least minimally facilitative. As shown in Table 2, the group mean on the nine point scale was 3.6.

Table 2

Summary of Premeasures (N=36)

Variable	Mean	SD	Possible Range	Actual Range
Empathy	3.6	0.76	1 to 9	2.2 to 5.3
Anxiety	39.4	9.47	20 to 80	20 to 57
Sex Knowledge	53.0	10.27	0 to 80	24 to 68

This meant that although the trainee was frequently aware of his client's more exposed feelings, he showed no understanding of the client's hidden feelings (Truax & Carkhuff, 1967, pp.48-50). That is, the trainees were accurate with their expressions of the clients' obvious feelings, but poorly understood or completely ignored the veiled feelings.

The distribution of the empathy scores was negatively skewed. The highest level reported was 5.3, while the lowest was 2.2. As indicated in Table 3, one third of the subjects were able to function above level four. This was one level below the mid-point which was five on the nine point scale. Table 3 also shows that there was only one subject who performed above level five which is the mid-point on the scale. Therefore, he was the only subject with the skill required to show awareness of the client's less evident feelings and experiences since this was only possible when the level of response was rated at a minimum of five (Truax & Carkhuff, 1967, p.51).

Table 3

Cumulative-Frequency Distribution of Empathy Scores (N=36)

Level of Empathy (rated above)	Cumulative Frequency	Percent of Sample
8.0	0	0.0
7.0	0	0.0
6.0	0	0.0
5.0	1	2.8
4.0	12	33.3
3.0	27	75.0
2.0	36	100.0

Twenty-five percent of the subjects fell below level three on the accurate empathy scale. In effect, these counsellor trainees were unable to respond with any accuracy to the client's feelings apart from the most

obvious (Truax & Carkhuff, 1967, p.48). Finally, as shown in Table 3, none of the subjects managed to respond above level six. This revealed the fact that no subject was able to express accurate empathy in reference to the veiled and underlying feelings of his client. This form of communication required movement beyond level six on the scale (Truax & Carkhuff, 1967, pp.52-57).

Anxiety levels. The anxiety levels exhibited by the subjects were measured immediately following their sex counselling interviews. After the experiment, most subjects readily admitted that their own tension and apprehension, created by the sexual content, made them ineffective as helpers. Their response to the anxiety questionnaire indicated that these self disclosures were genuine.

The range of possible scores for the test was twenty to eighty. The lower scores were indicative of lower levels of anxiety. As shown in Table 2, there was a wide range of scores reported by the subjects. One subject had the minimum while another was as high as fifty-seven. The group mean was 39.4.

In developing a scheme of classification, Spielberger et al. (1968) administered the anxiety scale to a variety of groups. This procedure allowed comparisons to be made between groups experiencing various degrees of anxiety. The higher levels of anxiety were reported by neuropsychiatric patients and hospital patients with psychiatric complications. The respective group means were 40.5 and 42.4 (Spielberger et al., 1968, p.17). In contrast, the group mean for undergraduate students under relaxed conditions was 31.2. However, under experimental conditions where stress was generated, the mean rose to 43.4 (Spielberger et al., 1968, pp.63-64). In effect, it

was possible to have the student group temporarily experience levels of anxiety reported by psychiatric patients.

Approximately twenty-two percent of the subjects in the present study were able to maintain minimal levels of anxiety. However, as indicated in Table 4, 77.8 percent of the subjects surpassed the group mean of 31.2 reported by students under relaxed conditions. In addition, 41.7 percent of the subjects experienced feelings of anxiety comparable to those reported by the various neuropsychiatric groups. At the extreme point of the continuum, 36.1 percent of the subjects reported levels of anxiety above the 42.4 mean recorded for hospital patients with psychiatric complications. Finally, thirty percent of the subjects surpassed the mean of 43.4 reported for undergraduate students who were placed in high stress situations.

Table 4

Cumulative-Frequency Distribution

of Anxiety Scores (N=36)

Anxiety Levels (exceeds STAI score of):	Cumulative Frequency	Percent of Sample
43.4	11	30.6
42.4	13	36.1
40.5	15	41.7
31.2	28	77.8
20.0	36	100.0

Therefore, in terms of the Spielberger et al. (1968) classification scheme, thirty-six percent of the sample reported anxiety levels similar to those reported for the groups at the higher extreme of the continuum.

Levels of sex knowledge. The results indicated that individual differences in sex knowledge existed to the extent that some trainees were not aware of the most basic facts of human sexuality. In some instances the subjects lacked basic knowledge in areas that would frequently be topics of concern with their clients. The norms for the Sex Knowledge Inventory were based on scores obtained from premarital counsellees. There were separate norms for the male and female populations (McHugh, 1968b). In the present analysis, the female norms were employed for comparisons because the standard was higher than for the males. It was felt that the higher standard should be attained by all counsellors since they would likely meet both male and female clients.

As shown in Table 2, the group mean for the Sex Knowledge Inventory (McHugh, 1967) was fifty-three with a standard deviation of 10.27. As a group, the subjects placed in the sixty-fifth percentile when compared with the normative groups. The large standard deviation indicated that the scores were widely scattered around the sixty-fifth percentile rank. The range of scores as shown in Table 2 went from twenty-four to sixty-eight.

In the reported norms, a score above fifty-eight was required to reach the ninetieth percentile (McHugh, 1968b). As indicated in Table 5, thirty percent of the subjects attained this level, but there were also twenty-two percent of the subjects below the fiftieth percentile. It may also be observed that the tendency was for the subject to fall within the range of the fortieth and eightieth percentile ranks. Just under forty-five percent of the subjects were within this range. In other words, for the most part, the subjects did not distinguish themselves from the lay population.

Table 5

Distribution of Scores on the
Sex Knowledge Inventory (N=36)

Score on SKI exceeding:	Percentile Rank	Cumulative Frequency	Percent of Sample
58	90 - 99	11	30.5
56	80 - 89	14	38.8
54	70 - 79	19	52.7
50	60 - 69	25	69.4
48	50 - 59	28	77.7
46	40 - 49	30	83.3
43	30 - 39	33	91.6
23	00 - 29	36	100.0

The personality dimension. One aspect of this research was concerned with prediction. Efforts were made to determine the feasibility of utilizing the Sixteen Personality Factor Questionnaire (Cattell, 1968) in conjunction with the subjects' ages, to predict the counsellor trainee's level of competence with respect to the dependent variables. The analysis proved meaningful in that the results indicated the existence of a relationship between the counsellor trainee's sex counselling skills and his personality profile.

A variation of multiple regression, known as the stepwise regression method (Nie, Bent, & Hull, 1970, p.180), was employed to analyze the personality data. The subjects' ages combined with the sixteen factors yielded by the questionnaire served as the predictor variables. The raw scores for the Sixteen Personality Factor Questionnaire were used because Cattell et al.

(1970, p.61) advocated that raw scores be used for research purposes. The premeasures were used for the criterion variables of empathy, anxiety, and sex knowledge.

The results did suggest that the predictors could be used to forecast a trainee's competence in sex counselling. However, this was the case only when certain factors were used to predict performance. In Table 6 the data were summarized for each criterion variable. In the case of empathy, the multiple correlation was .71 which accounted for fifty-one percent of the variance. This was only slightly different from anxiety for which the multiple correlation was .74. This accounted for fifty-five percent of the variance. After the sixteen personality factors had been introduced for the prediction of the sex knowledge variable, the tolerance level was insufficient for further computation (F=.003). The age variable was excluded. As a result, the correlation of .79 allowing for sixty-two percent of the variance was achieved using only the Sixteen Personality Factor Questionnaire. Nevertheless, a .05 level of significance was not obtained in these instances.

Table 6

Summary of Stepwise Regression Results

Criterion Variable	Multiple R	R^2	df	F-ratio	p
Empathy	0.71047	0.50476	16/19	1.21	n.s.
Anxiety	0.73944	0.54677	17/18	1.28	n.s.
Sex Knowledge	0.78545	0.61694	16/19	1.92	n.s.

In Table 7, the three variables which were the best predictors for each criterion variable are listed. It was discovered that empathy and sex

knowledge had the same factors as the three best predictors, although the first two were in reversed order. As well, Factor L was among the first three in the case of anxiety. The other two were age and Factor C. As indicated in Table 7, when the three best predictors for each criterion were isolated, statistical significance was achieved.

Table 7

The Three Primary Factors
Contributing to Each Criterion

Criterion	Predictor Variables	Multiple R	R^2	Simple R
	Integration (Q_3)	.34	.12	-.34
Empathy	Suspicion (L)	.49	.24	-.26
	Intelligence (B)	.55	.31	.28
	df=3/32	F=4.71	p<.01	
	Emotional Stability (C)	.38	.15	-.38
Anxiety	Age	.46	.21	.16
	Suspicion (L)	.49	.24	-.09
	df=3/32	F=3.34	p<.05	
	Suspicion (L)	.46	.21	-.46
Sex Knowledge	Integration (Q_3)	.56	.32	-.21
	Intelligence (B)	.62	.39	.27
	df=3/32	F=6.67	p<.01	

Note: The complete summary chart for each criterion variable is presented in Appendix F.

The three common factors were level of integration (Q_3), level of suspicion (L), and degree of intelligence (B) (Cattell & Eber, 1962, pp.13-18). The three factors accounted for approximately thirty-one percent of the variance in terms of empathy, and thirty-nine percent in the case of

sex knowledge. The signs reported with the simple R (Table 7) allowed the direction of the relationship to be interpreted. Based on the reported data, higher levels of empathic responses and sex knowledge were to be expected from those subjects who exhibited limited integration with respect to social demands, who were more intelligent, and who had a low level of suspicion. The latter was manifested by the indication of few jealous tendencies and a high degree of trust.

The findings related to anxiety were different in that intelligence and integration did not occupy as prominent a position as they did in the other two variables. Instead, age and emotional stability proved more outstanding as predictors. A high score on Factor C indicated emotional stability and a realistic approach to life (Cattell & Eber, 1962, p.14). The inverse relationship suggested that reduced anxiety was coupled with emotional stability. The level of anxiety increased with age. Higher levels of anxiety were to be expected from those subjects with a lower score on the suspicion factor (L). The lower scores indicated more trust and more concern about other people (Cattell & Eber, 1962, p.16). In effect, one may score high in terms of trust but still experience anxiety as a result of his concern over the client.

The Effects of Treatment

The design for this research study called for an examination of the effects of specific training on a subject's ability to counsel people with sexual problems. The study involved three treatment groups and one control group. The treatment programs involved three distinct approaches to training: didactic, experiential, and conjoint. The effects of these

three training programs were determined by using empathy, anxiety, and sex knowledge as the dependent variables. The potential of personality traits in serving as predictors of response to treatment was also examined. Finally, the subjects in all the groups responded to the questionnaires reproduced in Appendices B and C. Their reports were also examined with a view to finding differences in responses among the four groups.

