

**IMPROVING SEXUALITY IN INTERPERSONAL
RELATIONSHIPS**

BY

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Promoter:	Prof Steve Edwards
Date:	30 March 2006

DECLARATION

I hereby declare that the work on: "Improving Sexuality in Interpersonal Relationships" is my own work; both in conception and in execution and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete reference.

Sonia Roopnarain

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List of abbreviations used in the study

APA	American Psychological Association
DM	Directed Masturbation
DSM	Diagnostic and Statistical Manual
EST	Empirically Supported Treatment
ED	Erectile Dysfunction
FSAD	Female Sexual Arousal Disorder
HSD	Hypoactive Sexual Desire
MMAS	Massachusetts Male Aging Study
NHSLS	National Health and Social Life Survey
PE	Premature Ejaculation
RAM	Relationship Attribution Scale
RCT	Randomised Critical Trial
SS	Sexuality Scale
SSRI	Selective Serotonin Reuptake Inhibitor
VVS	Vulvar Vestibulitis Syndrome

Some Definitions

Androgen	a group of hormones that influence the development of male sexual characteristics and libido
Anorgasmia	a condition in which a person is unable to achieve orgasm
Dysfunction	impaired functioning, as an organ of the body
Erectile dysfunction	commonly known as ED is the consistent inability to achieve/and or maintain an erection sufficient for sexual activity
Impotence	the quality or state of being weak; an incapacity for sexual intercourse
Potency	having the power of procreation; the capability of developing in accordance with nature
Premature ejaculation	an involuntary orgasm that occurs before sexual penetration or right after it begins
Priapism	a prolonged and potentially dangerous erection
Sex therapist	a psychologist who specializes in treating sexual difficulties, particularly in couples
Tumescence	swelling of the penis
Urologist	a doctor who specializes in treating disorders of the urinary tract and male reproductive organs

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ABSTRACT

Human sexuality refers to the way in which we experience and express ourselves as sexual beings. Healthy sexuality varies in individuals, relationships and societies. Sexual and relationship problems are common to all societies. Misunderstanding and misinformation related to sexual relationship problems as well as the solutions to such problems are widespread. This is understandable considering the diverse and multifactorial nature of sexual behaviour, which encompasses biological, psychological, social and spiritual aspects of existence. Sexual adjustment and satisfaction are important features of personal well-being and satisfaction with intimate relationships.

This thesis constitutes theoretical and practical investigations into the relationship between sexuality and psychological well-being with special reference to the improvement of sexual functioning in interpersonal relationships. The research methodology consisted of a self-report questionnaire, which included biographical, quantitative and qualitative components, administered to 100 volunteer patients attending an outpatient clinic in a local general hospital for sexual problems, who had given informed consent to participate in the research. Quantitative components consisted of standardized sexuality and psychological well-being scales. The qualitative component consisted of participants' responses to an open-ended question as to suggestions recommended to improve their sexual relationships.

Main quantitative findings were that the South African sample perceived them to be less psychologically well. This supported earlier comparative research with this scale on South African and USA samples. Analysis of sexuality scale data revealed that South African and USA samples perceived themselves as having equal sexual health. In terms of comparisons between the sexuality and psychological well-being scales, the sexual depression subscale was negatively correlated with psychological well-being dimensions of environmental mastery, positive relations with others and self-acceptance. Main qualitative findings with regard to improving sexual relationships related to improving communication, intimacy, affection, self-esteem and quality of life. Integrating theoretical and practical investigations, the thesis concludes with various recommendations with regard to improving sexuality in interpersonal relationships.

CHAPTER ONE: UNCHARTERED WATERS

1.1 Introduction

Sexuality forms a bridge between the deeper needs and interpersonal functioning of individuals. This “bridge” is a meeting place of physical, psychological, social, spiritual and sexual needs. Often, these “bridges are burnt” (as a normal consequence of aging, or an unfortunate side effect of accident, illness, or surgery) and needs are left unfulfilled. Until very recently, few treatments existed, and those, which did exist, often excluded the psychological aspect. The psychological aspect cannot be excluded. The results of this empirical study will later indicate that sexual preoccupation is positively correlated with sexual esteem.

The lifelong phenomenon of sexuality has been at the epicentre of psychopathology and Freudian researches. In his book ‘The Male Body’, Abraham Morgantaler (1993) noted the common aging wish for:

“a magical pill, or perhaps even better, a magical incantation, that would restore one’s penis to the glory days of youth” (Katzenstein, 1998, pp. 9).

In its search to “build or repair” such bridges, the thesis will examine sexual dysfunction, its psychological manifestation in human relationships as well as provide solutions for improving sexual relations amongst couples. Sexual dysfunction is characterized by disturbances in sexual desire, and/or psycho-physiological changes associated with the sexual response cycle in men and women. Sexual behaviour has been the focus of more religious and legal prescription and proscription than any other human function. Suffice to say emotional difficulties related to sexuality are typically ignored (Kinsey, Pomeroy & Martin, 1948). For example, for 500 years the public was “protected” from viewing the marble genitalia on Michelangelo’s David (the genitalia of the statute David was covered with a bronze loincloth).

Modern philosophers have described sexual desire and erotic love in surprising and paradoxical ways. For Kant, sexual desire can be understood only as part of the “pathology” of the human condition (Kant, 1963). Also of interest is Kant’s view on marriage, where he refers to marriage as an agreement between two people for the “reciprocal use of each other’s sexual organs” (Kant, 1963).

Sex is a challenging subject to communicate. Policed by social, religious and cultural taboos, complicated by psychological, emotional and existential significance, and profoundly implicated in (probably) all hegemonic processes and counter-hegemonic struggles, it is dauntingly easy to say the wrong thing about sex. By “saying the wrong thing,” the researcher does not mean only speaking about sex in ways which may offend (although it is not the researcher’s intention to offend, only to challenge). No author is able to control the manner in which the text is read, and the meaning of this particular text will, of course, be produced in the mind of each reader. Therefore, it is important at least to be explicit about the intended meaning/s of specific terms, if what follows is to be intelligible at all.

1.1.1 Conceptual and theoretical issues in studying sexuality in close relationships

The study of sexuality in close relationships involves key conceptual issues that must be clearly identified and addressed. These include:

- The definition of sexuality.
- The need to construct dyadic, interactional models rather than individual-level models.
- The impact of gender and the issue of whether distinct models are needed for males and females.
- The necessity of integrating race/ethnicity into theoretical models and research.
- The need for multiple levels of analysis of the phenomena of sexuality in relationships.
- Provision of treatment and recommendations so as to enhance the quality of human interpersonal relationships.

A complete theory of sexuality in close relationships would integrate individual, dyadic, biological, and sociocultural processes.

1.1.2 Asking the impossible question: what is sex?

The first task is a difficult one. Since the context of this research is to examine the way human sexuality integrates into society, one must settle upon a definition that is suitable for that goal. Rather, the definition must have some relatively universal applicability, which will be possible to test empirically. It cannot be an arbitrary definition, chosen for its utility or

convenience. This is so, because if one finds one's culture lacking in what this definition claims is the unique and essential quality of human sexuality, then at least the universal aspect of the definition must be rejected, for in such a case, what the researcher defines as sexuality will not have been present in every society.

The researcher wishes to develop a definition that eliminates more incidental aspects and focuses upon what appears to be essential aspects of human sexuality.

The researcher is searching for a societal-level definition, and thus one needs to seek the essential nature of sexuality in the shared conceptions that societies put forth. The essence one is searching for consists of the qualities, which, when present, most societies would label as sexual. In short, we are looking for that without which the sexual would not exist. That is what is meant by the essence of sexuality. Five textbooks consulted offered the following diverse definitions of sexuality:

"Sexuality means a dimension of personality rather than referring to a person's capacity for erotic response" (Masters, Johnson, and Kolodny, 1982: p. 2).

"Sex means all the physical, emotional and social implications of being male and female" (Karlin, 1997: p. 3).

"Sexuality refers to the awareness of a reaction to the biological characterizations of male and female. In essence, sexuality is our reaction to sex" (Luria and Rose, 1979: p. 6).

"The term sex will be used in this thesis to refer specifically to sexual anatomy and sexual behaviour" (Hyde, 1979: p. 3).

"There is no single one-dimensional definition of sexuality" (Sandler, Meyerson, and Kinder, 1980: p. 216).

The researcher will affix a definition of sexuality which the Sex Information and Education Council of the U.S. (SIECUS) put forth after an international conference in 1980, that sought to develop an internationally acceptable definition of sexuality: (Seidman, 1992).

The SIECUS, concept of sexuality refers to the totality of being a person. It includes all of those aspects of the human being that relate specifically to being boy or girl, woman or man, and is an entity subject to life-long dynamic change (Seidman, 1992).

These definitions make it obvious that much of the confusion of sexuality can be traced to the fact that we use vague and unclear concepts when we speak of sexuality, and thus, very often, we really do not know precisely what we are discussing. This lack of conceptual clarity is apparent in the preceding list of attempts at defining human sexuality.

The evidence of some conceptual confusion is detailed. The first definition cited hardly gives much insight by asserting that sexuality is a dimension of personality. Temperament, intelligence, empathy, and many other characteristics may also be conceived of as "a dimension of personality." So we are not brought very close to the special and unique characteristics of sexuality by such a definition. The same is even more apparent with the second definition, which involves all the physical, emotional and social implications of being male and female.

The other definitions suffer from the same over inclusiveness and vagueness of the first few. This makes the definition circular and of little value, for it hardly illuminates the issue to say that sexuality is sexuality. The SIECUS definition is perhaps the broadest and includes "the totality of being a person," which is about as far from specificity as one can move.

We must have some agreement regarding separate and distinctive terms for these three potential meanings of the word sex, or we will not be able to write or talk clearly about sexuality. Some people prefer to use the term sex role rather than gender role, but since sex role uses the word sex in a second way, for clarity's sake it is preferable here to use the term gender role. However, Money's current usage combines gender identity and gender role into one concept (Money, 1995: pp 279-290). For the sake of conceptual clarity, the researcher would separate these concepts. The widespread use of gender role as a definition of the roles that culture creates for males and females is really confined to the last 15 or 20 years.

Finally, we are left with the remaining use of the term sex - something to do with activities like heterosexual or homosexual physical intercourse. For this meaning the researcher suggests that we use the term sexuality, instead of the short form (sex) in order to avoid any confusion with genetic sex. (The term sexual is an adjective that indicates that something possesses the characteristics of sexuality, for example, a particular experience or act, an object, or a story). Sexuality is a phenomenological experiential term. It refers to our experience of sex/gender identity/sexual activity etc.

Consequently, one cannot change the everyday usage of terms, but one can change scientific concepts to gain greater clarity than everyday usage affords. Such

reconceptualization is an essential part of the scientist's attempt to use concepts in ways that are clear and precise as to meaning (Hempel, 1952, pp. 1-93).

Conversely, there is a need for a clear definition of sexuality that stresses the distinctive nature of that which we call sexual. We cannot exclusively base our definition on behaviour, like genital contact, for at times, genital contact is not what we would conceptualise as sexual, and the sexual can occur without genital contact. The behaviour is surely not irrelevant, but it is insufficient by itself to define what is sexual.

The term "cultural script" means a shared, group definition of the type of situation, type of people, and type of behaviour appropriate in a particular social context. There are cultural scripts aimed at producing an erotic response in the participants, and the researcher shall call these sexual scripts. Used this way, the broad concept of cultural script is quite close in meaning to an "interaction model" or a social role, but since the term script is more informal, and has been popularised by sociologists like Gagnon and Simon (1982), it will also be used here. The sexual scripts derive from the shared, consensual beliefs people have about what is "good" and "bad" sexuality in their society. These sexual scripts act as guides regarding what society believes are the proper circumstances for experiencing an erotic response. When one is dealing with a complex society, the sexual scripts will vary somewhat by ethnic groups, social classes, and age groups. But there will be much similarity, and within each social group, the majority of people in that group will typically share a dominant script.

One other element besides culturally shared scripts related to erotic arousal is a second essential part of what all societies call sexuality. That other element is genital response. It is true that some minor erotic arousals may not lead to any obvious genital response. In addition to learning the sequence of experiences or acts that our society asserts should produce genital responses, we also have been taught norms (standards for behaviour) informing us when, and with whom such experiences or acts should occur. This entire "package" is what a sexual script means.

Such normative controls implicitly assert the power of certain sexual experiences or acts to evoke genital responses when performed in a particular setting. Nevertheless, such norms also explicitly assert that specific scripts must be followed if we are to achieve our sexual pleasures in socially sanctioned fashions. In this sense, the same norms that instruct us about what is erotic also seek to control our performance of those erotic actions when we are not acting in accord with the shared sexual script.

Finally, the definition of the universal, shared meaning of human sexuality is offered. Human sexuality in all societies consists of those scripts shared by a group that are supposed to lead to erotic arousal and in turn to produce genital response.

The definition is illustrated in Diagram 1.1

Cultural Scripts* —→ *Erotic Arousal* —→ *Genital Response

Diagram 1.1 Taking the definition of sexuality further

There is a feedback relationship between erotic arousal and genital response, that is, erotic arousal and genital response mutually reinforce each other. The stronger either one of them is, the more likely the other will be strengthened. They are separable, though, for erotic arousal is the state of feeling turned on, and genital response is a physiological response such as penile erection or vaginal lubrication. There are research reports of strong emotions such as fear producing erection or lubrication (Masters & Johnson, 1988). But in a social system, one would expect that most of the time it would be erotic arousal that would lead to genital response. In addition, the assumption is that the erotic arousal occurs in most instances because of the congruence of the behaviour with the sexual scripts present in that group. Thus, what arouses us is not a given, biologically fixed set of stimuli, but rather a set of stimuli that a particular group decrees to be erotic.

If one is not socially trained regarding which cultural scripts are supposed to be sexually arousing, one can experience considerable difficulty in sexual interactions.

It also happens, in complex societies, that some people, compared to others, are raised in groups, which are relatively sexually restrictive. In other instances, low-permissive people who do become erotically aroused in situations that are taboo to them may fail to label their erotic arousal as sexual, because they find that arousal unacceptable. In this connection research by Gunter Schmidt (1988) on genital reactions to erotic slides, indicates that similar percentages of females and males do exhibit genital responses. Despite the genital responses, in their verbal reports, females were more likely to assert that they found the erotic films disgusting and unpleasant. The sexual scripts presented in the erotic slides did not fit with these females' sense of proper sexual stimuli, and thus they likely allowed their feelings of disgust to overwhelm any awareness of erotic feelings. They could not legitimate their feelings by calling them sexual.

Each society promotes compatibility among individuals in sexual experience; to the degree that they train people to react in compatible ways to specific sexual scripts. In this sense having shared scripts is important. Nevertheless, it is not just to avoid conflict that agreed-upon scripts are required, but because sexuality is learned predominantly by interacting with other people. Without reasonably compatible sexual scripts in a society, there would be a block to initial social interaction and future learning of the basic aspects of sexual interaction might not take place. This does not contradict the fact that there are sizable minorities who would strongly reject such a position. It surely is a legitimate psychological investigation to study these diverse groups and their different shared sexual customs, as much as it is to study the overall consensus on sexual customs.

It should be noted here that the researcher is focusing on the major heterosexual patterns in human societies, but the reader should be aware that a psychological approach must also be able to explain homosexuality. Whether homosexuality can be attributed to a failure of the existing heterosexual scripts, or to other factors, is a much-debated question. Regardless of what one decides on that question, there surely are informal, covert sexual scripts that exist, to direct sexual interactions for homosexuals. The key difference is that sexual scripts promoting heterosexuality are given priority, and therefore, one typically does not come in contact with homosexual scripts until after joining the homosexual community in some fashion. The details of gay and lesbian sexual interaction models are not widely known.

The work of Harry Harlow with rhesus monkeys supports the conclusion that we learn our sexuality by interacting with other individuals (Harlow, 1962, pp. 1-9). Harlow found that infant monkeys who were raised in isolation from the playful interaction of peers and the nurturance of their mothers were unable to perform sexually when they matured. The monkeys seemed to require experience in grooming and touching each other in order to learn the interaction skills and motives needed for sexual intercourse (Harlow, 1962).

In our own society, we complicate sexual interaction by teaching men and women different beliefs about what are the preferable sexual interaction models. We train females to place great importance on the presence of stable affection, and we train males to place great importance on physical pleasure. In this sense, we eroticise the romantic component for females, and we eroticise the pleasure component for males. It is no wonder, then, that such differently socialized genders have difficulties living up to the expectations of each other's sexual scripts.

On the other hand, there are sexual acts that do not fit even informal cultural patterns. In

most, but not all cases, rape would be an action much like murder, and would not be directly supported by cultural norms, formal or informal. Nevertheless, one might contend that the conflict built into our gender roles, our male-dominant traditions, our acceptance of violence, and the view that sexuality is degrading may all indirectly pressure toward rape. There is some truth in that perspective, but these factors are unintentional endorsements of rape.

Even if not fully social, such private sexual acts are certainly sexual in a psychological sense, in that they entail erotic arousal and genital response even if the source of the arousal does not come from a shared cultural script. If, as the researcher contends, interaction models are the primary cause of erotic and genital reactions in the world, then such individualized sexual acts should be the source of only a minority of the total number of erotic and genital reactions that occur in any society. This should be even more the case for the adult, more socialized population in a society.

Ascertaining how much of the genital response in a society is due to sources outside the shared sexual scripts can test the explanatory power of a sociological explanation. The definition of the universal essence of human sexuality can easily be scientifically tested. One can search for a society that does not have shared sexual scripts to serve as models for erotic and genital responses. If a society were found without such scripts, then erotic arousal and genital response would be viewed as resulting from nonsocietal causes. Further, if a society is found in which there are sexual scripts, but most of the erotic arousal and genital response can be explained biologically, then my definition is inaccurate. Many people do seem to believe that sexuality is "natural" or biological, and that we do not need to be trained how to behave sexually. If this is true, the conception of sexuality would not explain very much of the sexual behaviour that occurs. However, if one accepts this natural, biological view of sexuality, then societies should not differ very much in their sexual patterns, for they all contain "natural" individuals. The evidence from Harry Harlow's work with monkeys questions such a natural view, for it documents that monkeys brought up in isolation for the first six months of their life are unable to perform sexually (Harlow, 1962).

Rather than looking to biology or individual experience, one must search for the sources of our sexual lifestyles by looking at our basic social system. Somewhere in that social system lie the answers to the reason for the particular sexual scripts that exist in that group.

1.1.3 Two key characteristics of sexuality

The preceding discussion suggests that sexuality would be universally viewed as important even if storks brought babies. The researcher is of the opinion that at the most fundamental level the importance of sexuality is based upon the two most common characteristics that accompany sexual behaviour everywhere. These two characteristics are physical pleasure and self-disclosure (Masters & Johnson, 1988). Neither of these characteristics is guaranteed to accompany every sexual act, nor will the presence of either always be maximal.

Certainly sexuality is not alone among life's valuables in its potential rewards, but equally apparent is its special nature, and thus its potential influence over our lives. It is the realization of the importance and power of sexuality that induces some societies which value self-oriented pleasures to promote sexuality, and some societies which are more fearful of loss of control, and less openly hedonistic, to seek to restrict sexuality. Nevertheless, both types of societies assert by their actions the importance of human sexuality, and their recognition of the pleasure and disclosure aspects of sexual relationships. At the most elementary level, pleasure and disclosure are the building blocks of social relationships. So, the importance of sexuality rests upon its partial possession of the key ingredients upon which the social relationships in society are founded.

1.1.4 Models for dyadic and interactional phenomena

The behavioural focus of much of the research on sexuality is closely tied to another limitation. Much of the literature focuses primarily on the individual. Numerous studies link sexual behaviour to attitudes, motives, prior experience, age, gender, and race, all characteristics of the individual. Much of the research on adolescent sexuality links it to parent-child relationships, media and peer influences, biological drive, and puberty; only rarely does research consider romantic relationships (Brown, Feiring, & Furman, 1999). Yet most forms of sexual expression involve two (or more) people. Thus, the behaviours or interaction sequences, which occur, reflect an interactional sequence involving those present and perhaps mental representations of others (parents, peers, other lovers) as well. Since most sexual expression is interpersonal, relying on individualistic explanatory models limits our understanding.

The influence of partner(s) is clear in incidents of sexual assault; in such cases, knowing the characteristics of the individual victim may be of little value in predicting the victim's sexual

behaviour. But such influence is involved in a broad range of sexual interactions. Research documents the occurrence of “unwanted” sexual activity, in which an unwilling person engages in sexual activity as a result of influence by the partner. Such experiences occur in male–female (O’Sullivan & Allgeier, 1998), male–male (Kalichman et al., 1995), and female–female interactions/relationships (Struckman-Johnson & Struckman-Johnson, 2002). In other circumstances, there may be unwanted abstinence or celibacy; the fact that sexual behaviour does not occur may reflect a partner’s refusal to participate (Donnelly, Burgess, Anderson, Davis, & Dillard, 2001), or the lack of a partner.

The importance of the couple as the unit, around which societies organize sexual norms or scripts, is the point of a recent paper by Gagnon and colleagues (2001). Analyses of data from the National Health and Social Life Survey in the United States (N = 3, 432) and the Analysis of Sexual Behaviour in France (N = 4, 580) support the conclusion that one of the principal influences on sexual activity is whether the individual is in a long-term, coupled relationship. Living as a couple (compared to living alone) and the type of coupled relationship are major correlates of type and frequency of sexual activity. “The role of *living in a couple* [is] a primary regulator of the sexual behaviour of individuals in western societies” (Gagnon, Giami, Michaels, & de Colomby, 2001, p. 24).

In some cases, adherence to an individualistic model reflects commitment to a discipline or theoretical perspective that emphasizes individual characteristics in explaining behaviour. Such a view is congenial with the American cultural emphasis on the importance of the individual. The predominance of theories and research methods that focus on the individual creates a barrier to taking the couple into account. There are few conceptual frameworks or methods of gathering data that are designed to be employed by the couple. One attempt to conceptualise interaction in a dyad is the *interdependence* framework (Kelley, Berscheid, Christensen, Harvey, Huston, Levinger, McClintock, Peplau & Peterson, 1983). This model analyses interaction as a sequence of actions by two persons; it can be used in the study of a variety of aspects of close relationships. Another model with the potential to illuminate couple interaction is *script theory* (Gagnon & Simon, 1973). Scripts are explicitly conceptualised as occurring at three levels: intrapsychic, interactional, and social/cultural.

The barrier to the study of couples is methodological. Most of the methodologies sexuality researchers traditionally rely on involve measuring the behaviour and psychological responses of the individual. Some experiments involve careful attention to the temporal order of behaviour. Such research typically studies a very short sequence of activity. Some observational studies have captured interaction over time. Limits on the observer can be

overcome by audio taping and videotaping. Conversational analysis provides one useful approach to such data. Some research on marriage is leading the way in developing multimethod strategies, involving real time recording of interaction and physiological processes, and post interaction interviews to assess the meaning of interactional events to the participant (e.g., Gottman, Conn, Carrere, & Swanson, 1998).

The stage is now set for a psychological analysis of human sexuality. Furthermore, the researcher has suggested that such cultural scripts are universal, because sexuality is ubiquitously viewed as important, and therefore in need of societal regulation of some sort. The basic reason for this importance is that sexuality typically encompasses the elements of physical pleasure and self-disclosure, at least in some rudimentary form. The precise way that sexuality is expressed will reflect the social system in question. It is apparent that the possibilities are vast and, as we shall see, they include both heterosexual and homosexual forms.

There is one exercise in imagination that the researcher believes will give the reader more of a feeling for the important linkages of society to sexuality, and set the stage for the chapters that follow. Try to imagine a world without sexuality. Suppose that children were bred in laboratories by scientific means and humans had no erotic feelings. The genital area was to be used only for elimination. How would that alter our world? The answer is - immensely! In these, and many other ways much of our political, economic, and intimate life would be radically altered.

An increase in gender equality would be a necessary outcome of a world without sexuality. By removing sexuality from marriage, one might remove some of the special ties of females to males, and this might remove one of the factors that restrain the exploitation of one gender by the other. The very link of men and women with the physical and psychic rewards of sexuality might be a major impediment to more abusive male dominance. Thus, sexuality may well, in part, operate as a force for equality. We all know that sexuality can be used to promote inequality, but its equalitarian possibilities must also be kept in mind.

Gender roles will reflect the power differentials of males and females that exist in a society and thereby afford us a direct path, potentially connecting sexuality with power. Finally, ideologies put forth the group's conception of what is normal human behaviour. Since sexuality is an important part of all societies, ideologies will define normality partially in sexual terms. The broader areas from whence these more specific foci derive are stressed,

because near these central sources may well be additional linkages that others may wish to explore.

1.2 A brief history

Treatments for sexual dysfunction/ disorders can be traced back to the ancient Egyptians, who developed “love potions,” the ancient Greeks and Romans who treated it with mythology, and the ancient Chinese, who treated it with ginseng (Bancroft, 1989). The Greek ideas remained more or less dominant until the nineteenth century, when advances in science allowed new kinds of questions to be posed about sex and sexual behaviour. The lack of what might be called scientific answers, did not, however, prevent people in the past from attempting to frame answers to questions about human sexuality. These answers varied from culture to culture and changed through time, but generally they were a combination of observations, mythology, morals, and magic. Even when investigators came up with more rational explanations for some aspects of human sexual activity, they continued to rely on tradition for most answers, simply because the science of the time was not sophisticated enough to give more complete explanations.

Sexual problems are often a consequence of many factors- social, legal, psychological, religious, genetic, and physiological. Sexual dysfunction can impact a person's ability to form or sustain intimate relationships. Furthermore, this translates into dysfunctional relationships coupled with anxiety, depression and decreased self-esteem. Yet epidemiological, etiological, and health associations to sexual dysfunctions have only begun to be explored via pharmacological management, and psychosocial influences have been neglected. Thus many doctors feel ill equipped to help or advise patients with complaints such as loss of desire, sexual aversion or anorgasmia. Indeed, the medical model of history, examination, diagnosis and treatment is a poor tool when faced with “dysfunction” of what is fundamentally a psychosomatic event – sexual activity and orgasm.

The fact that sexual functioning in women has not gained much attention in the literature is reflected in the small number of publications. Sexuality is an important aspect of quality of life. Sexual dysfunction carries a high psychological burden, which can have a negative impact on interpersonal and marital relations. Sexuality is, perhaps more than most cultural spheres, the most transcendent of human pleasures, yet the most shameful; it is thought to be the last remaining “refuge of the natural” (Jeffery Weeks, 1985).

Furthermore, given that the topic under scrutiny is so intimate (sexual pleasures, desires, and upheavals in the realm of the erotic), it is important to speak in a language that is clear

and unambiguous. However, this does not insinuate launching language into stripped simplicity.

1.3 Motivation for the study

The need for research on the extent of sexual function in the general population has become more urgent, given recent debates surrounding the identification and definition of 'sexual dysfunction,' the increased availability of pharmacological interventions, and possible changes in our expectations of what constitutes sexual function and fulfilment (Moynihan, 2003: 45-7). The thesis is also an attempt to offer more information about human sexual activities, in the production of data, theories, perceptions of participants, and treatment of sexual dysfunction.

1.4 Aims of the Investigation

1. A major aim of the study is to explore the relationship between sexuality and psychological well-being, including the link between sexuality and mental health or psychological well-being.
2. To explore perceptions related to sexual dysfunction in interpersonal relations.
3. The provision of guidelines for improving sexual dysfunction stemming from everyday practical experience and recommendations.
4. The development of a practical and theoretical model for improving human sexuality.

1.5 Hypotheses

The thesis was essentially exploratory and descriptive in nature with two general hypotheses related to interpersonal and individual levels of analyses. On an interpersonal level, it was hypothesized that sexual functioning and interpersonal relationships would be positively correlated with each influencing the other.

On an individual level it was hypothesized that perceptions of sexuality and psychological well-being would be positively correlated i.e. individuals scoring highly on a sexuality scale would score highly on a psychological well-being scale and those scoring low on a sexuality scale would also score low on a psychological well-being scale

Many studies have dealt with the relationship of gender and attitudes concerning sexuality (DeLamater & MacCorquodale, 1979). These studies point to an important generalization: there are clear gender differences in attitudes. Generally, men tend to be much more negative and disapproving about sexual dysfunction than women are (Herek & Capitanio, 1995; Kempf & Kasser, 1996; Kite & Whitley, 1996; Moulton & Adams-Price, 1997; Whitley & Kite, 1995).

The integrated model is the interplay of behavioural, cognitive, medical, and surgical approaches to sexual problems. Research demonstrates that prognosis and outcome of patients with sexual diseases dramatically improves when medical solutions are proposed, along with the evaluation of the therapies' sexual impact on the couple's dynamics. Physicians dealing with sexual dysfunction must consider the psychological and behavioural aspects of their patient's diagnosis and management, as well as organic causes and risk factors. Integrating sex therapy and other psychological techniques into their clinical practice will improve effectiveness in treating sexual dysfunction. This thesis will provide information about the psychological forces of patient and partner resistance which impact patient compliance, and sex lives beyond organic illness and mere performance anxiety. Shakespeare recognized this problem 400 years ago when he wrote, "is it not strange that desire should take so many years and outlive performance?"

1.6 Method of investigation

In order to trace the operations of discourse in the self-fashioning of women and men, a research process is required which involves many strands. One has to identify the discourses, which are circulated in the wider sphere, as well as their impact on individuals. The following research strategies will be used:

- ▶ examination of the existing literature on sexuality
- ▶ distribution of a short questionnaire to a South African sample experiencing sexuality problems
- ▶ an open-ended question assessing respondent's recommendations. One of the key strengths of qualitative research methods, especially open-ended, in-depth, is that it allows the researcher to set the agenda, thus making it more likely that issues of importance to the researcher will come to the foreground, whatever the hypothesis-related bias of the researcher. The nature of the research will be mainly explorative and descriptive.

1.7 Study sample

The sample will consist of 100 persons who have experienced sexuality problems.

1.8 Data collection methods

The research aims require a combination of qualitative and quantitative data collection methods and information from various sources, such as:

- Literature review of both published and unpublished documents in order to accomplish the analysis with information about the population under study, e.g. on the social and psychological dynamics of sexuality in relationships.
- The questionnaires will include semi-structured and open-ended questions.
- A structured questionnaire, including standard demographic questions, the Sexuality Scale (Snell, 1997) and the Psychological Well-being Scale (Ryff, 1995). The questionnaires enquire about sexual behaviour, sexual difficulties, and sexual orientation with the Kinsey scale. This will provide sufficient information to make a diagnosis of sexual dysfunction according to ICD- 10 (international classification of diseases, 10th revision) (WHO, 1992).
- The questionnaire will include a solution-oriented section, where individuals and/or couples can offer suggestions/solutions as to the reason for, and the attempted remedying of sexual dysfunction.
- The emphasis on sexual dysfunction, gender, relationships and intimacy will be explored, and an improvement/management/ therapy approach will be added, which participants themselves will provide.

1.9 Value of research

The physical sciences currently enjoy hegemony when it comes to authoritative claims about the nature and meaning of sexual behaviour. A significant need exists for basic research on human sexuality since reports of studies of low-level fact-finding activities in favour of well-grounded methodology, can eventually provide better answers to questions raised by sexual experience. Application of this knowledge toward the solution of problems can alleviate the vacuum found to occur when basic research is absent.

1.10 Scheduling

The intention is to carry out the research during several consecutive phases.

Chapter 1	Introduction
Chapter 2	Models and muddles
Chapter 3	Problems and pleasures
Chapter 4	Research methodology
Chapter 5	Results and discussion
Chapter 6	Conclusion
Chapter 7	Summary, recommendations and limitations

1.11. Resume

Although sexuality is an integral part of close, romantic relationships, research shows that:

- Sexual dysfunctions are more prevalent for women (43%) than men (31%), and are associated with various demographic characteristics, including age and educational attainment (Laumann, Paik & Rosen, 1999).
- Adequate sexual functioning appears to be associated with personal well being and ongoing relationship stability, though this may be truer for men than for women.
- Research is lacking in understanding sexual functioning, sexual disorders, and the impact of treatments on specific symptoms and broader health issues for individuals and couples.
- Particular areas of treatment research that are important are (a) prevention of sexual disorders using current knowledge from different disciplines and (b) treatments that

compare and combine psychological and pharmacological approaches to dysfunctions. As has been shown in the research on depression and anxiety (e.g., Keller, McCullough, Klein, Arnow, Dunner, Gelenberg, Markowitz, Nemeroff, Russel, Thase, Trivedi & Zajecka, 2000), different treatment choices are important for patient consumers and combined treatments often are more efficient and enduring.

- With the strong association between sexual dysfunction and impaired quality of life, this problem warrants recognition as a significant public health concern.

Many issues are raised in the research process such as bisexuality, transsexuality and homosexuality. It is important to mention them here, as their absence should not be taken as a sign of insignificance. Due to severe time and research constraints, the study will be confined to heterosexual relationships. Perhaps, it will also challenge other researchers to hone in on sexuality in homosexual relationships.

CHAPTER TWO: MODELS AND MUDDLES

In this chapter, the myriad implications of this seemingly innocuous assertion for evolutionary, cultural, and psychological theories of human sexual expression are examined. The following expose will reflect a landscape of theoretical directions ranging from Masters and Johnson to Sigmund Freud.

The point of takeoff is the duality of human sexuality. Sex is pleasurable, true, but it is also necessary for the survival of the human species. The long-standing tension between the procreative and the pleasurable aspects of sex has mystified theoreticians ranging from Aristotle to Freud. The failure to adequately resolve this conflict has resulted in the conceptual muddle of the present day, in which sexual enjoyment is sometimes pathologized as an obsessive/compulsive disorder, rather than celebrated as an evolutionary adaptation extraordinaire.

2.1 Introduction

Debates concerning sexuality have tended to polarise across different schools from Freud to Kinsey. From the perspective of the social sciences, the word “sex” stands for a particular bundle of experiences, desires, sensations and behaviours, though the study of sexuality has not yet become a mature field of science with its own methodological and theoretical paradigms. The area of human sexual dysfunction is clearly one in which psychological and physiological components must both be considered. This chapter describes the broad theoretical orientation of the thesis, which was developed through a review of local and international literature on sexuality.

Sex therapy and relationship counselling are specialties that cover broad bases. Most problems encountered in either of these disciplines require sweeping assessment, since no problem is easily diagnosed or treated. Masters, Johnson, & Kolodny’s (1992) textbook, “Human Sexuality”, begins by commenting on the complexity of this subject. “While keeping in mind the private, public, and historical sources of our sexual heritage, we can broaden and deepen our understanding by studying sexuality from biological, psychosocial, behavioural, clinical, and cultural perspectives” (p. 2). Their initial sex therapy case is presented and viewed through the various lenses of biology, psychology, and the culture to illustrate this complexity and the need for viewing a sex problem in all its many facets.

One of the facets, the concepts of femininity and masculinity, as well as the nuances of sex/gender differences, has found its way into the everyday language and popular spectra of human experiences. As Masters et al., (1992) point out, although one's sexuality is processed through an "intensely personal perspective", the perspective itself stems from "private, personal experience, and public, social sources" (p. 2).

Although the concepts of femininity and masculinity were in earlier times thought of as strictly sociological and psychological constructs, recent information on the effects of sex hormones on brain formation of males and females has resulted in a blurring of the definitions. Some current research indicates that a woman with high testosterone levels may have a tendency to express herself in masculine ways; a man with low testosterone levels may tend to express himself in more feminine ways (Dabbs, 2000). John Gray, the popular relationship therapist and author, uses the theory of brain differences to explain male and female differences as instinctually biological. Early in the conception of this dissertation, the researcher realized the need to explore these expansive gender/sexual concepts from an anthropological perspective, which "investigates how human biology, social behaviour, and culture interact" (Masters, et al., 1992, p. 641). Indeed, to examine a culture's gender/sexual evolution requires viewing the mosaic of social elements, such as politics, economics, and lifestyles, along with the biological elements of the sexes. Coupled with this, must be spiritual and philosophical elements. The researcher has chosen to use the wide lens of qualitative research for this project of attempting to understand personal and cultural evolutionary processes foundational to the sexual experience.

Through the process, the researcher has begun to perceive the concepts of femininity and masculinity in three separate domains. First and foremost, the cultural perspective includes the various social roles that men and women have been assigned, and have played out over the years, which have been shifting as a result of complex social phenomena, such as contemporary feminist activism and recent technological advances. Secondly, the biological perspective puts females in a hormonal pool of femininity and males in a hormonal pool of masculinity, regardless of sexual orientation, social role, or political attitude. Thirdly, the spiritual/energetic perspective of these two concepts, evolving from such elements as religion, philosophy, and psychology, are present in the culture, and, although difficult to grasp or define, must be included in the examination (Masters et al., 1992). Therefore the researcher has attempted to represent the rich interplay of these three perspectives through qualitative methods.

Sex therapy today tends to present itself clinically in terms of research and interventions, being medically oriented and using scientific language and objectivity, especially in this “age of Viagra” (Lieblum & Rosen, 2000, p. 1). However, science and its various methods of objective investigation, with its lack of experience in its experiments, have been found to result in a disenchantment of the culture, particularly with regard to psychology and the more interpersonal treatment approaches (Pickering, 1997). Scientific approaches have generally been a masculine creation, and have been criticized by certain feminists, such as Keller (1985), for creating a masculine bias, and omitting elements of the human experience that involve more feminine concerns such as feeling and subjectivity (Brannon, 1999). Tantric practices, used to enhance the sexual experience by aligning it with spiritual expression, are clearly within the domain of sex therapy, yet are not a part of the scientific world (Butler, 1999). Sexuality, at its best, is a balancing act of masculine and feminine forces. In keeping with that, the researcher has attempted to weave balance into this project, by contrasting and comparing the various presentations of the historical, psychological, sociological and biological research.

2.2 Beginnings

2.2.1 Roaring twenties

Man’s desire is perpetual and woman’s intermittent. If man’s desire naturally wells up everyday, and woman only every fortnight or every month, it may appear at first sight impossible for the unwarped needs of both natures simultaneously to be satisfied in paired union of two only” (Stopes, 1918: 21)

Masters et al., (1992) describe several elements contributing to the sexual revolution that were seen in the United States culture in the 1920s as particularly significant, since America had previously been puritanical and antisexual. In the eighteenth and nineteenth centuries Victorian Age, prostitution and the sale of alcoholic beverages were issues that caused political and legal uproar, and legislation banned pornography for the first time. Also at this time masturbation was viewed as physically damaging to the body by science and medicine, while women were blatantly viewed as inferior to men. Around the turn of the twentieth century, several respected scientists began to investigate sexual practices more objectively and to publish their reports. Sigmund Freud, at the time a neurologist, began to reveal his theory of personality, which included his belief that sex is the primary force in the motivation of all human behaviour. Skolnick (1991) explains that the preoccupation with sex that evolved during the 1920s overlapped with the last stages of the first wave of feminism.

2.2.2 The Kinsey Report

Dr. Alfred C. Kinsey, a professor of zoology at Indiana University, carried out an extensive study of sex practices secondary to his appointment to teach a sex education course in 1938 (Brannon, 1999). He and his research associates gathered the information through in-depth personal interviews, and eventually required national financial support and facilities to house the growing collection of confidential material, founding the Institute for Sex Research in 1947 (The Kinsey Institute, 2001). The results were published in two volumes, the first describing the sexual behaviours of males (Kinsey et al, 1948), and the second describing the sexual behaviours of females (Kinsey, Pomeroy, Martin & Gebhard, 1953).

Masters et al., (1992) state that overall, the results of the "Kinsey Report" were startling, as it revealed high incidences of socially unacceptable and illegal sex practices, with particular emphasis on homosexuality, infidelity, and masturbation. Although the first volume, which focused on males, was criticized as a threat to morality, it was generally positively received and stayed on the best-seller list for twenty-seven weeks. According to the same source, the second volume, which focused on female sexuality, was very poorly received by the culture and was even alleged to be "tainted with communism" (p. 15).

May (1988) explains that the emergence of same-sex communities and the increasing visibility of gay men and lesbians, fostered by the sex-segregation of the war, made the "Kinsey Report" especially threatening to the traditionalists of the day. Paranoia and persecution of same-sex communities and homosexuals as well as other forms of then-regarded deviant forms of sexual practices became intense.

2.3 Cultural upheavals of the 1960's

2.3.1 Sexual revolution

In keeping with the other movements of the 1960s, the legacy of sexual revolution had its actual foundation in the early decades of the twentieth century. Seidman (1992) explains that sexual reformers began in the 1920s and 1930s to modernize the cultural view of sex away from the Victorian restrictions, which they felt created a sexual underworld of vice and pathology that threatened the institutions of marriage and intimacy. Viewing the Victorian approach as a cultural failure, reformers felt that relaxing the moral code around sex within

marriage would help to reduce the amount of pathology, and secure the legitimacy and stability of marriage. According to Seidman, this reformed attitude contributed to a culture of eroticism.

Seidman, as well as other historians (Snolnick, 1992; Weiss, 2000), comment on the social liberalization that was evolving during the 1960s that made this eroticism possible.

Mentioned by most, is the open forum that evolved for discussions and writings with sexual topics, as well as the state deregulation of sexual behaviours and the production of explicit materials.

Many of the developments affecting the sexual revolution were found in the realm of femininity and the experience of women, and Ehrenreich (1986) regards the sexual behaviour of women as the most revolutionary development of the time period (Skolnick, 1992). Brown's bestseller "Sex and the Single Girl" was published in 1962, and advocated a life of independence through work and casual, pleasurable sex. Betty Freidan's "The Feminine Mystique" (1963) inspired a female mass audience to re-evaluate their roles as wives and mothers, and to demand more meaningful regard. As the war and civil rights' protests were promoting a climate of individual expression and freedom, feminism began to re-emerge and sexual behaviours of women began to change.

2.3.2 Sexual revolution of the 1970's

Although some historians refer to the time period as a dull interim between the drama of the 1960s' and the rejuvenation of the 1980s, an overall review of the social climate of the 1970s leaves one with two impressions, and they are rather diametrically opposed. The first is that the political powers of the day, which the feminists referred to as the patriarchy, were exhibiting flaws and distortions that brought down national morale and called into question basic founding principles such as democracy and justice. On the other hand, the women's movement and the gay rights' movement found a receptive culture, resulting in a relaxation of sexual behaviours and attitudes. In terms of this particular discourse of sexual evolution, examining masculinity and femininity, one might imagine that it was a time when masculine ideals were depressed and choked, and feminine ideals were in metamorphosis and expansive.

2.3.3 Women's movement

"I suppose I do genuinely believe that any movement that liberates women will liberate men too...it's a difficult time to be a man: it's a difficult and fascinating time to be a woman. Right now we are the active ones and men are on the receiving end. I wish men would be more active in terms of initiating change and trying out different ways to be opposite women. I am sure this will come and I'm very optimistic about the outcome of the present sexual crisis" (Nancy Friday, interview in *Spare Rib*, p 45. February 1976).

The women's movement straddled both political and personal realms, and became phenomenally prominent during this decade. The movement was complex and wide sweeping, taking many forms. Two primary forms are often identified and designated as political or reform feminism and radical feminism. Although often opposed, these two divisions served to make the movement more expansive and far-reaching.

2.4 Sex roles of the 1970s

Carroll (1982) points out that many viewed the 1970s as a time of "extreme individualism" (p. 295), emerging from many sources. As a result of the women's movement and changing sexual morality, the sex role picture began to change dramatically. The superwoman image was popular at this time, reflecting women working, and taking care of their families at the same time. It began to reflect poorly on men, and they began to re-examine their lives. There was a movement for men to be more involved with their families, with a new emphasis on fathering. Dr. Benjamin Spock revised his famous parenting manual (1946) to encourage fathers to be involved in childcare. Overall, according to Carroll, there was movement toward androgyny in terms of sex roles.

Related to the changes in sex roles, there was a change in sex morality. As reported by the Gale Group (1998) there was more open marriage, open pornography, nudity, dirty language, interracial dating, open homosexuality, communal living, all indicating changes in the moral code. Although the sexual revolution began to emerge in the 1960s, it seemed to take root in the 1970s (McDaniel, 2001).

Historians have represented the history of sexuality in the last hundred years as a story of gradual but regular progress from the darkness of Victorian prudery to the light of sexual freedom. In a more recent work, Michel Foucault asks the following question:

“Why does sexual behaviour, and why do the activities and pleasures which pertain to it, form the object of a moral preoccupation? Why this ethical concern, which, at least at certain moments, in certain societies, or in certain groups, appears more important than the moral attention, paid to other domains equally essential to individual and collective life, such as the supply of provisions, or the accomplishment of civic duties? Why this problematisation? And after all, it is the task of a history of thought, in contrast to the history of behaviour or of representations, to define the conditions in which the human being “problematizes” what he is, what he does, and the world in which he lives” (Michel Foucault, *L Usage des plaisirs*, Paris, 1989, p 16).

Foucault supposes his question to be historical. He assumes that there could be societies in which this “problematization” of the sexual did not occur. The researcher asserts that there could be neither arousal, nor desire, nor the pleasures that pertain to them, without the presence, in the very heart of these responses, of the moral scruples, which limit them. What Foucault assumes to be an historical fact is no such thing, but rather an a priori truth concerning the human person. No history of thought could show the “problematization” of sexual experience to be peculiar to certain specific social formations: it is characteristic of personal experience generally and therefore of every genuine social order.

In his 1910 work, ‘Three Essays on the Theory of Sexuality’, Sigmund Freud postulated that females have two distinct types of orgasms- a clitoral and a vaginal. According to Freud, “well adjusted women repressed clitoral sexuality at puberty and thereafter experienced vaginal orgasms exclusively” (Cited in *Sexual Enlightenment of Children*).

Although Freud offered no proof to his theory, it was popularised by many Freudians. Those women who admitted that they did not experience the “approved” (vaginal) sexual response were often labelled frigid neurotics; who were denying their femininity and were in need of psychiatric assistance.

In 1968, feminist writer Anne Koedt wrote a four-paragraph statement titled “The Myth of the Vaginal Orgasm: a Thesis for Future Study” and published it in the mimeographed feminist paper “Notes from the First Year.” The article made a colossal impact on its readers. According to Koedt, the vaginal orgasm did not exist, the clitoris is the centre of female sexual pleasure, this however was not a new discovery, rather Koedt was simply reiterating the research findings of Masters and Johnson, which had been published two years earlier (Masters and Johnson, 1966).

Even before Masters and Johnson, doubts about Freud's theory had surfaced. The pioneer of sex research, Alfred Kinsey, reported as early as 1953 that "the vaginal walls are quite insensitive," and he bluntly termed the vaginal orgasm "a biologic impossibility" (Kinsey, et al., 1953, pp 580, 584).

2.4.1 The theories of Masters and Johnson

In 1970, Masters and Johnson published their highly publicized and influential book, *Human Sexual Inadequacy*, in which they concluded that 80 % of erectile dysfunction is due to psychological causes, known as "performance anxiety." They theorised that most men who had problems with their erections were overly concerned about performance. Masters and Johnson further attributed the other 20% of erectile dysfunction to physical causes. These included hormonal imbalances, cardiovascular disease, genital surgery and the use of certain medications (Masters and Johnson, 1970).

In 1966, Masters and Johnson released "Human Sexual Response", a book detailing the results of their studies. In spite of its scientific terms and presentation designed for medical professionals, it was a mainstream bestseller. Included in the book were the four stages of the sexual response cycle, showing women's orgasms to be "more similar than dissimilar to male orgasms" (Leiblum and Rosen, 2000, p. 120). They also contended to dispel a myth promoted by Sigmund Freud that clitoral orgasms were a more regressed form of orgasm, while orgasms achieved by intercourse (called vaginal orgasms) were reflective of more mature psychosexual development.

The findings of Masters and Johnson suggested that all female orgasms followed the same reflex response pattern, whether they were caused by intercourse or stimulation of the clitoris (Masters, Johnson, and Kolodny, 1992). Weiss (2000) purports that these findings on women's sexuality "treated the potential for a transformation in gender dynamics..." (p. 158).

Masters and Johnson gave public lectures, which heightened the interest in sex therapy, and they developed a big following of clients. The following summarises their research premise:

"When the partners in the sexually inadequate relationship see themselves as they have permitted the co-therapist to see them, when they can have their rationales for sexual failure and their prejudices, misconceptions and misunderstandings of natural sexual functioning explored with non-judgemental objectivity, and explained in understandable terms with

subjective comfort, a firm basis for mutual security in sexual pleasure is established” (Masters and Johnson, 1970: 62).

A typical therapy program included two weeks of intensive daily therapy and assignments, and periodic follow-ups for five years. One of their most famous techniques is sensate focus, which is a series of graduated sensory exercises carried out by a couple, designed to reduce performance anxiety in sexual interaction. The exercises are carried out with the understanding that the couple will abstain from sexual relations, and will instead give full attention to sensations involved in sensual touching. The goal is for the couple to develop interpersonal intimacy, sexual confidence and pleasurable intercourse (Leiblum and Rosen, 2000).

In 1976 a series of articles appeared in *Spare Rib* by Eleanor Stephens presenting “a feminist approach to female orgasm.” Based almost entirely on Masters and Johnson hypotheses, Stephens views everything through the physical lens,

“ Every woman with a clitoris can become orgasmic given the right kind and amount of stimulation, mysteriously, the physical becomes the spiritual when we are told that for women to have orgasms (literally) is for them to learn to love themselves” (Stephens, 1975, p 15).

Another ambitious attempt at female sexuality was *The Hite Report on Female Sexuality* (1976), which was widely appreciated by feminists. The report was focused on women’s unhappiness with male’s failure to respond or reciprocate.

According to the Hite Report:

“It is we (women) who know what we want at any given time and we who create sex in whatever image we want... Controlling your own stimulation symbolizes owning your own body, and a very important step towards freedom... you are free to explore and discover your own sexuality, to learn or unlearn anything you want, and to make physical relations with other people, of either sex, anything you like” (cited in the Hite Report, 1976 pp 434).

Books like the Hite Report have encouraged women to become more assertive sexually, and to object to male arrogance and insensitivity which views sex in terms of penile performance.

2.4.2 Freud: A father of the vaginal orgasm?

By studying sexual excitations other than those that are manifestly displayed, psychoanalysis has found that all human beings are capable of making a homosexual object choice, and have in fact made one in their subconscious. "Psychoanalysis considers that the choice of an object independently of its sex- freedom to range equally over male and female objects- as it is found in childhood, in primitive states of society and early periods of history, is the original basis from which, as a result of a restriction in one direction or the other, both the normal and inverted types develop... Thus from the point of view of psychoanalysis the sexual interest felt by men for women is also a problem which needs elucidating and is not a self-evident fact based on an attraction which is ultimately of a chemical nature" (Freud, 1986, pp 56-7).

Freud asserted that the clitoral orgasm was adolescent and that upon puberty, when women began having intercourse with men; women should transfer the centre of orgasm to the vagina. The vagina, it was assumed, was able to produce parallel, but more mature, orgasm than the clitoris. A substantial body of work was done to elaborate on this theory, but little was done to challenge the basic assumptions...

In discussing the frigidity of women, Freud's recommended cure was psychiatric care! According to Freud, a frigid woman was suffering from failure to mentally adjust to her "natural" role as a woman. Frank Caprio sums it up in the following:

"...Whenever a woman is incapable of achieving an orgasm via coitus, provided her husband is an adequate partner, and prefers clitoral stimulation to any other form of sexual activity, she can be regarded as suffering from frigidity and requires psychiatric assistance" (The Sexually Adequate Female, Greenwich, 1953, 1966, pp 64).

2.4.3 Critique of Freud and Masters & Johnson

Freud, by explaining that all neuroses had a sexual origin, appeared to give order to a disorderly world. In short, Freud's entire explanation of civilisation is based on the centrality of sex (cited in Elisabeth Roudinesco, *Histoire de la psychanalyse en France* Seuil, Paris, 1986: pp. 32.) It is important to emphasize that Freud did not base his theory upon a study of woman's anatomy, but rather upon his assumptions of woman as an inferior appendage to man, and her consequent social and psychological role. Nevertheless, Freud's theories

continued to be extremely influential. For example, Marie Bonaparte, in *Female Sexuality*, goes so far as to suggest surgery to help women. Having discovered a strange connection between the non-frigid woman and the location of the clitoris near the vagina,

“ It then occurred to me that where, in certain women, this gap was excessive, and clitoral fixation obdurate, a clitoral- vaginal reconciliation might be effected by surgical means, which would then benefit the normal erotic function”. Professor Halban, of Vienna, as much a biologist as a surgeon, became interested in the problem and worked out a simple operative technique. In this, the suspensory ligament of the clitoris was severed and the clitoris secured to the underlying structures, thus fixing it in a lower position, with eventual reduction of the labia minora (quoted in *Female Sexuality*, p 148).

Perhaps the greatest criticism levelled against Freud can be the effects of his theory on a woman's mental status. In the researcher's perspective it is abundantly clear that Freud's ideas are incoherent, blatantly sexist and completely outdated.

Kinsey and Masters and Johnson were major theoreticians in changing American ideas about sex, at least as much as any research findings can change attitudes. Kinsey received more public criticism and critical opposition in the field than Masters and Johnson did. In retrospect, some of this might well have been due to Kinsey's way of presenting data. Masters and Johnson were much more cautious in their public statements and apparently had a policy of avoiding controversy whenever possible. They accepted the world as they found it and tried to prescribe therapeutic measures to help. Regardless of the difference, however, both the Kinsey group and Masters and Johnson played significant roles in the development of sexology in the United States. Because of the growth of the rival organizations and the entrance of a variety of professionals into sex research, however, no one or two individuals have since dominated the field in the way Kinsey, Masters and Johnson did in their most active years or as Ellis, Hirschfeld, and others had earlier. In sum, Kinsey's studies challenged traditional ideas, and the development of new contraceptives gave an impetus for change. Masters and Johnson's research set the scene for a new generation of sexologists, who included educators, therapists, and researchers. Some of the results of this new interdisciplinary approach to sex are recounted in the next chapter.

2.5 Masculinity, femininity, sex differences and gender: an odyssey of sexual/gender evolution

Psychology is a central forum for unravelling the mysteries of male and female difference. As feminist anthropologist Gayle Rubin (1984) pointed out:

“There are historical periods in which sexuality is more sharply contested and more overtly politicised. In such periods, the domain of erotic life is, in effect renegotiated... Periods such as the 1880s in England and the 1950s in the United States recodify the relations of human sexuality. The struggles that were fought leave a residue in the form of laws; social practices and ideologies that then effect the way sexuality is experienced long after the immediate conflicts have faded. All signs indicate that the present era is another of those watersheds” (Rubin, 1984: 267).

The interdisciplinary nature of the emerging field of sexology in the years after Kinsey and Masters and Johnson is best exemplified by the research on what might be called gender issues. Gender is an old term that has been widely used in linguistic discourse to designate whether nouns are masculine, feminine, or neuter. It was not normally used either in the language of the social sciences or sexology, until John Money adopted the term in 1955 to serve as an umbrella concept to distinguish femininity, or womanliness, and masculinity, or manliness, from biological sex (male or female). In a sense, by using a new term to describe a variety of phenomena, Money opened up a whole new field of research. It was, however, a field ripe for exploration, since it appealed to the increasingly powerful feminist movement, which was concerned with overcoming the biology-is-destiny arguments that had been so long used to keep women in a subordinate status.

A history of any topic poses tremendous challenges, both to the reader and to the author, as it approaches the contemporary scene, and the history of sex research poses special difficulties. This is because, since the 1960s there has been an almost geometric expansion of research into sex (and gender), with the number of articles and books virtually doubling every decade. Inevitably, some individuals who have contributed to the field are not mentioned, and not all kinds of research have received equal attention. Such qualifying statements are necessary in any discussion of gender research, which has attracted the attention of numerous individuals interested in bringing about change, and many who hope to find scientific justifications for changes that have already occurred. Other researchers are striving to preserve the status quo. To include all the modern issues would necessitate a book in itself. The reader who wants to know more about the development of a particular

avenue of research should delve into the endnote references, as what is presented here is an overview of this rapidly expanding discipline.

"Men are by nature of a more elevated mind than women," opined an Italian writer of the fifteenth century; women, he went on, "are almost timid by nature, soft, slow and therefore more useful when they sit still and watch over things" (Alberti, quoted in Sydie, 1987).

A standard textbook on gynaecology published in 1888 had a concluding chapter titled "Gynaecology as Related to Insanity in Women". The author wrote:

"I take it for granted that all will agree that insanity is often caused by diseases of the procreative organs, and on the other hand, that mental derangement frequently disturbs the functions of other organs of the body, and modifies diseased action in them. Either may be primary and causative, or secondary and resultant. In the literature of the past, we find the gynaecologist pushing his claims so far as to lead a junior in medicine to believe that if the sexual organs of the women were preserved in health, insanity would seldom occur among them."

The primary thrust of this tale of sexual evolution focuses on the concepts of masculinity and femininity, with a particular interest in the psychological differences. Brannon (1999) has summarized the history of the study of sex differences in psychology. According to her review, when the study of psychology spread from Germany to the United States in the late 1800s, it became more practical in form and was termed functionalism. The theory of evolution was emphasized, particularly in the areas of adaptability and intelligence. Testing of abilities, particularly intelligence became popular, along with comparison of differences in the sexes. The psychologists of this early 1900 time period were not in tune with the social influence in sex differences, and "their findings usually supported the prevailing cultural roles for women and men" (p. 4). They tended to demonstrate that women were less intelligent than men and were more suited for maternal issues than education. Women began to publicly dispute the findings in the early 1900s.

In contrast, Freudian psychology, emerging at basically the same time, had a definite element of sex differentiation. Because of contradictory writings and interpretations, Freud's view of women and equality has been hotly debated. He undoubtedly had many negative views about women, including his belief that they were inferior, contemptuous of, or jealous of men. His theory held rigid standards for masculinity and men, as well.

Criticisms included the use of the term “sex differences,” many feeling that its use was confusing and that it implicated biological differences without regard for social elements. Rhoda Unger (1979) proposed the use of the term “gender” to describe cultural traits and behaviours appropriate to men and women, and for use when discussing social and psychological constructs of differences. The confusion remains, but “those who use the term ‘gender’ often intend to emphasize the social nature of differences between women and men” (Brannon, p. 13).

Finally, Brannon has reported that it has also been debated whether psychological research or information on differences between men and women can be carried out with bias eliminated. Some psychologists are concerned that this type of research exaggerates gender differences. Advocating a gender-neutral psychology of people, these critics are concerned that the research on differences may be misunderstood or used to perpetuate stereotypes and discrimination.

Finally, through this review one can begin to understand Radner’s view of “sexual identity and sexual norms as the product of a complex set of negotiations in which economics, politics, and social mores all play crucial roles” (Radner & Lockett, 1999, p. 29).

2.6 Early 1990s global and technological expansion

2.6.1 Eastern thought

Hinduism and Buddhism, the two primary forms of Eastern religions that were integrated into New Age spirituality, were introduced to America in the late nineteenth century, during a time when the immigration of Chinese and Japanese was heightened. At this time, exotic and unfamiliar people and ideas intrigued the population. Hinduism, which exists in many forms, originated in India and was introduced to Americans by missionaries. It was a primary focus of Ralph Waldo Emerson and other Transcendentalists of the nineteenth century. Buddhism was brought to America by the immigrants, as well as by high profile masters, who taught a form of Buddhism called Zen (Albanese, 1992). Also entering into the syncretism (religious combining) (Albanese, 1992) of contemporary New Age spirituality were other Chinese religions, mainly Confucianism and Taoism (Bowker, 1997).

Taoism, in its broadest sense, is the search for truth and reality. In a narrower sense, it is the original knowledge tradition of China. Taoism has already broadened its influence to many different fields of endeavour in the West ranging from science to sex. Next to Confucianism,

it ranks as the second major belief system in traditional Chinese thought. The philosophy of Taoism is outlined in Lao-tzu's *Tao-te Ching*, offering a practical way of life. Both philosophical Taoism and religious Taoism included in their classics many positive ideas about sex. The historical founder of the Taoist religion was Chang Ling, a popular religious leader and rebel. He urged his followers to read the *Tao-te Ching* and, in 143 C.E., organized them into Tao-chiao, or the Taoist religion.

Taoist sexual techniques were developed on the basis of the *fang shu*, also called *fang zhong*, or *fang zhong shu*, translated these three words mean "inside the bedchamber" or "the art in bedroom." *Fang-shu* was created by a combination of experts: *fang-shih* (alchemists or prescription writers), *fang-zhong-jia* (experts on sexual techniques or ancient sexologists), and physicians in or before the Han dynasty (206 B.C.E.—220 C.E.); mainly it belonged to the medical field. For descriptive and analytic purposes, the entire Taoist sexual system may be divided into two categories: (a) beliefs or myths, and (b) methods or techniques.

The major Taoist sexual belief is that longevity or immortality is attainable by sexual activity. The major Taoist sexual techniques include teaching how to master the differences of sexual arousal of male and female, harmonizing the sexual will and desire, and liberating and activating the female while relaxing the male.

Related to Eastern philosophy, sex therapy, and this discourse is the subject of Tantric sex practices that Butler (1999) refers to as "the West's most popular form of adult sex education" (p. 26). She also refers to the culture's current experience of it as a "post-modern hybrid" (p. 26) of Kama Sutra, which was a method of sexual practices presented in a sex manual from third century India. She also explained that it has evolved into positive sexual attitudes and techniques drawn from the combination of "Western humanistic psychology, Chinese Taoist sexology, and classical Indian Tantrism" (p. 26), and is related to yoga in the form of breathing, visualizing, and various techniques to transform sexual energy throughout the body. For example, in the original form of this practice, men participated in sex, but withheld ejaculation with the purpose of moving sexual energy from the genitals to the brain for an explosive experience of enlightenment and bliss. This approach to sex was viewed as a path to God. There are now many books on Tantric sexual practices in the popular market, with the intention of enhancing sexual practices for long-term couples and to broaden participants' sexual horizons. In Butler's article, Tantra teacher Charles Muir was quoted as saying, "You're going to learn to base love not on chemistry...but on alchemy.

When the chemistry is no longer there, alchemy says that you take what is there and you change it" (p. 27).

2.6.2 Jungian studies

The work of Swiss psychiatrist and depth psychologist Carl G. Jung (1875-1961) caught the attention of New Agers (Albanese, 1992), as his approach to mental health involved the mystical and mythical elements of nature religions, which he studied through travel to Africa, America (Southwest Indians), Asia, and the Far East (Pascal, 1992). He formed these elements into a path of achieving Self-wholeness and individuation through developing a dynamic relationship between conscious and unconscious processes, thus "becoming as complete a human being as it is possible for him or her to be" (Stevens, 1999, p. 9).

It was during this time that he developed his personality typology, which was later adapted and standardized as the popular and widely used Myers-Briggs Type Indicator (MBTI). It was also a time when he was in direct awareness of his unconscious processes, which led to his desire for travel expeditions to help decipher the meanings of the symbols and images that he encountered during this experience (Pascal, 1992; Stevens, 1999).

The notion of androgyny, revisited by psychologists as a preferred way of perceiving the equality of females and males, each having both feminine and masculine characteristics or energies, is actually not aligned with Jungian thought, as Stevens (1999) further explains. Jung believed in the cosmology of the interconnectedness of body, mind, and spirit, and that the biology of sex possessed the natural order. Androgyny would not align with those dynamics. Further, if each individual possessed the same potential, not only would the mystery of sex be diminished, but also there would be no polarity to ensure attraction. Stevens sums up by stating,

"Whatever we may think or say about them, the archetypes will prevail, and no archetypes possess greater power than those of the Masculine and Feminine. Our egos may do what they like, but these great archetypal constellations will continue to have their way with us as long as our species survives" (p. 219).

2.7 Late 1990's sexual and gender controversies

White's (2000) depiction of the late 1990s sexual climate eloquently reflects the primary controversy of a supposed sexual revolt against conservative, traditional Victorianism. In the

overview of his last chapter, there are brief accounts of the sex scandals that dominated the news, shifts to enhanced sexual explicitness in the movies and television, girl-power rebellion, gays and lesbians movement toward mainstream acceptance, uncontrolled Internet sexual activity, and much more. He effectively illustrated how traditional morality maintained its force in all the revolutionary cultural shifts. Another sexual debate that escalated with new fervour during this time was that of the differences between the sexes, as evolutionary psychology and biological discoveries gave new power to the arguments supporting the difference ideology, resulting in an outcry of many feminists.

It is interesting at this point to make note of Myers-Shirk's (2001) historical account of the social construct of sexuality in the United States, which she derives from cultural anthropology, feminist scholarship, gay and lesbian studies, and postmodernism. In this view, the meaning of sexuality is derived from social elements as much as biological factors. She first mentions power dynamics that have played a role, such as those in gender hierarchies. Although women in the late nineteenth century were seen as passive, and were confined to the domestic sphere, they were also viewed as morally superior, which put them on public missions and gave them power and influence in social reform movements.

In her presentation, Myers-Shirk (2001) outline the shift from sexuality as a reproductive tool in colonial times, to that of a pleasure tool in the twentieth century. Although colonial Americans shared assumptions of the importance of marriage, fidelity, and procreation, they began to highlight the importance of romance and pleasure. In the late nineteenth century, as the availability of contraception became widespread, the ideal of sexual pleasure was further enhanced and the importance of reproduction was decreased. During this time there was concern that modern civilization had feminised males, and an emphasis on the difference between masculinity and femininity evolved. Included in the movement was the unacceptability of the gender invert, or one who had the genitals of one sex, but adopted the characteristics of the opposite sex. Myers-Shirk (2001) wraps up her historical account by stating, "Much of that which earlier Americans had considered immoral, illegal, or abnormal, twentieth century Americans viewed as good and acceptable (p. 88)." She also mentions that the AIDS epidemic of the 1980s helped to draw ethical lines to the pleasure ideal, as Americans were encouraged to use protection and to be responsible. She also mentioned the effect of women working, the sex market, medical opinion, scholarly research, and individual experience (behind closed doors) as significant in shaping the definition of sexuality.

2.7.1 Gender issues

“Sexual difference would constitute the horizon of worlds of a still unknown fecundity...Fecundity of birth and regenerescence for amorous partners, but still production of a new epoch of thought, art, poetry, language... Creation of new poietics” (cited in Irigaray, *Sexual Difference*, 1984 pp 1).

During the late 1990s, there was an escalation of an evolving debate over feminism. Some felt that “the battle for women’s rights is won” and that “everybody is a feminist now”, as written in a 1997 article for “The Economist” (Anonymous, p. 87). This article (more objectively) presented similar information found in “Time” magazine in 1998 (Bellafante) on the changes in feminism, reflected by the reluctance of college women of the 1990s to call themselves feminists and the emergence of a new type of feminism with a different message to that of traditional feminists.

White (2000) reported on an interesting sex survey published under the name “Sex in America” in 1994 headed by Robert T. Michael, which “attempted to use state-of-the-art sociological techniques in an effort to update Kinsey but also to gauge what American behaviour was like in a land of sex saturation” (White, 2000, p. 195). The results were stunning in their revelation of the deeply conservative sexual behaviours of the American people. The average number of sexual partners had not significantly changed, and marriage remained an important institution. White also reported that Michael’s study found seventy-six percent believing that extramarital sex is wrong, and almost sixty-five per cent believing sexual activity between members of the same sex to be wrong (p. 196). Evidence of a shift toward more sexual freedom was found in a widespread acceptance of sex before marriage, cohabitation, and divorce. In the study, evidence was found that men were more sexually active than women, and that a significant number (twenty-two per cent) of women thought that they had been forced to have sex at some stage of their lives (p. 199). Based on this last set of statistics, White concluded “women apparently had not benefited as much as men from the sexual revolution” (p. 199).

2.8 Evolutionary studies: the biology of sexuality

“With respect to sexuality, I have often speculated on it, and have always concluded that we are too ignorant to speculate: no physiologist can conjecture why the two elements go to form a new being, and more than that, why nature strives at uniting the two elements from two individuals” (Darwin, 1903).

The thread of sexuality is woven densely into the fabric of human existence. There are few people for whom sex has not been important at some time and many for whom it has played a dominant part in their lives.

Sex is a motive force bringing two people into intimate contact. They may have nothing in common except mutual sexual interest. Their encounter may be brief, or it may lead on to the principal relationship in their lives. This is important not only at an individual, personal level, but also socially and politically. The nature of the relationships between men and women is crucial to our social and political systems. Sex has obviously come to play a much wider sociobiological function than the production of offspring.

The search for what accounts for a satisfying sexual relationship has long mystified researchers. Consequently, no dissertation on human sexuality will be inclusive without a section on the biological aspects of human sexuality. Therefore, this chapter is a response to this void. This chapter will look at female sexuality and thereafter - male sexuality.

2.8.1 Biological factors of sexuality

In most species, sexual behaviour principally serves the purposes of reproduction. In humans, and in some other primates, other purposes for sexual behaviour in addition to reproduction have evolved. In the human, such purposes have been shaped and influenced by cultural factors, so that human sexuality has been expressed in many different ways, varying across cultures and over history. In spite of these powerful cultural influences, biological factors involved in sexual arousal and response remain fundamental to human sexual experience, and need to be taken into account in our attempts to understand and explain the complexities and problems, as well as the positive aspects of the human sexual condition. The relevant literature is vast, and the present research makes no attempt to provide a comprehensive review; rather, it should be considered a broad brush of a number of key concepts relevant to understanding the role of biology, and its interaction with culture in shaping human sexuality.

2.8.2 Sexual response

Sexual response in the adult is characterized by a subjective sense of sexual excitement or arousal, and physiological changes in the body involving the genitalia, but also the cardiovascular system, and a tendency, particularly in the male, to pursue sexual stimulation until orgasm occurs. This process is a complex interaction between cognitive (information processing), central brain mechanisms, including sexual arousal and other

emotional states, and peripheral physiological processes such as penile erection in the male and clitoral, vulvar, and pelvic vaso-congestion in the female. It can usefully be regarded as a "psychosomatic circle" (Bancroft, 1989) in which awareness of changes in the genitalia feeds back to influence the central processes in either an augmenting, excitatory, or inhibitory fashion. The activation of this psychosomatic system can start at various points in the cycle, such as the occurrence of a sexually exciting thought, a sexually stimulating image, or tactile stimulation of those parts of the body which are erotically sensitive. The information processing component identifies what is "sexual," a process which is heavily influenced by learning and cultural factors. The central brain mechanisms activate the neural signals that descend mainly down the spinal cord, along pathways that include reflex centers at certain levels of the cord (Steers, 2000), to evoke the peripheral sexual responses. The sensory input from these peripheral responses and further tactile stimulation, as well as continuing information processing of the experience, result in increasing levels of central arousal and excitement to the point when an orgasm is triggered.

Conversely, if the ongoing process is interpreted in negative terms suggesting threat, danger, fear of failure, or some other negative consequence, then the process may lead to inhibition of further sexual response. There is much that one does not understand about this psychosomatic circle. In the case of the cognitive component, a distinction has been made between automatic cognitive processes (of which the subject is more or less unaware) and controlled cognitive processes, involving ongoing awareness of the subject. In addition, the impact of emotional states on these cognitive processes has been recognized as important (Janssen & Everaerd, 1993). However, one understands little about the nature and origins of these automatic processes. The interface between such information processing (i.e., how we interpret what is happening to us in the sexual context) and the physiological systems involved in sexual response is also understood only in a limited manner. Research on brain mechanisms involved in sexual response has largely depended on animal studies, and much has been learned in this area over the past few years, particularly in relation to male sexual response (e.g., Steers, 2000).

Although such studies are important and helpful, they cannot investigate the role of cognitive processing of the kind that characterizes the human. Also, as we learn more about the physiological processes, so their complexity increases to the extent that our earlier, simple explanatory models become overwhelmed. At an earlier stage, one could envisage most of the key neuropsychological processes involved in sexual response, both in the brain and in the periphery, as being controlled by a small number of monoamines,

like norepinephrine, dopamine, serotonin, and acetylcholine. Also, neuropeptides, a different class of chemical messenger, are involved, often working in combination with more traditional monoamines. Whereas one once knew of a handful of such neuropeptides, they now number more than a hundred. Excitatory and inhibitory amino acids such as glutamate and GABA (gamma-aminobutyric acid) then became recognized as probably the most ubiquitous neurotransmitters in the central nervous system. (Powis & Bunn, 1995). Modern techniques of molecular biology are finding more and more different receptors for these chemical messengers, each with potentially different functions. According to Heaton (2000) "our current capacity to identify and manipulate these targets of control is in the process of explosive growth from an estimated few hundred identifiable systems to well over 100,000" (p. 562). Although, whether this is an exaggeration or not, such growth of inevitably fragmented knowledge may have benefits in the search for treatments for sexual problems, it is arguable that in the face of this overwhelming complexity, one should revert to simpler but new conceptual systems to guide research and shape explanatory models.

An example of such a conceptual system is the development of a dual control model to explain control of sexual response, which assumes that there are both excitatory and inhibitory conceptual systems in the brain and spinal cord, and that sexual response depends on the balance between them. Furthermore, the model postulates that individuals vary in their propensity for both excitation and inhibition (Bancroft, 1999). Such propensities are now being measured by simple questionnaire techniques showing that people do indeed vary considerably in both respects. Those with either high or low propensities for either excitation or inhibition are proving to be more vulnerable to problems such as sexual dysfunction (in the case of low excitation and/or high inhibition) (Bancroft & Janssen, 2000), or compulsive sexual behaviour (in the case of high excitation and low inhibition). Current research at the Kinsey Institute is focusing on the relationship between mood and sexuality. A significant minority of men experience an increase in sexual interest when they are anxious or stressed, and a somewhat smaller proportion when they are depressed. These paradoxical relationships between mood and sexuality can be predicted from excitation and inhibition proneness, and help explain some forms of high-risk sexual behaviour where sex becomes a form of mood regulator, or stress reliever (Bancroft, 1999).

A number of new methodological as well as conceptual developments offer promise for testing such theoretical models in the human rather than the laboratory animal. Of particular interest is the use of brain imaging, employing either PET scanning or functional

MRI to explore areas of activity in the human brain during sexual arousal. Such research is at an early stage. Stoleru and his colleagues (Redoute et al., in press; Stoleru, Gregoire, Gerard, Decety, Lafarge, Cinnotti, Lavenne, Le Bars, Vernet- Maury, Rada, Collet, Mazoyer, Forest, Magnin, Spria & Comar, 1999), using PET scanning, have made an interesting start, showing that sexual arousal in men in response to visual stimuli is correlated with activation (rCBF) in limbic and paralimbic cortex and some subcortical structures, together with deactivation in several parts of the temporal cortex. This is consistent with the dual control model, and its basic assumption that there is an inhibitory tone in the CNS, which needs to be reduced (deactivated) to allow sexual arousal to develop (Bancroft & Janssen, 2000). However, one should not expect such evidence to provide simple answers. Already, on the basis of limited evidence, it is apparent that sexual arousal, as we conceptualise it, involves a variety of processes, some of which are specific to sexual response and some which are involved in other types of emotional or motivational states.

New techniques of molecular genetics, which can identify individual variations in levels or potency of genetic factors linked to key neurotransmitters such as dopamine (Miller, Pasta, MacMurray, Chui, & Comings, 1999) or serotonin (Lesch, Bengel, Heils, Sabol, Greenberg, Petri, Benjamin, Muller, Hamer & Murphy, 1996), offer the potential for explaining individual differences in human sexuality, particularly if combined with more sexual response oriented approaches such as the dual control model.

2.8.3 The role of sex hormones

During childhood, the capacity for sexual response and the experience of sexual pleasure as well as the potential for orgasm exists, at least in a proportion of children. Whether this apparently variable potential among children reflects different learning experiences during childhood, different opportunities for realizing the potential or different genetic influences is not known. The importance of gonadal hormones, in particular testosterone, in organizing early brain development and function has been discussed earlier. During childhood, gonadal steroid hormones are rarely in evidence, but from the ages of 9 or 10 years they start to increase as the child approaches puberty. From then on the activating role of these hormones on sexuality, and the impact they have on sexuality during three stages of the life course: around puberty and during early adolescence, during adulthood until middle age, and during the later years has to be considered.

In the male, the role of testosterone and related androgenic hormones is relatively well understood and straightforward for the adult phase of the life course, and less clear during

the early and late phases. The onset of puberty has a major organizing effect on the emergence of sexual responsiveness and interest. Shortly before, or shortly after puberty, the large majority of boys start to masturbate (Bancroft, Herbenick, & Reynolds, in press; Kinsey, Pomeroy, & Martin, 1948), and for most of their teen years they remain at their maximum capacity for sexual arousability and response. This is, to a considerable extent, a result of the activating effect of the major increases in testosterone and other androgens that accompany and follow puberty. However, puberty is a complex process: There are both hormonal and physical changes as well as psychological and social reactions to such changes, and it is likely that during these early years of increasing testosterone the body is adapting to higher levels, and at the same time developing and activating inhibitory mechanisms to allow control of these newly activated excitatory responses. This may explain why studies of the relationship between testosterone and the unfolding sexuality of the adolescent boy have produced complex, and somewhat contradictory results (Halpern, Udry, Campbell, & Suchindran, 1993; Udry, Billy, Morris, Groff, & Raj, 1985). More research is required to throw light on this developmental stage. The evidence is relatively consistent, however, in showing that boys with an earlier onset of puberty also tend to show higher levels of sexual interest and activity when they are older (Halpern et al., 1993; Kinsey et al., 1948).

An adult male's continued interest in sex depends on his having a normal level of circulating testosterone. If an otherwise normal male has his testosterone lowered by testicular suppressive drugs, he experiences a decline in sexual interest, which returns when the process is reversed (Bagatell, Heiman, Rivier, & Bremner, 1994). In cases of testicular impairment (primary or secondary hypogonadism), when testosterone levels fall below the normal range, almost all males experience a decline in sexual interest and capacity for ejaculation. This is reversed by testosterone replacement therapy. This is a robust, predictable finding across a substantial number of placebo-controlled studies.

A similar pattern is observed with spontaneous erections during sleep, or nocturnal penile tumescence, which decline and return with testosterone withdrawal and replacement (Bancroft, 1988). These erections are interesting manifestations of the sexual arousability of the brain uncomplicated by cognitive processes, and this evidence clearly points to the role of testosterone in central sexual arousal mechanisms. It is important to emphasize, however, that normal levels of testosterone are necessary but not sufficient for normal levels of sexual desire. There are other factors, which can inhibit or alter sexual desire in the presence of normal testosterone levels.

Therefore, the role of testosterone becomes less clear as men get older. There is a normal, but variable, tendency for testosterone levels to decline in men beyond the fifth decade, and this is often accompanied by an age-related decline in sexual interest. This is sometimes referred to inappropriately as the "male menopause." However, there is no clear evidence that this pattern can be reversed by testosterone replacement. It is possible that there is a decline in responsiveness to testosterone in addition to a fall in the hormone level (Schiavi, 1999).

There is also a common (though variable) age-related decline in erectile responsiveness, such that, as men get older, erections develop less consistently and are less strong and less well sustained. The mechanisms for this are not well understood, but may be related to changes in neurotransmitter responsiveness in the erectile tissues (Lerner, Melman, & Christ, 1993).

In the female, one finds the relevance of hormones, particularly testosterone, to sexuality less clear at each of the three phases of the life course. First, there is not the same organizing effect of puberty on sexual interest and response as is found in boys. Interest in masturbation does not peak around puberty as it does in boys (Bancroft et al., in press-d; Kinsey, Pomeroy, Martin, & Gebhard, 1953) and age of onset of masturbation is much more widely distributed among females than males, suggesting a more variable constitutional propensity for sexual responsiveness and interest in females, with a proportion of females being affected strongly by hormones such as testosterone, whereas others are affected weakly or not at all. Girls are unlikely to engage in sexual intercourse before they reach puberty (Rowe, Rodgers, & Meseck-Bushey, 1989). As with boys, studies relating testosterone levels to emerging sexuality have produced conflicting results (Halpern, Udry, & Suchindran, 1997; Udry, Talbert, & Morris, 1986).

It is paradoxical that we have substantially more evidence of sex hormone-behaviour relationships in adult women than in men, and many more opportunities to study them, with the normal menstrual cycle, the widespread use of steroidal contraceptives, the impact of pregnancy and lactation, and menopause, and yet, compared with the male, the picture remains unclear and the evidence often contradictory (Bancroft, in press-b).

With the menstrual cycle the most predictable pattern is for women to feel least interested sexually when they are menstruating. There are a number of possible explanations for this, which do not involve hormonal effects. A proportion of women experience a predictable peak in sexual interest around ovulation, which would suggest hormonal determinants. But these women are a minority and some premenstrually and

postmenstrually report peaks, while other women say that they are not aware of any consistent pattern (Hedricks, 1994).

The impact of steroidal contraceptives on the sexuality of women has been poorly studied. But there is evidence that in a proportion of women oral contraceptives (OC) reduce sexual interest (Graham, Ramos, Bancroft, Maglaya, & Farley, 1995), and such adverse effects are strong predictors of early discontinuation of oral contraceptive use (Sanders, Graham, Bass, & Bancroft, 2001). Whether such effects result from the invariable reduction of free testosterone that results from OC use, or from other effects of the OC, (e.g. progestagenic), has not yet been established. Clearly, in many women these negative effects do not happen, and the freedom from fear of pregnancy may be associated with an enhancement of sexual pleasure and interest.

Women may vary in their sexual responsiveness to other hormonal mechanisms as well. Why should women be more variable than men in this respect? An explanation, which is again plausible, but not as yet proven, is that men who are behaviourally unresponsive to their reproductive hormones are unlikely to reproduce, and hence such men will be selected out in the evolutionary process. Women, on the other hand, will continue to reproduce, whether or not they are sexually responsive to their reproductive hormones. As a consequence, we may expect to find a more variable genetic pattern of sexual responsiveness in women. While such an explanation is plausible, it is not so easy to account for a genetically determined tendency being expressed in women but not in men. A theoretical explanation for this apparent conundrum, based on a desensitisation of the central nervous system (CNS) to testosterone effects in the male during early development, has been proposed elsewhere (Bancroft, 1988). There is much that we have to learn about the role of hormones in sexuality, particular in women.

2.8.4 The interaction between the individual's biology, the environment and culture

As indicated earlier, the biological individual is interacting with his or her environment more or less from conception, and such interaction influences the continuing development of the nervous system well into childhood. We can consider the interaction between the individual and the environment at several different levels.

There are biological influences from the environment—thus, sexual contact with a male partner on a regular basis, presumably as a result of pheromonal signals, increases the likelihood of a regular ovulatory cycle (Cutler, Garcia, & Krieger, 1980; Stern & McClintock, 1998); chronic stress can alter the neuropeptidergic system resulting in suppression of

sexual interest or fertility (Herbert, 1996). There is the impact of learning, by which sexual response patterns are shaped. Such learning can basically result from immediate positively or negatively reinforcing consequences of behaviour, where little cognitive processing may be involved. And there is the impact of culture. Here we can assume that learning plays a crucial mediating role; the culture provides guidelines or scripts for appropriate sexual responses, and the individual learns them accordingly. However, we also have to consider the possibility that one cultural group, particularly if it is relatively specific and genetically homogeneous, may carry with it a different set of genetic determinants than another cultural group.

Although a certain amount of evidence of the effects of environment on the biological individual exists, very little addresses the interaction between culture and biology. Lock (1998) has studied women's experience of menopause in different cultures, finding that both the social construction of menopause and its significance to a woman's status in society, and its physical manifestations (e.g., vasomotor symptoms) vary across cultures.

Graham et al. (1995) studied the effects of oral contraceptives (OC) on two groups of women, one from Scotland, and the other from the Philippines. Negative effects of the OC on sexuality were observed in the Scottish but not in the Filipino women. It is not yet clear whether this difference was due to methodological inadequacies (one may not have been using the most appropriate methods of assessment for the Filipino women), differences in the scope for OC effects (the Filipino women reported more negative sexual lives at baseline), or a cultural impact which resulted in the Filipino women reacting differently to the OC hormonally mediated effects. In another study (Anderson et al., 1999), the effects of testosterone replacement for hypogonadal men were compared in a group of men from Scotland and another group from Hong Kong.