The present section reports on the effects of specific training in sex counselling. There were four aspects that required consideration. First, the differences between treatment and no treatment were examined in terms of the dependent variables. The differential effects between the three treatment groups were then considered. This was followed by an examination of the relationship between response to treatment, and the personality profiles of the subjects. Finally, the results drawn from the questionnaires were reported.

Treatment vs. control. An analysis of covariance with the pretreatment measures as the covariate was used to evaluate the effects of specific training in sex counselling. The pretreatment measures consisted of the reported scores (Table 2) on the dependent variables empathy, anxiety, and sex knowledge. The information obtained through this process made it possible to answer the research questions concerning trained counsellors that were presented in the previous chapter (pp.53-54).

The results indicated that counsellors who received training were no more effective than those who were untrained in expressing facilitative empathic responses while counselling clients with sexual problems. After adjusting the means using the pretest measures as the covariate, no difference among treatments was evident (Table 8). An examination of the pre-

and post-means reported in Table 9 clearly indicated that the average change on this criterion was negligible since the maximum change on the nine point scale was 0.3.

Table 8

Analysis of Covariance

Criterion: Empathy

Source	df	Sum of Squares	Mean Square	F-ratio	p
Between	3	0.9732	0.3244	0.411	n.s.
Within	31	24.4509	0.7887		

Table 9

The Means for the Four Groups

Criterion: Empathy

Group	Pretest Mean	Posttest Mean	Posttest Adjusted Mean From Covariate Analysis	Pre-Post Change
Didactic	3.7	3.6	3.6	-0.1
Experiential	3.5	3.6	3.7	0.1
Conjoint	3.7	3.4	3.4	-0.3
Control	3.6	3.8	3.8	0.2

During sex counselling, the anxiety levels of the trained counsellors in the conjoint group were significantly lower statistically than the anxiety levels displayed by the untrained counsellors. The analysis of covariance (Table 10), using the anxiety premeasures as the covariate, reported a degree of significance below the .10 level. The New Multiple Range Test (Duncan, 1955) was used for further analysis. In addition to the differences

between the conjoint and control groups, the test revealed significant differences between the methods of treatment. Since the latter involved treatment group differences, they have been reported in the following section.

Table 10

Analysis of Covariance

Criterion: Anxiety

Source	df	Sum of Squares	Mean Square	F-ratio	p
Between	3	833.0430	277.6809	2.590	p<.10
Within	31	3323.2539	107.2017		

After the completion of the training programs, the trained subjects in the three treatment groups showed a significant increase in their knowlege of human sexuality that was not witnessed in the control group. As shown in Table 11, an analysis of covariance, using the premeasures on the Sex Knowledge Inventory (McHugh, 1967) as the covariate, revealed a significant difference below the .001 level. Duncan's New Multiple Range Test

Table 11

Analysis of Covariance

Criterion: Sex Knowledge

Source	df	Sum of Squares	Mean Square	F-ratio	p
Between	3	313.0212	104.3404	15.547	p<.001
Within	31	208.0469	6.7112		

(Duncan, 1955) was employed for further analysis. The range test indicated

that there were no homogeneous subsets among the four groups. This meant that any two means differed significantly at the .05 level. These computations suggested that significant differences also occurred between the treatment groups. However, it was necessary to examine the within group variance in terms of the change scores in order to find which treatment groups accounted for the variance. These within group differences have been reported in the following section.

Differential effects. The differential effects of the three treatment methods were also under scrutiny in this research study. Accordingly, the data were examined to determine the individual effects of the three modes of treatment. This process did not reveal any differences among the treatment groups in terms of the empathy variable. It has been shown in Tables 8 and 9 that the pre-post change for each group on the empathy scale was minimal, and not statistically significant. However, intertreatment group differences were discovered with the anxiety and sex knowledge dependent variables.

The group means for the anxiety criteria (Table 12) indicated that the didactic and control groups remained static statistically. They also remained static with reference to the system of classification developed on the basis of the anxiety scale (Spielberger et al., 1968, p.17; pp.63-64; Table 4). However, changes did occur in the experiential and conjoint groups.

A one way analysis of variance was employed on each group to examine the pre-post changes in anxiety. The results have been reported in Table 12. Since the predicted change was directional, the .1 value of p indicated significant change. This downward prediction was realized in

the case of the conjoint group. The subjects in the experiential group did not change in the predicted direction. As a result, the .95 level of confidence was required for statistical significance. The experiential group's increase in anxiety was not sufficient to reach this level.

Table 12

One-Way Analysis of Variance
Pre-Post Measures for Four Groups
Criterion: Anxiety

Group	Pretest Mean	Posttest Mean	Total Mean Square	df	F-ratio	p
Didactic	41.1	40.3	95.39	17	0.027	n.s.
Experiential	34.1	42.4	106.87	15	2.864	n.s.
Conjoint	39.6	30.9	131.95	17	2.839	.10
Control	41.8	37.2	106.26	19	0.995	n.s.

The experiential and conjoint groups showed change in terms of Spielberger's taxonomy (Spielberger et al., 1968, p.17; pp.63-64; Table 4). Prior to treatment the anxiety mean for the experiential group was the lowest of the four groups, but it was the highest following treatment. Their posttest mean (42.4) was identical to the mean reported by Spielberger and his associates (1968, p.17) for hospital patients with psychiatric complications. The conjoint group responded in the opposite manner. Their pretest mean of 39.6 was comparable to the 40.5 group mean of neuropsychiatric patients. However, following treatment the conjoint group managed to reduce their anxiety levels to a point which was below the group mean (31.2) reported for undergraduate students who had responded to the anxiety questionnaire under relaxed conditions (Spielberger, 1968, pp.63-64). Changes

of this kind were not found in either the didactic or the control groups.

The analysis of covariance computed for the sex knowledge criterion was reported in the previous section (Table 11). The reported significant differences justified further investigation. A one way analysis of variance was done on the pre-post measures for each group. As shown in Table 13, only the subjects in the control group failed to register significant change

Table 13

One-Way Analysis of Variance

Pre-Post Measures for Four Groups

Criterion: Sex Knowledge

Group	Pretest Mean	Posttest Mean	Total Mean Square	df	F-ratio	p
Didactic	50.1	61.7	218.69	17	3.095	0.10
Experiential	53.3	58.3	24.47	15	5.243	0.04
Conjoint	55.9	63.3	48.72	17	6.893	0.02
Control	52.9	56.0	78.05	19	0.603	n.s.

in their knowledge of sexual matters. The three treatment groups showed a significant increase, but the greatest gains were made by the subjects in the didactic group. The mean changes for the four groups have been reported in Table 14.

Table 14

The Means for the Four Groups

Criterion: Sex Knowledge

Group	Pretest Mean	Posttest Mean	Posttest Adjusted Mean From Covariate Analysis	Pre-Post Change
Didactic	50.1	61.7	63.6	+11.6
Conjoint	55.9	63.3	61.5	+ 7.4
Experiential	53.3	58.3	58.1	+ 5.0
Control	52.9	56.0	56.1	+ 3.1

The personality dimension. The change scores for all subjects in the experimental groups (N=26) were used in a stepwise regression method of analysis (Nie et al., 1970, p.180). The purpose was to examine the feasibility of predicting the response of a person to training in sex counselling. The predictor variables included each subject's age and his score on the Sixteen Personality Factor Questionnaire (Cattell, 1968). The criterion variables were empathy, anxiety, and sex knowledge. The differences between the pre-and posttest scores were used for the criterion variables.

The results indicated that personality trait measures assist in the prediction of those people most likely to respond to treatment in a positive fashion when anxiety is the criterion variable. However, in the case of empathy and sex knowledge the predictor variables did not prove useful in forecasting response to treatment.

The complete summary charts for the three criterion variables have been reproduced in Appendix G. It may be observed that with empathy as the criterion variable, the multiple correlation was .68 which accounted for approximately forty-six percent of the variance. When the subjects' in-

creases in sex knowledge were used as the criterion variable, the multiple correlation was .76. This accounted for approximately fifty-eight percent of the variance. The .05 level of significance was not reached in either of these cases.

The summary chart (Appendix G) for the anxiety criterion shows that collectively the predictor variables accounted for sixty-five percent of the variance with a multiple correlation of .81. This did not result in significance at the .05 level. However, as shown in Table 15, when the three best predictors were isolated, significance at the .05 level was achieved. This was not the case with the empathy and sex knowledge variables.

Table 15

Stepwise Multiple Regression
Totals for the Three Best Predictor Variables
Criterion Variables: Empathy, Anxiety, Sex Knowledge

Criterion Variable	Multiple R	R^2	df	F-ratio	p
Empathy	0.44658	0.19944	3/22	1.83	n.s.
Anxiety	0.55836	0.31177	3/22	3.32	.05
Sex knowledge	0.45285	0.20507	3/22	1.89	n.s.

Note: The"F" Statistics reported here are for the third R-square value reported. See Appendix G for complete summary charts.

In the case of anxiety, it was observed that the three best predictors were the subjects' scores on the factors related to morality (G) and emotional stability (C), and their age. When the three factors were combined the multiple correlation was .57 which accounted for slightly more than thirty-one percent of the variance. This was significant at the .05 level.

The three principal predictors related to pre-post change in anxiety were Factor G, Factor C, and age. The more conscientious and moralistic received higher scores on Factor G, while a high score on Factor C indicated emotional stability and a realistic approach to life (Cattell & Eber, 1962, pp.14-15). The simple R sign was negative for Factor G and positive for Factor C (Appendix G). This meant that the more conscientious and moralistic subjects showed the least amount of change in anxiety. Similarly, those subjects who reported low emotional stability showed the least response to treatment. Finally, the inverse relationship reported for the age factor indicated that the older subjects showed the least change on the anxiety scale.

Emotional stability and age were the two best predictor variables for the anxiety criterion when the subjects had been sex counselling before their training (Table 7). It was shown that the higher levels of anxiety were to be expected from the subjects who showed less emotional stability, and were older. These two predictors also were significant in terms of response to treatment. In effect, age and emotional stability were consistently associated with the reported levels of anxiety.

Self-reports. When the data had been collected, the subjects in the four groups responded to the questionnaires reprinted in Appendices B and C. The questionnaire entitled, "My Approach to Sex Counselling", was devised to provide a method for discovering the subjects' perceptions of their own behavior and their evaluations of their skills as sex counsellors. The second questionnaire simply sought the subjects' opinions on the worth of the treatment programs. With regard to the questionnaire "My Approach to Sex Counselling", the use of item analysis made it possible to develop

the profiles outlined below.

Responses to the questionnaire indicated that certain similarities existed in self-perceptions among the members of the four groups. In fact, there were areas where all of them responded in the same fashion. All of the subjects, irrespective of the group to which they belonged, reported themselves as sympathetic, friendly, and close to their client. They also reported that when they were sex counselling they were nice, attentive, realistic, and mature.

The item analysis also pointed up important differences. Most striking was the confidence exhibited by the subjects in the conjoint group. Only the subjects in this group viewed themselves as efficient. In addition, over half the subjects in the conjoint group believed themselves to be meaningful, skilful, competent, and clear when sex counselling. In contrast, the other three groups interpreted their clinical behavior as clumsy, lacking meaning, confusing, and incompetent. This interpretation was made by over ninety percent of the subjects in these three groups.

All of the subjects in the experiential and conjoint groups reported themselves as comfortable and at ease with the sexual content. Although the members of the experiential group did experience anxiety from feelings of incompetence, the sexual content in itself did not generate anxiety. However, seventy percent of the controls and forty percent of the didactic group reported that they were either uncomfortable or "hung-up" when sex counselling.

The control group further isolated itself by reporting negative traits not found in the other groups. Most saw themselves as insecure, while fifty percent believed that they were defensive when sex counselling.

Not one subject in the control group believed himself to be efficient, and eighty percent interpreted their behavior as indecisive.

In conclusion, a few remarks on the questionnaire reproduced in Appendix C are appropriate. The general theme was positive. With the exception of one subject, everyone agreed that specific training in sex counselling was necessary. Most subjects believed that the training should involve a half-course, while eight suggested that such training be provided as a module of the practicum course. There was total agreement on the fact that such training had a positive effect - both personally and professionally. A recurring theme in the answers involved explanations of how training reduced defensive behavior and widened the boundaries of acceptance.

Chapter V

Discussion

The present chapter provides an interpretation and discussion of the results obtained from this study. It includes an examination of the empirical data collected before the implementation of the treatment programs. These premeasures provided the evidence which supports the claim that counsellors require specific instruction in human sexuality.

The implications of the differential treatment effects are examined in terms of future program development. Emphasis is placed on delineating the advantages and limitations of the most effective training model. The feasibility of utilizing personality profiles to assist in the screening and selection processes is considered. In addition, suggestions for future research are presented. At the conclusion of the chapter, an outline is presented in which the counsellor education curriculum is altered to include courses in human sexuality.

The Need For Training: Empirical Evidence

The initial stages of the research project concentrated on the subjects prior to their participation in the training programs. It was postulated that the subjects would communicate minimal levels of empathy and would experience high levels of anxiety when sex counselling. It also was predicted that they would have a limited knowledge of sexual matters. The data indicated the need for counsellors to receive specific

training in sex counselling procedures.

The results reported in Table 2 (p.75) indicated that the subjects were unable to cope effectively with the unique demands of sex counselling. The subjects' performances in terms of the independent variables did not correspond to the standard usually associated with positive counselling outcomes. The most evident example was the negatively skewed distribution of the empathy scores. The group mean of 3.6 was well below the established minimal level of five required for positive outcome (Truax & Carkhuff, 1967, p.51).

Martin and Sroufe (1970, p.216) have indicated that it is difficult to quantify or scale degrees of anxiety. Therefore, it is difficult, in an absolute sense, to classify the group's level of anxiety. Nevertheless, a comparative approach allows for the identification of the more extreme levels of anxiety. In terms of the classification scheme set forth by Spielberger et al. (1968), the subjects in this sample tended to cluster at the higher levels. In fact, thirty percent of the subjects reported scores that surpassed the mean level of anxiety (43.4) experienced by the groups of students who were placed under extreme conditions of stress in the studies conducted by Spielberger et al. (1968, pp.63-64). In contrast, only twenty-two percent of the subjects clustered about the lower end of the classification scale. These objective measures corresponded with the subjective verbal reports of the subjects. When questioned, most of the subjects claimed that the heavy emphasis which was placed on sexual material during the interviews caused them to experience considerable apprehension, uneasiness and tension.

The subjects' group mean of fifty-three indicated that their know-

ledge of sexual matters was limited. Sheppe and Hain (1966) showed concern when their sample of fourth year medical students obtained a mean of seventy on an earlier edition of the same test (McHugh, 1950). The sample used in this research presented a more serious situation. When compared with the lay population, members of the group did not distinguish themselves as experts. The group mean of fifty-three placed the sample in the sixty-fifth percentile (McHugh, 1968b).

The large standard deviation (10.23) indicated that the scores were widely scattered about the mean. In fact, thirty percent of the subjects were above the ninetieth percentile, but twenty-two percent were below the fiftieth percentile rank. It is unlikely that a person with a sexually related problem would receive adequate assistance from a counsellor in this sample. The client could encounter either a sexual illiterate, or at best, an individual with limited knowledge about sexual matters. The scores clearly indicated that the counsellor trainees did not have either an adequate or an equal amount of knowledge with regard to sexual matters.

These results suggest that the counsellor's standard training does not prepare him adequately to help people seeking his assistance in matters related to sex. The findings reflect what seems a basic inadequacy in the methods utilized in the training of counsellors. It is important to recognize that, as a group, the subjects had proven themselves competent in other areas of counselling which included theory and practice. In fact, they were selected as the "cream of the crop" from amongst the many applicants who sought entrance into the program. In relation to sex counselling, the shortcomings existed, not with the subjects, but within the curriculum. The results show that it is not feasible to ignore the sexual dimension of

the human condition when training counsellors.

Three Training Models

The principal purpose of this research was to develop and implement three training programs in sex counselling. In order to determine the effects of the training programs, the data collected after treatment were compared with the premeasures. The programs were designed to increase the subjects' ability to communicate empathy, decrease their anxiety, and extend their knowledge of sexual matters. The research questions were formulated with the expectation that the three training programs would produce positive results. That is, when compared with the subjects in the control group, the subjects in the experimental groups would be more empathic and less anxious when sex counselling, and would be more knowledgeable about sexual matters. In this regard, the treatments were presumed to be similar.

It also was deemed a distinct possibility that the treatment programs could differ in terms of quality. Although the three treatments were intended to generate positive results, it was recognized that the differential effects might provide useful information in future endeavors which would be geared to the construction of similar programs. The results have proven these assumptions to be accurate. In the light of the results, the treatments proved unique, not for their similarities, but for their differences. The present section begins with a discussion of the similarities among the training programs. The remainder of the section is devoted to an examination of the treatment differences. Particular emphasis is placed on the preferred model for training.

The empathy variable. The three training programs produced similar results in relation to the empathy variable. It was found that the three models proved ineffective as methods for improving the subjects' skills at communicating empathically with their clients. There are two possible explanations for this negative outcome. The most obvious explanation is that there were shortcomings within the three training programs which did not favor the development of empathic skills. The time element is a relevant factor in this matter. Perhaps the ten hours of treatment were not sufficient for the subjects to develop their empathic skills within the sex counselling setting. This suggests that an experiential component devoted specifically to empathy training should be introduced into the didactic program and further extended in the experiential and conjoint models.

The second explanation for the subjects' lack of response in terms of empathy examines the subjects' potential to respond in a positive fashion. When the three programs were developed, it was assumed that the subjects had received sufficient training to communicate empathically in most counselling settings. It was suggested that the subjects would be unable to transfer their empathic skills to the sex counselling situation. Possibly the assumption that the subjects already possessed empathic skills was unfounded. If this were the case, then, even in those instances where improvement was forthcoming on the knowledge and anxiety variables, a corresponding improvement would not have been witnessed with the empathy variable.

The lack of significant results with the empathy variable indicated that further research was required. The most meaningful results may be achieved where the research design is limited to an examination of the empathy construct. Liberal financial support would be required for the project.

This would make it possible to measure the subjects' level of empathy during counselling sessions that were not concerned with sexual matters. There would be a baseline then to serve as the point of reference for the empathy levels measured in the sex counselling sessions. This would be followed by an analysis of the change scores for the experimental and control groups. The above process involves an elaborate research study. However, it appears to be the only reliable method for discovering the effect of the three treatment models on the empathy variable.

Inadequate models. The positive results derived from participation in the didactic and experiential training programs were limited. These two approaches were successful in so far as they increased the subjects' knowledge of matters related to human sexuality. However, neither of the training models proved efficacious as a means for reducing the level of anxiety experienced by the subjects when they were sex counselling.

The experiential approach was distinguished by its lack of direct didactic input, yet the subjects significantly improved their sexual knowledge. The experiential exposure provided sufficient stimulation for the participants to do outside readings in human sexuality. During the treatment program the subjects frequently sought the guidance of the facilitator in the selection of reading materials. Nevertheless, the lack of a systematic didactic structure prevented the members of the experiential group from acquiring an amount of knowledge equal to that attained by the subjects in the other two experimental groups. The gains reported for the didactic and conjoint groups were significantly greater than those reported for the experiential group. The experiential model is not, therefore, the preferred mode of treatment even when the purpose for treatment is limited to the acquis-

ition of knowledge concerning sexual matters.

The didactic approach produced the most significant increase in the subjects' knowledge of human sexuality. The gains made by the didactic group were significantly greater than those made by the other three groups. The results showed that the didactic model is useful when the goal of treatment is limited to assisting the trainee in his search for sexual knowledge.

The didactic and experiential approaches were not successful in reducing the anxiety levels of the subjects when they were sex counselling. It was hypothesized that the experiential model with its heavy emphasis on desensitization would prove particularly effective as a means for reducing anxiety. The results proved that this was inaccurate. In fact, the reported change in anxiety for the experiential group approached significance in the opposite direction. This suggested that the approach may prove harmful if it is used with other groups. The anxiety levels of the members in the didactic group remained stable.

The results led to the conclusion that the experiential method was not an effective model for the training of sex counsellors. Participation in the program did not increase the subjects' level of empathic communication. It did not alter their anxiety levels. It may even increase anxiety if used with other groups. Although an increase in sexual knowledge did result, the didactic treatment proved more effective in this regard. In view of these results, the experiential approach must be discounted as a positive method of training.

The didactic program altered only the knowledge variable in a positive fashion. Nevertheless, it must not be discarded as an impractical approach to training. Its usefulness is related to the goals of treatment.

It would be fallacious to suggest that the treatment was effective in training counsellors to treat clients with sexual problems. However, a distinction must be made between treatment and the providing of information. All counsellors must be capable of providing accurate information on sexual matters. The sex counsellor must, in addition, be prepared to treat clients seeking assistance with sexual dysfunctions. In the first instance, the didactic approach has a role to play in counsellor education. However, in the second, it is inadequate.