The results of androgen withdrawal and replacement which had been demonstrated in a series of studies in Europe and North America, were as expected in the Scottish men, but much less marked in the Hong Kong subjects. Once again, one does not have an adequate explanation for this difference, but it is conceivable that the cultural environment of Hong Kong would influence male sexuality in such a way, that the direct effects of testosterone would be experienced differently. There is a great need for more systematic study of the interaction of biology and culture in many aspects of human sexuality especially here in South Africa, which is multi-cultural and highly diversified. Until progress is made in this respect, one will remain with a very partial understanding of the human

sexual condition. Therefore, the researcher makes this important recommendation for future studies.

2.8.5 Sexual selection and the evolution of human sex differences

2.8.5.1 The mechanisms of evolutionary selection

Sex differences in brain, behaviour, and cognition are inherently interesting to the scientist and the layperson alike. In fact, some level of interest in sex differences would be expected for nearly all individuals of any sexually reproducing species, given that one of the most fundamental goals of life-to reproduce-necessarily involves negotiating some type of relationship with at least one member of the opposite sex. Not surprisingly, research on sex differences has occupied biological and social scientists for more than a century but, with a few notable exceptions (e.g., Daly & Wilson, 1983; Buss, 1994); the research programs in these two broad areas have largely developed independently of one another. In recent years, biologists have used Darwin's (1871) principles of sexual selection to provide a coherent theoretical framework for the study of sex differences across hundreds of studies and across scores of species (Andersen, 1995).

At the same time, social scientists have, for the most part, been studying sex differences from a completely different theoretical perspective, gender roles (e.g., Eagly, 1987). The gist is that most non-physical human sex differences are the result of the culturally mediated social roles that are adopted by boys and men and girls and women. In many cases, the belief that human sex differences are the result of the adoption of such roles is accepted; it seems, without a critical evaluation of this perspective. The goal is not to provide such a critical evaluation-but rather to approach the issue of human sex differences from the same theoretical perspective that is used to study sex differences in all other species-sexual selection. In fact, it is the essence of this thesis that human sex differences can never be fully understood without an understanding, and an appreciation of sexual selection, and an understanding of how the associated processes are manifested in other species.

Any process, event, or ecological condition that in any way influences life, death, and reproduction is a potential selection pressure. Any such pressure acts on individuals, but not in a random fashion, although random or chance events do occur and can influence evolutionary processes (Mayr, 1983). Rather, for nearly all features of physiology, body structure, or behaviour, individuals of the same species will differ to some degree. In many cases, these individuals' differences are unrelated to life, death, and reproduction. In other

cases, even slight differences can determine which individuals will live and reproduce and which individuals will die. It is in these cases that evolutionary selection is occurring (Darwin, 1859).

2.8.6 Developments in biology

“Does biology determine destiny and are men and women so different in every respect: intellectually, emotionally and in terms of their social relationships and careers? Alternatively, are they similar creatures falsely presumed to be ideally biologically equipped for a variety of non-interchangeable sex-linked roles?” (Walczak, 1988, pp.1).

Alongside the technological advances of the 1990s were those in biology, and many were related to sex/gender issues. Most controversial were those involving human and animal genetics, sparked by the Human Genome Project, which decoded the entire human genetic makeup (McConnell, 2001, p. 513). The ethical arguments, primarily related to right-to-life advocates, are holding up research in this area. (Begley, 2001).

Sex therapy educators Leiblum and Rosen (2000) refer to a “watershed event” (p. 3) that occurred in 1998 when the drug Viagra (sildenafil citrate) was approved as an oral treatment for erectile dysfunction, and “a tidal wave of demand for prescriptions” (p. 3) resulted in a “revolution” (p.3). The phenomenal sale of the drug quickly pushed its distributor, Pfizer, Inc., into first place for pharmaceutical sales. Previous treatments had involved injections or suppositories directly into the penis, and had been difficult for many men to deal with. As Leiblum and Rosen described, men of all ages and relationship status began to obtain prescriptions from general practitioners and specialists, as well as through Internet alternative sources. Although many viewed it as an aphrodisiac, it actually works to provide an erection simply by increasing blood flow to the penis. It does not serve as a sexual desire stimulant and does not work without sexual stimulation. Therefore there were some Viagra failures and subsequent lawsuits, which, along with deflating Pfizer, made apparent the need for education, training, and monitoring of its use, thus enhancing the profession of sex therapy. Forms of it are being used to treat female arousal and desire disorders, as well.

Biological studies of differences in the brains and hormones of the sexes gained popularity, and helped to support those advocates of sex differences of both the scientific and the popular genres. Books and articles on biological research related to differences proliferated during the late 1990s, and helped to popularise the ideas, such as Barash and Lipton (1997), Dabbs (2000), Blum (1997, 1999), Lacayo (2000), Levay (1993) and Moir & Jessel (1992).

Although simplified, relationship psychologist John Gray implied evolutionary theory in explaining sex/gender differences, and he emphasized biological differences in his approach, primarily that of the actual structures of the brain and the processes of the sex hormones. The material is actually very complicated to explain and to understand; however, it is intriguing to a wide public audience, evidenced by the number of books and articles being written on the subject, and its infusion into the realms of the general public.

One theme that recurs in these biological accounts are the findings that males tend to have more liberalization between the two brain hemispheres than females, resulting in a tendency to use more linear, organized, and focused thinking. Some researchers have claimed that female brains have a larger corpus callosum and anterior commissure, which connect the two hemispheres, allowing for more rapid access of various centers of both hemispheres (Durdan-Smith & Desimone, 1983; Moir & Jessel, 1991). This has been used to explain the tendency for female thinking to be more web-like or expansive in comparison to males (Fisher, 1998, p. 11). This brain difference has been described as enabling women to have a more abstract and expressive style of talking, moving quickly from one subject to another, and having the ability to think about and carry out several activities at one time. Blum disputes these findings (1996, pp. 47-48), stating that the actual findings have been too insignificant to constitute such behavioural differences.

The male tendency for more brain liberalization supports Gray's (1992) famous concept of the masculine cave, which he described as an intense focus on some activity, usually recreational, used to dissociate from problems and to relieve stress. Similarly, the idea of the larger connection between the two hemispheres in females supports his concept of females being naturally more talkative, and actually having a need to talk to relieve stress, since, biologically, they are not as proficient as males in using the cave-escape method. Perhaps brain liberalization differences also help to explain the slower sexual response in females when compared to men. Within this theory, females have a more difficult time clearing their mind of general problems and demands so that they can relax into and focus on the sexual experience. Men are taught, in Gray's approach, to be supportive to women as they talk to relieve stress. Likewise, women are taught to accept the cave phenomenon in men, and to be tolerant of it as something that is biologically determined and natural.

Similar to the criticisms of evolutionary studies, research on biological sex differences has been strongly criticized by the scientific and academic communities. Many of the studies are contradictory and inconclusive, and to fully understand the biological material is challenging. The simplifications by the media and other public writers can easily distort the findings and

implications of the studies. Nonetheless, it is an area of exciting new developments and intriguing theories.

To fully comprehend and appreciate human sex differences, an understanding of the evolutionary, hormonal, and ecological conditions that underlie sex differences in other species is essential, as noted earlier. In fact, a full understanding of human sex differences requires that one begins with a consideration of the evolution of sexual reproduction itself. This is so, because the substance of evolutionary selection is heritable individual differences, and the ultimate source of this variability—is sexual reproduction. In relation to asexual reproduction, sexual reproduction appears to provide a number of benefits, including the elimination of harmful mutations (Crow, 1997), ecological adaptation (Williams, 1975), and the generation of a complex and varied immune system (Hamilton & Zuk, 1982). In all of these cases, the result is greater variability, or individual differences, within sexually reproducing species than within asexually reproducing species.

Once sexual reproduction evolved, an essential feature of the life history of all individuals of sexually reproducing species is to find a mate, or mates. To further complicate this life-task, the individual variability that results from sexual reproduction will ensure that all potential mates are not equal, which, in turn, results in competition for the most suitable mate, or for the most mates. The process associated with choosing and competing for mates is sexual selection (Darwin, 1871). Sexual selection is a dynamic process that is influenced by a host of factors, including sex differences in the relative costs and benefits of reproduction (Trivers, 1972) and the ecology of the species (Emlen & Oring, 1977), among others. These dynamics are most typically expressed in terms of female choice of mating partners, and male-male competition over access to mates, or for control of those resources that females need to rear their offspring (Anderson, 1994). Following the discussion of the dynamics of female choice and male-male competition, the focus shifts to discussion of the mechanisms that influence the expression of the associated sex differences in brain, behaviour, and cognition, that is, sex hormones.

The research reviewed reveals that nearly all of the sex differences found in humans are evident in many other primate species. As an example, one of the more thoroughly studied aspects of primate social behaviour is male-male competition. For many species of primate, including humans in many contexts, males compete by means of physical attack and physical threat to establish social dominance over other males. Position within the resulting dominance hierarchy often has rather dramatic reproductive consequences for individual males. In many contexts, only the most dominant or alpha male sires offspring (e.g., Altmann

et al., 1996). The achievement of social dominance is complex, however. In some species, social dominance is achieved through one-on-one physical contests, in other species it is more dependent on the coalitional activities of groups of males, and in still other species it is influenced by the social support of females in the group (Dunbar, 1984; Goodall, 1986; Smuts, 1985).

With the exception of humans, female choice has not been as systematically studied in primates, as male-male competition or female choice in other species (e.g., birds). The research that has been conducted clearly indicates that females in many, if not all, primate species prefer some males to others as mating partners (Smuts, 1985). The basis for female choice appears to vary with social and ecological conditions, but is often influenced by infanticide risks and the social support that a male partner might provide (Hardy, 1979). For instance, in the olive baboon (*Papio anubis*) females prefer as mating partners those males who provide social protection (e.g., from other males) and other forms of care for them and their offspring (Smuts & Gubernick, 1992).

One of the more consistent consequences of male-male competition in primates is a larger and more aggressive male than females (Plavcan & van Schaik, 1997a). The more intense the male-male competition, the larger the sex difference in physical size, although these differences are somewhat less pronounced in species where male-male competition is coalition based, as in our cousin, the chimpanzee (*Pan troglodytes*) (Goodall, 1986). The consistent relation between physical sex differences and the intensity of male-male competition allows inferences to be drawn about the likely nature of male-male competition in our ancestors. Beginning with our Australopithecine ancestors and continuing to modern humans, males are physically larger than females. When these patterns are combined with the patterns of male-male competition and female choice that are evident in extant primates inferences can be, and are drawn about the potential pattern of sexual selection during the course of human evolution (Foley & Lee, 1989).

As with other primates, the dynamics of sexual selection in humans is complex and can vary from one culture or context (e.g., different historical periods within a culture) to the next. For instance, men throughout the world compete for cultural success (Irons, 1979), that is, they compete for control of culturally important resources and for the establishment of social status. Cultural success can be achieved in many different ways, ranging from obtaining the head of one's competitor to securing a high-paying job. However it is achieved, successful men typically have more wives and children, or at least more mating opportunities, than their less successful peers (Chagnon, 1988; Irons, 1993; Pé russe, 1993).

In this view, sex differences that are evident during development should be a reflection of later sex differences in reproductive strategies. More specifically, the research covers sex differences in physical development, during infancy, play patterns, social development, and parenting influences, all from the perspective of sexual selection. As an example, for primate species characterized by relatively intense male-male competition, males are not only larger than females; they also show a different pattern of physical development (Leigh, 1996). The most general pattern is for males to mature later than females and to show a longer growth spurt during puberty (this contributes to their larger size). For species in which there is relatively little male-male competition and a monogamous mating system, males are the same size as females and males and females show nearly identical growth patterns (Leigh, 1995).

Sex differences in human physical development follow the pattern found in species with relatively intense male-male competition (Tanner, 1990).

Sex differences in brain and cognition are approached using a proposed system of evolved cognitive modules developed. This system of modules corresponds to the motivation to control social, biological, and physical resources. Social modules, for instance, are divided into individual level cognitions—such as language, facial processing, and theory of mind (i.e., the ability to make inferences about the intentions, emotional states, and so on of other people)—and group-level cognitions—such as the formation of in-groups and out-groups. The use of this theoretical framework provides a unique organization to the research on human sex differences in brain and cognition, and reveals patterns that are consistent with the view that many of these sex differences have been shaped by sexual selection. As an example, while girls and boys and women and men readily classify other human beings in terms of favoured in-groups and disfavoured out-groups (Stephan, 1985), there appear to be sex differences in the dynamics of in-group and out-group formation. In comparison to girls and women, boys and men appear to place more social pressures on in-group members to conform to group mores, and appear to more easily develop antagonistic attitudes and behaviours towards members of an out-group, especially during periods of competition or conflict. The sex difference in the dynamics of in-group and out-group formation can be readily understood in terms of coalition-based male competition.

2.9 Resume

Sexuality is a complex challenge to all individuals. It occurs in a complex social context, where long-term relationships are important to successful social living. Sexual behaviour is both disruptive to these social relations, as well as important in maintaining them. This

seeming paradox — that sex both enhances and threatens social cohesion — suggests why sexual behaviour is sensitive to social context, and why adaptations have evolved allowing it to occur at any time and with few physiological restraints. This also suggests why the psychological effects of reproductive hormones are so important in primate sexuality. Without the strong interest in the opposite sex and the desire to engage in sexual intercourse produced by these hormones, sexual behaviour would be less likely to occur and would be only weakly coupled to fertility. The system of hormonally modulated sexual motivation combined with a physical capacity to mate at any time has evolved in primates to balance the social and reproductive uses of sex. Under some social contexts, such as low ranking females in strictly hierarchical social structures, sex is limited almost exclusively to reproductive contexts. In contrast, sex may be less limited to reproductive contexts in less rigidly hierarchical contexts, or when high social status removes hierarchical constraints. Under these conditions, sex serves social functions other than reproduction, including alliance formation and sexual affiliation. Increased sexual motivation coupled to fertility assures that sex is more likely to result in reproduction than it is likely to simply serve a nonreproductive social function.

Men are animals, and none of their functions is more deeply rooted in their animal nature than that of sexual reproduction. It is precisely in the day-to-day experience of sexual conduct that the idea of our 'animality' lies uppermost in our thoughts. We may condemn this or that act as 'bestial', but in doing so, we are usually aware of its overwhelming resemblance (at least when judged from a certain light or from a certain point of view) to other acts, which form the daily currency of sexual expression. And who could deny that, judged from the evolutionary point of view, the basic motor of all this elaborate ritual is reproduction, of a kind that occurs throughout the animal kingdom, and according to a rhythm that is common to almost all creatures who engage in it?

Gaining increasing popularity in the 1990s, related to the hotly debated question of sex/gender differences were studies in the area of evolutionary psychology.²⁷ Through these studies, Darwinian perspectives are being applied to sex differences within a new discipline called evolutionary psychology that attempts to identify underlying psychological mechanisms that are a product of evolution (Buss, 1994, p.3). The evolutionary perspective includes both social and biological constructs since the hominid world is so strongly affected by both. Ross (2000) explains that this kind of study is more accurately called socio-biology, and that the name evolutionary psychology advanced from negative reactions to the cultural implications of their various findings. Major studies and written works of this perspective have been completed by outstanding scientists in the various fields, often in collaboration

with each other (Cosmides & Tooby, 1987; Buss, 1989, 1994; Geary, 1998; Townsend, 1998).

A basic tenet of these studies is that our evolutionary past affects human behaviour, in spite of the modern environment. Within this view, natural selection for reproductive success has resulted in sexual strategies that are different for males and females. For instance, females have, over time, risked enormous investment secondary to offspring as a consequence of having sex; therefore females are interested in the resources that mates can provide and, to this end, are highly selective of mates, tending to withhold sex until they are assured of commitment. Reproductive success has been aligned with marriage in terms of intercourse availability and survival of offspring, so males have evolved to being desirous of marriage.

A major criticism is the theories' ineptness to date, of explaining same sex attraction, since it has been viewed as not supporting reproduction. Theorists have generally presented same sex attraction as an accidental happenstance, maladaptive, and insignificant. There are other valid criticisms of this perspective, particularly that the theories require imagination and are often "fanciful", since they require understanding of large time spans, even dating back to times when history was not in written form. (Buss, 1994.) The implications of the theories can be misused politically, as in supporting racial discrimination and sexual superiority. Many misinterpret the theory as explaining what should be, or is natural to be, and these studies allow little room for social adaptation to new situations brought about by social change. (Blustain, 2000).

In a broad sense, human sexuality is dependent on the future of sexual science. Advances in theory and research on the components of, and factors related to, human sexual experience allow for further growth regarding interventions to alleviate sexual dysfunction. However, it is also incumbent on those who actually perform sexuality interventions to elaborate their theoretical assumptions and test the relative efficacy of their interventions through empirical study; such is the aim of this thesis.

CHAPTER THREE: PROBLEMS AND PLEASURES

3.1 Introduction

To begin a psychological investigation into sexual dysfunction is not easy. The subject is encumbered by a number of conflicting prejudices, especially in terms of gender. This chapter will begin with a description since it is necessary to locate the phenomenon of sexual desire, or its lack thereof. In trying to dissect the problem of sexual dysfunction this chapter will attempt to discuss the conditions for sexual fulfilment. Sexual desire, like the human person, is as social artefact, and can be built in many ways. But if it is to be properly built, so that its fulfilment is available to those who experience its normal forms, then it must be given the institutional conditions that it demands intrinsically, since this stems from the inner quality of the most private human experience. The chapter will then turn to sexual relationship conflicts and solutions.

The purposes of this chapter are:

- to summarize some of the basic theoretical and empirical literature examining general relationship conflict patterns;
- to suggest a model for assessing general relationship conflict as a comorbid feature of sexual dysfunction;
- to suggest several objectives and solutions in treating the negative behaviours, cognitions, and emotions involved in the relationship conflict component of sexual dysfunction.

There is a general acceptance in the literature that this topic is under researched (Basson et al., 2000; Fugl-Meyer & Sjogren Fugl-Meyer, 1999; Glatt, Zinner & McCormack, 1990). Attempts to estimate the true population prevalence of sexual problems are important for a number of reasons.

- a) Firstly, such relevant information would aid in the determination of the number of people who may be helped by therapy. For example, Ansong, Lewis, Jenkins, and Bell (1998) report that only 32% of 649 men reporting impotence in their study said they had sought treatment.

- b) Secondly, such information would help determine the need for new or potential treatments, for example, Viagra and Sildenafil for male impotence; however, the argument applies equally to nonpharmacological treatments such as psychotherapy.
- c) Thirdly, such information would assist in planning the allocation of resources to solve problems.

3.2 Sexual dysfunction: overview of prevalence, etiological factors and treatments

In the absence of any physical pathology, sexual dysfunction is viewed as a learned phenomenon, maintained internally by performance anxiety, and externally by a nonreinforcing environment, namely the partner. In addition, a lack of sexual skill, knowledge, and communication on the part of one or both partners contributes to the dysfunction.

Sexual dysfunction has been found to interact with mental health conditions such as anxiety and depression. According to Kinsey, women were having more sex, but the question arose: was it the sort of sex that they wanted? A generation of experts thought not. Kinsey had noted that up to 50 per cent of women did not find sex pleasurable. He had also rediscovered the clitoral orgasm, which had been 'lost' or denied by the psychoanalysts. In his words, the vagina was 'of minimum importance in contributing to the erotic responses of the female' (Kinsey, Pomeroy, Gebhard, 1953, p.592).

Sexual dysfunctions and sexual problems are reviewed from the perspective of prevalence, broad etiological factors, and available treatments. Although a large percentage of individuals experience sexual problems the prevalence of sexual dysfunctions that meet diagnostic criteria is lower, and less well established by large-scale population-based studies. Sexual problems and dysfunctions are correlated with other health conditions, including cardiovascular disorders, common diseases such as diabetes, health habits, and mental health. Adequate sexual functioning also appears to be associated with personal well-being and relationship stability.

Efficacious and effective treatments exist for some of the sexual disorders, and there is an increasing focus on medical (particularly pharmacological) treatments. Sexual problems and dysfunctions have been notably under-researched, particularly from the perspective of consequences to individual mental health, relationships, and family functioning.

3.2.1 Prevalence estimates

Recent research indicates that sexual problems are highly prevalent in both sexes. Community samples estimates range from 10% to 52% of men and 25% to 63% of women (Feldman, Goldstein, Hatzichristou, Krane, & McKinlay, 1994; Frank, Anderson, & Rubenstein, 1978; Rosen, Taylor, Leiblum, & Bachman, 1993; Spector & Carey, 1990). The National Health and Social Life Survey (NHSLs), a 1992 national probability sample of 1410 men and 1749 women between the ages of 18 and 59 years living in U.S. households, comprises the best estimate of sexual problems in the U.S. (Laumann, Gagnon, Michael, & Michaels, 1994; Laumann, Paik, & Rosen, 1999). In the analyses which included only those individuals who reported any sexual activity with a partner in the 12-month period prior to the survey, the prevalence of sexual dysfunction was 43% for women and 31% for men (Laumann, et al., 1999). Although this study did not use the Diagnostic and Statistical Manual (DSM-IV, American Psychiatric Association, 1994) criteria, and thus does not connote clinical dysfunction, it provides an estimate of potential sexual dysfunction, and the researcher will often rely on these figures as the dysfunctions are discussed. Nevertheless, one must keep in mind that these are not formal clinical diagnostic categories, which in fact may overestimate the prevalence (e.g., Simons & Carey, 2001).

3.2.2 Etiological factors

Though data are scarce, there are some general etiological indicators that have been implicated in specific sexual dysfunctions. For example, the Massachusetts Male Aging Study (MMAS) reported erectile dysfunction in 34.8% of men aged 40 to 70 years old with the factors of age, health status (cardiovascular disease, diabetes, disease-related medications, cigarette smoking), and emotional factors (depression, anger) being highly related to the erectile disorder (Feldman et al., 1994). In the NHSLs, a variety of risk factors were identified using adjusted odds ratios (Laumann, Paik & Rosen, 1999). Demographic factors that influence reported problems included age, education, and race/ethnicity. For women, sexual problems, except for problems lubricating, tended to decrease with age; for men, erection problems in particular increased with age. Higher education was correlated with less dysfunction. Though race and ethnicity effects were more modest, Hispanics reported the least dysfunction, followed by the White and then the Black samples, which showed higher rates. Among the health and lifestyle variables, the NHSLs found that stress and emotional problems were related to experiencing sexual problems. Reported urinary tract infections were associated with sexual arousal and pain disorders in women and erectile dysfunction in men. Among the social status variables, all categories of female

sexual dysfunction were associated with decreasing household income while only erectile dysfunction was associated in men.

Liberal sexual attitudes were associated only with premature ejaculation in men. Several sexual experience variables were important. Men reporting any same-sex sexual activity were more likely to experience premature ejaculation and low sexual desire, than men who reported no same sex experience, though this variable did not differentiate for women (Travis & Travis, 1986). Arousal disorder in women was highly associated with their experience of adult-child sexual contact or any experience of male sexual force. Women's desire disorder was also associated with male sexual force. For men, being sexually touched before puberty was associated with a three-fold increase in erectile dysfunction and a two-fold increase in premature ejaculation and low sexual desire compared to men without this history. Men who reported sexually forcing a woman were 3.5 times as likely to report erectile dysfunction. While the MMAS and the NHLS data sets sample only a small percentage of potential etiological factors, they suggest that sexual dysfunctions are complexly determined and highly related to physical and psychosocial dimensions of an individual's life. This implies that preventative treatment measures would be useful, and that optimal treatments require careful histories and the ability to impact psychological and physiological sexual response.

3.2.3 Efficacy and sexual dysfunction treatment

In this thesis, the term sex therapy is defined broadly and refers to any systematic attempt by a health professional to alleviate sexual dysfunction or difficulties experienced by a specified client. In treating sexual problems with either pharmacological/medical or psychological techniques, one hopes for changes in physical (genital response, orgasms) and subjective (increased desire, ease of orgasm) responses. Psychological techniques use cognitive and/or behavioural methods to change sexual problems. Historically, this position was crystallized by Masters and Johnson (1970), whose work was as revolutionary in its time for impacting psychotherapy as sildenafil citrate (Viagra: Pfizer, Inc.) has been for pharmacological treatments. Medical treatments aim to change a person's physiological response. The focus of medical treatments for the past 20 years has been primarily on male erectile disorder, and only recently on premature ejaculation in men and sexual arousal and desire in women.

Before reviewing sexual dysfunction treatments, it is important to briefly note the differences between typical randomised clinical trials which test medications and those testing psychological interventions (Heiman & Meston, 1997). These include: (a) psychological

placebos require a consideration of many variables and, under most conditions, are ethically questionable; (b) double-blind designs are not feasible in psychosexual therapy; (c) treatment delivery systems are more variable in psychosexual therapy than in medication provision; (d) adequate comparison groups are needed and currently there are few available for psychological treatments; and (e) endpoints are more restricted and unidimensional in pharmacology clinical trials than in psychosexual studies.

In 1995, the American Psychological Association (APA) Task Force on the Promotion and Dissemination of Psychological Procedures proposed two categories of empirically supported treatments (ESTs): well-established and probably efficacious (APA, 1995). Well-established treatments require group studies by different investigators by showing superiority to another treatment or placebo, or by demonstrating equivalency to an established treatment in studies with adequate statistical power; or a large series of well-designed single case studies compared to another treatment or placebo; using treatment manuals and clear specification of patient/client samples.

Probably efficacious criteria are somewhat less stringent: two studies showing treatment is more effective than a waiting-list control group, or studies otherwise meeting well-established criteria, or at least two good studies demonstrating effectiveness, but flawed by client sample heterogeneity, or a small series of single case design studies otherwise meeting the well-established treatment criteria. Since the original report of the task force, there has been further discussion of the criteria and meaning of empirically supported treatment (e.g., Borkovec & Castonguay, 1998; Chambless & Hollon, 1998). There is recognition that some level of efficacy must be demonstrated with controlled research with a delineated population. Efficacy research is similar in scope and intent to traditional randomised clinical trial (RCT) research.

After establishing efficacy there is reason to examine treatment effectiveness or utility, referring to whether treatment can be shown to be beneficial in actual clinical practice. Effectiveness addresses the concept of generalisability, that a RCT is often unable to assess, since sample selection is more criteria restricted than in clinical practice. To test efficacy, quasi-experimental and nonexperimental designs may be usefully employed.

A number of sexual dysfunctions have treatment data that meet the probably efficacious criteria for an empirically supported treatment. Few meet the well-established criteria. Reasons for this are summarized elsewhere (Hieman & Meston, 1997). The primary issues have been funding and availability of comparable treatments and ethical placebos.

3.3 Empirically supported treatment by sexual dysfunction category

3.3.1 Sexual desire disorders

Although a Consensus Conference was convened in the late 1990s to propose revisions to the diagnostic system for female sexual dysfunction (Basson et al., 2000), the researcher will utilise the DSM-IV (APA, 1994) criteria since all of the research to date has had the DSM system available and it is the major diagnostic system used in U.S. research. The DSM-IV lists two categories of sexual desire disorders, Hypoactive Sexual Desire and Sexual Aversion. Hypoactive Sexual Desire (HSD) is defined as persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity. This sexual category is of special concern to women since the Laumann et al. (1994) national probability-sampled U.S. data revealed that 33.4% of women and 15.8% of men reported a lack of sexual interest for several months or more during the past year. Sexual Aversion refers to persistent or recurrent extreme aversion to, and avoidance of, genital sexual contact with a sexual partner. There are no prevalence figures available for sexual aversion but it is thought to be a rather rare disorder.

Although many different approaches have been tried on a case-by-case basis (Leiblum & Rosen, 1988), there are almost no controlled studies documenting an efficacious approach for either disorder in men or women. Recently, a waiting-list controlled study testing a cognitive-behavioural treatment for HSD has been reported to show improvement in sexual and marital functioning in women with HSD (Trudel et al., 2001). There is also one uncontrolled prepost study of "impaired sexual desire," using a modified Masters and Johnson (1970) approach with 154 British couples presenting for treatment (Hawton & Catalan, 1986). Only two of the men reported impaired sexual interest so their data cannot be discussed. However, of the 57% of the women reporting impaired desire, 56% were rated as having the problem largely or fully resolved after a mean of 14.8 treatment sessions. The treatment approaches cited would be promising treatments to compare to each other or to medications treating HSD.

Currently, there are no effective pharmacological agents for HSD in men or women. There is evidence that testosterone can be an effective treatment for individuals who are hypogonadal, or who have other conditions causing low levels of bio available testosterone (Davis, 1998; Heaton, 1998), but careful research specifically treating low sexual desire is lacking. One study has shown some promise for women who have had a hysterectomy and who used a transdermal testosterone patch compared to placebo in combination with oral conjugated equine estrogen (Shifren, Braunstein, Simon, Casson, Buster, Redmond, Bukri,

Ginsburg, Rosen, Leiblum, Caramelli & Mazer, 2000). At the higher testosterone dose, the women reported increases in fantasy, masturbation, and sexual intercourse as well as greater well being. However, the higher dose showed testosterone levels considerably above the normal premenopausal range, so longer-term effects of this dose will need to be studied further. The clinical and research data raise the obvious point that the hypoactive sexual desire category would be best subdivided into logical subcategories by age and hormonal status, as well as the DSM-IV modifiers of Lifelong/Acquired and Global/Situational (Heiman, 2001).

3.3.2 Sexual arousal disorders

Two categories of sexual arousal disorders are defined by DSM-IV: Female Sexual Arousal Disorder (FSAD) and Male Erectile Disorder (ED). In the DSM-IV, FSAD is described in terms of the inability to attain, or to maintain until completion of the sexual activity, an "adequate lubrication-swelling response of sexual excitement." A revision of this category by an international consensus panel proposed that this category include a lack of subjective excitement (Basson et al., 2000). There are no prevalence data for FSAD, and clinically it is rarely identified as separate from either sexual desire or orgasmic disorders. Of controlled studies specifically related to FSAD, none are published and few have been reported. Since the release of sildenafil citrate for men in 1998, there has been considerable interest in finding parallel agents for women. Sildenafil citrate, a phosphodiesterase inhibitor type 5, has a relaxant effect on human cavernous tissues (at this point still best demonstrated in the male penis as only indirect data exist for the human female).

Several different pharmaceutical agents are under investigation, including those with more peripheral action on genital vasocongestion such as sildenafil citrate and L-arginine, and those acting on the brain such as apomorphine HCl, a dopaminergic chemical (Bartlik, Kaplan, Kaminetsky, Roentsch, & Goldberg, 1999; Everaerd & Laan, 2000). No differences in female sexual arousal were found when sildenafil was compared to a placebo in a double-blind study of over 500 women with FSAD in Canada, Europe, and the U.K. (Basson et al., 2000). In sexually functional premenopausal women in The Netherlands, sildenafil produced greater vaginal vasocongestion than did placebo to sexually explicit stimuli in a laboratory study. However, there was no difference in genital or subjective response when sildenafil was compared to placebo in postmenopausal women with FSAD (Laan, van Lunsen, Everaerd, Heiman, & Hackbert, 2000). The only study thus far to show significant a change in sexual functioning was a study of young (ages 22-28) Italian women with arousal disorders (Caruso, Intelisano, Lupo, & Agnello, 2001). All were ovulating normally and not on hormonal

medications. Arousal, orgasm, and the frequency of enjoyment and vaginal intercourse improved significantly in the women treated with 25mg or 50mg of sildenafil. At this point it is unclear whether sildenafil might be effective for a specific subgroup among women with sexual dysfunction. Given the lack of genital focus of women, it is possible that genitally targeted pharmacological agents would be best compared to and combined with psychological treatments.

Male ED is a common clinical complaint, though only 10.4% of men between 18 and 59 years of age reported it being a problem in the past year (Laumann et al, 1994). ED prevalence increases with age (Feldman et al., 1994; Laumann et al., 1999). It is defined as the persistent or recurrent inability to attain or maintain an adequate erection until the completion of the sexual activity. The primary psychological treatments that have been used to treat ED are systematic desensitisation and general sex therapy that includes a combination of education, sensate focus exercises, and sexual communication skills. Of the six (N = 146 men) comparison controlled studies, systematic desensitisation was found to be better than psychoanalytic treatment and an attention placebo (Heiman & Meston, 1997). Among the wait-list and own controlled studies (N = 85), masturbation, sex education, behavioural assignments, and communication skills resulted in increased satisfaction with erectile functioning, sexual frequency, and increased marital satisfaction (Heiman & Meston, 1997).

Erectile dysfunction in men is unique among the sexual dysfunctions for the variety of medical treatments available (prostheses, injections or urethral suppositories of PGE-1, vacuum devices) but a completely different option for treatment began with the emergence of sildenafil (Goldstein, Lue, Padma-Nathan, Rosen, Steers, & Wicker, 1998). Sildenafil marked the beginning of an effective and relatively safe pharmacological agent for treating ED with a variety of etiologies, including psychogenic or non-illness, non-injury induced erectile disorder. In addition, this medication could be taken 1 hour prior to sexual activity as opposed to continuously. The appeal and success of sildenafil has stimulated interest in other medications for ED, including other phosphodiesterase inhibitors, and they are currently in various stages of research (Rowland & Burnett, 2000).

3.3.3 Orgasmic disorders

These disorders include Female Orgasmic Disorder, Male Orgasmic Disorder, and Premature Ejaculation. Female Orgasmic Disorder is defined in the DSM-IV as persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase. Difficulty with orgasm is common, reported by 24.1% (Lauman et al., 1994). There are

effective psychological treatments for this disorder, although treatments are more effective for primary (never experiencing orgasm) than secondary (infrequent or situational) orgasmic problems (Andersen, 1983; Heiman, 2000). Across all comparison controlled studies (N=577), using 6 to 14 sessions, directed masturbation (DM) was more effective than systematic desensitisation; and DM plus sensate focus was more effective than sensate focus alone (Heiman & Meston, 1997). Although group, individual, and couple therapies appear to be effective, comparisons between them are too infrequent to make any conclusions. For most criteria, primary orgasmic disorder fits the well-established efficacy designation, and secondary orgasmic disorder fits the probably efficacious criteria. The difficulty with these designations is that most of the studies have significant weaknesses in how well they characterize their samples.

Male Orgasmic Disorder is uncommon, with 8.3% of men reporting problems with lack of orgasm in the past year (Laumann et al., 1994) and it being rather rarely treated in clinics. There are no controlled treatment studies for this condition, though there are case examples and the original Masters and Johnson (1970) program data.

For both female and male orgasmic disorder, a new sub-category has emerged in the past decade, related to pharmacologically induced orgasmic disorder. This refers primarily to the selective serotonin reuptake inhibitor (SSRI) class of drugs, which have the known side effect of delayed or absent orgasm in men and women. Other psychotropic medications, including other antidepressants, have been found to affect sexual functioning but with more variable impacts and lower rates of being prescribed (Meston & Frohlich, 2000; Rosen, Lane, & Menza, 1999). Though exact frequencies are rarely documented, orgasmic disorder side-effects seem to be reported in 9% to 40% of patients taking SSRIs, with females reporting symptoms more often than men (Rosen et al., 1999). There are no prospective comparative studies comparing hypothesized augmentation (to SSRI) agents (Rosen et al., 1999), though one recent report of women on flouxetine suggests that adding dopaminergic and serotonergic agents did not improve the sexual side effect more than the placebo (Michelson, Bancroft, Targum, Kim, & Tepner, 2000). It is unlikely that pharmacologically induced orgasmic disorder can be impacted by a psychological intervention alone.

Premature ejaculation is defined as the persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration, and before the person desires it. It is the most common sexual problem reported in men, with approximately 28.5% of U.S. men reporting it to be a problem during the past year (Laumann, et al., 1994). The primary psychological intervention that has been used for premature ejaculation is the squeeze

technique (Masters and Johnson, 1970). This technique involves stimulating the penis to full erection and almost to the point of ejaculation (“moment of inevitability”) and then applying a firm squeeze just below the glans of the penis. Stimulation then resumes, and two more trials occur before the person allows himself to ejaculate. It is usually first practiced in masturbation and then in partner sex. Although Masters and Johnson (1970) found excellent success (97% treatment success) treating 189 men with this condition, they had no comparison group. The only controlled (own-control) study testing this procedure found that foreplay duration significantly increased, as did intercourse duration (Heiman & LoPiccolo, 1983). Some of these gains decreased at 3-month follow-up post therapy (Heiman & Meston, 1997). The pause technique, a variant of the squeeze technique, is often used by clinicians (e.g. Kaplan, 1989), but there do not appear to be efficacy evaluations of this technique.

The SSI side effect of orgasm delay has been incorporated into the pharmacological treatment of premature ejaculation. Clomipramine, sertraline, fluoxetine, and paroxetine have been tested in placebo-controlled or comparison treatment studies, and have been found to significantly increase latency to ejaculation (Althof, 1995, Althof et al., 1995; Rowland & Burnett, 2000) and sexual satisfaction (Althof, 1995). Thus pharmacological intervention can be a reliable source of improving ejaculation latency, and possibly of sexual satisfaction for those men who wish to take medication for this condition (Rowland & Burnett, 2000). There is no evidence to date that the medications can be discontinued without the premature ejaculation returning.

3.3.4 Genital pain disorders

The two categories of pain disorders are Dyspareunia and Vaginismus. Vaginismus without concurrent dyspareunia appears to be a relatively rare condition. Over their 5-year study, Masters and Johnson (1970) treated only 29 women with vaginismus compared to 342 women who were treated for orgasmic disorders. The low prevalence of this condition may play a role in the fact that there are no treatment comparison studies. There are two uncontrolled studies (total N= 54) plus a number of case studies. Almost all studies used a gradual dilation procedure with considerable success. Completed sexual intercourse was possible in approximately 75% to 100% of women by the end of treatment. In the past 10 years, perineal biofeedback procedures have been used for both diagnosis and treatment of vaginismus, though no empirical data are available for this diagnosis (Galzer, Rodke, Swencionis, Hertz, & Young, 1995). There is considerable evidence that this is a promising

and useful procedure either by itself or with dilators, and sex therapy, but to date no comparison studies have been published.

Dyspareunia generally refers to pain associated with intercourse, but the location, duration, and patterns of pain can be quite variable. Dyspareunia is defined as pain during sexual intercourse. The NSHLS survey asked about "pain during sexual activity" and found that 3% of men and 14.4% of women reported this as a problem during the past 12 months (Lauman et al., 1994). Vulvar vestibulitis syndrome (VVS) is thought to be the most common subcategory of dyspareunia and it has a more precise diagnosis (Bergeron, Binik, Khalife, & Pagidas, 1997; Geotsch, 1991). There are very limited reports of treatment success with the general category of dyspareunia and no controlled studies. However, there are some suggestions from research with VVS patients that a psychological treatment may be helpful (Bergeron et al., 1997; Glazer Rodke, Swencionis, Hertz & Young, 1995). Bergeron reported on a randomised comparison study and found that vestibulectomy resulted in significantly higher rates of improvement than biofeedback or a pain management/sex therapy intervention. However, mean levels of self-reported pain during intercourse were significantly lower at post-treatment for all three-treatment conditions, and vestibulectomy patients were not significantly different from biofeedback patients on this measure. Perineal biofeedback may be particularly effective when there is presumed hypertonicity of the pelvic floor muscles. Preliminary work by Glazer et al., (1995) found that after 28 weeks of biofeedback training practice, 17 out of 33 women with VVS reported pain-free intercourse.

In spite of indications of effective treatment for a notable number of women with genital pain disorders, the lack of controlled studies prevents us from concluding that there are any clearly efficacious treatments for women. Given the more recent research, we can expect that new treatments will evolve that will be combination therapies of more than one intervention for the majority of cases (Bergeron, 1999).

Sexual dysfunctions are characterized by disturbances in sexual desire and in the psychophysiological changes associated with the sexual response cycle in men and women (American Psychiatric Association; 1994: 493-522). Sexual problems are common in the general population (Lewin & King; 1997: 4132), and textbooks emphasise their association with other areas of people's lives, including sexual functioning, psychological status, and physical illness (Usher & Baker, 1993). The area of people's social life that is thought to have the most relevance to sexual problems is that of difficulties with marriage or long-term relationships.

Despite increasing demand for clinical services and the potential impact of these disorders on interpersonal relationships and quality of life, epidemiological data are relatively scant (Morokoff & Gilliland; 1993: 43-53; Fugl-Meyer A.R., Lodnert, Branholm & Fugl-Meyer K.S.; 1997: 141-148). Based on the few available community studies, it appears that sexual dysfunctions are highly prevalent in both sexes, ranging from 10% to 52% of men and 25% to 63% of women (Frank, Anderson & Rubinstein; 1978: 111-115; Rosen, Taylor, Leiblum & Bachmann; 1993: 171-188; Spector & Carey; 1990: 389-408).

Professional and public interest in sexual dysfunction has recently been sparked by developments in several areas. First, major advances have occurred in our understanding of the neurovascular mechanisms of sexual response in men and women (Raifer, Aronson, Bush, Dorey & Ignarro; 1992: 90-94; Burnett, 1995: 485-489; Park, Goldstein; Andry, Siroky, Krane & Azadozi; 1997: 27-37).

Several new classes of drugs have been identified that offer significant therapeutic potential for the treatment of male erectile disorder, (Boolell, Gepi-Attee, Gingell & Allen; 1996: 257-261; Heaton, Morales, Adams, Johnston & el-Rashidy; 1995: 200-206; Morales, Heaton, Johnston & Adams; 1995: 879-886) while other agents have been proposed for sexual desire and orgasm disorders (Rosen & Ashton; 1993: 521-543; Seagraves, Saran & Seagraves; 1993: 198-200). Availability of these drugs could increase dramatically the number of patients seeking professional help for these problems. Epidemiological data would be of obvious value in developing appropriate service delivery and resource allocation models. Additionally, changing cultural attitudes, and demographic shifts in the population have highlighted the pervasiveness of sexual concerns in all ethnic and age groups. Sexual dysfunction is common at any age. The most common problems are loss of sexual drive, anorgasmia, vaginismus in women, and erectile failure and premature ejaculation in men. Up to 38% of women report anxiety and inhibition during sexual activity, 16% complain of lack of pleasure, and 15% have difficulties reaching orgasm (Rosen, Taylor, Lieblum & Bachmann; 1993:171-188). Up to 40% of middle aged men report some kind of sexual dysfunction (Solstad & Hertoft; 1993: 51-8). The dysfunction may be purely psychological or physical but is usually a mixture of two (Crowe & Jones; 1992: 474-82).

It is convenient to consider sexual problems as dichotomies (organic or psychogenic, primary or secondary, male or female), but such distinctions are often inaccurate and unhelpful. The presence of a problem is a subjective perception influenced by many factors. However, there is no doubt that for most men and women sexuality is a highly rated aspect of their quality of life.