Many experts (Bernard, 1968, pp.260-262; Juhasz, 1969; Kaplan, 1974, p.123; Masters & Johnson, 1970, p.21) have argued that a primary etiological factor in sexual dysfunction is the client's lack of accurate sexual information. These observations indicate that all counsellors can perform a useful service by being reliable sources of information. In this capacity the counsellor's role would be a preventative one. The trained sex counsellor could then concentrate on the remedial aspects of sexual dysfunctions. Thus, the didactic approach would serve as an efficient means for properly preparing counsellors to fulfill their professional role as facilitators of human growth. This is most applicable in the case of school counsellors. Participation in a didactic program would be of definite assistance to the school counsellor in his effort to provide his students with accurate sexual information.

The preferred model. The conjoint program showed the most promise as a method for training sex counsellors. The members in the conjoint group were the only subjects to show a significant decrease in anxiety levels when sex counselling. As well, the anxiety level for the conjoint group after treatment was significantly lower than the group means for anxiety in the

other three groups following treatment. Following participation in the training program, the conjoint group also showed a significant increase in sexual knowledge. These results were achieved only where the didactic and experiential components were incorporated into the single treatment process.

The increase in sexual knowledge reported for the conjoint group was not as high as that reported for the didactic group. The conjoint group's adjusted mean was significantly greater than the means for the experiential and control groups but was significantly lower than the didactic group's mean. This may be explained by the fact that the conjoint approach devoted five hours to didactic instruction while the didactic method involved ten hours. The participants in the conjoint group devoted additional time to independent readings on human sexuality. They were provided the same reference sources as were the members of the didactic group. However, the results indicated that this procedure was not sufficient to compensate for the reduced class time devoted to lectures and discussions. The structured didactic input by the instructor appeared to be the crucial variable contributing to the differences between the two groups.

The conjoint method's unique contribution lay in the fact that, in addition to increasing the subjects' knowledge of human sexuality, it also led to a reduction in the anxiety experienced by the subjects when sex counselling. A similar reduction in anxiety was not witnessed by the other groups. When first examining the treatment designs, there was an inclination to assume that the experiential approach would be the most likely method to employ in the altering of anxiety states. The fact that this was not the case focuses attention on the significance of the cognitive compon-

ent. Ellis (1975) has argued that treating anxiety in sex therapy requires heavy emphasis on cognition in the form of corrective information. If anxiety is to be reduced, the process must not be restricted to an emotive approach. In the light of the research results, this argument is equally applicable to the training of sex counsellors.

The conjoint approach was successful because the method addressed itself to the emotive and cognitive elements involved in the process of change. The process is best explained using Ellis' (1973, chap.4) theory as a point of reference. The instructor's didactic input provided the subjects with the material they required to refute the irrational elements of their sexual belief systems. The experiential exposure permitted them the opportunity to explore their attitudes and share their feelings regarding these new insights. It was the cognitive restructuring which facilitated a modified emotional response in the form of reduced anxiety to the sexual stimuli. The lack of emphasis on cognition in the experiential model prevented the occurrence of a similar change.

The Conjoint Model: Limitations

It was determined that the preferential treatment mode was the conjoint model. This was the only approach which induced change on the knowledge and anxiety variables in the desired direction. The statistical significance indicated a meaningful change in the quantitative sense. However, an examination of the quality or real nature of the change revealed that there were certain shortcomings associated with the conjoint method. These limitations are discussed in this section.

Insufficient knowledge. Although the subjects in the conjoint group

significantly increased their knowledge of sexual matters, the group's posttest mean of sixty-three leaves the degree of change open to question. The mean indicated that after treatment the subjects still missed, on the average, seventeen answers out of a total of eighty. It must be recognized that the Sex Knowledge Inventory was constructed to evaluate the examinee's basic knowledge of human sexuality (McHugh, 1968a; Sheppe & Hain, 1966). Therefore, an acceptable level of expertise was certainly not attained by the conjoint group. The statistical significance merely implied that the group's pretest mean was sufficiently low for significant change to occur without the acquisition of sophisticated knowledge. This is not adequate considering that with the exception of one or two questions where personal judgement may be involved, the counsellor should possess sufficient knowledge to answer all the questions correctly.

The subjects' limited knowledge of the basic aspects of human sexuality indicated that even after participation in the program they remained potential sources of misinformation. Although the treatment program improved the situation, it did not eliminate the high element of risk present in those circumstances where the counsellor had to provide his clients with sexual information.

The reduction of anxiety. The responses to the self-report (Appendix B) provided valuable information regarding the subjects' self perceptions. All the members in the conjoint group reported that they were at ease when discussing sexual matters with their clients. Most of them interpreted their sex counselling as skilful, clear and meaningful. It was the only group that was comfortable with the sexual content of the interviews, and possessed confidence in its competence to cope with the demands of sex counselling. It

logically follows that such self perceptions would facilitate control of anxiety levels when sex counselling. They did not experience the feelings of tension, nervousness and apprehension found in the other groups because they were comfortable with the topic and believed themselves professionally competent. In contrast, the subjects in the other three groups interpreted their clinical behavior as clumsy, confusing and incompetent.

The subjects' responses to the Spielberger questionnaire (Appendix A) and the self-report (Appendix B) supported the conclusion that the conjoint method was an effective means for stabilizing anxiety. The experiential exposure helped the subjects to relax when discussing sex. The didactic input helped them to gain confidence in their ability to be effective when sex counselling. Nevertheless, it would be misleading to generalize these results beyond the initial interview. Positive results were achieved with the conjoint approach, but these results must be viewed in proper perspective.

In this research, the subjects were only required to conduct initial interviews. They were not confronted with the prospect of having to work with their clients for a number of sessions. It was observed that before training even an initial interview proved to be an anxiety inducing experience. This was not so in the case of the conjoint group after treatment. However, the tension, nervousness and apprehension may have reappeared had the subjects been required to conduct further interviews with their clients. There is also the fact that, as discussed in the previous section, the sexual knowledge of the conjoint group was limited. Further sessions with the clients may have strained the boundaries of that knowledge. Once aware that they lacked adequate knowledge, they could have experienced the strain and tension associated with feelings of inadequacy. The experiential and

didactic components which were introduced during treatment allowed them to control their anxiety in the initial interview, but it is doubtful that the situation would have remained stable beyond this initial contact.

The time factor. Another shortcoming associated with the conjoint method was the length of the treatment. The time allotted for the treatment was not sufficient. With the completion of the programs, it became evident that the sheer quantity of relevant material militated against such a condensed training program. This was most obvious with the didactic component. The single hour which was devoted to etiological analysis left the subjects with an incomplete understanding of the causes of sexual dysfunction. The time restriction did not allow the subjects to receive the necessary instruction on intervention strategies. The treatment procedures utilized in sex counselling were covered superficially and were limited to the Masters and Johnson (1970) format.

The short time span was adopted to examine the feasibility of providing such training as a module of a regular practicum course. This no longer appears practical if the intention is to prepare counsellors to render effective help for people with sexual dysfunctions. The subjects indicated a similar bias when they responded to the last question in the questionnaire reproduced in Appendix C. Most of the subjects felt that the program should be expanded to a half-course. This suggests that other programs of approximately the same duration may contain similar shortcomings. For example, if the human sexuality programs developed by Tyler, the Howard University Health Service (Schiller, 1973, p.173; pp.177-178), and Tanner (1974) were examined under experimental conditions, the length of each program could prove to be a crucial variable. Further research is required to examine the

effect of course time on expertise in sex counselling. In the closing section of this chapter, suggestions are provided for lengthening the training program.

The Use of Personality Profiles

The research design for the present study called for an exploratory analysis of the subjects' personality characteristics. This aspect of the research was intentionally labelled "exploratory" because of the dearth of studies in this area. In the past, there have been attempts to examine the therapeutic outcomes that result from matching certain therapist-personality types (Allen, 1967; Bare, 1967; Betz, 1962; McNair, Callahan, & Lorr, 1962). However, as far as can be ascertained, no previous effort has been made to examine the effect which personality traits have on the outcome of sex counselling or on the response to training in sex counselling. The present research addressed itself to this problem. The results indicated that a relationship exists between counselling performance and certain personality characteristics of the counsellor. As well, there were indications that the personality measures may prove useful in the selection of people who are to undergo specific training in sex counselling.

Use of the Sixteen Personality Factor Questionnaire (Cattell, 1968) in conjunction with the subjects' ages showed potential as a predictor of the untrained sex counsellor's level of competence with respect to the dependent variables. In fact, it was found that the same three personality factors proved the best predictors of the subjects' sexual knowledge and their ability to communicate empathy. The significant results (i.e. .05 levels) indicated that those subjects who were more trusting, intelligent,

and least affected by social demands, tended to express more empathic responses and possessed more knowledge about sexual matters.

If further research involving larger samples should replicate these results, it would assist in efforts to provide clients with counsellors who show the most potential to meet their needs. The practical application of this approach is most evident in publicly supported counselling services. Frequently, the counsellors in a given agency have not received specific training in sex counselling. Under such conditions it is difficult to determine which counsellor should have clients with sexual problems assigned to him. The solution may lie in the compilation of personality profiles for the counsellors in each agency. In that way, the client could be assigned to the counsellor whose personality profile resembled the profile previously established as the best predictor of positive performance. This process may prove equally valid in a variety of settings including colleges, family service centers and universities.

In the present study, attention was given to the subjects' response to the specific training programs. The personality dimension was examined with a view to determining those personality traits which would render a subject more-or-less responsive to the treatments provided in this study. The change scores were used to evaluate the response to treatment. It was impossible to develop personality profiles where empathy and sexual knowledge were involved since no significant relationship was established between these variables and the subjects' personality traits. However, there were significant indications that anxiety levels were susceptible to prediction.

The results indicated that subjects with certain personality traits

showed little change in their anxiety levels after treatment. Those older subjects who exhibited a more pronounced tendency to be moralistic and emotionally unstable tended to change the least. It also was observed that the subjects who experienced the highest levels of anxiety prior to treatment had a similar profile. In fact, the profiles were identical when the moralism factor was substituted for the suspicion factor. The above relationships were established as significant at the .05 level of confidence.

These results suggest that people with certain personality traits may find it more difficult to fulfill the role of sex counsellor. These preliminary results imply that older people with certain personality traits experience high levels of anxiety when sex counselling, and the situation may not improve with specific training in human sexuality. If further research confirms these findings, personality profiles will certainly have a pragmatic function in screening and selecting candidates for training in sex counselling.

Suggestions for Future Research

This study focused on the development and implementation of three training programs in sex counselling. The nature of the problem did not lend itself to simplistic solutions. The research was designed with a pragmatic orientation. It was felt that people had a right to receive competent help with their sexual problems. However, it proved a difficult task to create a program which would assist counsellors in their efforts to meet the responsibilities inherent in such a demand. The present study has helped to resolve some of the difficulties associated with the problem, but in the process new questions have arisen which require attention. The present sect-

ion elucidates some new directions to be followed in future research. The areas to be considered may be broadly classified under the headings of descriptive research, instrumentation, and personality traits.

Descriptive research. In a recent article, Jacobs and Whiteley (1975) claimed that "if a helping professional, treating sexual problems, was not trained as a sexologist, and recently trained, it is unlikely that s/he is up-to-date" (p.5). The data collected on the counsellor trainees prior to their specific training in sex counselling indicated the accuracy of this statement. However, the problem is not limited to people who receive their training in counsellor education programs. The findings reported for the counsellors raise serious questions about other helping professions. In effect, further research is required to determine how far these results may be generalized. Indeed, if similar empirical evidence is found in parallel studies with different professional populations, the situation is more serious than anticipated.

This problem addresses itself particularly to those professional helpers involved in marital counselling where their clients' problems are frequently related to sexual matters. In many locations there are no legal restrictions to insure that only those professionals who are properly qualified are permitted to practice marital counselling. For instance, in Québec, the law which governs professional organizations (Dubé, 1973) does not concern itself with the field of marital counselling. Traditionally, the service has been provided by a variety of professionals which includes the clergy, social workers and psychologists. In this capacity, all of these professionals concern themselves with assisting people who are experiencing problems with sex-related matters.

Sheppe and Hain (1966) found that physicians lacked a basic knowledge of human sexuality. The present study reported the same situation in the case of counsellors. These results point up the need for similar studies in the corresponding professions. In the case of social workers, Tanner (1974) has observed:

> Social workers are another group of professional counsellors whose work with patients and clients often presumes a knowledge of and a comfort with the subject of sexuality. Yet social work graduate education remains a woefully neglected arena for the teaching and study of human sexuality. (p.283)

The implications of such claims require empirical support. Studies must be devised to measure the helper's level of sexual knowledge and the amount of anxiety he experiences when sex counselling. Descriptive data of this kind will make it possible to determine whether or not the present training procedures for psychologists, social workers and the clergy are sufficient to ensure competence when sex counselling. If the response is negative, suitable training programs must be designed to remedy the situation.

New instrumentation. The field of sex counselling is in need of a standardized test which will allow for a systematic evaluation of the counsellor's knowledge of human sexuality and sexual dysfunctions. The test must be comprehensive enough to show a valid relationship between the knowledge required for effective sex counselling and the amount of knowledge necessary to score well on the test.

The tests presently available and most frequently used in sex research are not adequate for an in depth evaluation of the counsellor's knowledge of sexual matters. Questionnaires such as the Sex Knowledge and Atti-

tude Test (Lief & Reed, 1968), and the more recently developed Attitude Measure of Sexual Behaviours (Fretz, 1975) may prove useful in assessing the attitudes of professionals. However, the tests lack the required precision necessary for a proper evaluation of the examinee's knowledge of sex. A similar problem exists with the Sex Knowledge Inventory (McHugh, 1967). Although the test concentrates on the evaluation of sexual knowledge, the material covered by the questions is too basic. Since professional helpers are unable to score well on the test, its very simplicity is useful in indicating the gravity of the problem. However, when the examinee responds to all questions correctly, this does not indicate that he has a sophisticated knowledge of human sexuality.

A new test must be devised that will effectively determine whether or not a given counsellor has sufficient sexual knowledge to warrant his becoming involved in sex counselling. The accepted procedures used to establish reliability and validity (Anastasi, 1968, chap.4-6) must be incorporated into the design for the test's construction. Furthermore, the test must be standardized on a population of reputable sex counsellors. Serious limitations are inherent when the lay population is used as the norm group. The purpose of the test is to examine in a comprehensive fashion one's knowledge of sex. It is expected that the sex counsellor will have considerably more sexual knowledge than the lay person. Therefore, the questions must go beyond basic anatomy. They must include material related to the etiological factors which contribute to sexual dysfunctions, material related to differential diagnosis, and the variety of intervention strategies used in treatment. The development of a test which followed these guidelines would permit a more realistic assessment of the counsellor's understanding

of human sexuality.

Personality traits. Since homogeneity does not exist in terms of counsellors' personality traits, certain personality types may prove more capable than others in functioning within a sex counselling setting. Commenting on therapy in general, Kiesler (1966) has indicated that research has substantiated the claim that personality factors are an important ingredient affecting outcome. This comment is applicable to sex counselling.

Programs designed to train sex counsellors should not be developed on the premise that all counsellors are potential sex counsellors. The results obtained in this study indicated that counsellors with certain personality characteristics may not be able to cope with the unique demands of sex counselling. Furthermore, it was suggested that specific training in human sexuality may not alter the situation. If this is consistently proven to be the case, it would be reasonable to exclude from the training program those people who exhibit the significant negative traits. Since the present sample consisted of thirty-six subjects, it would be premature to draw definite conclusions. Nevertheless, sufficient evidence was provided to warrant further investigation.

The scope of the study could be widened to include the examination of differences related to gender. The unequal distribution of the sexes in the present sample made it unrealistic to attempt an analysis of the differences between male and female responses to treatment. In future studies, efforts should be made to determine whether or not men and women with the same personality profiles respond to training in sex counselling in a similar fashion. A cluster of certain personality traits may prove a benefit to the female but a hindrance to the male. For instance, in the case of

anxiety, age appeared to be an important variable when it was combined with specific personality factors. However, it is possible that different results would be obtained if the sexes were considered separately. A number of questions remain unanswered in this area but considerable progress may be made with future studies involving large samples.

Curriculum Planning

Attitudes toward human sexuality and sexual behavior have changed rather rapidly during the last few years. More people want to be comfortable with their own sexuality, and many want to find solutions for the sexual problems they may be experiencing. As a result of the public's increasing willingness to talk about sex and sexual behavior, people are seeking related professional help in significantly increasing numbers. This new demand on professional services has strained available resources. It also has encouraged the proliferation of sex counselling services which are staffed by people with questionable qualifications.

Present circumstances place the public in a position in which it is subject to exploitation by so-called sex counsellors. In a recent interview with Gordon (1975), Dr. Stephen Neiger, the founder of the Sex Information and Education Council of Canada, warned the public to exercise a great deal of caution when seeking the help of a sex counsellor. Considering the absence of legal controls in the field of sex counselling, his advice is well founded. The case was clearly described by Brenton (1975) when he explained that "almost anywhere, any man or woman who wants to can set up shop as a sex therapist - regardless of education, background, or training" (pp.22-23). The potential for such abuses must be eliminated from the counselling pro-

fession. Certain revisions in the counsellor education curriculum are prerequisites for the attainment of this goal.

Master's level. The present research study assisted in identifying some of the difficulties associated with training sex counsellors. The conjoint method proved to be the most satisfactory approach to follow when training sex counsellors. The didactic method also facilitated positive change in certain respects. Nevertheless, all of the treatments had serious shortcomings that indicated the need for further improvements. The problems experienced in the implementation and evaluation of the training programs have provided direction for future curriculum development. In this regard it is necessary to distinguish between master's and doctoral level studies.

Throughout this manuscript it has been argued that sexuality is a vital component of the human condition, and as such must not be ignored in counsellor education programs. At the master's level the counsellor trainee should be prepared to discuss sexuality without experiencing discomfort, and to serve as a resource person by providing accurate information about sexual matters. This approach rests on the premise that all counsellors must be prepared to meet their clients' needs for accurate information. At this level it is not intended that the counsellor have the skills needed to treat various sexual dysfunctions. Instead, his role is to facilitate positive sexual development in his clients.

The above objective could be attained with a minimal alteration of the existing counsellor education curriculum. The program would have to be expanded to incorporate a course in human sexuality. The conjoint method should be adopted with special emphasis on the didactic component. Extensive use of experiential methods would not be necessary since the objective

is limited to making the trainees comfortable and confident when providing information. There is no need to help them overcome the anxiety associated with the treatment of sexual problems since they would not be expected to treat clients with sexual dysfunctions.

The content of the course could resemble the content of the didactic program used in this research. However, it would be expanded to meet the requirements dictated by a complete course since it would not be offered as a module of the practicum course. The course requirements may be similar to those developed for other courses on the curriculum. McCary's (1973) book is certainly adequate as a primary text. It could be supplemented by a variety of readings in the realm of human sexuality.

It must be stressed that this procedure is not designed to make the counsellor a specialist in the area of sex counselling. Upon completion of such a course, a trainee is not a sex counsellor but he is properly informed about sexual matters. It is the profession's responsibility to make the public aware of this distinction. The sex counsellor requires training beyond the master's level.

The doctoral level. The responsibilities of the sex counsellor move beyond the necessity of providing accurate information regarding sexual matters. He must also be equipped to help his clients when they seek his assistance with psychosexual disturbances and/or sexual dysfunctions. The counsellor's training program must be adjusted to meet these added demands. The results obtained from the present study suggest that these objectives will only be attained through extensive specific training in sex counselling. The demands of sex counselling are unique and too complex to expect the counsellor with general training to function effectively in this distinctive

setting. The counsellor requires doctoral level training if he is to prove competent in this field. In effect, the sex counsellor should be a highly trained, competent specialist.

At the doctoral level there should be adequate inclusion of both the didactic and experiential components of education. The candidate must be provided sufficient experiential exposure to render him capable of functioning comfortably in all forms of sex counselling. In addition to the experiential elements utilized in this research, the trainee should be given ample practicum and internship experiences under proper supervision.

The didactic component of the program must be designed to furnish the student with a highly sophisticated understanding of human sexuality. This includes a thorough knowledge of the etiological factors contributing to sexual dysfunctions (Masters & Johnson, 1970), as well as the variety of intervention strategies employed during treatment. To function effectively in the clinical setting, it is essential that the counsellor master a variety of sex counselling techniques. In addition to the global programs designed by Masters and Johnson (1970), and Kaplan (1974), there are Semans' (1956) approach to the treatment of premature ejaculation, Lo Piccolo and Lobitz's (1972) programs for the treatment of orgasmic dysfunction, the modeling procedures employed by Hartman and Fithian (1972), and the eclectic approach advocated by Lazarus (1974). The sex counselling trainee will acquire competence in the application of these methods if he is exposed to extensive systematic didactic input coupled with appropriate practicum and internship experiences. The student's participation in a doctoral program of this nature will ensure that he has attained the level of competence required for sex counselling.

Conclusion

Recent years have witnessed many new developments in the roles counsellors are expected to play in the fulfillment of their duties. In many instances it is unrealistic to expect counsellors to adapt to these changes without a corresponding change in their training. Counsellor educators must accept the responsibility for ensuring the public that they will receive competent help when seeking a counsellor. This responsibility must be broadened to include those instances where a person seeks help with a problem related to sex.