From various studies in the general population and primary care it seems that 15-20% of men describe some sort of sexual problem. The proportion of men who actually seek help is unknown. For many men this is difficult, and their presentation may be hesitant or disguised in terms of another complaint.

3.4 Problems in paradise

3.4.1 Assessing the role of relationship conflict in sexual dysfunction

The presence of unresolved conflict in couples' relationships has long been thought to cause or maintain sexual dysfunctions, as well as influence the outcome of therapeutic interventions for sexual problems. However, empirical studies of the causes of sexual dysfunction are rare. Most published reports are clinical observations and uncontrolled studies. Nevertheless, multiple clinical observations suggest a strong association between relationship conflict and sexual dysfunction (Hartman, 1980a, 1980b; Heiman, LoPiccolo, 1981; Hof, 1987; Kaplan, 1974; McCarthy, 1998, 1999; Metz & Dwyer, 1993; Rosen & Leeiblum, 1992).

Conflicts are inevitable among couples, and how these conflicts are handled can have a major impact on satisfaction in relationships, such as the attributions that partners make about each other's intentions (Bradbury & Fincham, 1992) and the ways that partners interact (Gottam, 1994, 1999). Clinical reports suggest a bi-directional causal link between unresolved or escalating relationship conflict (regarding nonsexual as well as sexual areas) and the development of sexual dysfunction. On the one hand, distressing relationship conflict can interfere with sexual desire, arousal, and intimate behaviour. On the other hand, sexual dysfunction may give rise to increased conflict and distress in a couple's overall relationship.

3.4.2 The influence of the quality of relationship on sexual dysfunction

There has been a substantial body of research, which has explored the role of the quality of the relationship on the sexual functioning of the partners. Some studies have examined particular variables, while others have pursued the impact of the broader relationship dimensions (McCabe, 1994: 2-8). A number of studies have focused on events, others on attitudes. The subject population has varied from those in satisfied relationships, to those experiencing relationship distresses to those with problems in sexual functioning. The results from this research are often conflicting and, at first sight, difficult to interpret.

Synder and Berg (1983) found that the major causes of sexual problems in males and females related to the quality of their interactions with their partner. The general level of enjoyment of sexual activities, as well as satisfaction with the frequency of sexual activities was associated with sexual distress. Lack of affection for the partner was also an important predictor of sexual dissatisfaction.

Similarly, Wiseman (1985) found that although heavy drinking contributed to the sexual dysfunction of alcoholic men, the relationship these men had with their partner also played a part. Wiseman interviewed partners of both alcoholic and non-alcoholic men. The results indicated that problems in other areas of the relationship, as well as a lack of information about skills needed in sexual play, were imperative contributors to sexual problems in both groups of men. It was these problems, combined with the effects of alcohol on sexual performance, rather than the alcohol on its own, which impeded the sexual functioning of alcoholic men.

Pietropinto (1986) found that the most prevalent rationale for sexual problems among females was a scarcity of knowledge among their partners of their sexual desires, and a lack of communication between partners. Likewise, a paucity of communication in the sexual arena was found by Hoch, Safir, Peres and Shepher (1981) to be the primary factor contributing to the sexual dysfunction. In this study, Hoch et al., (1981) established that there was an insufficiency of imperative information about the desire for various interactions experienced by the partner. A further finding was that males in dysfunctional couples were more likely to initiate sexual activities than males in functional relationships. As a result, females within the dysfunctional population were more likely to comply with a request for intercourse when they were sexually uninterested, which led to a reinforcement of their negative attitudes towards sex.

An association between sexual assertiveness and sexual functioning was recognized by Hurlbert (1991). He found that sexually assertive women were more likely than non-assertive women to report higher frequencies of sexual activities and orgasms, increased levels of sexual desire, as well as greater marital and sexual satisfaction. In direct contrast to these findings are results reported by Heiman, Gladue, Roberts and LoPiccolo (1986). Heiman et al., (1986) found that sexual satisfaction and marital satisfaction could be experienced quite independently of one another. Further, they found that sexual satisfaction could be accomplished even when a sexual problem occurred. This finding also applied to non-clinical respondents who reported high levels of sexual satisfaction, even though they also reported the presence of a sexual dysfunction. It may be the approach in which the

sexual interaction and level of communication with one's partner is viewed that relates to the sexual dysfunction, rather than the objective levels of sexual interaction and communication patterns.

Mehrabian and Stanton-Mohr (1985) indisputably provided data to support this proposal. They investigated the effects of emotional condition on sexual desire and sexual dysfunction. They found that sexual desire was greater when respondents experienced pleasure, arousal and dominance, regardless of how these emotions were achieved.

Similarly, Beer and Barlow (1984) cautioned that anxiety might play different roles in precipitating and maintaining sexual dysfunction depending upon how this level of arousal is cognitively processed. This model was further developed by Barlow (1986) in which he provided evidence for associations between arousal levels, labelling of this arousal in either a positive or negative manner or sexual dysfunction. To further explore this relationship, Bozman and Beck (1991) examined sexual desire and sexual arousal under anxiety or anger-provoking conditions. Sexual desire, but not sexual arousal, was encumbered in the anxiety condition, and both sexual desire and sexual arousal were impeded in the anger condition.

Roffe and Britte (1981) found evidence for extreme levels of antagonism among couples seeking sexual dysfunction therapy. However, they also found that a lack of expressiveness and low levels of affection within the relationship contributed to sexual dysfunction.

The study of the association between sexual dysfunction and relationship harmony has produced some conflicting results. McCabe's (1994) study was concerned with the impact of a range of sexual and non-sexual relationship factors, feelings about those factors and the desire to alter them, on the severity of sexual dysfunction. Functional, non-clinical dysfunctional and clinically dysfunctional males and females took part in this study. They completed a self-report questionnaire measure, which assessed sexual and non-sexual dimensions of their relationship, as well as the presence, frequency and duration of any sexual dysfunction. There were no differences between the non-clinical dysfunctional and clinically dysfunctional subjects. Dysfunctional subjects were more likely to have experienced instability, extra-marital relationships, conflict, and a lack of communication in their relationships than functional subjects. The findings suggest that it is not sexual experiences per se which are associated with sexual dysfunction, but rather the feelings associated with these experiences and the desire for adjustment.

3.4.3 Intimacy and quality of life among sexually dysfunctional men and women

There are many different approaches to the study of intimacy in a committed relationship and quality of life among sexually functional and dysfunctional men and women. Many studies have not directly evaluated intimacy, but have investigated relationships between intimacy and sexual functioning by focusing on factors related to intimacy such as marital satisfaction. Stuart, Hammond, and Pett (1987) found that a number of relationship factors were associated with inhibited sexual desire (ISD) among women. The findings of this study revealed that women with ISD were more likely to experience lower levels of emotional closeness, love, and romantic love. Although there were no differences between the ISD and non-ISD participants in the level of satisfaction with the amount of time they spent talking with their spouse, and so the interpersonal aspect of intimacy, there was a difference between the groups in the level of emotional intimacy.

Synder and Berg (1983: 237-246) found that for both men and women, sexual dysfunction was associated with a partner's lack of response to sexual requests, infrequent intercourse, and lack of affection for the partner. These findings suggest that a lack of sexual intimacy accompanied sexual dysfunction, as well as the possibility of decrements in other areas of intimacy.

Donnelly (1993:171-179) found that there were many markers of a lack of intimacy among people who were involved in sexually inactive marriages. There were lower levels of marital happiness, fewer shared activities, and fewer arguments over sex. These findings seem to indicate that a lack of sexual activity is associated with lower levels of connectedness between couples, even to the point that they are no longer discussing their sexual difficulties.

Morokoff and Gilliland (1993: 43-53) discovered that marital satisfaction mediated the level of stress and also the level of sexual dysfunction in men. The particular aspects of marital satisfaction that produced these findings are unclear, but since intimacy is related to marital satisfaction (Fish & Sprenkle, 1984: 3-12), men with high levels of intimacy may cope better with stress and so experience lower levels of sexual dysfunction. Although McCabe (1992: 288-296) also demonstrated problems with intimacy among sexually dysfunctional men, this finding was refuted by Donahey and Carroll (1993: 25-40), who found that both intrapersonal and interpersonal problems were more likely to lead to ISD in women, than in men.

In contrast to the above findings, Hartman (1980: 560-563) found that although inadequate interpersonal relationships and lack of communication may sometimes be associated with sexual dysfunction, this is not always the case. However the data from Hartman's study

were based on a sample of 20 couples that were divided into four sub-groups, and so the confidence and reliability that can be placed on these findings is limited.

A number of theoretical models have been developed to explain the interrelationships between intimacy and sexual dysfunction. Fish et al., (1984: 3-12) proposed that a lack of intimacy reflects relational problems, which in turn lead to sexual dysfunction. Within their theoretical model, Fish et al., (1984) suggested that ISD serves as a distance regulator in a relationship; the ISD stems from the low levels of intimacy in the relationship. If an individual in a relationship feels too close to his or her partner, and there is a fear of too much intimacy, ISD is used to create distance. This theory was illustrated by Fish et al., (1984) through the use of a case study, but there are no data from a larger population to indicate whether this theory is supported, or if it can be generalized to other types of sexual dysfunction.

Travis and Travis (1986: 21-27) further explored the relationship between ISD and intimacy. They suggested that intimacy is composed of three aspects: erotic intimacy, sensory intimacy, and viewing the partner as a special person. They proposed that deficits in some or all of these areas would result in sexual dysfunction, most particularly ISD. Although Travis and Travis (1986) indicated that this view had been tested and supported in sex therapy over a period of 11 years, no data were presented to support the validity of the model. Further, other aspects of intimacy and their contribution to other types of sexual dysfunction were not considered.

A similar argument was developed by Talmadge and Talmadge (1986:3-21), who claimed that a lack of intimacy is at the source of ISD. Aspects of their therapeutic model were illustrated by use of case studies. Their theory was drawn from a psychodynamic base, and defined intimacy as "trust, interdependence, vulnerability, power, mutuality and the knowing and seeking of self" (p. 8). However, Talmadge and Talmadge did not make it clear how this definition of intimacy can be operationalized into assessment measures, and so an evaluation of their model is problematic.

Although claiming that intimacy is something different from sexual desire, McCarthy (1995:132-141) stated that people need to value intimacy within their relationship if they want their sexual desire to remain strong. McCarthy (1995) emphasized the importance of both emotional and sexual intimacy and claimed that the valuing of intimacy was primarily a male problem. However, no data were presented to support the proposed strategies to enhance sexual desire.

The above studies generally support the suggestion that lack of intimacy is an important factor contributing to sexual dysfunction. However they leave many questions unanswered. It is not clear whether a lack of intimacy is likely to be associated with sexual dysfunction among both men and women. These studies have largely focused on ISD, but the impact of a lack of intimacy on other sexual dysfunctions has not been addressed. Further, the theories are frequently not supported by research data, or case studies are the only data presented to support the proposed relationships between intimacy and sexual functioning. Finally, the above studies have considered a very limited range of intimacy dimensions (for example considering one or two aspects of intimacy); it is important to determine which aspects of intimacy are associated with which sexual dysfunctions for men and women.

The second variable evaluated in this review is the association between quality of life and sexual dysfunction. Bell and Bell (1972: 136-144) and Masters and Johnson (1970) found that sexual satisfaction was associated with both life satisfaction and well-being. More recently, Donnelly (1993: 171-179) found no relationship between sexual activity, which has some relationship with sexual dysfunction, and either of these variables. Donnelly's findings were obtained from a sample of 6,029 married people and applied to both men and women. However, conclusions were drawn from responses to single questions, and so the study may not adequately have evaluated the association between quality of life and sexual dysfunction. A consideration of the above studies seems to suggest that some aspects of quality of life may be associated with sexual dysfunction, whereas others are not. However, no theoretical models have been developed to explain the associations between quality of life and sexual dysfunction. Further, it is not clear whether these factors may vary for different dysfunctions or may be different for men and women.

3.4.4 General findings from studies of conflict resolution in couples

Conflict features are strongly associated with marital quality. Findings from empirical studies examining conflict in intimate relationships (Baucom & Epstein, 1990; Fincham & Beach, 1999; Weiss & Heyman, 1990) suggest a number of conclusions:

First, it is both common and normal for couples to have disagreements or conflicts. The important factor is how constructively couples resolve their differences, either by instituting mutually acceptable behaviour changes, or by deciding that aspects of their differences are unchangeable but acceptable (Epstein, Baucom, & Rankin, 1993; Gottman, 1999; Jacobson & Christensen, 1996; Markham, 1990).

Second, couples who resolve their conflicts with mutual satisfaction tend to be more satisfied with their relationships than couples who do not (Christensen & Shenk, 1991; Gottman, 1993a; Markman, Floyd, Stanley, & Storaasli, 1998; Metz, Rosser, & Strapko, 1994). Baucom, Epstein, Rankin, and Burnett (1996b) found that individuals' marital satisfaction was more strongly associated with the degree to which they were satisfied with the ways in which their personal relationship standards (the characteristics that they believed their relationships should have) were being met, than with the degree to which the two partners' standards were similar. Thus, couples that find ways to adapt to areas of conflict experience overall relationship satisfaction.

Third, individuals' cognitions about their relationships influence how satisfied or distressed they are in the relationships, and how they communicate with their partners (Baucom & Epstein, 1990; Epstein & Baucom, 1993; Fincham et al., 2000). Concerning the cognition-behaviour link, Bradbury and Fincham (1992) and Miller and Bradbury (1995) found that individuals (particularly wives) who made negative attributions about their partners' intentions and responsibility for negative behaviour, engaged in less supportive and more negative behaviour, as well as more negative reciprocation of their partners' negative acts during problem-solving discussions with their partners. Similarly, Bradbury and Fincham (1993) found that spouses' adherence to unrealistic relationship beliefs (assumptions and standards) was associated with their negative behaviour toward each other during problem-solving discussions.

Fourth, differences in conflict-resolution styles are associated with levels of relationship satisfaction (Christensen & Heavey, 1990; Epstein et al., 1993; Gottman, 1994; Metz et al., 1994), and are different among satisfied couples, physically abusive couples, and non-abusive yet discordant couples (Berns, Jacobson, & Gottman, 1999; Rosenbaum & O'Leary, 1981; Schaap, 1984). Relationship satisfaction is moderated by the process or manner in which a couple manages conflict (Christensen, 1988; Christensen & Walczynski, 1997; Gottman, 1993b). Couples who address their conflicts with constructive styles (for example, assertion, cooperation), avoid destructive styles (for example aggression, withdrawal), and resolve their conflicts with equity and mutual emotional satisfaction are more likely to be satisfied with their relationship and not divorce (Gottman, 1994; Weiss & Heyman, 1990). Various studies comparing distressed with non-distressed relationships have found that distressed partners: (a) engage in less-assertive behaviour (constructive verbal behaviours, such as calmly discussing issues together; Epstein, DeGiovanni, & Jayne-Lazarus, 1978; Gambrell, 1977; Metz & Dwyer, 1993); (b) exchange aggression (negative verbal and nonverbal behaviours, such as criticism or pushing/ slapping; Christensen & Shenk, 1991;

Heavey, Christensen, & Malamuth, 1995; Metz & Dwyer, 1993; O'Leary & Curley, 1986); (c) withdraw more from each other (Gottman & Krokoff, 1989; Heavey et al., 1995; Metz & Dwyer, 1993); and (d) behave in more-submissive or acquiescent ways (Lloyd, 1990). Evidence suggests that expressions of criticism, contempt, and disgust are detrimental behaviours (Gottman, 1994).

Fifth, in distressed relationships, there tends to be a gender difference in the ways that partners deal with relationship conflict; women more commonly engage their partners with verbally demanding behaviour when conflict occurs, whereas men more commonly avoid their partners or withdraw when conflict occurs (Christensen & Shenk, 1991; Gottman & Krokoff, 1989; Gottman, 1993a, 1993b; Heavey et al., 1995; Metz & Dwyer, 1993). However, Klinetob and Smith (1996) pointed out that the studies found this gender difference tended to ask couples to discuss topics that were more relevant to females than to males (e.g., intimacy, contraception and child-rearing practices). Klinetob and Smith allowed couples to identify areas in which they would like their partners to make changes, and had the couple hold two discussions, one for the topic that each person considered the most important one on his or her list. The results of the study indicated significantly more woman demand/man withdraw behaviour during the discussion of the women's top issue, but significantly more man demand/woman withdraw behaviour during discussions of the man's most important issue. Thus it is crucial to avoid stereotyping gender patterns in partner's conflict styles; salience of the issue to each party also affects conflict behaviour.

An interesting question about relationship conflict is whether there is biological gender differences in response to conflict that may produce the patterns noted among distressed couples. There is some empirical evidence that men and women react differently physiologically to couple conflict. Gottman and Levenson (1992) reported that men, compared to women, react to disagreements with a heart rate of 10-12 beats per minute more, experience accelerated respiration, and exhibit higher levels of epinephrine release in their endocrine system, which may facilitate quicker and more severe reactions. A study by Kiecolt-Glaser and colleagues (1996), however, suggested that certain hostile conflicts might accelerate women's stress hormones as well.

In contrast to physiological explanations of gender differences in conflict behaviour, feminist theorists have argued that differences reflect power differentials in male-female relationships (Julien, Arellano, & Turgeon, 1997). In this view women, who traditionally have less power as a result of gender roles and deficits in career and economic resources, pursue their male

partners in order to change the status quo. In contrast, males avoid or withdraw from conflict resolution in order to maintain the status quo in which they have more powerful positions.

Sixth, whatever actual gender tendencies may exist, among satisfied couples gender-typed conflict-resolution behaviours are less likely to be found (Metz & Dwyer, 1993). Members of satisfied couples tend to use familiar conflict resolution styles in order to reconcile their differences and achieve mutually acceptable conflict resolution.

As noted from the study, clinical writers have proposed that although positive conflict resolution can facilitate positive sexual feelings in a relationship, a negative process of conflict resolution can play a direct or indirect negative role in sexual dysfunction, through its injurious effect on the emotional environment of sexual activity, as well as on the couple's general relationship. In turn it is also thought that sexual dysfunction, which may at times have a physical cause, can undermine a couple's overall sense of intimacy and mutual acceptance, thereby creating a negative atmosphere for resolving conflicts in the relationship. In this case, sexual dysfunction caused by non-relationship features (for example, biological or psychological factors in an individual) may have a detrimental effect on a couple's conflict resolution.

Past as well as more recent proposals in the clinical literature have regularly associated sexual dysfunction with interpersonal conflict. For example, Kaplan (1974) and Sager (1976) viewed "resistance" in sexual therapy as evidence of unresolved marital conflict that was the source of the sexual dysfunction. Dickes and Strauss (1980) suggested that relationship conflict played a greater role in sexual dysfunction than was previously considered, and offered the observation that in some relationships, it was when the sexual dysfunction was successfully treated, that a new problem developed, suggesting that the underlying relationship conflict was unresolved. More recently, Hof (1987), Spence (1991), and McCabe and Cobain (1998) have described the importance of treating the conflicted marital component of sexual dysfunction, and McCarthy (1998; 1999) has argued that negative relationship conflict and other negative marital styles contribute to sexual dysfunction, which in turn deprives a marriage of intimacy and vitality.

There are a number of empirical studies that suggest a role for relationship conflict in sexual dysfunction, and point to either a possible etiologic association or the importance of addressing conflict-interaction patterns in achieving successful sex therapy (McCabe, 1994; Heiman, Gladue, Roberts and Lo Piccolo; 1986). In a cross sectional population survey of 789 men and 979 women conducted by Dunn, Croft, and Hackett (1999), sexual problems

among men were associated with anxiety and medical problems, whereas for women sexual dysfunction was associated with marital difficulties. Stravynsky, Gaudette, Lesage, Arbel, Petit, Clerc, Fabian, Lamontagne, Langiois, Lipp & Sidoun (1997) conducted a controlled study of three behavioural group approaches to treating sexually dysfunctional men and noted that sex therapy that included attention to the man's "interpersonal difficulties" resulted in significantly better outcomes overall. O'Farrell, Choquette, Cutter, and Birchler (1997) found that both alcoholic and non-alcoholic maritally conflicted couples reported more sexual dissatisfaction and dysfunction than non-controlled couples. McCabe and Cobain (1998), in an investigation that attempted to distinguish the impact of individual and relationship factors on sexual dysfunction among males and females, reported that in 145 sexually functional and 198 sexual dysfunctional adults, dysfunctional men and women experienced deficits in relationship quality. In particular, they found a major difference between the sexually functional and dysfunctional groups of males in the frequency of arguments with their partners.

Empirical studies directly exploring the association between dysfunctional conflict patterns and sexual dysfunction are not conclusive, and they appear to point to both direct and indirect links between negative relationship conflict and sexual dysfunction. Rosenheim and Neumann (1981) compared 19 sexually dysfunctional couples with 25 "normal" couples, and noted that the men (attending sex therapy) were less assertive and more submissive, whereas the women were more verbally aggressive. Chesney, Blakeney, Chan, and Cole (1981) compared 36 sex therapy couples with 36 volunteer couples, and noted that the sexual dysfunction couples had more communication and conflict resolution problems than the controls, and concluded that what is important in sex therapy is "a communication process...which allows the couple to solve problems constructively, whether the problems are sexual or of another source" (p.138). Tullman, Gilner, Kolodny, Dombush, and Tullman (1981) evaluated 43 sex therapy couples with 45 marital therapy couples and reported that both marital and sex dysfunction couples were characterized by substantial distress across a broad range of areas related to marital functioning. They noted that the sexual dysfunction couples were particularly distressed, exhibiting difficulties with problem-solving communication. Frank, Anderson, and Kupfer (1976) and Frank and Kupfer (1976) found that a sample of sex therapy couples had less frequent arguments, and more consistently agreed about what their problems were when compared with a sample of marital therapy couples, but they noted that there was clear evidence of interpersonal conflict playing a role in sexual dysfunction by negatively influencing "the affective tone of the marriage" (p.115).

On the other hand, there is evidence that some couples can compartmentalize their distress concerning sexual dysfunction to the point where it can exist in conjunction with overall relationship satisfaction. Hartman (1980a; 1980b) compared sexual dysfunction, marital dysfunction, and combined sexual and marital dysfunction couples with nonclinical control couples and reported that the sexual dysfunction couples were more similar to the control couples, than to the other groups. Hartman suggested that the sexual dysfunction played a positive functional role in the couple's relationship; it seemed to allow for better marital adjustment on many variables, because the sexual dysfunction provided "the distressed couple with an attributional strategy to perceive and explain their problems in a specific, functional way" (Hartman, 1980a, p. 579).

In a basic study of the role of conflict dynamics in sexual disorders, Metz and Dwyer (1993) compared sexual dysfunction, sex offender, and satisfied couples for cognitive and behavioural differences in styles assessed by the Styles of Conflict Inventory (SCI; Metz, 1993), and found that sexual dysfunction couples and sex offender couples (both where the male had the sexual problem) exhibited distinct interspousal conflict-management patterns when compared to each other and to satisfied couples. Sex therapy couples manifested a stable and polarized "avoiding (male)/engaging (female)" pattern of conflict resolution similar to generally distressed couples (for example, Christensen, 1988; Christensen & Shenk, 1991), whereas sex offender couples manifested a more complicated and chaotic pattern of "engaging- avoiding (male)/ engaging- avoiding (female)" interaction with higher levels of aggression (engaging), combined with withdrawal and denial (avoiding) styles. Men with sexual dysfunction were conflict avoidant, or hypersensitive to overt conflict. These men typically denied and withdrew from conflict, shunning the use of aggression, perhaps because they perceived their partners as critical (verbally aggressive) and quelled reprisal. Their female partners reported that they themselves made little effort to resolve conflict, and perceived their partners to be more powerful than themselves. The women were verbally critical, perhaps exasperated with the male partners because they were perceived as avoidant of conflict. These findings for sexual dysfunction couples are similar to those previously reported by Rosenheim and Neuman (1981). The satisfied couples in the study, as expected, showed strong constructive conflict-resolution styles, minimal destructive styles, and no significant gender differences. Such findings suggest that couples with sexual dysfunctions have distinct conflict-resolution patterns when compared to couples with other types of sexual problems (sex offenders), although they are not really different from generally distressed couples in their conflict resolution styles.

Although maritally distressed couples, and couples with sexual dysfunctions are similar in conflict-resolution styles, the couples with sexual dysfunctions reported greater general satisfaction with their relationships and no greater occurrence in the actual rate of sexual dysfunction than distressed couples (Mketz & Lutz, 1990). On the one hand, couples who seek professional assistance for a sexual dysfunction may have conflicts about general relationship issues, however, focusing on the sexual dysfunction serves to insulate their relationship from more generalized distress, consistent with findings by Hartman (1980a, 1980b), Frank et al. (1976), and Frank and Kupfer (1976). On the other hand, for some couples, sexual dysfunction may exist in the absence of any significant general relationship problems, and the couple's awareness of that factor contributes to their overall relationship satisfaction. For example, both partners may attribute a person's sexual dysfunction to that individual's family-of-origin experiences, anxiety disorder, and so forth, and then make no negative attributions about each other other's intentions or other characteristics that could elicit distress about the general relationship.

It would appear that the samples and measures used in various studies offer glimpses of the differing relationships between couple conflict and sexual dysfunction. The studies suggest that there likely is more than one pattern in the relationship between couples' conflict interactions and their sexual dysfunctions. Dysfunctional conflict resolution may be a cause or a result of sexual dysfunction, or the two may be unrelated in some cases. It is reasonable to expect a number of conflict patterns among sexual dysfunction couples: (a) a pattern wherein the sexual dysfunction may be the direct result of negative conflict impasse; (b) a pattern in which the sexual dysfunction may insulate the couple from generalized relationship damage by providing them a focus or rationale for understanding and thereby limiting their relationship distress; and (c) a pattern wherein the sexual dysfunction develops independently from relationship conflict, but may itself precipitate negative feelings and conflictual interactions between partners. These patterns need to be addressed in assessment and treatment planning in sex therapy.

3.4.5 The paths between sexual dysfunction and conflict resolution

General theoretical models of relationship adjustment versus dysfunction (Karney & Bradbury, 1995; Kelley et al., 1983; Kobak, Ruckdeschel, & Hazan, 1994; Wile, 1993) focus on a number of features, such as how couples establish and maintain intimacy and mutual support, how partners provide for each other's autonomy needs, and how they solve life's problems together. Identification of how couples respond to inevitable areas of conflict in their needs and preferences is frequently viewed as a metaphorical "window" through which

one can observe how close relationships function (Braiker & Kelley, 1979). Unresolved relationship conflict can be defined as “the dissatisfying impasse partners reach in unsuccessful attempts to resolve differences” (Kelley & Thibault, 1978). In contrast, successful resolution of conflicts can contribute to a couple’s positive expectations that they will be able to resolve other differences in the future, a positive cognitive set associated with relationship satisfaction (Vanzetti, Notarius, & NeeSmith, 1992).

In theory, relationship conflict may be related to sexual dysfunction through three different processes: (a) as a consequence of conflict and distress generated by sexual dysfunction, (b) as a contributor to sexual dysfunction, or (c) as a means by which a couple can increase emotional and sexual intimacy. Figure 1 presents possible paths between relationship conflict and sexual functioning that represent each of these three processes. Some paths involve negative effects that individual partner characteristics have on sexual functioning, and thereby on relationship conflict. Other paths involve negative impacts of relationship conflict on sexual functioning. Figure 1 also includes a path by which positive handling of relationship conflict enhances intimacy and satisfaction in the couple’s overall relationship and sexual relationship.

In the first set of paths, characteristics of an individual partner can contribute to a sexual dysfunction that creates distress and negative conflict interactions in the couple’s relationship. Some individuals bring to their couple relationships a personal legacy of painful experiences, such as childhood physical and/or sexual abuses. The long-term negative effects of such prior trauma on the person’s adult functioning (Gold, 1986; Lisak, 1995; McCarthy, 1997; Tallmadge & Wallace, 1991) can result in tension, disappointment, and hurt between partners, which can decrease the sense of intimacy and cohesion that otherwise would allow them to tolerate other areas of conflict in their relationship. Other individuals have personality characteristics or psychopathology symptoms that directly interfere with sexual functioning and thereby affect the couple’s sexual and overall relationship. For example, individuals with panic disorder commonly fear any bodily symptoms of arousal (Barlow, 1988), including those associated with sexual arousal and physical exertion during sex with their partners (Sbrocco, Weisberg, Barlow & Carter, 1997). Even when both partners intellectually understand that the anxiety disorder is unrelated to their affection and sexual attraction to each other, the individual’s inhibited sexual responsiveness can contribute to general relationship distress and conflict. Other individuals have sexual dysfunctions that result from physical causes such as vascular diseases. The partners’ understanding may not be sufficient to maintain intimacy and minimize conflict in their relationship.

Figure 1. The interactive paths between relationship conflict and sexual dysfunction

Conflict Feature	Effect	Consequence
1. Relationship conflict as a Consequence of Distress Generated by Sexual Dysfunction: Characteristics of Individual Partners		
Personality traits, psychopathology Unresolved issues from personal history	→ Sexual dysfunction	→ Negative impact on couple's general relationship conflict
Physical causes of sexual dysfunction	→ Sexual dysfunction	→ Negative impact on couple's general relationship conflict
2. Relationship Conflict as a cause of Sexual Dysfunction: Problems in Couple's Resolution of Relationship Conflicts		
Negative sentiment override	→ Negative cognitions & emotions about partner & relationship	→ Sexual Dysfunction
Interaction narrowing	→ Repetitive negative interactions create "anti-sexual" conditions	→ Sexual Dysfunction
Focus on power and control	→ Self-protective interactions create that decreases intimacy	→ Sexual Dysfunction
Negative behavioural Reciprocity	→ "Vivid" negative experiences with the partner, relative to intimate and seductive exchanges	→ Sexual Dysfunction
3. Relationship Conflict as a Means to enhance Emotional Intimacy: Constructive Conflict Resolution and Intimacy Skills		
Positive interactions focused on Resolving specific conflictual issues	→ Atmosphere of cooperation, trust, acceptance & mutual empathy functioning	→ Positive sexual functioning

Second, there are several paths by which relationship conflict can lead to sexual dysfunction. The relationship conflict itself can be due to characteristics of one or both partners, such as personality characteristics, psychopathology, and family-of-origin experiences. For example, neuroticism has been found to be associated with marital distress (Karney & Bradbury, 1995). In addition, individuals who grew up in families characterized by stressful experiences, such as substance abuse, are at increased risk for adult relationship problems (for example, Seilhamer & Jacob, 1990). However, even when neither partner has any notable characteristic that interferes with his or her functioning in close relationships, a couple may still have conflict based on marked differences in their needs, preferences, or personality styles. Couples who lack the ability to communicate and negotiate about such differences constructively are likely to develop distressing levels of conflict. For example, if members of a couple have different preferences for autonomy versus togetherness, and lack good skills for solving problems together, their unresolved differences may create significant distress (Baucom & Epstein, 1999; Epstein & Baucom, 1999) and precipitate sexual dysfunction.

Figure 1 also includes several specific paths through which general relationship conflict may contribute to sexual dysfunction. One path involves sentiment override (Weiss, 1980), in which conflict leads each member of a couple to experience global negative emotions and attitudes toward the partner. If the mere presence of the partner elicits a negative affect, then that emotion can interfere with sexual desire and arousal. A second path involves interaction narrowing, in which the presence of unresolved conflict narrows the ways that the two people behave toward each other, so that their interactions become automatic, repetitive, and negative (Gottman, 1994). These negative behavioural patterns may then dominate, and replace any patterns that were intimate, seductive, sexually arousing, and so forth. Third, and related to interaction narrowing, a relationship characterized by chronic conflict may shift toward a focus on control and power, because each person feels a need to protect himself or her from being hurt, abused, or controlled. Whereas earlier in the relationship the two people interacted in many ways that were based on meeting their intimacy needs (which involve closeness, sharing, and even vulnerability), now they focus on interactions that are self-protective and even controlling. Fourth, and related to the other paths, once some strong conflictual interactions have occurred, it tends to take a lot of positives to balance them. The negatives are very "vivid" stimuli that arouse emotion, dominate the partners' perceptions, and illicit self-protective aggressive or withdrawal responses. When couples respond to relationship conflict with a pattern of negative reciprocity, in which they reciprocate negative acts such as threats and criticism, they escalate marital distress. Negative reciprocity can be maintained by the negative cognitions

that distressed partners tend to have about each other's feelings and intentions (Bradbury & Fincham, 1990). As noted, Miller and Bradbury (1995) found that spouses' negative attributions about each other's negative behaviours were associated with more negative communication during problem-solving discussions. These negative cognitions and behaviours are likely to be a "turn-off" sexually. Such negative couple processes are the antithesis of the components of positive sexuality, because they interfere with the positive emotional, cognitive, and behavioural aspects of healthy sexual functioning. Although it is not known how such processes may contribute differentially to the various types of sexual dysfunction (such as sexual aversion, hypoactive sexual desire, arousal dysfunction, orgasm dysfunction, or even sexual pain disorder), it seems likely that they can influence the more vulnerable phases(s) of sexual response for each individual.

In contrast to the processes through which relationship conflict contributes to sexual dysfunction, conflict may present opportunities for couples to deepen their emotional and sexual intimacy. With a positive, respectful, affirming process of conflict resolution, partners may develop a greater sense of self-esteem in their relationship, reinforce respect and admiration for each other, develop more confidence that future conflict can be positively resolved, and create positive feelings and comfort with each other that facilitate their sexual desire for each other. The important feature is less the existence of relationship conflict, and more the manner in which the couple deals with conflict. Positive and constructive relationship conflict interaction may produce emotional relief or even an affirmation of the couple's intimate bond and directly or indirectly serve as a sexual aphrodisiac. The heightened pleasure and enjoyment that some couples report when they have sex after "making-up" (resolving conflict affirmatively) offers further evidence of the emotional link between conflict resolution and sexual feelings.

3.4.6 Assessing relationship conflict in sexual problems

Assessment of the potential role of relationship conflict in sexual dysfunction first requires an adequate general evaluation of the sexual problem, including medical evaluation, individual psychological evaluations (regarding psychopathology, personality characteristics, and unresolved past traumas), sexual histories of each partner, each person's relationship history, and the history of the couple's relationship. In addition, the potential role of conflict in a couple's sexual problem can be evaluated by assessing several features of conflict itself. In a clinical interview, inviting the couple to report on detailed descriptive features of their conflict helps them to objectify (that is, depersonalise) and understand the nature, dynamics, and meaning of their distress. With those couples that report that they do not

have overt disagreements, the assessment shifts from “when you experience conflict or disagreement in your relationship... “To “when you experience events that might lead to disagreement... “Clinical interview guides such as, “Assessing the Five Features of Relationship Conflict” and self-report measures such as the SCI (Metz, 1993) or the Areas of Change Questionnaire (Weiss, Hops & Panerson, 1973) help couples to see that although the partners may have conflicting needs or preferences in particular areas of their relationship, there are choices to be made in how they interact to resolve the differences; they can reach solutions in a cooperative manner.

In the “Five Features of Relationship Conflict” interview guide, the conflict features to assess are: (a) environment, (b) subject, (c) severity, (d) styles of interaction, and (e) the meaning of conflict to the members of the couple. Understanding these features allows the clinician and couple to grasp in detail the nature of the particular couple’s disagreement (if overt), and its possible role in the sexual problem. It can also guide treatment planning.

The environment of the conflict refers to the circumstances and typical situations in which conflict occurs-the “who,” “where,” and “when” of conflict. Assessment in this area includes evaluating how each partner’s relatively stable psychological characteristics, current psychopathology, and/or unresolved issues from his or her personal history are expressed in ways that elicit conflict between partners. Assessment also explores the context that characterizes the couple’s quarrels, such as the places where conflict occurs, the time of day or week, and other common circumstances. For example, a couple may commonly argue while driving in the car after visiting the husband’s mother on Sunday afternoon, or in the bedroom Saturday night after an adolescent’s misbehaviour and after both have been drinking alcohol. The couple, understanding that their conflict may occur in one situation more than another, can anticipate and regulate conflict more competently.

The subject of the conflict refers to the content of the topic or topics on which disagreement typically focuses- the “what” the fight is about such as finances, household chores, parenting, sex, family relations, social life, religious beliefs and practices, or use of alcohol or drugs. Degrees of disagreement about various core areas of daily life are commonly used in indexes of global relationship adjustment, such as the widely used Locke-Wallace Marital Adjustment Test (Locke & Wallace, 1959) and Dyadic Adjustment Scales (Spanier, 1976). Commonly, couples can identify particular topics that elicit the distress and conflict, and may even report that the topics seem “too trivial” to warrant the level of upset that is generated. Thus identifying the topics of conflict helps focus the assessment, but it is important to probe

for underlying themes in these areas, because conflict over specific content issues often reflects deeper, broader meanings that the issues represent for the members of the couple.

The severity of conflict involves the frequency and intensity of the couple's conflictual interactions- the "how much," or magnitude, of the conflict. This assesses the amount of subjective distress that each partner experiences, whether expressed or concealed. Conflict that is frequent and about personal qualities, values, or beliefs is usually more serious than infrequent conflict about routine or mundane issues. Severe negative expressions of conflict are more likely than moderated ones to decrease emotional intimacy.

The styles of conflict refer to forms of the partner's interactions with each other during conflict- "how" they deal with conflict. Some styles inherently have a positive or constructive effect, whereas others have a negative or destructive effect on conflict resolution and directly influence the "meaning" of conflict to the partner. Clinically, this is illustrated by partners' responses to assessment probes such as, "How do the two of you behave toward each other when you are having a disagreement?" Individuals who report behaviour patterns of aggression and withdrawal (and who feel hurt, anger, resentment, or rejection because of these negative or disrespectful interactions) also tend to report detrimental impacts of conflict on their sexual desire and interactions. One model for explaining this process and assessing interactive styles has been used as the basis for the SCI (Metz, 1993), which organizes conflict-resolution styles according to two basic dimensions: (a) the classic engaging versus avoiding conflict styles (Raush, Barry, Hertel & Swain, 1974) modified to comprise three engaging styles: - assertion, aggression, and adaptation - and three avoiding styles - withdrawal, submission, and denial; and (b) constructive (beneficial) versus destructive (alienating) styles distinguished by their inherent effect on conflict resolution. These two dimensions define the styles according to their role in promoting or contaminating conflict resolution, and, subsequently, overall relationship and sexual satisfaction.

Styles that promote a constructive process of conflict resolution are assertion, adaptation, and submission (in moderation), whereas styles that facilitate a destructive process are aggression, denial (in extreme), and withdrawal. These styles tend to promote constructive or destructive effects, based on the inferences (attributions and expectancies) that each partner makes about such responses. The following are descriptions of constructive and problematic styles.

Assertion refers to constructive and cooperative responses conveyed in a clear, direct, noncoercive manner (such as, "let's work this out together"). Aggression refers to

destructive, threatening, punitive verbal or physical responses intended to compel compliance (such as, "I'll get you back").

Adaptation refers to positive efforts to adjust, modify, or circumvent a conflict through playfulness, hyperbole, or fatuous acknowledgment. Examples are humour, self-deprecation, affirming teasing, kidding, or silliness.

Submission responses include yielding, obliging, acquiescing, or placating reactions (such as preventing a problem from developing by not telling partner your feelings or immediately apologizing).

Denial responses disown, disavow, fail to acknowledge, or are dissociated from conflict (such as refusing to talk).

Withdrawal is the shunning or evading of conflict through retreating, drawing back, or escaping responses (such as silence, or staying away from the partner). As noted earlier, results of conflict-resolution research suggest that high levels of assertion and adaptation, moderate levels of submission and denial, and low levels of aggression and withdrawal characterize satisfied couples.

The meaning of conflict refers to the idiosyncratic importance of disagreement for this couple- "Why" is the couple struggling together, and what does the disagreement mean to each member of the couple? Discovering the meaning of the conflict is the pre-eminent goal for understanding a particular couple's disharmony and the feature that the partners ultimately need to address together. Understanding the cognitive appraisal made by each partner about the basic features of conflict - environment, content, severity, and interaction styles - is the basis for assessing and determining the meaning of the couple's conflict. The subjective meaning that a conflict has for each partner is determined by that person's assumptions and standards about the partner and relationship, his or her attributions about causes of problems in the relationship, expectations about future interactions with the other person, and selective perceptions of the events that occur between partners (Baucom & Epstein, 1990). These cognitions influence the individual's emotional experiences in the relationship and, when negative, can have negative effects on sexual functioning (see Figure 1).

The members of a couple may not be fully aware of, or fully express the special meanings that particular topics have for them, so an important aspect of the clinical assessment is to

make these explicit. Common meanings underlying relationship discord include feeling devalued, abandoned or rejected, isolated, blocked in one's attempts to achieve personal goals, and engaged in a struggle for power or control. The meaning of a conflict typically has substantial emotional significance for the partners, and ultimately determines whether the conflict serves to deepen mutual understanding, acceptance, and love, or is destructive to emotional intimacy. For example, a couple may have frequent arguments on the way home from the husband's parent's home that is focused on the wife's distress over the extended time that they typically spend there. Thus, the topic of the couple's arguments is the amount of time spent with the in-laws, however, these arguments may in fact reflect unstated concerns that the wife has about the husband's loyalty to his parents rather than to her, and her desire to feel special and appreciated to him. Identifying such underlying meanings and understanding their importance can help couples devise ways to resolve the core issues more constructively.

The meaning of conflict - that is, the cognitions associated with constructive versus negative problem-solving behaviour - can be assessed through systematic interviewing of partners, using questions such as those in the Appendix. In addition, cognitive assessment can be aided by self-report measures. For example, concerning attributions that partners make about each other's positive and negative behaviour, Fincham and Bradbury's (1992) Relationship Attribution Measure (RAM) asks respondent's to report causal and responsibility attributions that they make about hypothetical negative partner behaviours (for example, "Your husband criticizes something you do"). Causal attributions are the degrees to which the individual views the cause of the partner's behaviour as internal to the person or external, global versus specific, and stable versus unstable. Responsibility attributions concern the degree to which the respondent views the partner's behaviour as blameworthy and due to negative motivation and intent. Individual's RAM scores have been found to be associated with both marital distress and the degrees to which they exhibit negative behaviour during problem-solving discussions with their partners (Bradbury & Fincham, 1992). Pretzer, Epstein, and Fleming's (1991) Marital Attitude Survey (MAS) assesses the degrees to which the respondent attributes relationship problems to his or her own behaviour and personality, the partner's behaviour and personality, the partner's lack of love, and the partner's malicious intent.