If the public is to gain such reassurances, provisions must be made to furnish counsellor trainees with specific training in sex counselling. It is necessary to develop and implement sex counselling programs that will meet the specific and unique needs of the counsellor. Furthermore, a variety of approaches should be utilized and examined under experimental conditions. The objective is to evaluate sex training programs in reference to those clinical behaviors which are deemed essential for positive counselling outcomes. It is not sufficient for such programs to be developed simply on the basis of what appears reasonable. Instead, a variety of methods must be implemented on an experimental basis. This procedure allows for the comparison of several methods. The best possible approach can then be employed to help facilitate the development of competent sex counsellors. It is hoped that the present study may move the profession a step closer to the realization of this goal.

APPENDIX A

Self-Analysis Questionnaire

Form X-1

Name _____ Date _____

DIRECTIONS: A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate number to the right of the statement to indicate how you feel right now, that is, at this moment.

There are no right or wrong answers.

Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.

	Not at all	Somewhat	Moderately so	Very much so
1. I feel calm	1	2	3	4
2. I feel secure	1	2	3	4
3. I am tense	1	2	3	4
4. I am regretful	1	2	3	4
5. I feel at ease	1	2	3	4
6. I feel upset	1	2	3	4
7. I am presently worrying over possible misfortunes	1	2	3	4
8. I feel rested	1	2	3	4
9. I feel anxious	1	2	3	4
10. I feel comfortable	1	2	3	4
11. I feel self-confident	1	2	3	4
12. I feel nervous	1	2	3	4
13. I am jittery	1	2	3	4
14. I feel "high strung"	1	2	3	4
15. I am relaxed	1	2	3	4
16. I feel content	1	2	3	4
17. I am worried	1	2	3	4
18. I feel over-excited and "rattled"	1	2	3	4
19. I feel joyful	1	2	3	4
20. I feel pleasant	1	2	3	4

Source: Spielberger, C.D., Gorsuch, R.L., & Lushene, R.E. 1968, Appendix A, p.52.

APPENDIX B

My Approach to Sex Counselling

Name: _____

Directions: Put an X between each set of words, indicating how you perceive yourself with regard to SEX COUNSELLING.

skilful	____	____	____	____	____	____	____	clumsy
competent	____	____	____	____	____	____	____	incompetent
confusing	____	____	____	____	____	____	____	clear
meaningful	____	____	____	____	____	____	____	not meaningful
sympathetic	____	____	____	____	____	____	____	unsympathetic
close	____	____	____	____	____	____	____	distant
socially inept	____	____	____	____	____	____	____	socially adept
decisive	____	____	____	____	____	____	____	indecisive
friendly	____	____	____	____	____	____	____	hostile
realistic	____	____	____	____	____	____	____	unrealistic
irritable	____	____	____	____	____	____	____	pleasant
insecure	____	____	____	____	____	____	____	secure
nice	____	____	____	____	____	____	____	awful
erratic	____	____	____	____	____	____	____	stable
consistent	____	____	____	____	____	____	____	inconsistent
indifferent	____	____	____	____	____	____	____	conscientious
mature	____	____	____	____	____	____	____	immature
inattentive	____	____	____	____	____	____	____	attentive
defensive	____	____	____	____	____	____	____	at ease
efficient	____	____	____	____	____	____	____	inefficient
uncomfortable	____	____	____	____	____	____	____	comfortable
hung-up	____	____	____	____	____	____	____	at ease

APPENDIX C

Questionnaire on the Research Study

Regarding the sex counselling research that you have recently participated in:

1. What defense postures or defense mechanisms did you utilize during the interview sessions?

2. Did any of these defenses change from the first time you met a client with a sexual problem six weeks ago to the second sexual problem you met just recently? How?

3. How did you feel about your counselling after the first sexual interview six weeks ago? After the last interview this week?

4. If you participated in the sex education program between the first and second client interviews, how would you describe the effect that the program had on you personally? Professionally?

5. What specific attitudes with regard to sexuality and sex counselling have changed in the last five weeks?

6. Do you feel that students should be given specific training in sex counselling? Yes _____ No _____

   Should the format be: a module of a practicum _____

   a half-course _____

APPENDIX D

Instruction Card

Immediately before entering the counselling session, the counsellor was issued a card with the following instructions written on it:

This interview is with a coached client who wants your help with some serious concerns.

The session will not be used for evaluation purposes by any of your instructors.

After your client leaves remain seated until a supervisor arrives.

APPENDIX E

Form Used for the Empathy Ratings

DEGREES OF THERAPIST ACCURACY IN THE PERCEPTION OF CLIENT FEELINGS ON THE ACCURATE EMPATHY SCALE.

Present Obvious Feelings	Stage 1 Ignores	Stage 2 Under-stands poorly	Stage 3 Often accurate	Stage 4 Usually accurate	Stage 5 Accurate	Stage 6 →	Stage 7 →	Stage 8 →	Stage 9 Unhesitating accuracy
Veiled Feelings	→	Ignores	Senses but under-stands poorly	Accuracy very low but trying	Sensitive but in-accurate and tentative	Content accurate but not intensity	Accurate	←	
Preconscious Feelings	→	→	→	→	→	Ignores	A pre-cise "pointing toward"	Sensitive trial and error ex-planation	

Tape #

1	1	2	3	4	5	6	7	8	9
2	1	2	3	4	5	6	7	8	9
3	1	2	3	4	5	6	7	8	9
4	1	2	3	4	5	6	7	8	9
5	1	2	3	4	5	6	7	8	9
6	1	2	3	4	5	6	7	8	9
7	1	2	3	4	5	6	7	8	9
8	1	2	3	4	5	6	7	8	9
9	1	2	3	4	5	6	7	8	9
10	1	2	3	4	5	6	7	8	9

Source: Truax, C.B., & Carkhuff, R.R., 1967. This schematic presentation of a scale for the measurement of accurate empathy was developed at the University of Florida by Richard A. Melloh.

APPENDIX F

Stepwise Multiple Regression

with Premeasures (N=36)

Criterion Variable: Empathy

Factors	Multiple R	R Square	Simple R
Integration (Q_3)	0.33959	0.11532	-0.33959
Suspicion (L)	0.48843	0.23857	-0.25703
Intelligence (B)	0.55365	0.30653	0.27731
Age	0.60751	0.36907	-0.21128
Self-sufficient (Q_2)	0.64502	0.41605	-0.24332
Dependent (I)	0.66788	0.44607	-0.06236
Shrewdness (N)	0.67737	0.45883	0.05995
Outgoing (A)	0.68205	0.46519	-0.07074
Aggressive (E)	0.68763	0.47284	0.05613
Insecure (O)	0.69351	0.48096	0.02977
Free-thinking (Q_1)	0.70184	0.49258	-0.09481
Unconventional (M)	0.70619	0.49870	0.02650
Cheerful (F)	0.70772	0.50087	0.23502
Emotional Stability (C)	0.70857	0.50207	0.12262
Adventurous (H)	0.70998	0.50407	-0.05348
Morality (G)	0.71047	0.50476	-0.25830

Note: The .05 level of significance was obtained only with the first three factors.

Stepwise Multiple Regression

with Premeasures (N=36)

Criterion Variable: Anxiety

Factors	Multiple R	R Square	Simple R
Emotional Stability (C)	0.38033	0.14465	-0.38033
Age	0.45455	0.20661	0.15647
Suspicion (L)	0.48820	0.23834	-0.09254
Insecurity (O)	0.52341	0.27395	0.28173
Dependent (I)	0.54383	0.29575	-0.07949
Unconventional (M)	0.59188	0.35033	0.04387
Morality (G)	0.60902	0.37091	-0.00352
Self-sufficient (Q_2)	0.63341	0.40120	0.17083
Aggressive (E)	0.64774	0.41957	-0.21080
Cheerful (F)	0.67718	0.45858	-0.04730
Tense (Q_4)	0.69130	0.47789	0.26342
Adventurous (H)	0.71520	0.51151	-0.25798
Intelligence (B)	0.72347	0.52341	-0.18156
Integration (Q_3)	0.73204	0.53588	-0.01099
Free-thinking (Q_1)	0.73507	0.54033	-0.17729
Outgoing (A)	0.73674	0.54278	0.05377
Shrewdness (N)	0.73944	0.54677	0.00451

Note: The .05 level of significance was obtained only with the first three factors.

Stepwise Multiple Regression

with Premeasures (N=36)

Criterion Variable: Sex Knowledge

Factors	Multiple R	R Square	Simple R
Suspicion (L)	0.45451	0.20658	-0.45451
Integration (Q_3)	0.56317	0.31716	-0.21089
Intelligence (B)	0.62034	0.38483	0.26722
Adventurous (H)	0.65209	0.42522	0.22434
Insecurity (O)	0.69516	0.48324	-0.08287
Outgoing (A)	0.70799	0.50125	0.10480
Shrewdness (N)	0.72765	0.52947	0.09076
Aggressive (E)	0.73893	0.54602	-0.07757
Dependent (I)	0.74958	0.56187	0.14675
Unconventional (M)	0.77204	0.59605	0.23972
Tense (Q_4)	0.77615	0.60240	0.04821
Free-thinking (Q_1)	0.77882	0.60655	-0.15351
Cheerful (F)	0.78132	0.61047	0.28405
Self-sufficient (Q_2)	0.78382	0.61437	-0.16254
Emotional Stability (C)	0.78545	0.61694	0.21205
Morality (G)	0.78585	0.61757	-0.32925

Note: The .05 level of significance was obtained only with the first three factors.

APPENDIX G

Stepwise Multiple Regression

using pre-post change scores

Criterion Variable: Empathy (N=26)

Factor	Multiple R	R Square	Simple R
Age	0.31260	0.09772	0.31260
Cheerful (F)	0.40369	0.16296	-0.19355
Suspicion (L)	0.44658	0.19944	0.12404
Unconventional (M)	0.49810	0.24810	0.19158
Aggressive (E)	0.52155	0.27201	-0.07898
Tense (Q_4)	0.54256	0.29437	-0.08080
Outgoing (A)	0.56231	0.31620	0.01295
Morality (G)	0.57501	0.33064	-0.24597
Integration (Q_3)	0.59697	0.35637	0.08398
Free-thinking (Q_1)	0.61781	0.38168	0.02980
Insecurity (O)	0.63674	0.40544	-0.09956
Self-sufficient (Q_2)	0.66454	0.44162	0.13314
Shrewdness (N)	0.67355	0.45367	0.07963
Dependent (I)	0.67695	0.45826	-0.00130
Adventurous (H)	0.67759	0.45913	0.01338

Note: The F-ratio was 0.566 for the final R-square value reported. It is not significant at the .05 level.

Stepwise Multiple Regression

using pre-post change scores

Criterion Variable: Anxiety (N=26)

Factor	Multiple R	R Square	Simple R
Morality (G)	0.39437	0.15552	-0.39437
Emotional Stability (C)	0.46675	0.21786	0.23912
Age	0.55836	0.31177	-0.13742
Aggressive (E)	0.58868	0.34654	-0.16024
Adventurous (H)	0.61636	0.37990	0.08556
Outgoing (A)	0.68015	0.46261	-0.27888
Dependent (I)	0.71702	0.51411	0.04885
Shrewdness (N)	0.75045	0.56318	-0.05555
Integration (Q_3)	0.76349	0.58292	-0.05201
Intelligence (B)	0.77179	0.59565	0.22793
Self-sufficient (Q_2)	0.77862	0.60625	-0.05623
Free-thinking (Q_1)	0.78826	0.62135	0.19370
Cheerful (F)	0.79420	0.63075	-0.11996
Suspicion (L)	0.80180	0.64289	-0.24595
Tense (Q_4)	0.80536	0.64860	-0.10988
Unconventional (M)	0.80868	0.65397	0.12751

Note: The F-ratio was 1.063 for the final R-square value reported. It is not significant at the .05 level.

Stepwise Multiple Regression

using pre-post change scores

Criterion Variable: Sex Knowledge (N=26)

Factor	Multiple R	R Square	Simple R
Cheerful (F)	0.30298	0.09180	-0.30298
Morality (G)	0.42025	0.17661	0.22448
Aggressive (E)	0.45285	0.20507	0.14448
Integration (Q_3)	0.49651	0.24652	0.30083
Insecurity (O)	0.60575	0.36693	0.20584
Adventurous (H)	0.62736	0.39358	-0.25903
Dependent (I)	0.65586	0.43016	-0.16389
Unconventional (M)	0.68895	0.47466	-0.28887
Intelligence (B)	0.72897	0.53140	-0.11491
Self-sufficient (Q_2)	0.75280	0.56671	0.10499
Age	0.75628	0.57195	-0.19227
Emotional Stability (C)	0.75877	0.57573	-0.13238
Free-thinking (Q_1)	0.75972	0.57718	-0.00501
Tense (Q_4)	0.76022	0.57793	0.14021
Shrewdness (N)	0.76056	0.57845	0.15923

Note: The F-ratio was 0.915 for the final R-square value reported. It is not significant at the .05 level.

References

Adams, C.R. Review of sex knowledge inventory. In O.K. Buros (Ed.), The sixth mental measurements yearbook. New Jersey: Gryphon Press, 1965.

Allen, G.T. Effect of three conditions of administration on trait and state measures of anxiety. Journal of Consulting and Clinical Psychology, 1970, 34, 355-359.

Allen, T.W. Effectiveness of counselor trainees as a function of psychological openness. Journal of Counseling Psychology, 1967, 14, 35-40.

Anastasi, A. Psychological testing (3rd ed.). Toronto: Collier-Macmillan, 1968.

Athanasiou, R. A review of public attitudes on sexual issues. In J. Zubin & J. Money (Eds.), Contemporary sexual behavior: Critical issues in the 1970's. Baltimore: John Hopkins University Press, 1973.

Bare, C.E. Relationship of counselor personality and counselor-client personality to selected counseling success criteria. Journal of Counseling Psychology, 1967, 14, 419-425.

Bell, R.R. Premarital sex in a changing society. New Jersey: Prentice-Hall, 1966.

Belliveau, F., & Richer, L. Understanding human sexual inadequacy. New York: Bantam Books, 1970.

Berenson, B.G., Carkhuff, R.R., & Myrus, P. The interpersonal functioning and training of college students. Journal of Counseling Psychology,

1966, 13, 441-446.

Bernard, J. The sex game. New Jersey: Prentice-Hall, 1968.

Betz, B.J. Experiences in research in psychotherapy with schizophrenic patients. In H.H. Strupp & L. Luborsky (Eds.), Research in psychotherapy (Vol.2). Washington, D.C.: American Psychological Association, 1962.

Blackwell, E. The human element in sex. (2nd ed.). London: J. & A. Churchill, 1886.

Blackwell, E. Essays in medical sociology (Vol.1). London: Ernest Bell, 1902.

Blalock, H.M. Social statistics. New York: McGraw-Hill, 1960.

Blocher, D.H. Developmental counseling. New York: Ronald Press, 1966.

Blocksma, D.D., & Porter, E.H., Jr. A short-term training program in client-centered counseling. Journal of Consulting Psychology, 1947, 11, 55-60.

Brammer, L.M., & Shostrom, E. Therapeutic psychology. New Jersey: Prentice-Hall, 1968.

Brecher, E.M. The sex researchers. Toronto: New American Library of Canada, 1971.

Brecher, R., & Brecher, E.M. (Eds.). An analysis of human sexual response. New York: New American Library, 1966.

Brenton, M. Sex talk. Connecticut: Fawcett Publications, 1972.

Brenton, M. Phony sex therapists. Sexology, 1975, 41(6), 20-23.

Brown, D.G., & Lynn, D.B. Human sexual development: An outline of components and concepts. Journal of Marriage and the Family, 1966, 28, 155-162.

Burnap, D.W., & Golden, J.S. Sexual problems in medical practice.

Journal of Medical Education, 1967, 45, 1025-1031.

Carkhuff, R.R. Helping and human relations (Vol.1). New York: Holt, Rinehart and Winston, 1969.

Carkhuff, R.R., & Berenson, B.G. Beyond counseling and therapy. New York: Holt, Rinehart and Winston, 1967.

Carkhuff, R.R., Douds, J., & Truax, C.B. Toward an integration of didactic and experiential approaches to training in counseling and psychotherapy. Journal of Counseling Psychology, 1964, 11, 140-147.

Carkhuff, R.R., & Truax, C.B. Training in counseling and psychotherapy: An evaluation of an integrated didactic and experiential approach. Journal of Consulting Psychology, 1965, 29, 333-336.

Carson, R.C. A and B therapist types: A possible critical variable in psychotherapy. Journal of Nervous and Mental Disease, 1967, 144, 47-54.

Cattell, R.B. The scientific analysis of personality. Baltimore: Penguin Books, 1965.

Cattell, R.B. Sixteen personality factor questionnaire: Form A (Rev.ed.). Illinois: Institute for Personality and Ability Testing, 1968.

Cattell, R.B., & Eber, H.W. Manual for form A and B: Sixteen personality factor questionnaire. Illinois: Institute for Personality and Ability Testing, 1962.

Cattell, R.B., Eber, H.W., & Tatsuoka, M.M. Handbook for the sixteen personality factor questionnaire. Illinois: Institute for Personality and Ability Testing, 1970.

Chall, L. A survey of advances in modern sex research. In A. Ellis & A. Abarbanel (Eds.), The encyclopedia of sexual behavior: Sex and today's society (Vol.5). New York: Hawthorn Books, 1961.

Cole, W.G. Sex in Christianity and psychoanalysis. New York: Oxford University Press, 1966.

Dearden, R.F. Instruction and learning by discovery. In R.S. Peters (Ed.), The concept of education. London: Routledge & Kegan Paul, 1967.

De Blassie, R.R. Diagnostic usefulness of the 16 PF in counseling. The Journal of College Student Personnel, 1968, 9, 378-381.

Dickenson, W.A., & Truax, C.B. Group counseling with college underachievers: Comparisons with a control group and relationship to empathy, warmth, and genuineness. Personnel and Guidance Journal, 1966, 45, 243-247.

Dominian, J. Marital breakdown. London: Penguin Books, 1968.

Donnan, H.H., Harlan, G.E., & Thompson, S.A. Counselor personality and level of functioning as perceived by counselees. Journal of Counseling Psychology, 1969, 16(6), 482-485.

Drever, J. A dictionary of psychology (Rev. ed.). Baltimore: Penguin Books, 1964.

Dubé, C.H. (Ed.). Bill 250: Professional Code. Québec City: Québec Government Printing Office, 1973.

Duncan, D.B. Multiple range and multiple F tests. Biometrics, 1955, 11, 1-42.

Elias, J.E. Current research - sex practices and attitudes on campus. In D.L. Taylor (Ed.), Human sexual development. Philadelphia: F.A. Davis, 1970.

Elias, J.E., & Gebhard, P. Sexuality and sexual learning. In D.L. Taylor (Ed.), Human sexual development. Philadelphia: F.A. Davis, 1970.

Ellis, A. The art and science of love. New York: Bantam Books, 1969.

Ellis, A. The sensuous person. New York: Institute for Rational Living,

1972.

Ellis, A. Humanistic psychotherapy. New York: McGraw-Hill, 1973.

Ellis, A. The rational-emotive approach to sex therapy. The Counseling Psychologist, 1975, 5(1), 14-22.

Ellis, H. Psychology of sex. New York: New American Library, 1938.

Fisher, S. Understanding the female orgasm. New York: Bantam Books, 1973.

Foote, N. Sex as play. In E. Larrabee & R. Meyerson (Eds.), Mass leisure. Glencoe, Ill.: Free Press, 1958.

Frankfort, E. Vaginal politics. New York: Bantam Books, 1972.

Freedman, M.B. The sexual behavior of American college women: An empirical study and an historical survey. In A. Shiloh (Ed.), Studies in human sexual behavior: The American scene. Springfield, Ill.: Charles C. Thomas, 1970.

Fretz, B. Assessing attitudes towards sexual behaviours. The Counseling Psychologist, 1975, 5(1), 100-106.

Freud, S. Three contributions to the theory of sex. In J. Strachey (Ed. and trans.), The standard edition of the complete psychological works of Sigmund Freud (Vol.7). London: Hogarth Press and the Institute of Psychoanalysis, 1953. (Originally published, 1905.)

Freud, S. A general introduction to psychoanalysis. (J. Riviere, Ed. and trans.). New York: Washington Square Press, 1960. (Originally published, 1920.)

Fried, E. The fear of loving. In G. Goldman & D. Milman (Eds.), Modern woman. Illinois: Charles C. Thomas, 1969.

Gagnon, J.H., & Simon, W. Prospects for change in American sexual patterns:

V.D. - challenge to man. In A. Shiloh (Ed.), Studies in human sexual behavior: The American scene. Springfield, Ill.: Charles C. Thomas, 1970.

Gordon, L. Hucksters prey on sexual hangups. Victoria Times, June 1975, p.25.

Hartman, W., & Fithian, M. Treatment of sexual dysfunction. California: Genter for Marital and Sexual Studies, 1972.