Concerning relationship standards, the Inventory of Specific Relationship Standards (ISRS; Baucom, Epstein, Rankin & Burnett, 1996b) assesses the personal standards that an individual holds regarding core meaning dimensions of boundaries (degrees of autonomy versus togetherness), distribution of power/control, and investment in one's relationship in

twelve areas of the relationship (for example, finances, leisure time, expression of positive and negative feelings, household tasks, affection, etc.). Conflict between partners' standards concerning these important areas of relationship functioning can be assessed in terms of discrepancies in the partners' ISRS sub-scale scores. It has been found that the less satisfied that individuals are with the ways in which their relationship standards are being met in their relationship, the more marital distress and negative communication patterns that they exhibit (Baucom et al., 1996b; Gordon, Baucom, Epstein, Burnett, & Rankin, 1999).

Assessing the five features of relationship conflict with a couple will invite deeper exploration and understanding of their individual and relationship histories and current relationship dynamics, and will identify specific areas for therapeutic change. Evaluating these features in the couple's overall relationship may provide a perspective for judging the relevance of the relationship conflict as a potential cause of a nonmedical sexual problem. The manner in which partners interact concerning the sexual dysfunction may itself also be evaluated in terms of these five features of conflict. When the conflict topic is the sexual difficulty, investigating the five features of conflict surrounding the sexual problems - the environmental circumstances surrounding experiences of sexual dysfunction, the intensity of the distress with the sexual problem, the manner in which the partners address it, and the subjective meaning that the sexual problem has for each partner will help to illuminate the features of conflict that warrant direct attention in sex therapy.

3.4.7 Social exchange theory and sexuality

The social exchange perspective provides a lens through which we can examine why sexual satisfaction might be associated positively with general relationship quality (Sprecher, 1998). To some degree, sexual satisfaction represents a favourable balance of rewards and costs in the sexual aspect of the relationship. For example, according to Lawrance and Byers' (1992, 1995) Interpersonal Model of Sexual Satisfaction, sexual satisfaction is increased to the degree that, within the sexual relationship, rewards are high, costs are low, the difference between rewards and costs compares favourably with a comparison level, and there is equality between partners in the exchange of rewards and costs (Byers, Demmons, & Lawrance, 1998). A rewarding sexual relationship can then lead to overall relationship quality (satisfaction, love, and commitment). In general, the more rewards in an important area of the relationship (e.g., the sexual relationship), the more the overall relationship quality. In addition, the more equitable the exchange in the relationship, including sexual behaviours and feelings, the more likely the partners are to be satisfied with the relationship

(e.g., Hatfield, Greenberger, Traupmann, & Lambert, 1982; Hatfield, Utne, & Traupmann, 1979).

3.4.8 The association between sexual satisfaction and relationship quality

Several studies have shown an association between sexual satisfaction and overall relationship satisfaction in marriage. More specifically, husbands and wives who say they are sexually satisfied in their marriage are also likely to report high levels of overall satisfaction with their relationship (e.g., Blumstein & Schwartz, 1983; Cupach & Comstock, 1990; Edwards & Booth, 1994; Henderson-King & Veroff, 1994). The few studies that have examined this association in dating relationships have also found a link between sexual satisfaction and relationship satisfaction (Byers et al., 1998; Davies, Katz, & Jackson, 1999). Sexual satisfaction and related subjective measures of sexuality (e.g., sexual intimacy) have also been found to be associated positively with other indicators of relationship quality, including love (Aron & Henkemeyer, 1995; Grote & Frieze, 1998; Sprecher & Regan, 1998; Yela, 2000) and commitment, or the likelihood that the relationship will last (Pinney, Gerrard, & Denney, 1987; Sprecher, Metts, Burleson, Hatfield, & Thompson, 1995; Waite & Joyner, 2001). For a more thorough review of this literature, see Christopher and Sprecher (2000) and Sprecher and Regan (2000).

Most of the research demonstrating the association between sexual satisfaction and relationship quality has been cross-sectional. In one exception, Henderson-King and Veroff (1994) analysed data from the Early Years of Marriage Project (Veroff, Douvan, & Hatchett, 1995), and found positive associations between sexual satisfaction (joy and excitement during sex, absence of upset with sex) and measures of relationship quality during both the first and third years of the couples' marriage. They also conducted cross-lagged correlations, which indicated no significant differences in strength between the correlations of measures of sexual feelings at Year 1 with measures of relationship quality at Year 3 and the correlations of measures of relationship quality at Year 1 with measures of sexual feelings at Year 3.

Edwards and Booth (1994) examined the association between change in sexual happiness and change in marital well being by correlating change scores. These correlations were positive and significant, leading the researchers to conclude, "Although we cannot sort out the causal direction of these changes, it is clear that changes in sexual behaviour are generally related to changes in psychological well-being and marital quality" (Edwards & Booth, 1994, pp. 247). Overall, though, almost no longitudinal studies have been conducted that include measures of both sexual satisfaction and relationship quality at two or more

times, and to the researcher's knowledge, no such longitudinal research has been conducted with premarital couples.

3.4.9 Sexual satisfaction as a predictor of relationship stability vs. instability

A related issue to address is whether sexual satisfaction contributes to relationship longevity. Does satisfying sex help sustain a relationship? Two of the above longitudinal studies have relevant data. Oggins, Leber, and Veroff (1993), using data from the Early Years of Marriage project, reported that measures of sexual satisfaction at Year 1 predicted (negatively) marital dissolution by the fourth year of marriage (also see Veroff et al., 1995). Furthermore, Edwards and Booth (1994) reported that a decline in sexual satisfaction between 1980 and 1983 was associated with the probability of divorce by 1988. White and Keith (1990), using a national sample of married individuals first interviewed in 1980 and again in 1983, reported that a measure of sexual problems (dissatisfaction) at Time 1 was associated positively with the likelihood of divorce by Time 2.

Although no longitudinal study has been conducted that examines whether sexual satisfaction predicts premarital relationship break-ups, the associations of more objective aspects of sexuality and premarital relationship stability have been studied. In the Boston Dating Couples Study, Hill, Rubin, and Peplau (1976) found that whether or not the dating couple was sexually intimate at the time of the initial contact had no effect on the status of the relationship two years later. Furthermore, no difference was found in relationship stability between the couples who had sex early in their relationship and couples who had sex later (Peplau, Rubin, & Hill, 1977). However, in a 3-month longitudinal study of dating individuals, Simpson (1987) found that whether or not the couple had engaged in sexual intercourse had a significant and positive effect on relationship stability. The significant effect for sexual involvement was found even when other variables (e.g., satisfaction, closeness, length of relationship) were controlled. Furthermore, Felmlee, Sprecher, and Bassin (1990) found that an index representing sexual intimacy was a positive predictor of the stability of premarital relationships, although it was not significant when included in a model with several other predictors. Additional longitudinal research is needed with premarital couples to examine whether sexual satisfaction is predictive of relationship stability.

In this chapter, the researcher has surveyed some of the phenomenon and variants of sexuality. Human nature is determined in a number of ways, some argue historical, others biological, still others psychological. However, the researcher believes that in discussing sexual dysfunction, one has to pause to confront the difficult idea of individuality. For this idea lies at the root of the universally acknowledged mystery of sexual experience.

3.5 Behavioural treatment methods for sexual dysfunction

For couples seeking help for sexual problems, therapy should usually include significant attention to the couple's conflict-management patterns and skills. Even sex therapy with individuals should attend to the person's relationship-conflict history and current dynamics, because the individual may be reacting to interactions from the past in his or her current or former relationships, or he or she may anticipate conflict in the future. Every sexual problem, to some extent, embodies an actual or anticipated unresolved relationship conflict that is sufficiently distressing to bring the individual or couple to therapy. Whether the sexual dysfunction is caused by unsettled relationship conflict, or the sexual problem complicates a partner's ability to resolve disagreements, the conflict-resolution patterns that characterize couples in sex therapy warrant direct therapeutic attention.

Based on the data obtained by assessing the five measures of conflict, therapeutic attention can focus on assisting the couple to develop strategies to ameliorate the environmental precipitants to conflict, to exercise caution and skill when approaching the usual content of their conflict, and to devise strategies to decrease the frequency and lower the intensity of disagreement. It is particularly important to modify the couple's identified dysfunctional interactive behavioural styles, and to facilitate empathic discussion between the partners, of the meaning that the conflict has for each of them. For example, with regard to the styles of conflict, sex therapy addressing a specific male sex dysfunction - except for those couples who may be the exception to the typical pattern - should include a goal of creating more constructive communication (for example, assertion, empathic listening), less avoidance on the man's part, and less negative engagement (verbal aggression) on the woman's part. These are changes that would redress the common dysfunctional interaction pattern in male sexual dysfunction couples (Metz & Dwyer, 1993). Although in some couples a woman's aggressive verbal behaviour may be more obvious during clinical interviews than a man's avoidance of conflict, the therapist must maintain therapeutic balance and focus on both partners' contributions to the interaction. For example, the clinician may find that a man may elicit and reinforce his partner's aggressive verbal behaviour by ignoring her attempts to discuss issues until she escalates the intensity and negativity of her responses. In the absence of empirical findings regarding common conflict-resolution patterns among couples with female sexual dysfunctions, it is not clear what patterns may exist and what therapeutic goals may be appropriate. Even as empirical findings about gender-based conflict patterns accumulate, idiographic assessment and modification of each couple's conflict will be essential.

When the assessment reveals that a couple's negative interactions are influenced by one or both partners' cognitions about themselves, each other, and their relationship, cognitive restructuring procedures to address the negative meanings associated with the conflict will be an important component of therapy. For example, some individuals may hold unrealistic beliefs or standards about intimate relationships, which contribute to dissatisfaction about their own relationship and to negative problem-solving behaviour (Baucom, Epstein, Rankin, & Burnett, 1996b; Bradbury & Fincham, 1993; Epstein, Baucom, & Rankin, 1993). Cognitive interventions designed to encourage the individual to apply more realistic standards to his or her couple relationship (Baucom & Epstein, 1990; Epstein, Baucom, & Daiuto, 1997; Rathus & Sanderson, 1999) can contribute to more constructive conflict resolution. For example, some individuals fail to communicate their sexual preferences to their partners, because they believe that the partners should be able to "mind-read" their needs. A discussion of the advantages and disadvantages of adhering to such a standard, and coaching by the therapist in more open communication, often helps the individual adopt a more realistic approach.

Similarly, partners can be assisted in developing their abilities to challenge their own negative attributions about each other's intentions and traits, thereby creating a more positive atmosphere for working together to resolve conflicts. For example, when an individual attributes a partner's negative behaviour to a global, stable trait, he or she assigns a particular meaning to the conflict, is likely to hold an expectation that the couple will not be able to resolve their conflicts effectively (Pretzer et al., 1991), and is likely to behave negatively during problem-solving discussions with the partner (Bradbury & Fincham, 1992; Miller & Bradbury, 1995). Baucom and Epstein (1990) describe procedures for guiding couples in noticing how each other's behaviour varies across different situations, thus challenging the concept of an invariant negative trait. Thus an individual may have observed that his or her partner failed to pay attention on several occasions when the individual was expressing feelings, and may have attributed the partner's inattentiveness to a global lack of caring. With the therapist's guidance, the individual may be able to identify other instances in which the partner behaved in a more attentive manner, counteracting the trait attribution. The therapist can then help the couple explore the differences between situations in which the partner behaved attentively, and those in which he or she did not, so they can consider possible solutions to the problem. Partners can also be coached in devising ways of eliciting and reinforcing more positive behaviours from each other, building on instances of positive behaviour that occur.

The degree to which a therapist will need to focus on the conflictual features of a couple's interactions during sex therapy will vary according to the severity of the negative interactions, and the meanings that the conflict has for the two individuals. As described above, couples who are experiencing levels and types of conflictual interaction that affect both their overall relationship and their sexual responses to each other, are likely to benefit from explicit attention to basic skills associated with positive conflict resolution. In addition, conflictual partners characteristically need assistance in empathizing with each other - that is, experiencing mutual acceptance or affirmation of important personal feelings, both positive and negative (Jacobson & Christensen, 1996). Partners need to feel that each is fully accepted, cared for, and positively regarded for his or her feelings, even when there is disagreement. Such affirmation is central to the emotional "glue" in an intimate, sexually satisfying relationship. In addition, encouraging fundamental interpersonal cooperation in the pursuit of conflict resolution-working together as a "team"-can enhance the couple's relationship (Jacobson & Christensen, 1996), and is required to resolve both relationship conflict and the sexual problem to the partners' mutual satisfaction. In successful sex therapy, couples are helped to achieve mutual emotional and sexual satisfaction, as well as adequate performance. When relationship conflict is limited in severity, or primarily focused on a sexual problem, it may be managed within the realm of cognitive-behavioural sex therapy. The climate of sex therapy provides a positive environment for couples to experience a specific form of constructive conflict resolution - cooperation for the mutual resolution of the sexual problem. The characteristics of standard sex therapy: open communication, cooperative "sensate focus," and other sex therapy components encourage empathy, equity (for example, the equal time of massage), respect and appreciation of differences, flexibility, coordination of leadership, and a spirit of cooperation.

In summary, although the biological and individual (intrapersonal) factors are significant, relationship conflict may play a defining role in relationship and sexual health. Unresolved relationship conflict may serve as cause of sexual dysfunction, and in turn, sexual dysfunction may act as a catalyst to precipitate negative relationship conflict and marital distress. The influence of destructive conflict in a couple's general relationship on their sexual functioning, and the influence of negative conflict surrounding sexual performance on the couple's general marital quality is an interrelationship warranting careful therapeutic attention. In general, conflict is an opportunity for increased emotional and sexual intimacy; it may even act as an emotional aphrodisiac, because when favourably resolved, partners feel positive and special about each other. In other words, constructive conflict resolution facilitates emotional intimacy and is indispensable to long-term, healthy sexual functioning.

Sex therapy invariably should assess and attend to the conflict-resolution environment as the “window” through which therapists may evaluate and treat the sexual problem.

Sex therapy should not be viewed as a distinct discipline, perhaps greater attention should be applied to integrating sex-therapy information, approaches, and research into the more general clinical domains of psychology, psychiatry, nursing, and social work. Therefore, research on sex-therapy process and outcome is a difficult enterprise, increased involvement from a greater number of individuals and disciplines may prove productive. Specifically, perhaps professional organizations whose members are currently invested in the proliferation of sex therapy would be wise in lobbying training programs in psychology, psychiatry, nursing, and clinical social work to include greater coverage of sexuality and sex-therapy issues. Also, on an individual level, established sex therapists and relationship psychologists should be encouraged to offer themselves as potential resources to ensure that sex therapy gains greater support and legitimacy.

CHAPTER FOUR: RESEARCH METHODOLOGY

“A research project is a specific research investigation; a study that completes or is planned to follow stages in the research process” (Zikmund, 2000:59).

4.1 Introduction

The value of research depends upon the integrity of study results. One of the ethical justifications for research involving human subjects is the social value of advancing scientific understanding and promoting human welfare by improving health care. Conducting research into human sexual behaviour is difficult for a number of reasons. The subject is controversial, intimate, and private. The normal assumptions behind other kinds of psychological research cannot be made. In other words, issues surrounding controls, random samples and refusal to participate are much more severe than in other kinds of research.

A contextual and methodological overview of the dissertation is presented in this chapter. This chapter details the design of the research study undertaken coupled with the goals and research questions.

4.2 Research design

The selection of the research design or appropriate research strategy depends upon the research problems or questions (Edwards, 1990). A design is selected if it generates answers to the research problems/questions, or if it adequately tests the hypothesis (Herbert, 1996).

It is argued that a research design is influenced by two sets of factors, namely paradigmatic and pragmatic factors (Smaling, 1994a: 234). Both these sets of factors will be discussed as the bases from which methodological decisions about the current project are made.

Furthermore, attention will also be given to an alternative conceptualisation of objectivity, namely Münchhausen-objectivity (Smaling, 1989:159). It is proposed that Münchhausen-objectivity (as a contra-factual principle) be used as a meta-paradigmatic methodological norm to guide and evaluate the current study throughout. Finally, the research techniques utilised in the current study will be explained.

4.2.1 Paradigmatic factors influencing a research design

Several paradigmatic factors influence the choice of methodological tools in a research design. It is this choice upon which much responsibility for scientific accountability lies. For example, questions such as “which instrument will best answer the research question?” Or “in what way can this project contribute to scientific knowledge?” are crucial in ensuring a relevant research design for any project in the social sciences.

However, different answers to the above (and other) questions are often the result of differences of opinions on a variety of philosophical levels underlying different paradigms. Hence, persons who support apparently mutually exclusive, incompatible ideas about the choice of research tools and/or methodological issues may operate from different paradigmatic perspectives, often without reflection on this fact. Bearing in mind the above, the first question relevant to any research project in the social science is: Which paradigm(s), including their specific methodological tools, should be used in the current project and to what extent do they add to, or detract from the scientificity of this project?

Before this question can be answered though, some attention needs to be given to the definition. Smaling (1994a: 223) concisely defines a paradigm as a set of beliefs, values and norms, which guides scientific endeavours. The way in which a paradigm is ordered or categorised, varies from author to author. For example, the father of the idea of multiple simultaneously functioning paradigms is Thomas Kuhn (1962), a historian who stated that there can be no one paradigm of social scientific research.

This basically means that more than one theory of truth can (and does) exist and that social scientific researchers are free to choose any one or more paradigms to find “the truth”, create “a truth”, or act upon one or several “truths” according to their ideological, scientific, and/or personal preferences. Building on the work of Kuhn, Cook & Reichardt (1979) distinguish between the qualitative and quantitative paradigms. On the other hand, Guba and Lincoln (1988) distinguish between the conventional and alternative paradigm, while Smaling (1994a; 1994b) distinguishes three different research paradigms, namely the empirical-analytical, the interpretive and the critical paradigms. Because Smaling’s (1994a: 234; 1994b) conceptualisation of the different paradigms is the most recent of the above and because it builds on the work of the philosopher Habermas, it will be utilised in the current study. Smaling’s work is also very comprehensive in terms of the philosophy of social science research, as will become evident from the discussion below.

Smaling (1994a: 223; 199b) argues that the empirical-analytical, interpretive and critical paradigms can be distinguished from each other on several philosophical levels, namely, ontology, epistemology, axiology, meta-theory and methodology. These philosophical levels will now be discussed, where necessary, and their relevance to the current study is indicated.

4.2.1.1 Ontology

According to Speake (1979: 255) ontology can be defined as follows:

“The branch of metaphysical enquiry...concerned with the study of existence itself...the assumptions about existence underlying any conceptual scheme or any theory or system of ideas.”

With regard to research design, ontology implies the way in which the researcher views the world and reality and, as a consequence of this, also the way in which the researcher views that which is studied. For the empirical-analytical perspective this implies realism (the object of study has an independent existence of what is thought about it), and a view, which regards a person as an organism, which can be studied independently from the researcher (Smaling, 1994a: 236; 1994b). In juxtaposition to this, ontology from the perspective of the interpretive paradigm implies idealism (the nature of the existence of the subject of study is constructed by the researcher), and a view which regards a person as an interpreter in interaction with the interpretive researcher while both are subject to the process of hermeneutics and the hermeneutic circle (Denzin, 1989: 141; Smaling, 1994a: 235).

The same ontological distinction can also be made on lower levels of abstraction such as the theoretical level, as can be seen for example, from the ethnographical work of Vidich & Lyman (1994: 24):

Qualitative ethnographical research, then, entails an attitude of detachment toward society that permits the sociologist to observe the conduct of self and others, to understand the mechanisms of social processes, and to comprehend and explain why both actors and processes are as they are...Sociology and anthropology are disciplines that, born out of concern to understand the “other”, are nevertheless also committed to an understanding of the self. If... we grant that the other can only be understood as part of a relationship with the self, we may suggest a different approach to ethnography and the use of qualitative methods, one that conceives the

observer as possessing a self-identity that by definition is re-created in its relationship with the observed-the other...

The current study utilises an interpretive ontological point of departure. Hence, the reality created throughout this work is the result of an effort towards constructing, in partnership with the respondents involved, within the context of South Africa, suggestions to improve sexuality in interpersonal relationships.

Finally, for the sake of comprehensiveness, the perspective of the critical paradigm is also postulated. From this perspective, ontology implies materialism and a view, which regards a person as an emancipator (Smaling, 1994a: 235). This is expanded upon by Kincheloe & McLaren (1994: 144), who state that:

Critical research has never been reluctant to point out the limitations of empirical research, calling attention to the inability of traditional models of inquiry to escape the boundaries of a narrative realism. The rigorous methodological approaches of empirical inquiry often preclude larger interpretations of the forces that shape both the researcher and the researched. Empirical observation cannot supplant theoretical analysis and critical reflection. The project of critical research is not simply the empirical representation of the world, but the transgressive task of posing the research itself as a set of ideological practices. Empirical analysis needs to be interrogated in order to uncover the contradictions and negations embodied in any objective description. Critical researchers maintain that the meaning of any experience will depend on the struggle over the interpretation of that experience...

4.2.1.2 Epistemology

Epistemology is defined by Speake (1979:109) as follows:

The branch of philosophy concerned with the theory of knowledge. Traditionally, central issues in epistemology are the nature and derivation of knowledge, the scope of knowledge, and the reliability of claims to knowledge.

Once again, as far as the research design is concerned, the nature and derivation of knowledge differs considerably within the three paradigms. In the empirical-analytical paradigm sensory experience is highly valued. Hence the emphasis is placed on what can be seen, heard and measured independently from the researcher (Smaling, 1994a: 235;

1994b; Rosnow & Rosenthal, 1998; Babbie, 1998:43). However, in the interpretive paradigm, language, the use of the metaphor, intuition, and interpersonal skills underlie the conceptualisation of the nature and derivation of knowledge, while action underlies the nature and derivation of knowledge in the critical paradigm (Smaling, 1994a: 236; 1994b, Silverman, 1997:121).

The epistemological dimension of the philosophy of social science research also concerns the theory of truth (Smaling, 1994a; 1994b; Ellis & Bochner, 1996:19). While truth is seen as correspondence in the empirical-analytical paradigm (for example, to what degree does what is found during the research process correspond with the hypothesis (Rosnow & Rosenthal, 1999:45), it is seen as coherence in the interpretive paradigm (for example, to what degree is what the researcher hears coherent with what the respondent says (Ellis & Bochner, 1996:20), and as consensus in the critical paradigm (for example, to what extent does consensus exist about the actions chosen by the group).

In the current study, the interpretive paradigm was chosen for the freedom which it allows the researcher to co-construct the reality of the research subjects through their responses, rather than trying to fit their reality into some pre-conceived hypothetical ideas as would be necessary when utilising the empirical analytical paradigm. The interpretive paradigm is also preferred above the critical paradigm since the interpretive paradigm is concerned primarily with the process of knowledge construction as opposed to the critical paradigm's primary concern with the implementation of emancipatory action.

4.2.1.3 Axiology

This is defined by Speake (1979: 34) as:

The philosophical study of values, undertaken especially in the fields of ethics, religion and aesthetics.

Both the empirical-analytical paradigm and interpretive paradigm attempt to obtain a value-free view of that which is studied, while the critical paradigm utilises an emancipatory ideology from within which knowledge is obtained and utilised in the formulation of various liberating actions (Kincheloe & McLaren, 1994: 144; Smaling, 1994a: 236; 1994b; Golden-Biddle & Locke, 1997: 11-12).

As far as axiology is concerned, the inter-paradigmatic difference between the empirical-analytical and interpretive paradigms lies primarily in the way in which an answer to the research question is obtained. While the empirical-analytical paradigm relies heavily on the often-predictive value of mathematical formulas copied from Newtonian-based natural sciences, the interpretive paradigm has continued to lean increasingly toward the understanding of human experiences. The position of those working within the interpretive paradigm is illustrated by Ellis & Bochner (1996:18), who state:

The walls between social sciences and the humanities have crumbled. In the 1970's and 1980's post modernist, poststructuralists and feminists challenged us to contemplate how social science may be closer to literature than physics. These critiques helped draw ethnographers who thought of themselves as sociologists and anthropologists closer to colleagues in history, women's studies, folklore, media studies and communication....

The interpretive paradigm is thus primarily concerned with the meaning which people construct around their experiences-another reason for utilising this particular paradigm for the current study. Such meaning cannot be objectively measured outside of a relationship between researcher and respondent. Rather, meaning is created through interaction. According to Kvale (1996: 109):

An interview inquiry (from within the interpretive paradigm) is a moral enterprise: The personal interaction in the interview affects the interviewee, and the knowledge produced by the interviewee affects our understanding of the human situation.

Spradley (1979:17) expands on the meaning construction process as follows:

Language is more than a means of communication about reality: it is a tool for constructing reality. Different languages create and express different realities. They categorise experience in different ways. They provide alternative patterns for customary ways of thinking and perceiving. In setting out to discover the...reality of a group of people, the ethnographer faces a crucial question: what language shall I use for asking questions and recording the meanings I discover?

The current study has strived toward a language wherein bias on the part of the research questionnaires has been avoided as far as possible, where information has been mutually

exchanged in a context of reciprocal trust and where all concerned have had an opportunity to contribute to the meaning creation process.

Again, for the sake of comprehensiveness, the critical paradigm, contrary to the other two paradigms, is not so much concerned with the actual creation of knowledge, as it is with how such knowledge is applied to bring about liberation through change. With a focus on action and liberation, knowledge becomes a means to an end, instead of the end in itself.

Also, the axiological dimension of any paradigm needs to take cognisance of the ethical issues confronting such a paradigm. Ethical issues common to the interpretive paradigm include harms and benefits for the respondent, anonymity versus confidentiality of respondents and, informed consent and deception, (Spradley, 1979:34; Beauchamp, Faden, Wallace & Walters, 1982:46; Gorden, 1987: 84; Kvale, 1996: 153; Johnson & Christensen, 2000: 64, 75-88). These will be discussed later.

4.2.1.4 Type of research

The nature of the research questions for the present study will best be addressed using a descriptive research design, since previous studies had been able to employ this design successfully (Snell & Papini, 1989: 256-263). This type of research is also referred to as ex post facto research (Huysamen, 1994). Ex post facto research is a study in which the variable or variables of interest to the researcher are not subject to direct manipulation but must be chosen "after the fact". The researcher begins with two or more groups of subjects who already differ according to one variable (such as age, gender, etc) and then records their behaviour to determine whether they respond differently in a common situation.

The descriptive approach is widely used and is of great importance. For example, we can observe the outcome of the descriptive approach whenever the results of Gallup polls or other surveys are reported (Gallup, 1970). Helmstadter (1970: 65) has even gone so far as to say that the "descriptive approaches are the most widely used...research methods". Descriptive studies are the existence of an association between variables; to establish correlates of individual's perception regarding sexuality and other related aspects, for example education variables. Descriptive studies are concerned with the following issues:

When initially investigating a new area, researchers use descriptive methods to identify existing factors and a relationship among them ensuring knowledge is used to formulate hypotheses to be subjected to experimental investigation. The descriptive method is also

frequently used to describe the status of a situation once a solution, suggested by experimental analyses, has been put into effect (Christensen, 1994).

This study embraces methods and procedures common to quantitative research approaches. An inherent characteristic of quantitative studies is the inclusion of many cases and many variables, which are measured in a predetermined and specific way (O' Sullivan & Rassel, 1999). Data that are collected using quantitative approaches are in numeric form and therefore can be summarized numerically. An essential goal of quantitative studies is to compare cases on different variables; therefore, factors unique to individual cases are not included.

This study involved a non-experimental, single-group post-test research design, which integrated the cross-sectional collection of data. A cross-sectional design is one used to collect data on all relevant variables at one time. A distinctive feature of the cross-sectional design is that its data represent a set of people or cases at one point in time (O' Sullivan & Rassel, 1999).

Survey research serves as the method by which this study was conducted. Survey research is a widely accepted and commonly used technique for collecting data. A questionnaire mailed to the population under study, eliciting primarily close-ended, highly measurable responses, served as the primary data collection instrument.

The questionnaire that was developed tested the relationship between a number of independent variables and the dependent variable. The assumptions made with regard to the research design and the study's limitations are also presented. The data analysis methods are elaborated upon, including the methods by which the data are described, displayed, and analysed. The questionnaire was developed from general hypotheses: satisfying sexual behaviour was associated with beneficial interpersonal relationships in general and its individual correlate that satisfying sexuality would be associated with elevated psychological well-being.

4.2.1.5 Research questions

As Oppenheim (1992) observes, one of the fundamental principles of questionnaire design is ensuring that the content is of direct relevance to the concerns and experiences of the study group for whom it is intended. While essential for the purposes of validity, relevance also enhances the likelihood of a high response rate.

The primary research question that this study was designed to answer concerned the relationship between sexuality and interpersonal psychological well-being. The open-ended question solicited advice, which subjects they would like to recommend in their interpersonal relationships. A summary of the study's corresponding research questions, hypotheses, variables, measured, and resultant outcomes is provided in Annexure A.

4.2.1.6 Research variables

4.2.1.6.1 Dependent variables

The dependent variable in this study consisted of the measures, scales and perceptions of interpersonal, intimate and sexual relationships.

4.2.1.6.2 Independent variables

The independent variables that were tested for the existence, strength, and significance of their relationship with the dependent variable were identified for inclusion in this study based primarily upon the review of literature. However, some variables were included in the study based upon the researcher's recommendations. The independent variables included in the study can be divided into a number of categories, which reflect the study's different research questions. Biographical variables consisted of

- age
- gender
- language
- occupation
- religion
- educational levels

4.3 Motivation for the study

Human sexuality is the way in which we experience and express ourselves as sexual beings (Rathus et al., 1993). There has not been much done by way of research and scholarly writing examining human sexuality (Abramson & Pinkerton, 1995; Beach, 1976; Karlin, 1997; Reinisch et al., 1990; Stalcup, 1995; Tiefer, 1995). An important reason to study human sexuality is that it is a primary source of motivation (Rathus et al., 1993). Sexual motivation does to some extent influence human behaviour (Molina, 1999). Another reason for studying human sexuality is that one faces various personal, psychological and social

problems involving sexuality, such as sexual deficiencies, sexually transmitted diseases, unwanted pregnancies, and sexual harassment, which require therapeutic interventions (Aral & Holmes, 1991; Rathus et al., 1993).

4.4 The method of sampling

The basic principle of sampling is that by selecting some or the elements in a population, a researcher may draw conclusions about the entire population (cited in Malhotra, 1996, pp. 359). While a population refers to an entire collection of scores or individuals being investigated; a sample refers to only a part of the total population under investigation (Huysamen, 1994). Harris (1995: 436) defines a population as “all scores or members of a group that are of interest to a researcher, the group to which the researcher wishes to generalise”. He goes on to define a sample as, “The group of scores that the researcher has or the people providing the scores, ordinarily, a subset of a population” (Harris, 1995: 436).

The manner in which the sample of subjects is selected depends on the goals of the research. It is important that the results obtained from the sample mirror the results that would have been obtained if the total population had been included (Rosnow & Rosenthal, 1999).

A sample size can be determined through the use of statistical procedures or through ad hoc methods. Ad hoc methods are used when the researcher knows from experience what sample size to select or when there are known constraints. Such constraints entail time availability or funding. Patten (2004) suggests that a researcher should first consider obtaining an unbiased sample and then seek a relatively large number of participants. Four factors can influence the determination of a sample size:

- the value of the information in the study in general and the degree of reliability that is to be placed in on the results,
- the number of groups or subgroups to be analysed within the sample → the cost of collecting the sample,
- the variability of the population – as variability increases, so does the required sample size.

4.5 Research participants

The sample size for this study comprised 100 individuals, males and females, aged between 18 to 50 years presently in a heterosexual intimate relationship, residing in the Durban Metropolitan area attending the King Edward VIII hospital. The sample size of 100 patients was dictated by considerations of time availability and budgetary constraints. The sample was made up of patients attending state hospitals; hence there were severe time constraints (in terms of long waiting hours, use of public transport etc). The number 100 is a round figure, thus making it easier to compute. Research was conducted via a postal questionnaire. All subjects gave informed consent.

The standardized questionnaire was also translated into Isizulu to cater for Zulu speaking persons in Kwa-Zulu Natal. The study was conducted in the gynaecology and urology clinics held once a week on Tuesday morning from 8h: 00- 13h: 00 at the King Edward VIII hospital. Patients selected were from both sexes and different racial groupings (This information was ascertained from the patients' hospital folders. The data extracted from each folder consisted of age, gender, education, race, home language, occupation and place of residence).

In order to be eligible for this research, patients selected had to have an ICD-10 diagnosis of sexual dysfunction present in their case history files over the past six years.

4.6 The pilot study

The pilot study incorporated the use of two questionnaires (the Sexuality and Psychological Well-being Scales) consisting of close-ended questions and one open-ended question regarding responses/suggestions and recommendations. The closed-ended questions provided the respondents with a variety of alternative answers. The respondent was asked to choose one answer from the alternatives that have been provided. Closed questions enable subjects to make a quick decision and this enhances the enthusiasm and commitment of the subjects (Rosnow & Rosenthal, 1999). Closed questions also facilitate the quick coding of information for analysis.

Attention was devoted throughout to the key tenets of questionnaire design, this included (adapted from Oppenheim 1992, Czaja and Blair, 1996)

- simplicity of wording
- optimum length of questions
- avoiding leading questions and double-barrelled questions
- ordering of items within questions and
- clarity of routing instruction.

The piloting process

The pilot study for developing the isiZulu questionnaire had three stages and pilot cohort members were involved in one or more.

Stage 1: in-depth interviews

In this stage, one -to-one in-depth interview was held to determine questionnaire content. The emphasis, however, was on keeping the interview as open as possible, to ensure that interviewees could raise those issues important to them. Another aim of the first stage interviews was to explore the common understanding of terminology.

Stage 2: testing drafts in interview

In the second stage, questions were drafted on the basis of the interview material, and then tested in face-to-face interviews with further members of the pilot cohort. The aim at this stage was to assess whether items within closed questions were comprehensive and relevant and whether the instructions within questions were clear. The questions were then assembled into a draft questionnaire; this was tested in further interviews to assess whether routing directions within questions, and to other questions, were clear, and whether the length of the questionnaire was acceptable. The draft questionnaire was modified and re-tested until it was sufficiently developed for interviewees to work through on their own.

The pilot study helped determine the following:

- that questions were easy to understand
- the adequacy of the questionnaire. This helped check for ambiguities and terminology that may not be easily understood
- the efficiency of the instructions.

4.7 The data sources

There are two types of data sources, primary and secondary data (Cooper and Schindler, 1998:256). Primary data is original data collected specifically for the purpose of the research question. Researchers gather secondary data for their own purposes, which can be used for the purpose of the research in question. Secondary data may be obtained from internal organisation sources or from external sources. This study will rely on both primary and secondary research data as sources.

4.8 The method of data collection

Data collection is concerned with how the researcher gathers information, i.e., which psychological instruments are used and the rationale for their use. The nature of the research can be either qualitative or quantitative. Qualitative research is an unstructured, exploratory research method based on small samples intended to provide insight and understanding of the problem setting (Malhotra, 1996: 164). Quantitative research involves the collection of primary data from a large number of individuals, frequently with the intention of projecting the results to the larger population (Martins, Loubser & Van Wyk, 1996: 125). The primary research data required for this research was both qualitative and quantitative in nature.

Various methods of collecting primary research data exist namely: mail based self-administered questionnaires, telephone interviews, personal interviews (face-to-face) and focus groups. There are numerous ways of gathering scientific evidence about human sexuality (Molina, 1999). While, some methods focus on description, other methods concentrate on identifying relationships between variables, and still others, in identifying causal relationships.

In the present study the researcher employed a survey research method. Surveys collect information about behaviour through interviews with participants or questionnaires. The aim of this particular method is to gather information on the sexual attitudes and behaviour of a particular population or group of people. This particular method does have limitations. For example, drawbacks of this method are that surveys require self-report from participants, therefore, it is likely that the data collected might contain a plethora of inaccuracies. Depending on the question posed to the individual they may want to present themselves in a socially acceptable way or to be embarrassed to answer truthfully. In addition, many people refuse to even participate in human sexuality survey studies, thus one may get a selection

bias because the sample attained may not be representative of the population needed for generalization.

Arguably, one of the seminal studies in human sexuality employing the survey method was that completed by Kinsey and colleagues (1948, 1953). Kinsey and colleagues interviewed about 5300 men and 5900 women between 1938 through 1949 and asked them a variety of questions about their sexual behaviour and attitudes. This approach was well advised since Kinsey was particularly interested in the frequency of certain sexual behaviours (e.g., oral sex, masturbation, and intercourse) rather than the underlying causes. Dillon et al (1983: 158-164) provide factors that the researcher can consider during the selection of the best survey method. These factors are depicted in the following table.

Table 1: A summary of data collection methods as adapted from Dillon, Madden and Firtle (1993: 173).

Criteria	Mail	Telephone	Face-to –Face
Versatility	Not much	Substantial but complex, lengthy scales difficult to use	Highly flexible
Quantity of data	Substantial	Short, lasting between 15-30 minutes	Greatest quantity
Sample control	Little	Good, but non-listed households problematic	In theory, provides greatest control
Quality of data	Better for sensitive or embarrassing questions; no interviewer present to clarify what is being asked	Positive side: interviewer can clear up any ambiguities. Negative side- may lead to socially accepted answers	There is the possibility of cheating
Response rate	In general, low; as low as 10%	60-80%	Greater than 80%
Speed	Several weeks	Large studies can be completed in 3 to 4 weeks	Faster than mail but typically slower than telephone surveys
Cost	Inexpensive	Not as low as mail; depends on incidence rate and length of questionnaire	Can be relatively expensive; but considerable variability
Uses	Executive, industrial, medical and readership studies	Particularly effective in studies that require national samples	Still prevalent in product testing and other studies that require visual cues or product prototypes

In the collection of data on sexual behaviour, a variety of approaches have been used. Some studies use interviewer-administered questionnaires (e.g., Fox, Odaka, Brookmeyer, & Polk, 1987; Martin, 1987; McCusker et al., 1988; Winkelstein, Lyman, & Padian, 1987) while others use self-administered questionnaires (e.g., Joseph et al., 1987; Marmot et al., 1982; McKusick, Hortsman, & Coates, 1985). Because sexual behaviour is complex, survey designs may require elaborate skip and branch instructions so that the information gathered is tailored to the sexual histories of individual respondents. This approach may yield survey questionnaires that are too complex for reliable administration as a self-administered paper

questionnaire. Reporting sexual behaviour in a face-to-face interview, however, may be embarrassing to the respondent, and may cause some respondents to conceal important aspects of their sexual histories. Therefore, the use of reporting bias becomes central to the assessment of the different modes of data collection: how the properties of a specific mode influence reporting bias and how modes compare in their effects on reporting bias (Groves, 1989).

In the current research the self-administered questionnaire (SAQ) were employed since it provided an alternative approach for conducting in-person interviews. By reducing the fear of embarrassment or disclosure, self-administered questionnaires provide a more private and less threatening means of reporting sensitive behaviours (Catania, McDermott & Pollack, 1986). An increasing number of studies have investigated the effect of the mode of interview in surveys of self-reported data, often reporting a mode effect for a number of sexual behaviours (a significant mode effect was found among women who were offered SAQs to report on abortion, National Survey of Family Growth, 1990).

4.8.1 Limitations of self-administered questionnaires

Although some variation is seen, self-administered questionnaires offer a number of advantages over in-person interviews. In addition to the substantial reduction in reporting bias, SAQs can be less expensive to administer if given to many people simultaneously in-group situations such as STD clinics, HIV testing centres, etc (Catania et al., 1990). Using in-person surveys that include a self-administered questionnaire component, however, can be a high-cost method of data collection. Although self-administered questionnaires provide a setting for reporting sexual and other sensitive behaviours, there are limitations to their use. Because sexual behaviour is complex, survey instruments that collect such data are designed with contingent questioning (branching or skip patterns) that may be too complex for respondents to follow in a self-administered form (Lessler & Holt, 1987).

4.8.2 Rationale for selection of type of research

Survey research has long been established as an effective method of measuring the characteristics, attitudes and perceptions of a population. Researchers use surveys as a scientifically sound method in which to interview a representative sample instead of an entire population (Dillman, 1994). Monette, Sullivan, and DeJong (1998) espouse the flexibility the survey provides, noting that the data collection technique can be used for exploratory, descriptive, explanatory, and evaluative studies.

The utilization of a survey allowed the researcher to infer generalizations from the respondents to the broader population. Given that the primary collection of data for this study came from the distribution of a questionnaire to the population under examination, the utilization of a non-experimental single-group post-test research design was appropriate.

4.8.3 Steps for data collection

Summarized below are the steps involved in the collection, transfer, and archiving of the data collected for the study.

4.8.3.1 Mailing of the survey instrument

The mailing of the survey included three elements.

- Survey questionnaire cover letter

The signed questionnaire cover letter included those elements common to survey questionnaire cover letters: (1) an explanation of the importance of the study; (2) how respondents would benefit by participating in it; (3) the confidentiality of the data; (4) how respondents could learn about the study's findings; and (5) an appeal to participate.

- Survey questionnaire

The questionnaire served as the data collection instrument. Included on the questionnaire were a reiteration of the study's benefits, a reminder of the confidentiality of the data provided, and directions for completing and returning the instrument (see Appendix B).

- Survey questionnaire return envelope

A standard-sized, self-addressed, stamped return envelope accompanied the questionnaire and cover letter. In order to promote anonymity, no request was made to have respondents include their return address on the envelope.

4.8.3.2 Steps for processing the data

The researcher collected the returned questionnaires. To ensure anonymity, the researcher detached and discarded the envelopes in which questionnaires were returned. The upper

right hand corner of the survey questionnaire that indicated the number that was associated with study participant was cut off. Data collection ceased six weeks after the questionnaires were mailed. As the questionnaires were returned, the data from the questionnaires were entered into a computer using the SPSS software program.

It should be noted that all data collected as part of this study were stored in a safe and secure place, where it will remain for a period of three years, after which time the data will be destroyed.