Hastings, D. Can specific training procedures overcome sexual inadequacy? In R. Brecher & E. Brecher (Eds.), An analysis of human sexual response. New York: New American Library, 1966.

Hays, E.R. Those extraordinary Blackwells: The story of a journey to a better world. New York: Harcourt, Brace & World, 1967.

Heller, K. Laboratory interview research as analogue to treatment. In A. E. Bergin & S.L. Garfield (Eds.), Handbook of psychotherapy and behavior change: An empirical analysis. New York: John Wiley & Sons, 1971.

Horney, K. Feminine psychology. New York: W.W. Norton, 1967.

Hyman, R.T. Ways of teaching. Philadelphia: J.P. Lippincott, 1970.

Jacobs, M., & Whiteley, J. Approaches to sexual counseling. The Counseling Psychologist, 1975, 5(1), 3-8

Juhasz, A.M. Background factors, extent of sex knowledge and source of information. Journal of School Health, 1969, 39(1), 32-39.

Kaplan, H.S. The new sex therapy. New York: Brunner/Mazel, 1974.

Kiesler, D.J. Some myths of psychotherapy research and the search for a paradigm. Psychological Bulletin, 1966, 65, 110-136.

Kiesler, D.J., Mathieu, P.L., & Klein, M.H. Measurement of conditions and process variables. In C. Rogers, C.B. Truax, E.T. Gendlin, & D.J.

Kiesler (Eds.), The therapeutic relationship and its impact. Wisconsin: University of Wisconsin Press, 1967.

Kinsey, A.C., Pomeroy, W.B., & Martin, C.E. Sexual behavior in the human male. Philadelphia: W.B. Saunders, 1948.

Kinsey, A.C., Pomeroy, W.B., Martin, C.E., & Gebhard, P.H. Sexual behavior in the human female. Philadelphia: W.B. Saunders, 1953.

Kleegman, S. Frigidity in women. Quarterly Review of Surgery, Obstetrics, and Gynecology, 1959, 16, 243-248.

Krich, A. (Ed.). The sexual revolution: Pioneer writings on sex (Vol.1). New York: Dell Publishing, 1963.

Lazarus, A. Multimodal therapy: Basic id. Psychology Today, March 1974, pp.59-63.

Lief, H.I. Teaching doctors about sex. In R. Brecher & E. Brecher (Eds.), An analysis of human sexual response. New York: New American Library, 1966.

Lief, H., & Reed, D. Sex knowledge and attitude test. Philadelphia: University of Pennsylvania, 1968.

Lo Piccolo, J., & Lobitz, W.C. The role of masturbation in the treatment of orgasmic dysfunction. Archives of Sexual Behaviour, 1972, 2, 163-171.

Martin, B., & Sroufe, L.A. Anxiety. In C.C. Costello (Ed.), Symptoms of psychopathology: A handbook. New York: John Wiley & Sons, 1970.

Masters, W.H., & Johnson, V.E. The sexual response cycle of the human female. In J. Money (Ed.), Sex research: New developments. New York: Holt, Rinehart and Winston, 1965.

Masters, W.H., & Johnson, V.E. Human sexual response. Boston: Little Brown, 1966.

Masters, W.H., & Johnson, V.E. Human sexual inadequacy. Boston: Little Brown, 1970.

Mazur, R.M. Commonsense sex. Boston: Beacon Press, 1968.

McCary, J.L. Sexual attitudes and sexual behavior. In C.E. Johnson (Ed.), Sex and human relationships. Ohio: Charles E. Merrill, 1970.

McCary, J.L. Sexual myths and fallacies. New York: Van Nostrand Reinhold, 1971.

McCary, J.L. Human sexuality (2nd ed.). New York: Van Nostrand Reinhold, 1973.

McClain, E.W. Sixteen personality questionnaire scores and success in counseling. Journal of Counseling Psychology, 1968, 15, 492-496.

McHugh, G. Sex knowledge inventory: Form X. North Carolina: Family Life Publications, 1950.

McHugh, G. Sex knowledge inventory: Form X (Rev. ed.). North Carolina: Family Life Publications, 1967.

McHugh, G. Marriage counselor's manual and teacher's handbook. North Carolina: Family Life Publications, 1968. (a)

McHugh, G. Answer pad for form X: Sex knowledge inventory (Rev. ed.). North Carolina: Family Life Publications, 1968. (b)

McNair, D.M., Callahan, D.M., & Lorr, M. Therapist type and patient response to psychotherapy. Journal of Consulting Psychology, 1962, 26, 425-429.

Money, J. Psychosexual differentiation. In J. Money (Ed.), Sex research: New developments. New York: Holt, Rinehart and Winston, 1965.

Nie, N., Bent, D.H., & Hull, C.H. Statistical package for the social sciences. New York: McGraw-Hill, 1970.

O'Neil, H.F., Spielberger, C.D., & Hansen, D.N. The effects of state-anxiety and task difficulty on computer-assisted learning. Journal of Educational Psychology, 1969, 60, 343-350.

Paonessa, J.J., & Paonessa, M.W. The preparation of boys for puberty. Social Casework, 1971, 52(1), 39-44.

Perez, J.P. The initial counselling contact. Boston: Houghton Mifflin, 1968.

Peters, R.S. Ethics and education. London: George Allen & Unwin, 1966.

Pope Paul, VI. From humanae vitae (1964). In R. Wasserstrom (Ed.), Today's moral problems. New York: Macmillan, 1975.

Putnam, J.J. Forward. In S. Freud, Three contributions to the theory of sex (A.B. Brill, trans.). New York: E.P. Dutton, 1962.

Rachman, S., & Teasdale, J. Aversion therapy and behavior disorders. Florida: University of Miami Press, 1969.

Reiss, I.L. Personal values and the scientific study of sex. In H.G. Beigel (Ed.), Advances in sex research. New York: Harper & Row, 1963.

Reiss, I.L. Introduction to the sexual renaissance in America. Journal of Social Issues, 1966, 22(2): 3.

Reiss, I.L. The social context of premarital sexual permissiveness. New York: Holt, Rinehart and Winston, 1967.

Rogers, C.R. Client-centered therapy. Boston: Houghton Mifflin, 1951.

Rogers, C.R. The necessary and sufficient conditions of therapeutic personality change. Journal of Consulting Psychology, 1957, 21, 95-103.

Rogers, C.R. On becoming a person. Boston: Houghton Mifflin, 1961.

Rogers, C.R. Toward a science of the person. In A.J. Sutich & M.A. Vich (Eds.), Readings in humanistic psychology. New York: Free Press, 1969.

Rogers, C.R., Gendlin, E.T., & Moursund, J.P. Putting the design into effect. In C.R. Rogers, C.B. Truax, E.T. Gendlin & D.J. Kiesler (Eds.), The therapeutic relationship and its impact. Wisconsin: University of Wisconsin Press, 1967.

Rychlak, J.P. Manifest anxiety as reflecting commitment to the psychological present at the expense of cognitive futurity. Journal of Consulting and Clinical Psychology, 1972, 38(1), 70-79.

Ryle, G. Teaching and training. In R.S. Peters (Ed.), The concept of education. London: Routledge & Kegan Paul, 1967.

Salzman, L. Recently exploded sexual myths. In D.L. Taylor (Ed.), Human sexual development. Philadelphia: F.A. Davis, 1970.

Sarlin, S. A study of callers to community sex information inc. SIECUS Report, 1974, 3, 4-5.

Scheffler, I. Philosophical models of teaching. In R.S. Peters (Ed.), The concept of education. London: Routledge & Kegan Paul, 1967.

Schiller, P. Creative approach to sex education and counseling. New York: Association Press, 1973.

Semans, J.H. Premature ejaculation: A new approach. Southern Medical Journal, 1956, 49, 353-357.

Sheppe, W., & Hain, J. Sex and the medical student. Journal of Medical Education, 1966, 41, 457-464.

Sherfey, M.J. The nature and evolution of female sexuality. New York: Random House, 1972.

Spielberger, C.D., Gorsuch, R.L., & Lushene, R.E. The state-trait anxiety inventory: Test manual for form X. California: Consulting Psychologists Press, 1968.

Sprey, J. On the institutionalization of sexuality. Journal of Marriage and the Family, 1969, 31, 432-440.

Stotland, E., Sherman, S., & Shaver, K. Empathy and birth order. Lincoln: University of Nebraska Press, 1971.

Tanner, L. Teaching a course in human sexuality in a graduate school of social work: Strategy and content. The Family Coordinator, 1974, 23(3), 283-289.

Torok, M. The significance of penis envy in women. In J. Chasseguet-Smirgel (Ed.), Female sexuality. Ann Arbor: University of Michigan Press, 1970.

Truax, C.B. Effective ingredients in psychotherapy: An approach to unraveling the patient-therapist interaction. Journal of Counseling Psychology, 1963, 10, 256-263.

Truax, C.B., & Carkhuff, R.R. Toward effective counseling and psychotherapy. Chicago: Aldine, 1967.

Truax, C.B., Carkhuff, R.R., & Kodman, F. Relationships between therapist-offered conditions and patient change in group psychotherapy. Journal of Clinical Psychology, 1965, 21, 327-329.

Truax, C.B., & Mitchell, K.M. Research on certain therapist interpersonal skills in relation to process and outcome. In A.E. Bergin & S.L. Garfield (Eds.), Handbook of psychotherapy and behavior change: An empirical analysis. New York: John Wiley & Sons, 1971.

Truax, C.B., Wargo, D.G., & Silber, L.D. Effects of high accurate and non-possessive warmth during psychotherapy upon female institutionalized delinquents. Journal of Abnormal Psychology, 1966, 71, 267-274.

Van de Velde, T.H. Ideal marriage (Rev. ed.). (S. Browne, trans.).

New York: Random House, 1930.

Von Krafft-Ebing, R. Psychopathia sexualis (Rev. ed.). (C.G. Chaddock, trans.). Philadelphia: F.A. Davis, 1893.

Waxenberg, S.E. Psychotherapeutic and dynamic implications of recent research on female sexual functioning. In G. Goldman & D. Milman (Eds.), Modern woman. Illinois: Charles C. Thomas, 1969.

White, R.F., & Watt, N.F. The abnormal personality (4th ed.). New York: Ronald Press, 1973.

Wogan, M. Effects of therapist-patient personality variables on therapeutic outcome. Journal of Consulting and Clinical Psychology, 1970, 35(3), 356-361.

Wolpe, J. The practice of behaviour therapy. New York: Pergamon Press, 1969.

Wright, H. A contribution to the orgasm problem in women. In A.P. Pillay & A. Ellis (Eds.), Sex, society and the individual. Bombay: International Journal of Sexology Publications, 1953.

Zimmerman, C.C. The family of tomorrow. New York: Harper and Row, 1949.