4.9 The research instrument

Although high response rates are more difficult to achieve with self-completion questionnaires than by individual interviews (Cartwright, 1983), questionnaires were the choice of data collection instrument in this study. The sample size required for reliable estimates and viable statistical analysis (to test for differences between subgroups, for example, women and men) was such that it could be achieved only by postal questionnaire given the resources available to the researcher.

Two instruments were employed for data collection in this research study: a survey questionnaire and an open-ended question. According to Leedy and Ormond (2001, p. 94), "Research is a viable approach to a problem only when there are data to support it". Nesbary (2000) defines survey research as "the process of collecting representative sample data from a larger population" (p. 10). The main purpose of a survey is to estimate, with significant precision, the percentage of population that has a specific attribute by collecting data from a small portion of the total population (Dillman, 2000; Wallen & Fraenkel, 2001). The researcher wanted to find out from members of the population their view on one or more variables. As noted by Borg and Gall (1989), studies involving surveys comprise a significant amount of research done in the psychological field. Data are ever-changing and survey research portrays a brief moment in time to enhance our understanding of the present (Leedy & Ormrod, 2001).

Self-administered questionnaires (SAQs) are a commonly used method of eliciting information on sensitive topics (Couper, 1999). SAQs have been used in studies ranging from sexual behaviour (e.g., Catania, Gibson, Chitwood, & Coates, 1990; Catania, McDermott, & Pollack, 1986; Johnson & DeLamater, 1976; Smith, 1992; Tourangeau, Rasinski, Jobe, Smith, & Pratt, 1997; Tourangeau & Smith, 1996) to drug use (e.g., Aquilino, 1992, 1994; Turner, Lessler, & Gfroerer, 1992) and abortion reporting (e.g., Londona &

Williams, 1990). SAQs are hypothesized to improve reporting of sensitive information by increasing privacy and reducing social desirability effects associated with interviewer administration (Schoeber, Fe Caces, Pergamit, & Branden, 1992; Turner et al., 1992). Given the widespread use of SAQs it is important to understand the conditions under which they lead to improvements in data quality, and to examine potential limitations of their use.

Much of the research on SAQs has focused on non-response, both as the unit level (noncompletion of the entire SAQ, Johnson & DeLamater, 1976; Smith, 1992) and at the item level (noncompletion of some, but not all, items in the SAQ, Catania et al., 1986; Wiederman, 1993).

Several studies have examined the issue of non-response to SAQs. For example, Johnson and DeLamater (1976) found that 8.3% of adult respondents in the Erotic Materials National Survey refused to complete the SAQ. They found that persons who did not complete the SAQ were older and less educated. Similarly, Smith (1992) reviewed the sexual behaviour questions in the General Social Survey (GSS), which used a short SAQ. He found response rates to the SAQ of 93.4% in 1988, 91.2% in 1989, and 85.5% in 1990.

A number of studies (NHLSLS: Lauman, Gagnon, Michael & Michaels, 1995; Michael, Gagnon, Lauman & Kolata, 1994) examined item non-response or partial completion of SAQs. Catania et al., (1990) reported that refusal rates (item noncompletion) in SAQs ranged from 6% to 13% for items assessing the frequency of vaginal intercourse, from 6.7% to 19% for masturbation items, and an average of about 6% for number of sexual partners. All these studies (and others) that examined full or partial non-response to SAQs assumed that if an item was completed, it was done so by the respondent as intended.

The survey questionnaire used in this research appears in the Annexure B and C. It consisted of seven items eliciting biographical information followed by two USA standardized likert type scales assessing sexuality and psychological well-being. The final component consisted of a single qualitative question

4.9.1 The Psychological Well-Being Scale

Psychological well-being is influenced by personal, interpersonal, and environmental factors, and, invariably, by changes within the context of life stages and developmental tasks. Research has demonstrated that psychological well-being develops through a combination of emotional regulation, personality characteristics, identity and life experience (Helenson &

Shrivastava, 2001), increases with age; education, extraversion, consciousness, and decreases through neuroticism (Keyes, Shmotokin, & Ryff, 2002).

The assessment of psychological well-being in South Africa is pertinent at this time. As the country as celebrated its eleventh year of democracy, after decades of oppression, its people are affected by significant stresses, including high crime, violence, and unemployment. The psychological well-being of individuals is of special significance given their expected concerns in this regard.

The 18-item version of the Psychological Well-being Scale (Ryff, 1989) is a self-report measure of well-being on dimensions of autonomy, personal growth, environmental mastery, purpose in life, positive relations with others, and self-acceptance. The scale includes three items from each dimension. It uses a Likert-item format, and has a total rating ranging from 18 to 108. Similar to Erickson's theoretical perspectives (1959), each dimension articulates a form of life challenge, e.g., self-acceptance of personal strengths and weaknesses, mastering the environment to negotiate personal needs and life challenges. Although not as statistically powerful as the longer version of the scale, the 18-item Psychological Well-being Scale was considered suitable for the present research for various reasons. It has been carefully compiled, standardized, confirms the proposed theoretical structure of psychological well-being, is currently in use in various large-scale U.S. and international surveys, and is short and convenient for research (Ryff, 1989; Keyes, et al., 2002).

4.9.2 The Sexuality Scale: an instrument to measure sexual self-esteem, sexual-depression and sexual preoccupation

The Sexuality Scale (Snell & Papini, 1989: 256-263), is an instrument designed to measure three aspects of human sexuality: sexual-esteem, defined as positive regard for and confidence in the capacity to experience one's sexuality in a satisfying and enjoyable way; sexual-depression, defined as the experience of feelings of depression regarding one's sex life; and sexual-preoccupation, defined as the tendency to think about sex to an excessive degree. Factor analysis confirmed that the items on the Sexuality Scale form three conceptual clusters corresponding to these three concepts. Other results (Snell & Papini, 1989) reported also indicated that all three subscales had clearly acceptable levels of reliability.

The original Sexuality Scale manual procedure describes:

- item construction, selection and subsequent validation through item analysis;
- a factor analysis of the items on the Sexuality Scale and the establishment of factorial validity.

The construction of the Sexuality Scale

A set of items was written for the three subscales on the Sexuality Scale (SS). The items in each of the three groups were written in accord with the definitions of sexual-esteem, sexual-depression, and sexual-preoccupation specified earlier. The first author narrowed down the initial pool of items to a set of ten statements for each group. The Annexure D consists of the final ten items on each of the three subscales on the Sexuality Scale. For each item, the subjects were asked to indicate how much they agreed-disagreed with that statement. A 5-point Likert scale was used to collect data on the subjects' responses, with each item being scored from +2 to -2: agree (+2), slightly agree (+1), neither agree nor disagree (0), slightly disagree (-1), disagree (-2). In order to create subscale scores (discussed below), the item on each subscale were summed. Higher positive scores thus correspond to greater agreement with the statements.

The scale was piloted on a sample of 10 persons.

Results

The results are presented in four sections in the following chapter:

- (1) the factor analysis results for the items on the Sexuality Scale
- (2) the results of reliability analyses conducted on the three subscales for male and female subjects, both separately and in combination;
- (3) the correlations among the sexual-esteem, sexual-depression, and sexual-preoccupation subscales; and
- (4) normative data for male and female subjects.

4.9.3 The open-ended question

The final component of the questionnaire consisted of a single open-ended qualitative question: *What recommendation/suggestions would you recommend to individuals to improve/enhance their sexuality in their interpersonal relationships?*

Relation of items to the aims of the study

Questions 1 to 7: biographical information

Pertinent information such as age, gender, language, occupation, ethnic grouping, marital status and educational levels of the respondents was necessary; the names of the subjects were not required for the purpose of the study. According to Anastasi (1964: 546), anonymity is a desirable condition in many types of attitude surveys because it encourages frankness and may even provoke private perceptions.

4.10 Method of scoring

This type of attitude scale has been introduced by Likert (1903-1981) and is known as a Likert scale. This scale is extensively used in the social sciences (Kidder & Judd, 1986). Its popularity stems from the fact that it is easier to compile than any other attitude scale, such as the Guttman and Thurstone scales (Rosnow & Rosenthal, 1999). Furthermore, Likert scales may be used with multidimensional attitudes, which are not possible with other types of attitude scales (Huysamen, 1994).

A	=	Agree
B	=	Slightly agree
C	=	Neither
D	=	Slightly disagree
E	=	Disagree

The Sexuality Scale (SS) consists of three (3) subscales. The labels and items for each of these subscales are listed below:

1. Sexual Esteem (Items 1, 4, 7, 10, 13, 16, 19, 22, 25, 28):
 1. I am a good sexual partner.
 4. I would rate my sexual skill quite highly.
 7. I am better at sex than most other people.
 10. I sometimes have doubts about my sexual competence. (R)
 13. I am not very confident in sexual encounters. (R)
 16. I think of myself as a very good sexual partner.
 19. I would rate myself low as a sexual partner. (R)
 22. I am confident about myself as a sexual partner.

25. I am not very confident about my sexual skill. (R)

28. I sometimes doubt my sexual competence. (R)

2. Sexual Depression (Items 2, 5, 8, 17, 20, 23, 26, 29):

2. I am depressed about the sexual aspects of my life.

5. I feel good about my sexuality. (R)

8. I am disappointed about the quality of my sex life.

11. Thinking about sex makes me happy. (Filler item)

14. I derive pleasure and enjoyment from sex. (Filler item)

17. I feel down about my sex life.

20. I feel unhappy about my sexual relationships.

23. I feel pleased with my sex life. (R)

26. I feel sad when I think about my sexual experiences.

29. I am not discouraged about sex. (R)

3. Sexual Preoccupation (Items 3, 6, 9, 12, 15, 18, 21, 24, 27, 30):

3. I think about sex all the time.

6. I think about sex more than anything else.

9. I don't daydream about sexual situations. (R)

12. I tend to be preoccupied with sex.

15. I'm constantly thinking about having sex.

18. I think about sex a great deal of the time.

21. I seldom think about sex. (R)

24. I hardly ever fantasize about having sex. (R)

27. I probably think about sex less often than most people. (R)

30. I don't think about sex very often. (R)

Coding instructions for items

After several items (shown with an R) are reverse coded (A = E; B = D; C = C; D = B; E = A), the relevant items on each subscale are then coded so that A = 0; B = 1; C = 2; D = 3; and E = 4). Next, the items on each subscale are summed, so that higher scores correspond to greater sexual esteem, sexual depression, and sexual preoccupation.

4.11 Method of data analysis

According to Rosnow and Rosenthal (1999), statistics are mathematical techniques for analysing numerical data to accomplish various purposes. These purposes are directly related to the research aims and the type of research design chosen to accomplish in the study.

4.11.1 Data analysis techniques

The data collected via the survey questionnaires, once entered into a SPSS (v 10.0) database (see SPSS Inc., 1999) were analysed in order to provide answers to the study's research questions. Extensive data analysis was conducted to describe the population and to identify significant and interesting findings from the survey, from which conclusions were drawn, recommendations made, and a model for improving sexual dysfunction created.

Empirical data was being analysed as follows:

- The Statistical Package for the Social Sciences (SPSS) (Norusis, 1983) was utilized to analyse the data. A coding template was established in order to capture the key coding instructions for each variable, e.g. how responses related to variables.
- Inferential and descriptive statistics
- The means and the standard deviations were calculated
- The t-test and f-test were used in the analysis of data on biographical variables (age, gender, etc).
- The chi-square test used to determine the significance of the differences among independent groups when frequencies in discreet categories (nominal or ordinal) constitute the data of the research (Siegel, 1956). Although the use of χ^2 in research can be criticized, it continues to be widely used.
- One-way ANOVA was used to analyse the score on the questionnaires in relation to the following variables: age, gender, language, occupation, religion and education.

4.12 Reliability and validity of the questionnaire

4.12.1 Reliability

Babbie et al (2001: 125) summarise the general (empirical-analytical) definition of reliability as:

That quality of measurement method that suggests that the same data would have been collected each time in repeated observations of the same phenomenon.

Ideally this definition of reliability has special reference to the consistency of a measuring instrument, as well as the related issue of generalisability of research results. However, one of the main strengths of research conducted from within the interpretive paradigm is that the researcher is able to become part of the co-construction of unique meaning, as this is relevant to the life-world of the respondent. This means that reliability in its empirical-analytical definition is not applicable to the interpretive-hermeneutic paradigm.

Consequently, reliability as re-conceptualised so as to be applicable to the interpretive paradigm is utilised in the current study. This is discussed in detail by authors such as Smaling, 1992a: 309; Kvale, 1996:163; Kelle & Laurie, 1995:21; Lincoln & Guba, 1999: 398; Johnson & Christensen, 2000: 207). Smaling (1992a: 309) defines reliability across paradigms in the following manner:

Reliability is a methodological requirement that can be imposed on procedures (such as techniques, observations, methods (measuring) instruments, research processes (and framework) and on the results of research studies (such as collected data, interim and final conclusions and assessments). The core meaning of methodological reliability is the absence of random errors. These are errors that distort the object of study and for which no definitive regularity or system is assumed.

Lincoln & Guba (1999: 398) describe two types of reliability in the interpretive paradigm, namely, applicability and consistency. With applicability, these authors mean being able to determine the extent to which one or more findings may be applied across contexts, such as to other studies or other respondents. With consistency the authors mean being able to determine how well a study could be replicated in similar contexts. On a practical level, Smaling (1992a: 313) describes the following steps for enhancing reliability:

- triangulation (using more than one researcher, method, paradigm, etc.)
- peer examination (talking to one's research colleagues)
- member checks (checking the research findings with respondents)
- reasoned consensus (reaching agreement amongst project participants after open and rational debate)
- training of fellow researchers, observers, interviewer, encoders, etc.
- audit trail (independent methodologists examine the entire project)
- automation of aspects of data processing and analysis (such as with the use of the software package SPSS)
- description and explication (precise description (thick or dense description) of: the status and the role that the researcher had in the eyes of the research subjects, the relevant characteristics of the selected subjects...the concepts used, theoretical ideas and research methods, etc.)

According to Patten (2004), "...validity is more important than reliability" (p. 71). However, reliability does need to be addressed. Reliability relates to the consistency of the data collected (Wallen & Fraenkel, 2001). The reliability of the measuring instrument is determined using Cronbach's coefficient alpha. Cronbach's alpha is a reliability coefficient that reflects how well the items in a set are positively correlated with one another. Cronbach's alpha is computed in terms of the average interrelations among the measuring concept. The closer Cronbach's alpha is to 1, the higher the internal consistency (Sekaran, 1994).

4.12.2 Validity

According to Babbie et al, (2001: 122) validity can be defined in the following manner:

In the conventional usage, the term validity refers to the extent to which an empirical measure adequately reflects the real meaning of the concept under consideration

Like reliability, the concept of validity therefore also needs to be re-conceptualised in order to become applicable to the interpretive paradigm. Validity is defined by Smaling (1992a: 314) across paradigms as:

...A methodological requirement for procedures (such as observations, techniques, methods, (measuring) instruments, research processes and frameworks) and research results (such as collected data, assessments, interim and final conclusions

of the analysis). An important meaning of validity is the absence of random and systematic errors...

Validity within the interpretive paradigm can also be seen as the result of a thick (or dense) description of the phenomenon under study. This term, coined by Norman, K. Denzin (1989: 83) who states:

Description is the art of describing or giving an account of something in words. In interpretive studies, thick descriptions are deep, dense, detailed accounts of problematic experiences. These accounts often state the meanings and intentions that organize an action. Thin descriptions, by contrast, lack detail, and simply report facts.

An instrument is valid if it measures what it is intended to measure and accurately achieves the purpose for which it was designed (Patten, 2004; Wallen & Fraenkel, 2001). Patten (2004) emphasizes that validity is a matter of degree and discussion should focus on how valid a test is, not whether it is valid or not. According to Patten (2004), no test instrument is perfectly valid. The researcher needs some kind of assurance that the instrument being used will result in accurate conclusions (Wallen & Fraenkel, 2001). As Oppenheim (1992) observes, one of the fundamental principles of questionnaire design is ensuring that the content is of direct relevance to the experiences and concerns of the response group for whom it is intended. While essential for purposes of validity, relevance also enhances the likelihood of a high response rate.

Smaling (1992a: 314) distinguishes between two forms of validity, namely internal validity and external validity. Various types of internal validity are distinguished. According to Smaling (1992a: 314) the first type of internal validity is content validity, which refers mainly to the validity of the instruments used, for examine the questionnaire schedule. The second type of internal validity is concept validity, which is also described as descriptive validity by Johnson & Christensen (2000: 209) and refers to the factual accuracy of the data. Johnson & Christensen (2000: 209) add the notion of interpretive validity, referring to the degree of coherence between the meaning intended by the respondent and that reported by the researcher. Smaling also speaks of logical validity, which refers to the degree to which the research project is defensible in terms of its design and results obtained. This is closely linked to Johnson & Christensen's (2000: 210) notion of theoretical validity.

Validity involves the appropriateness, meaningfulness, and usefulness of inferences made by the researcher on the basis of the data collected (Wallen & Fraenkel, 2001). Validity can often be thought of as judgemental. According to Patten (2004) content validity is determined by the judgements on the appropriateness of the instrument's content. Patten (2004) identifies three principles to improve content validity:

- use a broad sample of content rather than a narrow one,
- emphasize important material, and
- write questions to measure the appropriate skill.

To provide additional content validity of the survey instrument, a focus group of five experts in the field of psychiatry, gynaecology, psychology and urology was formed. This group provided input and suggestive feedback on survey items. Members of the focus groups were professors, heads of department and directors at particular institutions. Comments from the focus group indicated that the skills listed in the survey were basic/intermediate skills and were appropriate for all individuals over the consensual age of eighteen years of age. Some members of the focus group suggested that the survey might be a bit long and that the skills could be generalized and consolidated for a more concise survey. The individuals are proficient in the nature of this study and were able to provide valuable suggestions regarding the wording of the questionnaire.

This validity testing served to:

- assess the internal consistency of items in the questionnaire,
- extract new content areas that may have been overlooked; and
- implement any changes in the questionnaire design that may have been necessary.

Two types of external validity are distinguished by Smaling (1992a: 314). Generalisability refers to the degree to which the results of the study can be applied to populations other than the one, which was studied, while transferential validity refers to the utilization by others of some findings, rather than across the broad generalization to another population. Johnson & Christensen (2000: 214) also add the notions of naturalistic generalisation and replication logic with regard to external validity. Naturalistic replication holds that generalisation is more likely to be valid when groups and situations generalised to be very similar to groups and situations generalised from. Replication logic states that the more

times a finding are the same in different studies, the more likely that finding is too being valid.

According to Smaling (1992a: 318) the following practical steps can be applied in enhancing validity in practice:

- preparing a comprehensive register of data, notes of relevant events and the state of affairs, and theoretical and methodological memoranda,
- regularly studying the above notes and memoranda,
- arranging and interpreting data without making use of special knowledge of the literature,
- member checks,
- peer debriefing,
- audit trail,
- external validity may be enhanced by the use of theory-driven data collection
- in terms of transferential validity the researcher should firstly contain an accurate description of the description of the research process, and secondly an explication of the arguments for the different choices of the method etc., and thirdly a detailed description (thick description) of the research situation and context.

With regard to the current study, it is argued that the following of Smaling's criteria apply directly to the present study and were therefore used:

In terms of internal reliability, peer examination, audit trail and automated data processing and analysis were utilised. As far as external reliability is concerned, both thick description and explication was used.

In terms of internal validity, a comprehensive register of data, theoretical and methodological memoranda were used. Furthermore data was also analysed separately from the theory in the first instance. It is argued that the logical validity of the current project was ensured by theoretical and methodological justification, used throughout the current project.

Transferential validity was adhered to by means of a description of the research process, justification of methodological decisions and a thick description of the research situation. The reliability and validity of the three subscales on the Sexuality Scale indicate that they might be useful for both future research and direct service delivery dealing with human sexuality (Allegeier & Allegeier, 1988). For example, this objective self-report instrument may allow researchers to investigate several important issues regarding the impact of

sexual-esteem, sexual-depression, and sexual-preoccupation on sexual preferences and behaviour, or gender differences in sexual disclosures (Snell, Belk, Papini, & Clark, 1988).

4.12.3 Ethical issues

McNamara (1994) identifies five ethical concerns to be considered when conducting survey research. These guidelines deal with voluntary participation, no harm to respondents, anonymity and confidentiality, identifying purpose and sponsor, and analysis and reporting. Each guideline will be addressed individually with explanations to help eliminate or control any ethical concerns.

- 4.12.3.1 Researchers need to make sure that participation is completely voluntary. However, voluntary participation can sometimes conflict with the need to have a high response rate. Low return rates can introduce response bias (McNamara, 1994). In order to encourage a high response rate, Dillman (2000) suggests multiple contacts.
- 4.12.3.2 McNamara's (1994) second ethical guideline is to avoid possible harm to respondents. This could include embarrassment or feeling uncomfortable about questions. Solutions to these harms will be discussed under confidentiality and report writing guidelines.
- 4.12.3.3 A third ethical guideline is to protect a respondent's identity. This can be accomplished by exercising anonymity and confidentiality. A survey is anonymous when a respondent cannot be identified on the basis of a response. A survey is confidential when a response can be identified with a subject, but the researcher promises not to disclose the individual's identity (McNamara, 1994).
- 4.12.3.4 McNamara's (1994) fourth ethical guideline is to let all prospective respondents know the purpose of the survey.
- 4.12.3.5 The fifth ethical guideline, as described by McNamara (1994), is to accurately report both the methods and the results of the surveys to professional colleagues in the medical community. Because advancements in academic fields come through honestly and openly, the researcher assumes the

responsibility to report problems and weaknesses experienced as well as positive results of the study.

4.12.4 Harms and benefits to the respondent

Babbie, Mouton, Payze, Vorster, Boshoff & Prozesky (2001:522) state that research in the social sciences should never harm the research participants, irrespective of whether or not such participants have given informed consent for inclusion in the study.

Spradley (1979: 35) states that informants should always be considered first, a view which is applied throughout the current study. In practice this means that several factors need to be considered before and during the research process. First, the researcher needs to clarify exactly what sponsors will require and whether this can be provided without harming the respondents. Also, successful negotiations need to be undertaken to bypass gatekeepers and ensure that all the necessary interviews can actually take place. Finally, it is of the utmost importance to ascertain carefully which actions will be in the best interests of respondents.

The avoidance of conflict of interests is an extremely complicated principle to apply in the actual research situation. For example, Payze & Keith (1993) were at one point confronted, via senior hierarchical organizational power structures, with pressure to reveal confidential data. While no information was eventually revealed, the experience clearly indicated how difficult it might become to put the interests of respondents first in the face of other stakeholders competing for preferential treatment.

Another way in which respondents may be harmed, namely intentional bias reporting, is explained by Gorden (1987: 90). Intentional bias reporting occurs when a researcher intentionally, or otherwise, alters the outcome of the meaning construction process for the sake of pursuing his or her own interests. For example, a study may exaggerate the difficulties of a group of respondents in order to try and rally more effective support for the group.

Respondents may also enjoy benefits from research projects (Spradley, 1979: 38; Gorden, 1987: 104; Kvale, 1996: 117; Johnson & Christensen, 2000: 86). Ideally the researcher needs to determine a "fair return" to respondents for participating in the study. These include payment, helping respondents in various ways (for example in helping them to find employment or providing information which can improve respondent's quality of life).

Providing respondents with a voice within the context of the broader society, etc. During the current study most respondents were glad for the opportunity they had to voice their intimate views and perceptions.

4.12.5 Anonymity versus confidentiality

The safeguarding of research participants' rights to privacy is stated as paramount by Babbie et al, (2000: 522). In this regard, Gorden (1987: 101) makes the important point that law against being forced to reveal confidential data does often not protect researchers. Hence, especially in South Africa's context of high crime rates and potentially volatile political situations, it may be important to ensure that the researcher does not know anything of use in, for example, a court of law. The difference between anonymity and confidentiality thus becomes relevant.

According to Gorden (1987: 104) and Babbie et al, (2001: 523), respondent anonymity means that the researcher never knows identifiable information concerning the respondent. Payze & Keith (1993), for example, used this principle by never asking respondents surnames and sometimes not even their names. The current study makes use of anonymity as was agreed upon by both the researcher and respondents.

4.12.6 Informed consent and deception

It is important to any study utilising the interpretive paradigm that informed consent be obtained before the actual meaning construction process begins. Beauchamp et al, (1982: 61) discuss several ways in which consent may be obtained in an unethical manner:

...consent (is) generated by the use of deception and by the violations of informed consent in social research. I shall use the term the pressure as shorthand designation of the various ways in which an individual's freedom of choice in the situation may be curtailed. At the extreme, this refers to the use of coercion or direct threats of punishment to induce participation by indicating that powerful authorities expect it, by offering irresistible rewards, by implying that failure to participate would result in penalties or place the individual in a bad light, by putting the individual on the defensive, or by identifying refusal with a lack of courage, courtesy, or patriotism. Both deception and pressure may occur at the point at which participation in the research is solicited, where they have a direct impact on the individual's capacity to give voluntary, informed consent. They may also occur at different points throughout

the research itself. For example, participants may be misled about various features of the situation or given false information about their performance; and they may be pressured to reveal information that they would prefer to withhold, or engage in activities they would prefer to avoid, or continue in the research when they would prefer to quit.

As far as the researcher knows it, no pressure was exerted on any individual involved in the current study at any time.

Babbie et al, (2001: 525) also discusses the issue of deceiving research participants and state that this can be done in several ways, including withholding relevant information about the study, lying about certain aspects of the study or not properly debriefing participants after the study, should they not be able to be fully informed at the outset. The current study attempted to function according to the norm of transparency, with both motivation for and purposes of the study explained before informed consent was obtained.

4.13 Level of measurement

Measurement can be undertaken at different levels. The levels reflect the correspondence of numbers assigned to the characteristics in question and the meaningfulness of performing mathematical operations on the numbers assigned. Nominal, ordinal, and interval data were collected via the survey questionnaire and subsequently were utilized in hypothesis testing.

4.13.1 Nominal measurement

Variables measured at nominal level generally represent questions that provide a limited number of alternative choice responses. Nominal measurement is where the numbers assigned allow the researcher to place an object in one and only one set of mutually exclusive and collectively exhaustive classes with no implied ordering (Dillon et al, 1993: 273).

4.13.2 Ordinal measurement

Ordinal measurement is a measurement in which the response alternatives define an ordered sequence so that the choice listed first, is less (greater) than the second, the second less (greater) than the third, and so forth (Dillon et al, 1993: 274). The number assigned does not reflect the magnitude of an attribute possessed by an object. The utilization of a

Likert scale was used to collect ordinal data on independent variables. Likert scaling is a method of index construction, also known as summated rating, and is often used to measure opinions or attitudes of individuals (O' Sullivan & Rassel, 1999). The use of a Likert scale allowed the characteristic of perceived intimacy to be measured and given a numerical value, which allowed for more extensive statistical analysis of the data. The Likert scale that was included in the survey questionnaire included five alternative responses:

4.13.3 Interval measurement

Interval measurement allows the researcher to indicate how far apart two or more objects are with respect to the attributes and consequently to compare the differences between the numbers assigned (Dillon et al, 1993:275). Variables measured at the interval level resulted in the collection of data that could be calculated in terms of length of time (in years). The duration of the relationship in different settings and the demographic variable of subjects' age are two examples.

4.14 Operational definitions

Several key terms used in the study are operationally defined here in order to clearly articulate their significance and to diminish any ambiguity that may exist in their meaning. It should be noted that the survey questionnaire pre-test results did not generate any comments from the respondents that revealed confusion or ambiguity concerning any of the terms.

4.14.1 Assumptions of the study

In any study, certain assumptions are made with respect to the quality of the data that are collected. Provided below is a summary of those assumptions that were made with respect to this research study.

4.14.2 Integrity of the data

One assumption made was that the questionnaires that were completed and returned contained honest and correct data.

4.14.3 Respondent's memory

A final assumption made in this study pertains to the subjects' ability to recall information. The survey instrument used in this study collected data that required the respondents to recall their self-perceived level of preparedness on numerous subject areas, skills, and perceptions.

4.15 Limitations of the study

While steps were taken to ensure that the data collection instrument used in this study was valid and that the overall design for this study was methodologically sound, there still exist a number of limitations to the research project that should be disclosed.

4.15.1 Cross-sectional design

While the utilization of a cross-sectional methodological design has its advantages, one of its drawbacks is that the design does not allow the researcher to measure the change in values of variables over time. Because investigators cannot control or manipulate the occurrence of independent variables in a cross-sectional study, they are unable to demonstrate causal relationships and therefore are unable to rule out alternative explanations as to the outcome of a given measurement.

4.15.2 Reliability of the survey instrument

Reliability is defined as the degree of random error associated with a measurement. Reliable measures are those that produce consistent and dependable data (O' Sullivan & Rassel, 1999). A standardized questionnaire was used as the data collection instrument and past history of the instrument's provision of reliable measurement exists. However, in order to assess the instrument's validity – the degree to which an item accurately measures what is intended – the instrument was pretested by a select group of individuals involved in an intimate relationship.

4.15.3 Respondent's self-evaluative abilities

One of the limitations of the study pertains to the issue of self-perception regarding the self-evaluative items on the questionnaire. The accuracy with which an individual assesses his

or her level of knowledge and ability may not be as valid as other's assessment of his or her knowledge, ability, and overall competency.

4.15.4 Response errors

Malhotra (1996: 102) defines a response error as the variation between the true value of the variable in the net sample and the observed mean value obtained in a marketing research project. A response error is a non-sampling error arising from respondents who do respond but give inaccurate answers or whose answers are misrecorded or misanalysed.

Researchers, interviewers or respondents can make response errors.

4.15.5 Dealing with non responses

According to Sudman and Blair (1999: 275) there has been a disturbing trend of a steady decline in sample co-operation. There are a number of reasons, which are not under the control of the researcher. The question then arises: whether careful probability design methods are valid and useful if co-operation rates continue to drop. Sudman et al (1999: 27) asserts that reasonably high-quality samples will continue to be possible but they will only be achieved with greater effort and cost. Further, Sudman et al (1999) suggest the following possibilities:

- more contact attempts to locate respondents,
- greater use of mixed modes to obtain co-operation,
- high compensation to interviewers and respondents,
- as co-operation declines, it will become increasingly important that intensive efforts be made to get a sample of previous non-respondents so that better post survey adjustments of data are possible and,
- current statistical efforts to adjust for non-cooperation as well as for imputation of missing data will be intensified and improved as problems grow worse, as seen in Groves (1989) and Rubin (1986).

4.15.6 Access to data

Steps have been incorporated into the study's design that facilitated access to sexual dysfunction clinics (i.e. Men's Health Clinic) and encouraged them to complete and return the questionnaire.

4.15.7 Overview of procedures

In accordance with established social sciences research procedures, steps were taken to address all facets of participant consent, and the collection, recording, analysis, and archiving of data. What follows is an overview of the procedures that were used in carrying out this research.

4.15.8 Access to the population

Consistent with the ethical tenets of social science research, the researcher abided by all the procedures required by American Psychological Association (APA), which provided a concise summary of the proposed study and included information on the targeted participant pool, the protocol for data collection, and the process for ensuring informed consent of study participants (see Annexure).

4.16 Conclusion

This chapter provided a description of the various data collection methods; the next chapter will provide a discussion on the results and interpretation thereof. Perhaps, it would be fitting to end this chapter with the following quote from the venerable sexual scientist and clinician John Money (1988:14):

Sex research today lives in a conceptual
ghetto, theoretically poverty
stricken, and lacking in consensus.
It is still mired in the organic versus
psychogenic dilemma, its own
version of the long-obsolete nature/nurture
dichotomy. For the
most part, it still follows the experimental
design of classical physics
and celestial mechanics, and searches
for univariate cause and effect,

whereas the phenomena of sex
research is, virtually without exception,
multivariately determined.

CHAPTER 5: RESULTS AND DISCUSSION

5. Introduction

This chapter provides an overview of what transpired during the data gathering process. During the preliminary process of data analysis, all relevant comments and suggestions were also noted and incorporated into the gathered data. Finally, themes were sifted and their relevance evaluated for the inclusion in the current study. Hence, it is now possible to present some comments on the data gathering process, as well as the analysis of the data.

5.1 Presentation of results

The results that follow will be presented in the following format where applicable: statistical summary, graphs and interpretation. The usual convention is followed where single asterisk (*) and double asterisk (**) refer to findings significant at the five and ten percent levels respectively. The following key will be applicable to all graphs and tables: sexual esteem (s.e.); sexual depression (s.d.); sexual preoccupation (s.p.); autonomy (a); personal growth (p.g.); environmental mastery (e.m.); purpose in life (p.l.); positive relations with others (p.r.) and self-acceptance (s.a.).

5.2 The process of analysis

The Statistical Package for the Social Sciences (SPSS) (Norusis, 1993) was utilized to analyse data that had been gathered. A coding template was established in order to capture the key coding instructions for each variable, e.g. how responses related to variables. All the steps proposed by Miles & Huberman (see Chapter 4) were followed.

5.2.1 Analysis of hypotheses

It was hypothesized that healthy sexuality and psychological well-being would be positively correlated with each the other.

5.3 Sample biographical descriptive data

Descriptive statistics provide a description and summarisation of the data collected from a group of individuals (Huysamen, 1998). The data obtained, using a Likert scale, was analysed using mean, standard deviations and range. Both descriptive and inferential

statistics were utilized to analyse the data in this study. The sample included 100 volunteer participants, 62 women and 38 men.

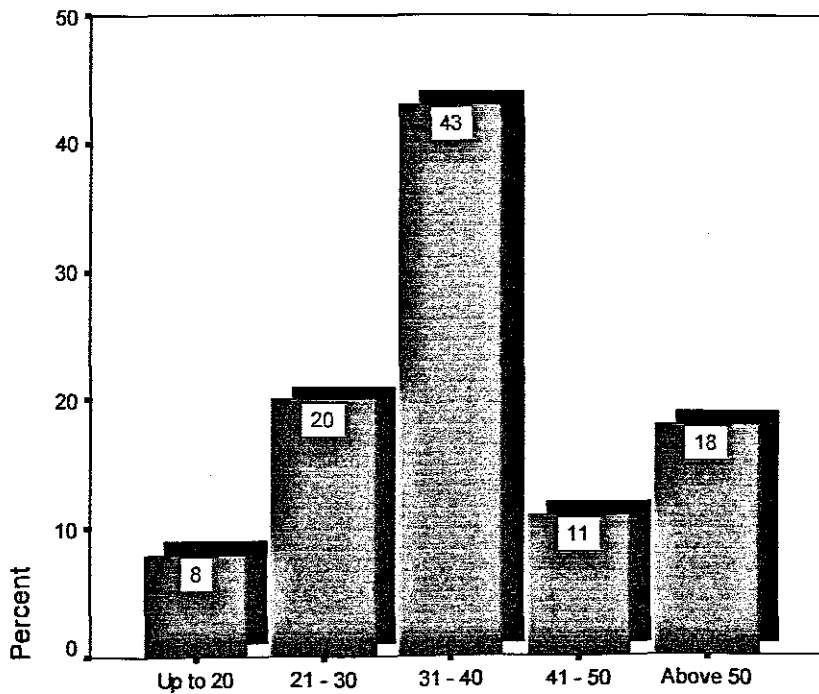
5.3.1. Age

Table 5.3.1.1: Age distribution

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Up to 20	8	8.0	8.0	8.0
21 – 30	20	20.0	20.0	28.0
31 – 40	43	43.0	43.0	71.0
41 – 50	11	11.0	11.0	82.0
Above 50	18	18.0	18.0	100.0
Total	100	100.0	100.0	

The above table results reveal the age dispersion of participated respondents in this project: 8.0 % are up to 20 years, 20.0 % are between 21-30 years group, 43.0 % are between 31-40 years group, 11.0 % are between 41-50 years group, 18.0 % are above 50 years groups. This age dispersion is graphically represented as follows.

5.3.1.2 Age dispersion graph



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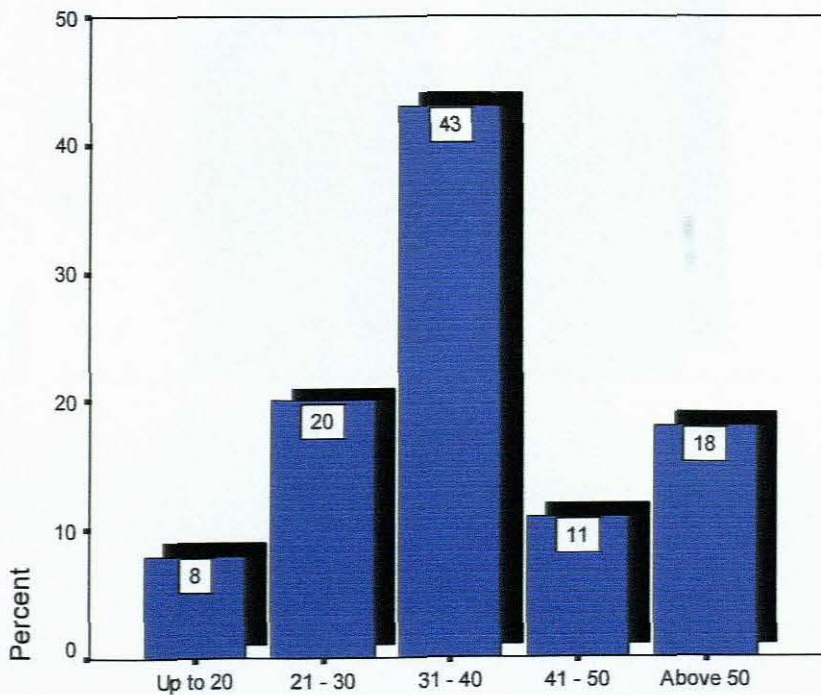
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31 – 40	43	43.0	43.0	71.0
41 – 50	11	11.0	11.0	82.0
Above 50	18	18.0	18.0	100.0
Total	100	100.0	100.0	

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5.3.1.2 Age dispersion graph



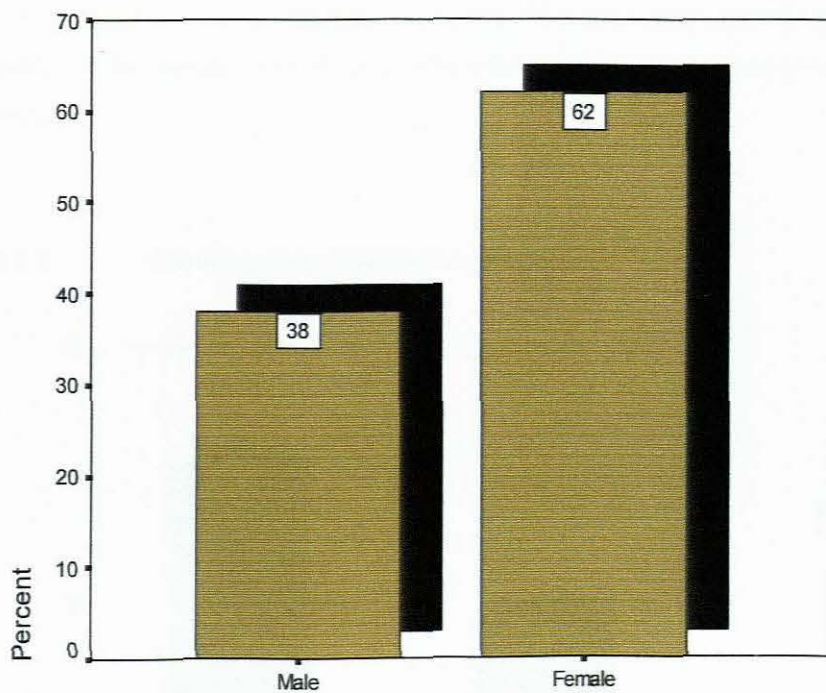
5.3.2 Gender

Table 5.3.2.1: Gender distribution

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	38	38.0	38.0	38.0
	Female	62	62.0	62.0	100.0
	Total	100	100.0	100.0	

Table 5.3.2.1 reveals the gender dispersion of participated respondents in this project: 38 are male and 62 are female. This gender dispersion is graphically represented as follows:

5.3.2.2 Gender dispersion graph



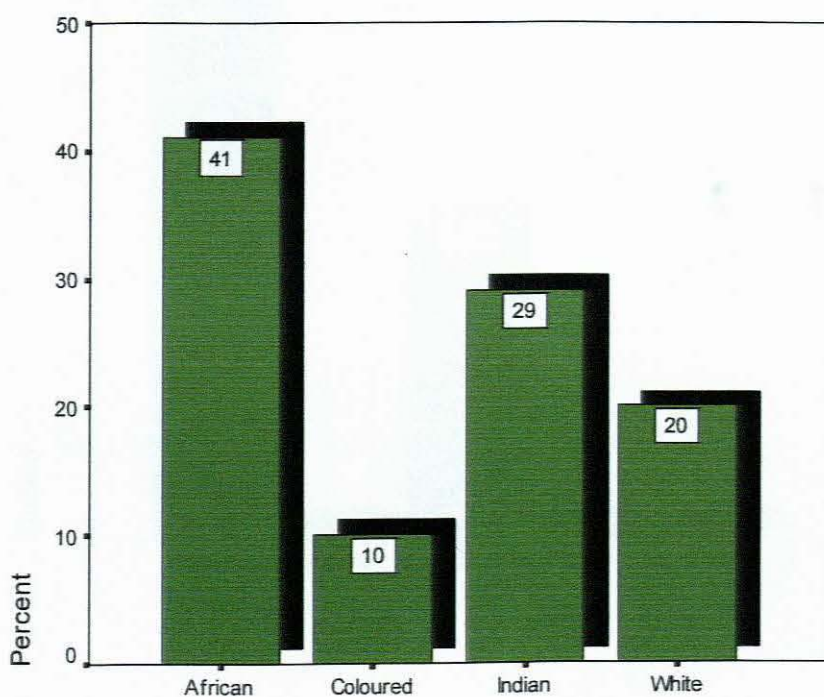
5.3.3 Ethnic group

Table 5.3.3.1: Ethnic group distribution

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid African	41	41.0	41.0	41.0
Coloured	10	10.0	10.0	51.0
Indian	29	29.0	29.0	80.0
White	20	20.0	20.0	100.0
Total	100	100.0	100.0	

The National Research Foundation, for purposes of equity and redress, currently uses these ethnic categories, which were previously used in the Apartheid regime. The above table results reveal the ethnic dispersion of participated respondents in this project: 41 of the participants were African, 10 were Coloured, 29 were Indian and 20 were White. Thus the majority of the sample was African. This ethnic dispersion is graphically represented as follows:

5.3.3.2 Ethnic group dispersion graph



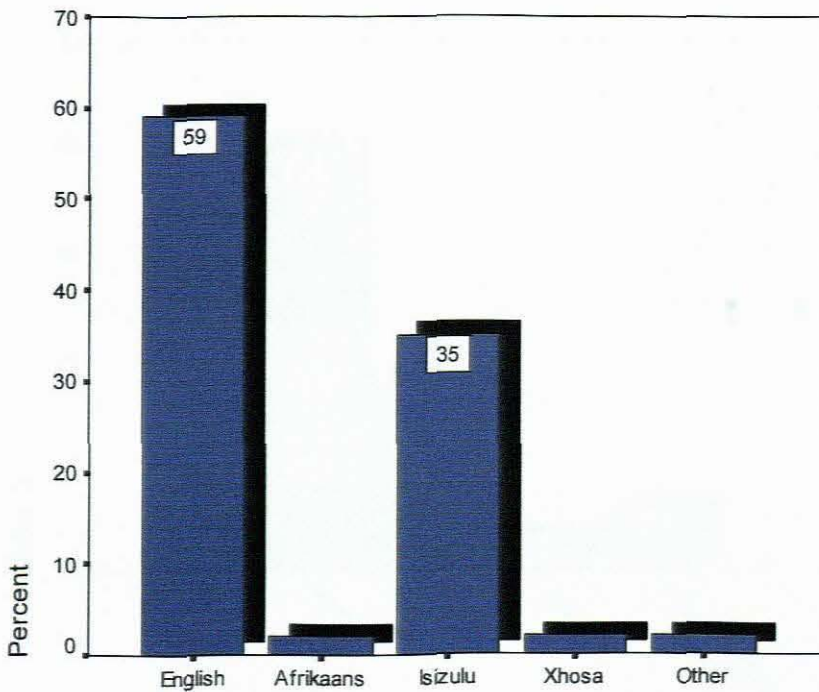
5.3.4 First (home) language

Table 5.3.4.1: Home language distribution

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	English	59	59.0	59.0	59.0
	Afrikaans	2	2.0	2.0	61.0
	Isizulu	35	35.0	35.0	96.0
	Xhosa	2	2.0	2.0	98.0
	Other	2	2.0	2.0	100.0
	Total	100	100.0	100.0	

Table 5.3.4.1 reveals the home language dispersion of participated respondents in this project: 59% were in the English speaking group, 2% were in the Afrikaans speaking group, 35% were in the Isizulu speaking group, 2% were in the Xhosa speaking, and 2% were are in the other group. This home language dispersion is graphically represented as follows:

5.3.4.2 Home language dispersion graph



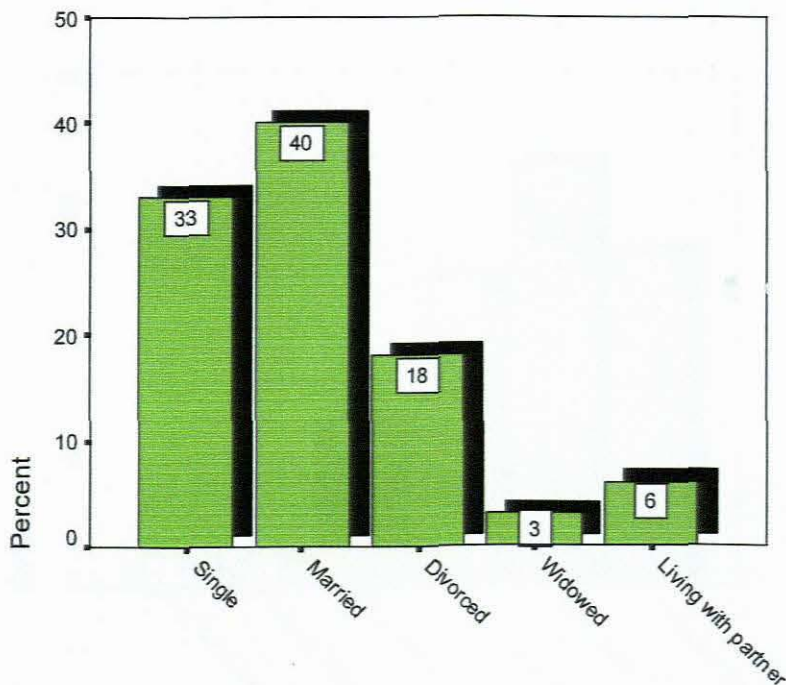
5.3.5 Marital status

Table 5.3.5.1: Marital status distribution

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Single	33	33.0	33.0	33.0
Married	40	40.0	40.0	73.0
Divorced	18	18.0	18.0	91.0
Widowed	3	3.0	3.0	94.0
Living with partner	6	6.0	6.0	100.0
Total	100	100.0	100.0	

Table 5.3.5.1 reveals the marital dispersion of respondents in this project: 33% were single, 40% were married, 18% were divorced, 3% were widowed and 6% were living with their partner. This marital dispersion is graphically represented as follows:

5.3.5.2 Marital status dispersion graph



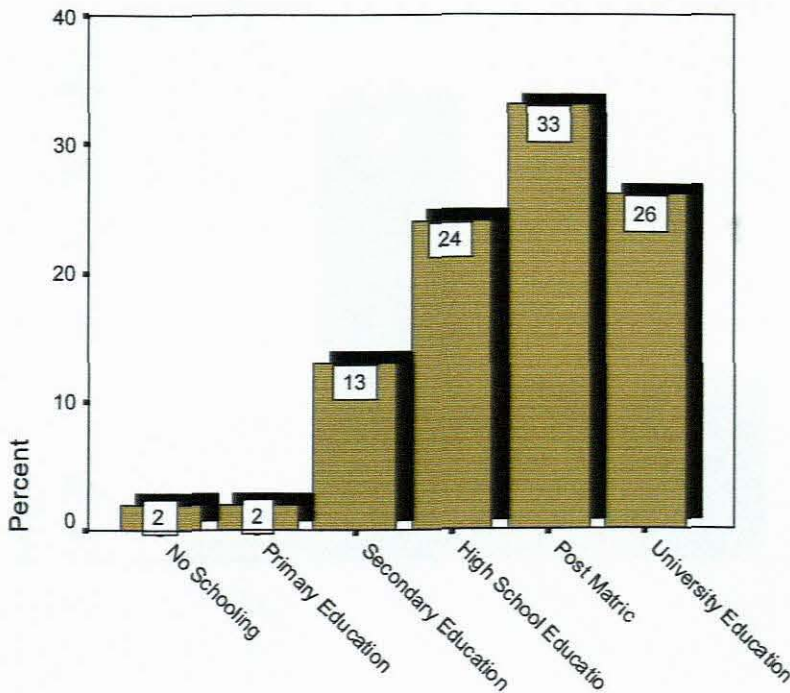
5.3.6. Education

Table 5.3.6.1: Educational level distribution

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid No Schooling	2	2.0	2.0	2.0
Primary Education	2	2.0	2.0	4.0
Secondary Education	13	13.0	13.0	17.0
High School Education	24	24.0	24.0	41.0
Post Matric	33	33.0	33.0	74.0
University Education	26	26.0	26.0	100.0
Total	100	100.0	100.0	

Table 5.3.6.1 reveals the educational level dispersion of participated respondents in this project: 2% had no schooling, 2% had primary education, 13% had secondary education, 24% had high school education, 33% had a post matric level of education and 26% had university education. This education dispersion is graphically represented as follows:

5.3.6.2 Education levels dispersion graph



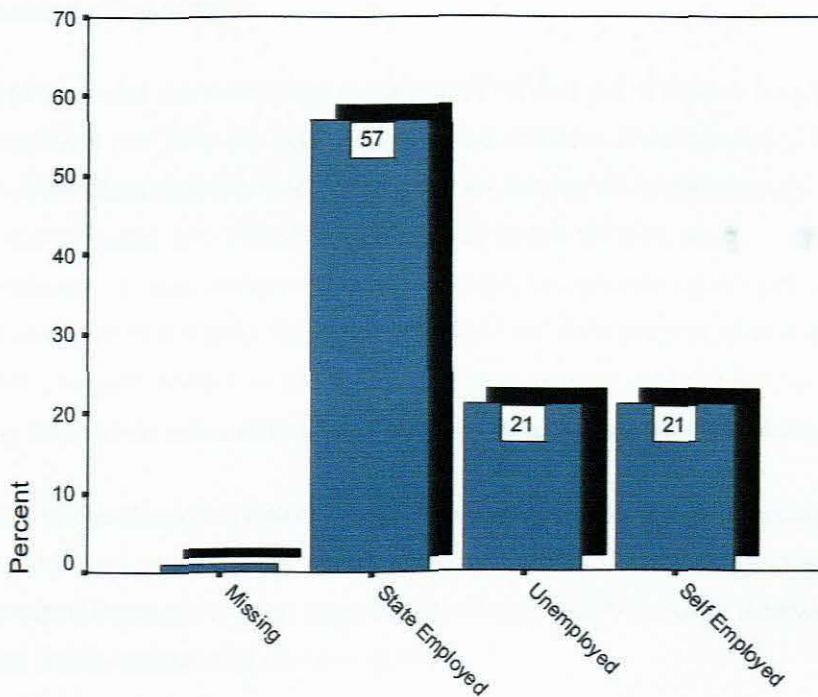
5.3.7 Occupation

Table 5.3.7.1: Occupation distribution

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	State Employed	57	57.0	57.6	57.6
	Unemployed	21	21.0	21.2	78.8
	Self Employed	21	21.0	21.2	100.0
	Total	99	99.0	100.0	
Missing	System	1	1.0		
Total		100	100.0		

Table 5.3.7.1 reveals the occupation dispersion of participated respondents in this project: 57% were state employed, 21% were unemployed, and 21% were self-employed. This occupational dispersion is graphically represented as follows:

5.3.7.2 Occupation levels dispersion graph



5.4 Sexuality Scale means and standard deviations

Table 5.4: Means and standard deviations for the subscales of the Sexuality Scale

Sexuality Subscales	SA Sample (N= 100)		US Sample (N= 296)	
	Mean	Std. Deviation	Mean	Std. Deviation
sexual esteem	4.4	5.9	6.2	8.8
sexual depression	2.1	4.4	0.6	7.9
sexual preoccupation	.9	10.0	.7	7.0
Total Score	2.46	6.8	2.5	7.9

A simple comparison of total sexuality mean scores suggests that while the US subjects perceived themselves to be 83% sexually healthy (i.e. scoring a mean of 2.5 out of 3), the South Africans perceived themselves to be 82% sexually healthy (i.e. scoring a mean of 2.46 out of 3). Regarding sex differences, women comprised 62% of the South African sample and 71% of the US sample, but there were no significant sex differences in the mean scale scores of either sample.

Many changes have occurred in the South African set of values during the past 10 years of democracy and they are also evident in the attitudes towards sexual morality. As a result of the AIDS pandemic the monogamist model for sex life is still strongly dominating people's sexual attitudes and behaviour during their entire lifetime, which is evident in their interpersonal relationships. Women have gained greater equity with regard to their male counterparts in the past 10 years. This has had an impact on their sexuality. As women have started to participate in working life as widely as men, and gained economic independence, they have been more empowered to make independent decisions also on their own sex life.

Many of the changes related to sex life seem to have occurred through a change in people's way of life as well as in the values of everyday life. The satisfaction with sex life has increased because women have become more active sexually and because of the more open public debate and communication.

Through the Gallup poll follow-up studies carried out in the US concerning sexual attitudes (Smith 1990), it has been established that attitudes towards premarital sex, pornography,

sex education and birth control were liberated in 1960s to the 1970s. These have been the most significant changes in attitudes in the time of the present generation. Since the beginning of the 1970s, attitudes have not become more liberal; in some respects (homosexuality, extra-marital relationships, pornography) they have even become somewhat more conservative (Snell and Papini, 1989).

South Africa is a strongly male-dominated society where violence against women is at a high level. Gender equality and freedom to express one's sexual orientation is enshrined in the new constitution of South Africa, but it is widely acknowledged that this is purely "paper" right.

In general, women and men negotiate their lives differently, as well as express their sexual vulnerabilities differently. In a patriarchal society like South Africa, one may expect these differences to be more prevalent than reported in the relevant international literature. Sex counselling will have to take into account the differing sexual socialization experiences of women and men in societies that institutionally and structurally accept the dominance of men, and where many women and men may also have accepted sexist stereotypes (Nicholas 1994a, 6).

As mentioned earlier, very little published research on the sexuality of South Africans is available, and hardly any sexuality research on black South Africans has been done. The sexual behaviour of blacks has been misrepresented to such a degree that an objective discussion is very difficult. The paucity of sociological and psychological studies is striking, with even the landmark studies of Kinsey and Masters and Johnson pay scant attention to the sexuality of black Americans. There is very little research in the field of sexology in South Africa. This is further discussed under "recommendations."

5.4.1 Sexuality Scale factor analysis

To verify the three conceptual dimensions underlying the Sexuality Scale (SS) for the South African data, the thirty items on the SS were subjected to a principal components factor analysis. A three-factor solution was specified and rotated to an orthogonal simple structure with the varimax procedure. The item loadings are shown in Table 5.4.1

Table 5.4.1 varimax rotation loading solutions of the items on the Sexuality Scale

Item	Item wording	1	2	3
SEXUAL ESTEEM ITEMS				
1.	I am a good sexual partner	.70	.09	-.22
4.	I would rate my sexual skill quite highly	.75	.19	-.07
7.	I am better at sex than most other people	.52	.23	-.06
10.	I sometimes have doubts about my sexual competence. (R)	.53	-.05	-.27
13.	I am not very confident in sexual encounters. (R)	.69	.01	-.24
16.	I think of myself as a very good sexual partner.	.82	.11	-.15
19.	I would rate myself low as a sexual partner. (R)	.74	.04	-.31
22.	I am confident about myself as a sexual partner.	.79	.02	-.32
25.	I am not very confident about my sexual skill. (R)	.74	-.02	-.23
28.	I sometimes doubt my sexual competence. (R)	.61	-.08	-.30
SEXUAL-PREOCCUPATION ITEMS				
3.	I think about sex all the time.	-.05	.78	.01
6.	I think about sex more than anything else.	.00	.67	.00
9.	I don't daydream about sexual situations. (R)	.15	.41	.06
12.	I tend to be preoccupied with sex.	-.04	.72	.04
15.	I'm constantly thinking about having sex.	-.11	.77	.07
18.	I think about sex a great deal of time.	-.05	.86	.13

21.	I seldom think about sex. (R)	<u>.17</u>	<u>.56</u>	<u>-.07</u>
24.	I hardly ever fantasize about having sex. (R)	<u>.04</u>	<u>.55</u>	<u>.10</u>
27.	I probably think about sex less often than most people(R)	<u>.28</u>	<u>.50</u>	<u>-.13</u>
30.	I don't think sex very often. (R)	<u>.18</u>	<u>.66</u>	<u>.05</u>

SEXUAL-DEPRESSION ITEMS

2.	I am depressed about the sexual aspects of my life.	<u>-.24</u>	<u>-.01</u>	<u>.77</u>
5.	I feel good about my sexuality. (R)	<u>-.48</u>	<u>-.07</u>	<u>.48</u>
8.	I am disappointed about the quality of my sex life	<u>-.14</u>	<u>.02</u>	<u>.76</u>
11.	Thinking about sex makes me happy. (R)	<u>-.28</u>	<u>-.28</u>	<u>.20</u>
14.	I derive pleasure and enjoyment from sex. (R)	<u>-.47</u>	<u>-.19</u>	<u>.20</u>
17.	I feel down about my sex life.	<u>-.22</u>	<u>.04</u>	<u>.84</u>
20.	I feel unhappy about my sexual relationships.	<u>-.24</u>	<u>.03</u>	<u>.75</u>
23.	I feel pleased with my sex life. (R)	<u>-.28</u>	<u>.01</u>	<u>.70</u>
26.	I feel sad when I think about my sexual experiences.	<u>-.27</u>	<u>.10</u>	<u>.49</u>
29.	I am not discouraged about sex. (R)	<u>-.25</u>	<u>.14</u>	<u>.56</u>

Note: (R) indicates that the item is reverse-scored. Where items loaded greater than .40 on their assigned factor, the relevant coefficients are underlined.

The first factor had an eigenvalue of 8.39 and accounted for 56 percent of the common variance. As an inspection of Table 5.4.1 indicates, the items on the sexual-esteem subscale characterized the first factor. All ten sexual-esteem items loaded on this factor with coefficients ranging from .52 to .82 (average coefficient, .69). The second factor had an eigenvalue of 4.75 and accounted for 32 percent of the common variance. All ten of the sexual-preoccupation items loaded substantially on this factor (i.e., greater than .41), with an average loading of .65 (range = .41 to .86).

The third factor, accounting for 13 percent of the common variance and having an eigenvalue of 1.88, dealt with the sexual-depression items. As can be seen in Table 5.4.1, eight of the ten items on this sexual-depression subscale had loadings greater than .43 on this factor (range = .48 to .84; average coefficient = .67). The other two items had loadings less than .20 and thus it was decided not to use them in subsequent subscale computations

and analyses. In summary, there was considerable factorial-validity evidence for the independence of the three measures of sexual-esteem, sexual-preoccupation, and sexual-depression.

The alphas for the *sexual-esteem* scale were: .92 for women, .93 for men, and .92 for all subjects. For the *sexual-depression* subscale, the alpha for women was .88 and the alpha for men was .94 (combined alpha = .90). The alphas for the *sexual-preoccupation* scale were: .88 for women, .79 for men, and .88 for all subjects. In brief, the three subscales had more than adequate internal consistency, thus justifying their use in the following analyses.

5.4.2 Sexuality Scale (SS) reliability analyses

The reliability of a measure, according to Sekaran (1994), indicates the extent to which the measure is without bias (error free) and hence, offers consistent measurement across time and across various items in the instrument. It indicates the stability and consistency with which the instrument measures the concept measured and helps to assess the “goodness” of a measure.

Cronbach’s alpha is a reliability coefficient that indicates how well the items in a set are positively correlated to one another. The closer Cronbach’s alpha is to 1, the higher the internal consistency reliability (Sekaran, 1994). The reliability coefficient is scale-free in that its value cannot be less than zero or greater than 1, 00. Cronbach’s coefficient alpha was used to determine reliability amongst individual items.

Table 5.4.2: Cronbach’s Coefficient Alpha for the Sexuality Scale

Number of Cases	100.0
Number of Items	30
Reliability Coefficients	Alpha = 0.7857

Table 5.4.2 indicates that the Sexuality questionnaire has a high degree of reliability and that the items in the questionnaire have a high level of inter-item consistency.

Reliability analysis for the questionnaire continuous variables reveals Cronbach’s alpha value is 0.7857, which indicates a satisfactory level of internal consistency and reliability of questionnaire variables.

The internal consistency of the three subscales on the Sexual Scale (i.e., sexual-esteem, sexual-depression, and sexual-preoccupation) was determined by calculating Cronbach alpha coefficients. These coefficients were computed for each of the three subscales, for women and men separately and together.

The alphas for the *sexual-esteem* scale were: .92 for women, .93 for men, and .92 for all subjects. For the *sexual-depression* subscale, the alpha for women was .88 and the alpha for men was .94 (combined alpha = .90). The alphas for the *sexual-preoccupation* scale were: .88 for women, .79 for men, and .88 for all subjects. In brief, the three subscales had more than adequate internal consistency, thus justifying their use in the following analyses.

The literature on human sexuality includes a focus on individual tendencies associated with sexual behaviours, thoughts, and affects (Allgeier & Allgeier, 1988). Snell and Papini (1989) have pursued a similar line of research with a focus on "positive, desirable" psychological tendencies associated with human sexuality. For this purpose, they developed the present Sexuality Scale. The results from Snell and Papini's (1989) initial investigation revealed considerable similarity between men's and women's sexual-esteem tendencies, while also indicating that among both males and females sexual-esteem was negatively related to the tendency to feel depressed about the sexual aspects of life.

5.4.3 Reliability and gender effects

5.4.3.1 Sexuality Scale correlational analysis for men

	S.E	S.D	S.P
S.E.	-.0		
S.D.	.13		
S.P.	-.11	-.33**	

5.4.3.2 Sexuality Scale correlational analysis for women

	S.E	S.D	S.P
S.E.			
S.D.	-.49**		
S.P.	.19*	-.07	

Sexual-esteem was strongly correlated in a negative manner with sexual-depression among both women and men. Two other gender-specific correlations were also statistically significant. Among women, sexual-preoccupation was positively correlated with sexual-

depression, whereas among men sexual-preoccupation was positively correlated with sexual-esteem. No other significant correlations were found.

Cronbach alphas were computed for the three SS subscales (separately for females and males). These measures of internal consistency were all sufficiently high to warrant their use in subsequent analyses (see Table 5.4.3.2): sexual-esteem (range = .91 to .91), sexual-depression (range = .93 to .93), and for sexual-preoccupation (range = .90 to .91). An inspection of Table 5.4.3.2 also indicates that sexual-esteem and sexual-depression scores were strongly and negatively correlated. Also, sexual-esteem correlated positively with sexual-preoccupation, whereas sexual-depression scores were unrelated to the measure of sexual-preoccupation for women.

5.5 Sexuality Scale correlational analyses

Table 5.5.1 Sexuality Scale correlational analysis for the three sexuality dimensions

	s.e.	s.d.	s.p
s.e.	.0	.0	.0
s.d.	.13	.0	.0
s.p.	.46**	.18	.0

** Correlation is significant at the 0.01 level (2-tailed).

Sexuality Scale correlational analysis reveals one statistically significant correlation between the subscales of sexual esteem and sexual preoccupation, (Pearson Correlation Coefficient of 0.46, $p < 0.001$).

Table 5.5.1 presents the correlation results associated with the sexual-esteem, sexual-depression, and sexual-preoccupation subscales. These analyses were conducted for women and men separately and in combination to determine whether gender might be a variable that influences the relationships among the three subscales. An inspection of this table indicates that sexual-esteem was strongly correlated in a negative direction with sexual-depression among both women and men. Also, it can be seen that the negative correlation between sexual-esteem and sexual-depression tended to be slightly stronger among the male subjects. Two gender-specific correlations were also statistically significant. Among women, sexual-preoccupation was positively correlated with sexual-esteem; whereas among men, sexual-preoccupation was positively correlated with sexual-depression. No other significant correlations were found.

5.6.1 ANOVA: Sexuality Scale

5.6.1.1 ANOVA: descriptive statistics with regard to age groups of participants

Descriptives :

		N	Mea	Std. Deviatio	Std. Error	Min mu	Maxi mu
s1 : Esteem	Up to	8	2.75	.463	.164	2	3
	21 -	20	2.85	.587	.131	2	4
	31 -	43	2.72	.454	.069	2	3
	41 -	11	2.64	.505	.152	2	3
	Above	18	2.67	.485	.114	2	3
	Total	100	2.73	.489	.049	2	4
s2:Sexua Depressio	Up to	8	3.00	.756	.267	2	4
	21 -	20	2.80	.616	.138	2	4
	31 -	43	2.67	.680	.104	2	4
	41 -	11	2.82	.751	.226	2	4
	Above	18	2.78	.548	.129	2	4
	Total	100	2.76	.653	.065	2	4
s3: Preoccupatio	Up to	8	3.00	.535	.189	2	4
	21 -	20	3.10	.641	.143	2	4
	31 -	43	3.07	.632	.096	2	5
	41 -	11	3.18	.603	.182	2	4
	Above	18	3.17	.857	.202	2	5
	Total	100	3.10	.659	.066	2	5

5.6.1.2 Summary results of Anova on age groups

ANOVA : Age groups

		Sum of Squares	df	Mean Square	F	Sig.
s1 : Sexual Esteem	Between Groups	.463	4	.116	.473	.755
	Within Groups	23.247	95	.245		
	Total	23.710	99			
s2:Sexual Depression	Between Groups	.851	4	.213	.488	.744
	Within Groups	41.389	95	.436		
	Total	42.240	99			
s3: Sexual Preoccupation	Between Groups	.273	4	.068	.152	.962
	Within Groups	42.727	95	.450		
	Total	43.000	99			

The Anova test results reveal no statistically significant difference in perceptions of different age groups of respondents towards the study items s1, s2 and s3.

5.6.2.1 ANOVA: descriptive statistics with regard to ethnic groups of participants

Descriptives

		N	Mea	Std. Deviatio	Std. Error	Mini um	Maxim m
s1 : Esteem	African	41	2.80	.401	.063	2	3
	Coloure	10	2.60	.516	.163	2	3
	India	29	2.72	.591	.110	2	4
	Whit	20	2.65	.489	.109	2	3
	Total	100	2.73	.489	.049	2	4
s2:Sexua Depressio	African	41	2.56	.594	.093	2	4
	Coloure	10	2.90	.738	.233	2	4
	India	29	3.03	.626	.116	2	4
	Whit	20	2.70	.657	.147	2	4
	Total	100	2.76	.653	.065	2	4
s3: Preoccupatio	African	41	3.00	.500	.078	2	4
	Coloure	10	2.90	.568	.180	2	4
	India	29	3.28	.797	.148	2	5
	Whit	20	3.15	.745	.167	2	4
	Total	100	3.10	.659	.066	2	5

5.6.2.2 Summary results of Anova performed on ethnic groups

ANOVA : Ethnic groups

		Sum of Squares	df	Mean Square	F	Sig.
s1 : Sexual Esteem	Between Groups	.528	3	.176	.729	.537
	Within Groups	23.182	96	.241		
	Total	23.710	99			
s2:Sexual Depression	Between Groups	4.077	3	1.359	3.419	.020
	Within Groups	38.163	96	.398		
	Total	42.240	99			
s3: Sexual Preoccupation	Between Groups	1.757	3	.586	1.363	.259
	Within Groups	41.243	96	.430		
	Total	43.000	99			

The Anova for ethnic group's scores on the sexuality scale indicated a statistically significant difference between the groups for the subscale sexual depression. This significant value indicates that there are differences among the means, but it does not determine where these differences lie, i.e., one cannot ascertain which factors significantly differ from each other.

5.6.3.1 ANOVA: descriptive statistics with regard to home language groups of participants

Descriptives

		N	Mea	Std. Deviatio	Std. Error	Mini um	Maxi um
s1 : Esteem	Englis	59	2.66	.545	.071	2	4
	Afrikaan	2	3.00	.000	.000	3	3
	Isizul	35	2.80	.406	.069	2	3
	Xhosa	2	3.00	.000	.000	3	3
	Other	2	3.00	.000	.000	3	3
	Total	100	2.73	.489	.049	2	4
s2:Sexua Depressio	Englis	59	2.86	.655	.085	2	4
	Afrikaan	2	2.50	.707	.500	2	3
	Isizul	35	2.57	.608	.103	2	4
	Xhosa	2	3.00	.000	.000	3	3
	Other	2	3.00	1.414	1.000	2	4
	Total	100	2.76	.653	.065	2	4
s3: Preoccupatio	Englis	59	3.17	.723	.094	2	5
	Afrikaan	2	2.50	.707	.500	2	3
	Isizul	35	2.97	.514	.087	2	4
	Xhosa	2	3.50	.707	.500	3	4
	Other	2	3.50	.707	.500	3	4
	Total	100	3.10	.659	.066	2	5

5.6.3.2 Summary results of ANOVA performed on ethnic groups

ANOVA : Home language

		Sum of Squares	df	Mean Square	F	Sig.
s1 : Sexual Esteem	Between Groups	.890	4	.222	.926	.452
	Within Groups	22.820	95	.240		
	Total	23.710	99			
s2:Sexual Depression	Between Groups	2.253	4	.563	1.338	.261
	Within Groups	39.987	95	.421		
	Total	42.240	99			
s3: Sexual Preoccupation	Between Groups	2.223	4	.556	1.295	.278
	Within Groups	40.777	95	.429		
	Total	43.000	99			

The Home language Anova test results in Table 5.6.3.2 reveal no statistically significant difference in perceptions by respondents from different home languages towards the study items s1, s2 and s3.

5.6.4.1 ANOVA: descriptive statistics with regard to marital status of participants

Descriptives

		N	Mea	Std. Deviatio	Std. Error	Mini um	Maxi um
s1 : Esteem	Singl	33	2.82	.528	.092	2	4
	Marrie	40	2.73	.452	.071	2	3
	Divorce	18	2.67	.485	.114	2	3
	Widowe	3	2.33	.577	.333	2	3
	Living with	6	2.67	.516	.211	2	3
	Total	100	2.73	.489	.049	2	4
s2:Sexua Depressio	Singl	33	2.88	.696	.121	2	4
	Marrie	40	2.83	.636	.101	2	4
	Divorce	18	2.56	.616	.145	2	4
	Widowe	3	2.33	.577	.333	2	3
	Living with	6	2.50	.548	.224	2	3
	Total	100	2.76	.653	.065	2	4
s3: Preoccupatio	Singl	33	3.09	.765	.133	2	5
	Marrie	40	3.23	.660	.104	2	5
	Divorce	18	2.89	.471	.111	2	4
	Widowe	3	2.67	.577	.333	2	3
	Living with	6	3.17	.408	.167	3	4
	Total	100	3.10	.659	.066	2	5

5.6.4.2 Summary results of ANOVA performed on marital status

ANOVA : Marital Status

		Sum of Squares	df	Mean Square	F	Sig.
s1 : Sexual Esteem	Between Groups	.826	4	.206	.857	.493
	Within Groups	22.884	95	.241		
	Total	23.710	99			
s2:Sexual Depression	Between Groups	2.339	4	.585	1.392	.243
	Within Groups	39.901	95	.420		
	Total	42.240	99			
s3: Sexual Preoccupation	Between Groups	2.020	4	.505	1.171	.329
	Within Groups	40.980	95	.431		
	Total	43.000	99			

The Anova test results reveal no statistically significant difference in perceptions of different marital status groups towards the study items s1, s2 and s3.

5.6.5.1 ANOVA: descriptive statistics with regard to educational level of participants

Descriptives

		N	Mea	Std. Deviatio	Std. Error	Minim m	Maxi um
s1 : Esteem	No	2	3.00	.000	.000	3	3
	Primary	2	3.50	.707	.500	3	4
	Secondary	13	2.92	.277	.077	2	3
	High School	24	2.71	.464	.095	2	3
	Post	33	2.70	.529	.092	2	4
	University	26	2.62	.496	.097	2	3
	Total	100	2.73	.489	.049	2	4
s2:Sexua Depressio	No	2	2.50	.707	.500	2	3
	Primary	2	3.50	.707	.500	3	4
	Secondary	13	2.85	.555	.154	2	4
	High School	24	2.63	.711	.145	2	4
	Post	33	2.73	.674	.117	2	4
	University	26	2.85	.613	.120	2	4
	Total	100	2.76	.653	.065	2	4
s3: Preoccupatio	No	2	3.00	.000	.000	3	3
	Primary	2	3.50	.707	.500	3	4
	Secondary	13	3.15	.555	.154	2	4
	High School	24	3.04	.751	.153	2	5
	Post	33	3.09	.723	.126	2	5
	University	26	3.12	.588	.115	2	4
	Total	100	3.10	.659	.066	2	5

5.6.5.2 Summary results of ANOVA performed on educational levels

ANOVA : Education level

		Sum of Squares	df	Mean Square	F	Sig.
s1 : Sexual Esteem	Between Groups	2.205	5	.441	1.928	.097
	Within Groups	21.505	94	.229		
	Total	23.710	99			
s2:Sexual Depression	Between Groups	1.993	5	.399	.931	.465
	Within Groups	40.247	94	.428		
	Total	42.240	99			
s3: Sexual Preoccupation	Between Groups	.468	5	.094	.207	.959
	Within Groups	42.532	94	.452		
	Total	43.000	99			

The Anova test results reveal no statistically significance difference in perceptions of different educational group's respondents towards study items s1, s2 and s3.

5.6.6. 1 ANOVA: descriptive statistics with regard to occupational level of participants

Descriptives

		N	Mea	Std. Deviatio	Std. Error	Mini um	Maxi um
s1 : Esteem	State	57	2.74	.518	.069	2	4
	Unemploye	21	2.81	.402	.088	2	3
	Self	21	2.62	.498	.109	2	3
	Total	99	2.73	.491	.049	2	4
s2:Sexua Depressio	State	57	2.67	.607	.080	2	4
	Unemploye	21	2.76	.700	.153	2	4
	Self	21	3.00	.707	.154	2	4
	Total	99	2.76	.656	.066	2	4
s3: Preoccupatio	State	57	3.02	.641	.085	2	4
	Unemploye	21	3.19	.602	.131	2	5
	Self	21	3.24	.768	.168	2	5
	Total	99	3.10	.662	.067	2	5

5.6.6.2 Summary results of ANOVA performed on occupational levels

ANOVA : Occupation

		Sum of Squares	df	Mean Square	F	Sig.
s1 : Sexual Esteem	Between Groups	.393	2	.197	.812	.447
	Within Groups	23.243	96	.242		
	Total	23.636	98			
s2:Sexual Depression	Between Groups	1.706	2	.853	2.023	.138
	Within Groups	40.476	96	.422		
	Total	42.182	98			
s3: Sexual Preoccupation	Between Groups	.960	2	.480	1.096	.338
	Within Groups	42.030	96	.438		
	Total	42.990	98			

The Anova test results reveal no statistically significance difference in perceptions of different occupational levels towards study items s1, s2 and s3.

5.7 Sexuality Scale multivariate analyses

A two-group (females and males) MANOVA was conducted on the three subscales on the Sexuality Scale to determine whether women and men would report experiencing different levels of sexual-esteem, sexual-depression, or sexual-preoccupation. The overall gender effect was highly significant, $F(3, 290) = 15.68, p < .001$. Univariate analyses revealed a significant gender effect for only the sexual-preoccupation subscale, $F(1, 292) = 47.23, p < .0001$. Table 5.13 reveals that males reported much higher levels of sexual-preoccupation ($M = 2.42$) than did females ($M = -3.99$). This table also indicates that males and females were quite similar in terms of their sexual-esteem and sexual-depression.

The means for both women and men on the sexual-esteem subscale were both positive, indicating that they felt rather positive about themselves and their sexuality. Likewise, women's and men's scores on the sexual-depression scale were negative, thus indicating that on the average these respondents were not feeling particularly depressed about the sexual aspects of themselves.

The purpose of the present investigation was to provide additional evidence for the reliability and validity of the Sexuality Scale, a measure of psychological tendencies associated with sexual-esteem, sexual-depression, and sexual-preoccupation. The findings provided preliminary evidence for the Sexuality Scale as a measure of these three sexual tendencies by identifying predictable associations with measures of sexual attitudes and interpersonal approaches to sexual relations.

5.8 Psychological Well-Being Scale

Table 5.8.1 Psychological Well-Being Scale means and standard deviations

Psychological Well being Dimension	SA Sample (N= 100)		US Sample (N= 1108)	
	Mean	Std. Deviation	Mean	Std. Deviation
autonomy	12.3	2.6	15.2	2.6
Personal growth	12.6	2.6	15.7	2.5
environmental mastery	11.4	2.4	14.9	2.8
purpose in life	11.8	2.5	14.4	3.2
positive relations with others	10.9	2.4	14.8	3.2
self-acceptance	11.5	2.3	14.6	3.1
Total Score	11.8	2.5	14.9	2.9

While the available US data did not permit comprehensive statistical comparisons, a simple comparison of total psychological well-being mean scores suggests that while the US subjects perceived themselves to be 83% psychologically well (i.e. scoring a mean of 14.9 out of a possible 18), the South Africans perceived themselves to be 66% psychologically well (i.e. scoring a mean of 11.8 out of a possible 18). Regarding the sex differences, women comprised 62% of the South African sample and 59% of the US samples, but there were no significant sex differences in the mean scale scores of either sample, except in the positive relations dimension where US sample where women scored higher than men (Snell and Papini, 1989).

Spearman's correlations analysis of the South African sample revealed that all dimensions correlated significantly with each other at the level $p < 0.01$. As in the research of Ryff and Keyes (1995), all correlations were modest, ranging from 0.14 (purpose in life and autonomy) to 0.33 (environmental mastery and autonomy). Principle component factor analysis revealed that a single factor of psychological well-being accounted for 35.22% of variance. All dimensions were moderately and positively correlated with this factor, with

correlations ranging from 0.47 (purpose in life) to 0.65 (autonomy and environmental mastery). Multivariate analyses indicated no significant influences of age, gender, ethnic grouping, home language, marital status or occupation on any of the dimensions of psychological well-being.

The present South African scores are lower than all the US scores reported by Ryff and Keyes (1995). In the early 1990s, South Africa was faced with a major upheaval, politically, socially, and economically. The uncertain political, social, and economic future of South Africa, faced with the transition from an apartheid-dominated government to a multiracial multiparty democracy, had posed many challenges for the country. It is, therefore, not surprising that their sense of psychological well-being is lower than people elsewhere. The psychologically damaging effects of apartheid are well documented (Duncan & Van Niekerk, 2001). The large difference that is apparent (in the absence of statistical tests of significance) between the two samples on the Purpose in Life scale must be viewed in this context. Given the uncertainty these young peoples have grown up with, their comparatively low scoring is understandable. Similarly, the lower Positive Relation with Others scores can be linked to the shift in social roles and relationships since the inception of democracy in 1994. This is a major adjustment to make after years of oppression and legislation that classified Black South Africans as second -class citizens (Edwards, Ngcobo & Pillay, 2004).

It is important that self-reports of psychological well-being evidenced by the present subjects are understood in the context of the socio-developmental variables in their lives.

5.8.2 Psychological Well-Being Scale factor analysis results

To verify the three conceptual dimensions underlying the Psychological Well-being Scale, the 18 items on the scale were subjected to a principal components factor analysis. A six-factor solution was specified and rotated to orthogonal simple structure with the varimax procedure. The item loadings are shown in Table 5.8.2.

Table 5.8.2 Factor analysis: Psychological Well- being

Total Variance Explained : Well being

Component	Initial Eigenvalues			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	5.711	31.726	31.726	3.001	16.670	16.670
2	1.981	11.007	42.733	2.393	13.294	29.964
3	1.508	8.380	51.113	2.301	12.784	42.748
4	1.303	7.239	58.353	1.875	10.419	53.167
5	1.148	6.376	64.729	1.589	8.826	61.993
6	.931	5.175	69.904	1.424	7.911	69.904
7	.884	4.911	74.815			
8	.775	4.306	79.121			
9	.662	3.678	82.799			
10	.598	3.320	86.119			
11	.508	2.823	88.942			
12	.406	2.257	91.200			
13	.364	2.022	93.222			
14	.296	1.646	94.867			
15	.273	1.516	96.383			
16	.257	1.429	97.812			
17	.239	1.329	99.142			
18	.154	.858	100.000			

Extraction Method: Principal Component Analysis.

Rotated Component Matrix

	Component					
	1	2	3	4	5	6
st1						.715
st2		.509	.380		-.335	
st3	.416	.325	.514	.367		
st4	-.345		.351			.562
st5				.466	.585	
st6					.823	
st7	.359		.763			
st8			.796			
st9					.457	.507
st10	.461	.645				
st11	.800					
st12	.848					
st13	.752		.362			
st14		.785	.355			
st15	.461	.341	.328			.373
st16		.800				
st17				.861		
st18				.671		

Extraction Method: Principal Component Analysis.

Rotation Method: Varimax with Kaiser Normalization.

a. Rotation converged in 7 iterations.

5.8.3 Reliability of the Psychological Well-Being Scale

Table 5.8.3: Cronbach's Coefficient Alpha for the Psychological Well-being Scale

Number of Cases	100.0
Number of Items	18
Reliability Coefficients	Alpha = 0.8146

Reliability analysis for the Psychological Well-being questionnaire continuous variables reveals Cronbach's alpha value of 0.8146 which indicates a satisfactory level of internal consistency.

5.8.4 Psychological Well-Being Scale correlational analyses

Table 5.8.4: correlations between Sexuality sub Scales and Psychological well-being dimensions

	s.e.	s.d.	s.p.	a.	p.g.	e.m.	p.l.	p.r.	s.a
s.e	1	.13	.46(**)	.08	-.02	-.15	.13	-.11	.01
s.d	.13	1	.18	-.18	-.16	-.20(*)	-.03	-.29(**)	-.25
s.p	.46(**)	.18	1	-.36	-.00	-.16	.01	-.15	-.16
A	.09	-.18	-.04	1	.43(**)	.50(**)	.24(*)	.44(**)	.43(**)
p.g.	-.20	-.16	-.00	.43(**)	1	.55(**)	.59(**)	.42(**)	.40(**)
e.m.	-.15	-.20(*)	-.16	.50(**)	.55(**)	1	.46(**)	.48(**)	.58(**)
p.l.	.13	-.03	.01	.24(*)	.59(**)	.46(**)	1	.26(**)	.46(**)
p.r	-.11	-.29(**)	-.15	.43(**)	.42(**)	.48(**)	.26(**)	1	.58(**)
s.a	.00	-.24(*)	-.16	.43(**)	.40(**)	.58(**)	.45(**)	.58(**)	1

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

There are only three significant correlations between the scales. These concern sexual depression only as negatively correlated with environmental mastery (-.2), positive relations with others (-.3) and self-acceptance (-.2)

In general, sexual esteem is positively correlated with three of the six well-being dimensions, sexual depression is negatively correlated with all of the six well-being dimensions and sexual preoccupation is negatively correlated with five of six well-being dimensions.

Both therapists and the general public see the quality of a couple's romantic relationship and their psychological well-being as linked (Sprecher, 2002; Wincze & Carey, 2001). In fact, researchers consistently have shown that there is a strong positive association between psychological satisfaction and sexual satisfaction (e.g., Haavio-Mannila & Kontula, 1997; Purnine & Carey, 1997).

The goal of this study was to explore the association between psychological well-being and sexuality in men and women in order to provide evidence about possible explanations for the association between the two variables. A finding that psychological well-being predicts change in sexual satisfaction would be consistent

with the hypothesis that psychological well-being affects sexual satisfaction. A finding that relationship satisfaction does not predict change in sexual satisfaction would be inconsistent with the hypothesized relationship.

Consistent with past research, individuals with greater relationship satisfaction also reported greater sexual satisfaction (Haavio-Mannila & Kontula, 1997; Purnine & Carey, 1997). In addition, changes in sexual satisfaction were associated with changes in relationship satisfaction for these individuals in long-term relationships, as Sprecher (2002) found in her study of dating couples. There was evidence base to support the hypothesis that low sexual satisfaction leads to a decrease in relationship satisfaction or the view that low relationship satisfaction leads to a decrease in sexual satisfaction for either men or women. Thus, it may be that very small increments or decrements in relationship satisfaction cause equally small changes in relationship satisfaction (or vice versa) over so short a time period that relationship satisfaction and sexual satisfaction change concurrently.

Past research has shown that intimate communication is associated with both sexual satisfaction and relationship satisfaction (Cupach & Comstock, 1990; Fowers & Olson, 1989). In sum; the results suggest that low relationship satisfaction leads to decreased sexual satisfaction and, higher relationship satisfaction was associated with a greater increase in sexual satisfaction.

5.9 Thematic content analysis

Several themes were identified in the current data, which were obtained by reviewing the suggestions made by the respondents to the open-ended question:

'What suggestions can you recommend to improve your sexual relationship?'

The data was analysed using the thematic approach as described by, amongst others Maso (1989), Miles & Huberman (1994) and Hughes (1994). It is important to note that the data analysis was done with the aid of the software package ATLAS/ti, in order to enhance the accessibility to the data, improve rigour in the pursuit of scientific knowledge, reduce errors and contribute to internal reliability.

The phase of data analysis included some basic steps described by Miles & Huberman (1994:9):

- Once the data for the current study had been gathered, transcribed, and notes inserted, the questionnaire data was then imported into the computer-aided qualitative data analysis software (Caqdas) package, ATLAS, ti for analysis.
- Noting reflections or other remarks. This step involves noting aspects of the research, which are not reflected in the transcript of the questionnaire. Such aspects include general comments about the setting wherein the research took place, etc. ATLAS/ti has extensive memory facilities designed for this purpose.
- Sorting and sifting through these materials to identify similar phrases, (what is termed quantitative methodology) relationships between variables, patterns, themes, distinct differences between subgroups, and common sequences. This step refers to what is commonly termed 'thematic analysis' by qualitative researchers, and involves the identification of certain themes from the results (Miles & Huberman, 1994).
- Gradually elaborating a small set of (themes) that cover the consistencies discerned in the database. This is the final step in the process of thematic analysis. It involves the incorporation of all the information that emerged from all the questionnaires into the various identified themes, as well as the creation of new themes where necessary. Furthermore, since ATLAS/ti facilitates the

- creation of relations between themes, this enhanced a holistic global view of, not only the issues at stake, but also of the interrelatedness of these issues.
- Confronting those (themes) with a formalized body of knowledge in the form of constructs or theories. The interpretative phase consisted of a process whereby the practical and theoretical aspects of the study were integrated in such a way as to expand the current body of theoretical knowledge on the subject of human sexuality and dysfunction.

Below is a list of the themes identified from the responses to the open-ended question, as produced by the Caqdas package ATLAS/ti.

5.9.1 Themes emerging from the data

Five main themes were identified in the current data set without confronting the data with the theory. These were:

- Communication
- Intimacy
- Affection
- Self-esteem
- Quality of life

These themes are discussed below.

5.9.2 Discussion of emerging themes from the current analysis

Dissatisfaction with various aspects of the sexual relationship was associated with sexual dysfunction. High levels of conflict in the sexual area and a desire for change in levels of communication were more likely to occur among dysfunctional couples. This study provides support for earlier studies that demonstrated that general dissatisfaction among couples within their relationship is associated with sexual dysfunction (McCabe, 1997:277-290). Perhaps this is consistent with Bleck and Loveless' (1987) view that suggested that it is the thinking about sex that is important in predicting sexual functioning: if sexual thinking is negative, it diminishes the pleasurable potential of sexual responses; if sexual thinking is positive, it will enhance sexual enjoyment.

A variation of this approach was expressed by Gagnon, Rosen and Leiblum (1982). They claimed that one's sexual scripts are what determine one's sexual functioning. These sexual scripts are developed during one's life as a result of life experiences. The manner in which these life experiences are interpreted influences the development of sexual scripts, which in turn, influence the manner in which current sexual stimuli are processed. Therefore these scripts shape the level of enjoyment of sexual interactions and, depending upon the congruity between the scripts and what is occurring in the sexual area, they may predict levels of sexual dysfunction. Sexual interactions within relationships can be changed. But to achieve this change it is necessary to communicate with one's partner about the nature of the desired change. This communication is made easier if the level of conflict in this area is low and if there are already high levels of communication between partners. This finding is consistent with the results of Travis and Travis (1986) that developed a model of sexual functioning which is dependent upon intimacy: sex life and non-sex life are not two separate camps, but are closely related to one another. Intimacy leads to particular kinds of behaviours, which in turn enhance the intimacy of a relationship.

Several theories of intimate relationship satisfaction have been proposed to explain which relationship processes truly provide for a happy relationship. The research results suggest three main variables as central to relationship satisfaction of interpersonal communication, sexual communication, and communication affect. Relationship communication skills proved to be the most reliable predictor of concurrent relationship satisfaction. Implications for this finding are discussed.

The search for the key to what accounts for relationship satisfaction has long mystified researchers. As such, inventory after inventory has been created to measure different variables within relationships. Researchers have created inventories assessing everything from sexual satisfaction and function (LoPiccolo & Steger, 1974; McCabe, 1998) and overall communication (Hecht, 1978); to interaction affect (Gottman & Levenson, 1985). Several questionnaires have been created that attempt to measure several variables at once on different (sometimes unfounded and ambiguous) subscales, such as intellectual intimacy or attitude to privacy, each assumed, but many times not supported, to relate to overall relationship satisfaction (Fletcher, Simpson, & Thomas, 2000; Holman & Li, 1997; Schaefer & Olson, 1981). There is even a debate as to which overall relationship satisfaction inventory to use, with new ones always being created and compared to the last (Locke & Wallace, 1959; Snyder, 1979; Spanier, 1976).

The most extensively researched applied approaches that measure variables related to relationship satisfaction are derived from general communication, sexual communication, and interaction affect theories. The communication processes within a couple have been strongly emphasized in relationship counselling, and it has been proposed that "the study of marriage and marital therapy can best be advanced at this time through a better understanding of marital communication processes" (Notarius, Markman, & Gottman, 1983, p. 118). Communication skills have even been claimed to be the "key" and "lifeblood," of a successful relationship (Bienvenu, 1969; Bienvenu, 1970). Research has backed up this claim and has found that good communication skills can differentiate satisfied from unsatisfied couples (Gottman, 1982; Gottman & Porterfield, 1981; Meeks, Hendrick, & Hendrick, 1998; Pasupathi, Carstensen, Levenson & Gottman, 1999).

Other researchers have taken a merely sexual stance, and proposed that sexual communication and the resulting sexual intimacy can alone distinguish satisfied from unsatisfied relationships (Banmen & Vogel, 1985; McCabe, 1999). When the sexual communication breaks down within a couple, this leads to frustration and resentment when neither member of the couple can express their desires. This may further result in people taking on outside sexual partners. Despite the obvious importance of sexual communication skills, there has only been one inventory created to solely measure this communication dimension, and despite its use in practice, the research on this is surprisingly quite minimal (Banmen et al, 1989; Bienvenu, 1980a; Bienvenu, 1980b; McCabe, 1999).

In addition to verbal communication skills, there is a growing body of research that emphasizes emotions in couple interactions. Researchers have begun to analyse the conflicts of couples in the laboratory, and can now predict marital happiness and stability after observing their interactions. Positive and negative affect have been measured in marital interactions, and a higher exchange of negative emotions associated with a low degree of positive emotions is characteristic of both unstable and unsatisfied couples (Carstensen, Gottman, & Levenson, 1995; Gottman, 1993; Gottman, Coan, Carrere, & Swanson, 1998; Gottman & Levenson, 1992).

Additional studies have looked at spirituality and sexual behaviour (Helminiak, 1989); gender differences (Walsh, 1991); effects of taking a human sexuality course (Zuckerman, Tushop, & Finner, 1976); sex-role—orientation (Willemsen, 1987); and sexual self-disclosure (Snell, Belk, Papini, & Clark, 1989).

Another important personality variable related to human sexuality is general self-esteem.

Self-esteem, the tendency to relate toward one's self and others in a positive manner, is very important as humans interact with each other. How we perceive others and ourselves will have an effect on daily living and interactions. How we relate to those in an intimate relationship can also depend on self-esteem. Self-esteem can be affected by many variables. Walsh and Balazs (1990) examined the effects of love on self-esteem. It was found that love had the greatest impact on one's self-esteem. The more one felt loved, the higher one's self-esteem, and the more one will relate toward others in a positive manner.

Willemsen (1987) investigated the role of sexual orientation and found males and females have different levels of self-esteem in different areas. Males tend to have more self-esteem in the sexual area while females tend to have more self-esteem in the social—domain. This would suggest that self-esteem could vary according to what particular area of relationships one looks at.

Sexual-esteem, as distinct from self-esteem, is defined as a generalized tendency to engage in non-specific internal reinforcement toward oneself, as a result of one's capacity to relate sexually to another person (Snell & Papini, 1989). A related concept to sexual-esteem is that of the sexual self-concept. Sexual self-concept is defined as an individual's evaluation of one's sexual feelings (Winter, 1996). Accepting the sexual self can influence how one behaves sexually toward others and one's self. The sexual self can be viewed positively or negatively.

Quality of life was strongly negatively associated with sexual dysfunction. Dysfunctional males and females reported poorer levels of health, intimacy and emotional well-being (Snell & Papini, 1989). Difficulties in the sexual area permeated all aspects of life and were associated with diminished achievements and satisfaction in the interpersonal, work, emotional, and community areas. Snyder and Berg (1993) found that the major causes of sexual problems in males and females related to the quality of their interactions with their partner. The general level of enjoyment of sexual activities as well as satisfaction with the frequency of sexual activities was associated with sexual distress. Lack of affection for the partner was also an important predictor of sexual dissatisfaction.

5.9.3 Conclusion

The purpose of the present research was to broaden the scope of the psychological approach to the study of human sexuality by constructing and validating a multidimensional measure of psychological constructs associated with men and women's sexual relations. To accomplish this goal, the literature on sexuality was canvassed to identify those tendencies that seemed to have the greatest likelihood of impacting the sexual aspects of men and women's lives.

This chapter provided an overview of the main themes, which emerged from the research. It needs to be noted, however, that while other themes were also present, they were often addressed by only one respondent. As such they were excluded from the current data set after the preliminary analysis phase.

This chapter presented the results of the study using both descriptive and inferential statistics. These statistics provided a description and interpretation of results using various methods. The results identify significant relationships and differences between the variables of the study and also points out areas that require improvement. Of all the themes identified, five are deemed key to the current study. These are the themes of: communication, intimacy, affection, self-esteem and quality of life. The results from this research indicate that the most significant factor predicting relationship satisfaction is relationship communication skills. Multidimensional research of this sort should continue to be done, and has implications for marital and premarital couples alike.

CHAPTER 6: CONCLUSION

6.1 Introduction

The key theme, as it emerges from the current data-set and with which most other themes can be integrated, is presented in this chapter as a conclusion to the current study.

6.2 Revisiting the theoretical definition of the current study

People's sexual adjustment and satisfaction are important features of their own personal well-being and their satisfaction with their intimate relationships. Occasionally, however, individuals experience problems and frustrations with the sexual aspects of their relationships. The purpose of the present study was to present the results of a study designed to devise an assessment inventory addressing three important, yet underemphasized sexual concepts: sexual-esteem, sexual-depression, and sexual-preoccupation. *Sexual-esteem was defined as a generalized tendency to engage in non-specific internal reinforcement toward oneself because of one's capacity to relate sexually to another person.* As such, it is important to note that this tendency may or may not be a realistic appraisal, but instead probably reflects people's prior experiences related to their sexuality.

By contrast, the concept of sexual-depression was defined as a tendency to engage in specific internal punishment toward oneself about one's capability to relate sexually to another individual. Again, this type of tendency was viewed as self-perceptive in nature rather than being necessarily true. It reflects and is based on people's perceptions of their *past history of sexual experiences.* The third concept examined in the present research was concerned with sexual-preoccupation. Sexual-preoccupation was defined as the persistent tendency to become so absorbed in, obsessed with, and engrossed in sexual cognitions and behaviours that one virtually excludes from one's mind thoughts of other matters. The source of this obsessional tendency is assumed to be the person's prior learning experiences in the area of human sexuality.

6.3 The focus of the current study

These three concepts (i.e., sexual-esteem, sexual-depression, and sexual-preoccupation) were studied in this scale adaptation project for the development of the norms for a South African isiZulu version of the Sexuality Scale (SS). The project involved several different

steps. First, a set of items was written and evaluated through the use of factor analysis. This procedure was used in order to examine the factorial validity of the items on the Sexuality Scale. Reliability analyses were then conducted on each of the subscales, and subscale intercorrelations were conducted. Finally, the concurrent validity of the Sexuality Scale was investigated by studying its relationship with the Psychological Well-being Scale (SS; Snell, Belk, Papini, & Clark, 1988).

It was predicted that sexual-esteem would be positively related to and that sexual-depression would be negatively associated with women and men's willingness to discuss their sexuality. This prediction was based on the rationale that people who feel good about their sexuality and who derive a positive sense of self from their sexuality will be more likely to discuss sexual aspects of them (Herold & Way, 1988). Likewise, the predicted negative relationship between sexual-depression and women's and men's willingness to be open and revealing about their sexuality was based on the notion that those who feel sad about the sexual aspects of their lives (i.e., those high in sexual-depression) will be more reluctant to share this information with others, including both female and male therapists. Predictions concerning sexual-preoccupation were less straightforward to make.

6.4 Major themes from the study

Five main themes emerged from the qualitative analyses:

- Communication
- Intimacy
- Affection
- Self-esteem
- Quality of life

Sexual health is inextricably bound to both physical and mental health. Just as physical and mental health problems can contribute to sexual dysfunction and diseases, those dysfunctions and diseases can contribute to physical and mental health problems. Sexual health is not limited to the absence of disease or dysfunction, nor is its importance confined to just the reproductive years. It includes the ability to understand and weigh the risks, responsibilities, outcomes and impacts of sexual actions and to practice abstinence when appropriate. Satisfaction with sex life increases in relation to the following factors: satisfaction with intercourse and intimacy, satisfaction with the amount of communication, ease of discussing sexual matters, happiness of relationships and gratification experienced

in sex life. These changes can be seen irrespective of whether the social background is standardized or not.

Sexuality is an intrinsic characteristic of all humans, which is multifactorial, and encompasses aspects of the physical, social, spiritual, and moral person. It is an important aspect of the human experience and comprises a portion of how people view themselves. It is important to address these issues because sexual dysfunction is a prevalent problem. More than any other subject, sex brings behavioural, social and biological scientists face to face with human interactions and human values. In sum, it can easily be stated that sex is necessarily powerful, personal and private. Theoreticians may test their models and clinicians their practices, in an area that is varying, essential, stimulating and multifaceted. Since sex is imperative and appealing to most people, nowhere else is the amount of dogmatically asserted misinformation greater, just as nowhere else is the pain caused by such misinformation greater. This dissertation's port of call stems from a model of human behaviour that is different from theological- moralistic, medical, mystic or legislative, rather this thesis subscribes to only what Michel Foucault states best:

...” The books I write constitute an experience from me that I’d like to be as rich as possible. An experience is something you come out of changed...I write precisely because I don’t know yet what to think about as a subject that attracts me. In so doing the book transforms me, changes what I think” (Michel Foucault, remarks on Marx, 1991).

CHAPTER SEVEN: SUMMARY, RECOMMENDATIONS AND LIMITATIONS

7.1 Introduction

Sexuality is an integral part of human life. It carries the awesome potential to create new life. It can foster intimacy and bonding as well as shared pleasure in relationships. It fulfils a number of personal and social needs, and we value the sexual part of our being for the pleasures and benefits it affords us. Yet when exercised irresponsibly it can also have negative aspects such as sexually transmitted diseases including HIV/AIDS, unintended pregnancy, and coercive or violent behaviour.

7.2 Future research

Public health problems are well documented and are increasingly understood within the context of poverty, family trauma, ethnic discrimination, lack of educational opportunities, and inadequate health services. However, there is little recognition of how these health crises are related to human sexuality or how sexual attitudes, beliefs, and values act as antecedents and contributing factors to these problems. What is needed is a more fully developed understanding of how early sexual experiences and socialization patterns, as they occur within society and culture, influence adult behaviours - both positive, as in one's ability to form lasting, affectionate relationships, and negative, as with coercive sexual behaviours. A comprehensive and effective approach to addressing these public health concerns depends on knowing answers to questions about what constitutes sexual health, what motivates sexual behaviour, how sexual norms are developed and sustained, and how these evolve over time.

7.2.1 Current status of sexuality research

Sexuality research today represents the continuation of a long tradition of primarily individual scholarship on the topic. Occurring most often within a clinical or academic setting, what is typically identified, as sexuality research is that which focuses on sexual physiology, anatomy, and therapeutic issues, rather than research that address the social, cultural, or behavioural topics of sexuality? Social and behavioural research on sexuality is often embedded within larger research questions in the range of social science disciplines, including sociology, psychology, anthropology, and history. Sexuality topics are also being addressed by researchers in education, biology, medicine, and public health, again

integrated within larger issues researched by each discipline. Very little of this research has sexuality as its primary focus, and that which does is mostly limited to small population samples with a very narrow focus on specific behaviours, within the framework of the discipline.

7.2.2 What is needed in sexuality research?

A much-needed framework for sexuality topics is the analysis of sexual behaviours in the context of society and culture. To accomplish the goal of understanding how societal and cultural forces "structure" sexuality, research is needed to examine how sexual socialization occurs in families, schools, the media, and peer groups and to address the complex perspectives of different situations, populations, and cultural communities. Cross-cultural research might compare differences on topics like sexual socialization patterns, or the developmental aspects of sexuality, in order to identify their meaning and importance within specific cultures.

7.2.3 The need for a developmental framework

Within the framework of society and culture, research on sexual behaviour should be structured within a developmental framework that utilizes an expanded view of human sexuality throughout the life cycle, starting with infancy and early childhood and extending beyond the reproductive years. This approach looks at the normative influence of sexual socialization as it is communicated, internalised, and acted upon by the individual. It recognizes that sexuality is not a series of individual, episodic behaviours linked to specific acts and the physical body, but represents a range of sexual activities and norms, whose meaning and significance for both the individual and society change over time. Research adopting a developmental approach would necessarily focus on those crucial junctures of sexual development, such as adolescence, as potential intervention points for educational prevention efforts.

7.3 The barriers in sexuality research

Two of the most formidable barriers to strengthening and developing social and behavioural research in sexuality are the lack of comprehensive research training and inadequate dissemination of research findings. The continuing fragmentation of the social science fields in sexuality research, the low status given to sexuality research, and lack of sufficient research funding comprise the major factors that hinder training in this area, a situation

which, consequently, has a significant impact on the availability of professionals to conduct sexuality research. Inadequate dissemination of existing data has hampered intervention and policy initiatives and has contributed to poorly inform public debates on issues related to sexuality.

7.3.1 Advancing the sexuality research field

These fall into three primary categories:

7.3.1.1.) Expanding the research base

There is a need for basic, fundamental research that advances our conceptual/theoretical frameworks as well as our understanding of sexuality-related behaviours, attitudes, and structures in populations of varied cultural and social backgrounds.

7.3.1.2.) Support for comprehensive training

The lack of comprehensive research training in sexuality is one of the primary obstacles to a more cohesive and well-developed field of multi-disciplinary research in sexuality. Varied disciplinary backgrounds can enrich interdisciplinary research, but cannot substitute for substantive training in the practical and theoretical concerns of a particular research field, including sexuality. A training model for sexuality researchers should include training in both human sexuality and research methodology.

7.3.1.3.) Building constituencies

There has been no strong constituency either in or outside of the research community that has been able to effectively advocate for the importance of sexuality as a substantive area of inquiry. The taboo nature of the topic has historically meant that proposed or existing research on sexuality has, at times, become the convenient focal point for large controversies regarding social norms and conceptions of the role of the family and the state.

7.3.1.4) Recommendations for strengthening research networks

There is a need for a unified constituency to link researchers with each other and with other professionals concerned with sexuality issues. An established network can publicly promote the usefulness of research in sexuality and provide greater public visibility to important sexuality issues. A support network can provide effective and timely support to individual researchers, providers, and/or policy official during times of controversy. Possible strategies for a support network include the following:

A compilation of case studies and resource material developed from past controversies, highlighting effective responses and resolutions; there is a need for a unified constituency to link researchers with each other and with other professionals concerned with sexuality issues. An established network can publicly promote the usefulness of research in sexuality and provide greater public visibility to important sexuality issues.

7.4 Research dissemination

A frequent grievance expressed by both practitioners and researchers pertains to inadequate mechanisms and efforts to disseminate research findings to those who need such information: policymakers, advocates, practitioners, and program representatives in diverse communities. In turn, the concerns of these groups are seldom integrated into the research agenda, making it difficult to obtain information needed to design educational and programmatic efforts. In the absence of public forums for explicit and rational discussions about sexuality, sporadic media coverage of sexuality research has become a default mode of dissemination, serving as a primary source of information and influence.

Effective dissemination of research findings is critical for well-designed policies, interventions, and services. Various dissemination projects, in the form of a publication series and well-designed public forums, for example, can provide opportunities for in-depth, rational discussions that provide greater access to sexuality research findings.

Use of a public health approach is requisite to promoting sexual health and responsible sexual behaviour. This approach has four central components: 1) identifying the problem; 2) identifying risk and protective factors; 3) developing and testing interventions; and 4) implementing, and further evaluating, those interventions that have demonstrated effectiveness. Additionally, public health focuses on involving communities in their own health and tailoring health promotion programs to the needs and cultures of the communities involved. Because sexuality is one of the human attributes most endowed with meaning and symbolism, it is of particular importance that addressing sexual health issues involve community wide discussion, consultation, and implementation.

7.4.1. Increasing public awareness of issues relating to sexual health and responsible sexual behaviour

- Begin a national dialogue on sexual health and responsible sexual behaviour that is honest, mature and respectful, and has the ultimate goal of developing

a national strategy that recognizes the need for common ground.

- Encourage opinion leaders to address issues related to sexual health and responsible sexual behaviour in ways that are informed by the best available science and that respect diversity.
- Provide access to education about sexual health and responsible sexual behaviour that is thorough, wide-ranging, begins early, and continues throughout the lifespan. Such education should:
 - recognize the special place that sexuality has in our lives;
 - stress the value and benefits of remaining abstinent until involved in a committed, enduring, and mutually monogamous relationship;
- Recognize that sexuality education can be provided in a number of venues—homes, schools, churches, other community settings—but must always be developmentally and culturally appropriate.
- Recognize that parents are the child's first educators and must help guide other sexuality education efforts so that they are consistent with their values and beliefs.
- Recognize, also, that families differ in their level of knowledge, as well as their emotional capability to discuss sexuality issues. In moving toward equity of access to information for promoting sexual health and responsible sexual behaviour, school sexuality education is a vital component of community responsibility.

7.4.2. Providing the health and social interventions necessary to promote and enhance sexual health and responsible sexual behaviour

- Eliminate disparities in sexual health status that arise from social and economic disadvantage, diminished access to information and health care services, and stereotyping and discrimination.
- Target interventions to the most socioeconomically vulnerable communities where community members have less access to health education and services and are, thus, likely to suffer most from sexual health problems
- . Improve access to sexual health and reproductive health care services for all persons in all communities.
- Provide adequate training in sexual health to all professionals who deal with sexual issues in their work, encourage them to use this training, and ensure

that they are reflective of the populations they serve.

- Encourage the implementation of health and social interventions to improve sexual health that have been adequately evaluated and shown to be effective.
- Ensure the availability of programs that promote both awareness and prevention of sexual abuse and coercion.
- Strengthen families, whatever their structure, by encouraging stable, committed, and enduring adult relationships, particularly marriage. Recognize, though, that there are times when the health interests of adults and children can be hurt within relationships with sexual health problems, and that sexual health problems within a family can be a concern in and of themselves.

7.4.3. Investing in research related to sexual health and disseminating findings widely

- Promote basic research in human sexual development, sexual health, and reproductive health, as well as social and behavioural research on risk and protective factors for sexual health.
- Expand the research base to cover the entire human life span-children, adolescents, young adults, middle age adults, and the elderly.
- Research, develop, disseminate, and evaluate educational materials and guidelines for sexuality education, covering the full continuum of human sexual development, for use by parents, clergy, teachers, and other community leaders.
- Expand evaluation efforts for community, school and clinic based interventions that address sexual health and responsibility.

7.5 Limitations

The present study is unique, particularly within the South African context. Thus, given the innovative nature of the present study, there are some limitations. Perhaps, the most significant and obvious limitation concerns the lack of a control group. The researcher deliberately omitted a control group, as it would have been nearly impossible to constitute a control group with the same constellation as the sample (i.e. age, occupation, gender, education, attendance, at the clinic). Secondly, it is extremely difficult to measure perception, as respondents can easily falsify information and human behaviour is difficult to predict. Perhaps, there should be a scientific instrument to measure perceptions. A third limitation concerns the lack of an interview accompanying the questionnaire. This would have allowed for more

spontaneous and unstructured responses. Perhaps, future research combining the two methods of data collection needs to be undertaken.

7.6 Conclusion

Based on the scientific evidence, society faces a serious public health challenge regarding the sexual health of the nation. Given the diversity of attitudes, beliefs, values and opinions, finding common ground might not be easy but it is attainable. This common ground is found through a national dialogue with honest, open and respectful communication.

Sexual health research also has tended to exclude older people and homosexuals, despite the demand for data in the context of therapeutic advances in the treatment of dysfunction, and the association between chronic disease, sexual function, and quality of life.

It is, however, only a first step—a call to begin a mature and thoughtful discussion about sexuality. One must understand that sexuality encompasses more than sexual behaviour that the many aspects of sexuality include not only the physical, but the mental and spiritual as well, and that sexuality is a core component of personality. Sexuality is a fundamental part of human life. While the problems usually associated with sexual behaviour are real and need to be addressed, human sexuality also has significant meaning and value in each individual's life. This dissertation, and the discussion it is meant to generate, is not just intended for health care professionals or policy makers, it is intended for parents, teachers, clergy, and social service professionals—all of us.

REFERENCE LIST

- Abrahamson, D. J., Barlow, D. H., Beck, J. G., Sakheim, D. K., & Kelly, J. P. (1985). The effects of attentional focus and partner responsiveness on sexual responding: Replicating and extension. *Archives of Sexual Behavior, 14*, 361-371.
- Abrahamson, Paul R., and Steven Pinkerton. *With pleasure: thoughts on the nature of human sexuality*. New York: Oxford University Press, 1995.
- Albanese, C. (1992). *American religions and religion*. (2nd Ed.) Belmont, CA: Wadsworth.
- Albanese, C. (1993). Fisher kings and public places: The old New Age in the 1990s. *ANNALS, AAPSS, 527 (May)* 131- 143.
- Albanese, C. (2000). The culture of religious combining: Reflections for the new American millennium. *Cross Currents, 50 (1-2)*, 16-22.
- Alder, E. M., Cook, A., Davidson, D., West, C. & Bancroft, J. (1986). Hormones, mood and sexuality in lactating women. *British Journal of Psychiatry, 148*, 74-79.
- Allgeier, E. R. & Allgeier, A. R. (1988). *Sexual interactions (2nd Ed.)*. Lexington, Mass: Health.
- Allison, M., & Travis, L.D. (Eds.) (1986). *The Jovian Atmospheres*. NASA. National Aeronautics and Space Administration. Washington: DC.
- Allwood, C. W., L. R. Friedland, A. S. Karstaedt, and J. A. McIntyre. (1992). AIDS - The Baragwanath experience, Part 4. Counselling and ethical issues. *South African Medical Journal, 82(2)*: 98-101.
- Althof, S. E. (1995). Pharmacological treatment of rapid ejaculation. *Psychiatric Clinics of North America, 18*, 85-94.
- Althof, S. E., Levine, M. D., Corty, E. W., Risen, C. B., Stern, E. B., & Kurit, B. A. (1995). A double-blind crossover trial of Clomipramine for rapid ejaculation in 15 couples. *Journal of Clinical Psychiatry, 56*, 402-407.

- Altman, C.R., Chow, R.L., Lang, R.A., & Hemmati-Briranlou. (1996). Pax6 induces ectopic eyes in a vertebrate. *Development*, 126 (19), 4213-4222.
- American Psychiatric Association. (1994). *DSM-V: Diagnostic and statistical manual of mental disorders* (4th Ed.). Washington, DC: Author.
- American Psychological Association. (1995). Training in and dissemination of empirically-validated psychological treatments: Report and recommendations. *The Clinical Psychologist*, 48, 3-24.
- Andersen, B. L. (1983). Primary orgasmic dysfunction: Diagnostic considerations and review treatment. *Psychological Bulletin*, 93, 105-136.
- Andersen, B. L. (1985). Sexual functioning morbidity among cancer survivors: Present status and future research directions. *Cancer* 55: 1835–1842.
- Anderson-Bricker, K. (1999). "Triple jeopardy": Black women and the growth of feminist consciousness in SNCC, 1964-1975. In K. Springer (Ed.), *Still lifting, still climbing: Contemporary African-American women's activism* (pp. 49-69). New York: New York University Press.
- Anderson, R. A., Martin, C. W., Kung, A., Everington, D., Pun, T. C., Tan, K. C. B., Bancroft, J., Sundaram, K., Moo-Young, A. J., & Baird, D. T. (1999). 7 α -Methyl-19-Nortestosterone (MENT) maintains sexual behavior and mood in hypogonadal men. *Journal of Clinical Endocrinology & Metabolism*, 84, 3556-3562.
- Andrews, J. (2001). Resurgent conservatism. In M.K. Cayton & P. W. Williams (Eds.), *Encyclopaedia of American Cultural & Intellectual History* (Vol. 2, pp. 205-213). New York: Charles Scribner's Sons.
- Anonymous. (1997). Men are from Mars: Women are from Venus. *The Economist (U.S.)*, 343 (8022), 87-90.
- Ansong, K. S., Lewis, C., Jenkins, P., & Bell, J. (1998). Help-seeking decisions among men with impotence. *Urology*, 52, 834-837.

- Anthony, D., Ecker, B., & Wilber, K. (Eds.). (1986). *Spiritual choices: The problems of recognizing authentic paths to inner transformation*. New York: Paragon House.
- Babbie, E. (1998). *The practice of social research*. Belmont, CA: Wadsworth Publishing Company.
- Babbie, E., Mouton, J., Vorster, P. & Prozesky, P. (2001). *The practice of social research*. Oxford: Oxford University Press.
- Baden, J. (Ed.) (1994). *Environmental Gore: A constructive response to earth in the balance*. San Francisco: Pacific Research Institute for Public Policy.
- Bagatell, C. J., Heiman, J. R., Rivier, J. E., & Bremner, W. J. (1994). Effects of testosterone and estradiol on sexual behavior in normal young men. *Journal of Clinical Endocrinology & Metabolism*, 78, 711-716.
- Bailey, W. C., Hendrick, C., & Hendrick, S. S. (1987). Relation of sex and gender role to love, sexual attitudes, and self-esteem. *Sex Roles*, 16, 637-648.
- Bancroft, J. (1988). *Reproductive hormones and male sexual function*. In J. M. A. Sitsen (Ed.), *Handbook of sexology*, Vol. 6. The pharmacology and endocrinology of sexual function (pp. 297-315). New York: Elsevier Science Publishers.
- Bancroft, J. (1989). *Human sexuality and its problems*. Edinburgh, Scotland: Churchill Livingstone.
- Bancroft, J. (1998). Central control and inhibitory mechanisms in male sexual response. *International Journal of Impotence Research*, 10(S-2), S40-43.
- Bancroft, J. (1999). Central inhibition of sexual response in the male: A theoretical perspective. *Neuroscience & Biobehavioral Reviews*, 23, 763-784.
- Bancroft, J. (2000). Effects of alpha-2 blockade on sexual response: Experimental studies with Delequamine (RS15385). *International Journal of Impotence Research*, 12(Suppl. 1), S64-S69.

- Bancroft, J. (2000). (in press-a). The medicalization of female sexual dysfunction: The need for caution. *Archives of Sexual Behavior*.
- Bancroft, J., Herbenick, D., & Reynolds, M. (2000). (in press). Masturbation as a marker of sexual development. In J. Bancroft (Ed.), *Sexual development*. Bloomington: Indiana University Press.
- Bancroft, J., & Janssen, E. (2000). The dual control model of male sexual response: A theoretical approach to centrally mediated erectile dysfunction. *Neuroscience and Biobehavioral Reviews*, 24, 571-579.
- Banmen, J., & Vogel, N.A. (1989). The relationship between marital quality and interpersonal sexual communication. *Family Therapy*, 12(1), 45-58.
- Banner, L. (1993). *Women in Modern America: A Brief History*. Orlando, FL: Harcourt Brace and Company.
- Barash, D., & Lipton, J. (1997). *Making sense of sex*. Washington, D.C.: Island Press/Shearwater Books.
- Barlow, D. H. (1986). Causes of sexual dysfunction: The role of anxiety and cognitive interference. *Journal of Consulting Clinical Psychology*, 54, 140-148.
- Barlow, D.H. (1988) *Anxiety and its disorders: The nature and treatment of anxiety and panic*. New York: Guildford Press.
- Barresi, J., & Juckes, T. (1997). Personology and the narrative interpretation of lives. *Journal of Personality*, 65(3), 693-719.
- Barrett, M., & Berman, J. (2001). Is psychotherapy more effective when therapists disclose information about themselves? *Journal of Consulting and Clinical Psychology*, 69 (460), 597- 3.
- Bartlik, B., Kaplan, P., Kaminetsky, J., Roentsch, G., & Goldberg, J. (1999). Medications with the potential to enhance sexual responsivity in women. *Psychiatric Annals*, 29, 46-53.

- Basson, R., Berman, J., Burnett, A., Derogatis, L., Ferguson, D., Fourcroy, J., Goldstein, I., Graziottin, A., Heiman, J., Laan, E., Leiblum, S., Padma-Nathan, H., Rosen, R., Seagraves, K., R. T., Shabsingh, R., Sipski, M., Wagner, G., & Whipple, B. (2000). Report of the international consensus development conference on female sexual dysfunction: Definitions and classifications. *Journal of Urology*, 163, 888-893.
- Baucom, D.H., & Epstein, N. (1990, November). *Cognitive-behavioural marital therapy*. New York: Brunner/Mazel.
- Baucom, D.H., & Epstein, N. (1999, November). *It takes two to tango: There are some individuals in there interacting with each other*. Paper presented at the annual meeting of the Association for Advancement of Behaviour Therapy, Toronto.
- Baucom, D.H., Epstein, N., Rankin, L.A., & Burnett, C.K. (1996a). Understanding and treating marital distress from a cognitive-behavioural orientation. In K.S. Dobson & K.D. Craig (Eds.), *Advances in cognitive-behavioural therapy* (pp. 214-236). Thousand Oaks, CA: Sage.
- Baucom, D.H., Epstein, N., Rankin, L.A., & Burnett, C.K. (1996b). Assessing relationship standards: The Inventory of Specific Relationship Standards. *Journal of Family Psychology*, 19, 72-78.
- Beach, F. A. (1976). Cross-species comparisons and the human heritage. *Archives of Sexual Behavior*, 5, 469-485.
- Beauchamp, T.L., Faden, R.R., Wallace, R.J. & Walters, L.R. (1982). *Ethical issues in social science research*. Baltimore: The John Hopkins University Press.
- Beck, J. G. & Barlow, D. H. (1984). Current conceptualisations of sexual dysfunction: A review and an alternate perspective. *Clinical Psychology Review*, 4, 363-378.
- Begley, S. (2001). Cellular divide. *Newsweek*, July 9, 22-27.
- Bell, R. & Bell, R. (1972). Sexual satisfaction among married women. *Medical Aspects of Human Sexuality*, 6, 136-144.

- Bell, R., & Coughney, K. (1980.) Premarital sexual expression among college females, 1958, 1968, and 1978. *Family Relations*, 29, 354.
- Bellafante, G. (1994). Are women too nice at the office? *Time*, 144 (14), 61-62. Bellafante, G. (1998). Feminism: It's all about me! *Time*, 151 (25), 54-60.
- Bem, S. (1978, 1981). *Bem sex-role inventory manual*. Redwood City, CA: Mind Garden.
- Berg, P. & Snyder, D.K. (1981). Differential diagnosis of marital and sexual distress: A multidimensional approach. *Journal of Sex & Marital Therapy*, 7, 290-295.
- Berger, L. (2001). Inside out: Narrative Autoethnography as a path toward rapport. *Qualitative Inquiry*, 7(4), 504-518.
- Bergeron, S. (1999, June). *A randomised comparison of vestibulectomy, biofeedback, and cognitive-behavioural therapy in the treatment of vulvar vestibulitis*. Paper presented at the 25th Annual Meeting of the International Academy of Sex Research, Stony Brook: New York.
- Bergeron, S., Binik, Y. M., Khalife, S., & Pagidas, K. (1997). Vulvar vestibulitis syndrome: A critical review. *Clinical Journal of Pain*, 13, 27-42.
- Berns, S.B., Jacobson, N.S., & Gottman, J.M. (1999). Demand-withdraw interaction in couples with a violent husband. *Journal of Consulting and Clinical Psychology*, 67, 666-674.
- Bienvenu, M.J. (1968). *Premarital communication inventory*. Natchitoches, LA: Northwest Publications.
- Bienvenu, M.J. (1969). *A counsellor's guide to accompany a marital communication inventory*. Natchitodnes, LA: Northwest Publications.
- Bloom, Allan. (1987). *The closing of the American mind*. New York: Simon and Schuster.
- Bloom, Alexander. (Ed.). (2001). *Long time gone: Sixties America then and now*. New York: Oxford University Press.

- Blum, A. (1996). The role of mobilized stem reserves in stress tolerance. In: *Proceedings of v111 IBOS*. P. 267-275. Saskatoon, Canada.
- Blum, D. (1997). *Sex on the brain: The biological differences between men and women*. New York: Viking.
- Blum, D. (1999). What's the difference between boys and girls? *Life*, July, 44-57.
- Blustain, S. (2000). The new gender wars. *Psychology Today*, 33 (6), 43-48.
- Bly, R. (1990). *Iron John*. New York: Addison-Wesley.
- Bochner, A., & Ellis, C. (1992). Personal narrative as a social approach to interpersonal communication. *Communication Theory*, 2: 2, pp. 165-172.
- Bochner, A., & Ellis, C. (Eds.). (1996). *Composing ethnography: Alternative forms of qualitative writing*. Walnut Creek, CA: Sage.
- Bondi, V. (Ed.). (1996). *American Decades* (Vol. 8). Detroit: Gale Research.
- Bordo, S. (1993). *Unbearable weight: Feminism, western culture, and the body*. Berkeley: University of CA Press.
- Borg, W.R. & Gall, M.D. (1989). *Educational research*. New York: Longman.
- Borkovec, T. D., & Castonguay, L. G. (1998). What is the scientific meaning of empirically supported therapies? *Journal of Consulting and Clinical Psychology*, 66, 136-142.
- Bowker, J. (1997). *World religions*. New York: DK.
- Bozman, A. W. & Beck, J. G. (1991). Covariation of sexual desire and sexual arousal: The effects of anger and anxiety. *Archives of Sexual Behaviour*, 20, 47-60.
- Bradbury, T.N., & Fincham, F.D. (1990). Attributions in marriage: Review and critique. *Psychological Bulletin*, 107, 3-33.

- Bradbury, T.N., & Fincham, F.D. (1992). Attributions and behaviour in marital interaction. *Journal of Personality and Social Psychology*, 63, 613-628.
- Bradbury, T.N., & Fincham, F.D. (1993). Assessing dysfunctional cognition in marriage: A reconsideration of the Relationship Belief Inventory. *Psychological Assessment*, 5, 92-101.
- Braiker, H., & Kelley, H.H. (1979). Conflict in the development of close relationships. In R.L. Burgess & T.L. Huston (Eds.), *Social exchange in developing relationships*. (p. 135-168). New York: Academic Press.
- Branonn, M., Brown, J.D., Bates, R. Kimelman, D. & Moon, R.T. (1996). XctBP is an XTct-3 co-repressor with roles throughout xenopus development. *Development*, 126 (14). P. 3159-70.
- Bridges, N. (2001). Therapist's self-disclosure: Expanding the comfort zone. *Psychotherapy*, 38(1), 21-30.
- Brinkley, D. (1998). *American heritage: History of the United States*. New York: Viking.
- Brown, B. (1978). Social and psychological correlates of help seeking behaviour among urban adults. *Annual Journal of Community Psychology*, 6. 425-4398.
- Brown, H. (1962). *Sex and the single girl*. New York: Random House.
- Brown, T. (1991). *The vision*. New York: Berkley Publishing Group.
- Burke, P. (1996). *Gender shock: Exploding the myths of male and female*. New York: Doubleday.
- Burman, S., and E. Preston-Whyte. (Eds.). (1992). *A Questionable Issue: Illegitimacy in South Africa*. Cape Town: Oxford University Press.
- Burr, C. (1993). Homosexuality and biology. *Atlantic Monthly*, 272(3), 47-65.
- Burr, C. (1996). *A separate creation: The search for the biological origins of sexual orientation*. New York: Hyperion.

- Buss, D. (1989). Sex differences in human mate preferences: Evolutionary hypotheses tested in 37 cultures. *Behavioural and Brain Sciences*, 12, 1-49.
- Buss, D. (1994). *The evolution of desire: Strategies of human mating*. New York: Basic Books.
- Butler, J. (1990). *Gender trouble: Feminism and the subversion of identity*. New York: Routledge.
- Butler, K. (1999). Satori in the bedroom. *Family Therapy Networker* 23(2), 22-32, 52.
- Byers, E.S., & Demons, S. (1999). Sexual satisfaction and sexual self-disclosure within dating relationships. *The Journal of Sex Research*, 36, 1-10.
- Byers, E.S. (2005). Relationship satisfaction and sexual satisfaction: a longitudinal study of individuals in long-term relationships. *Journal of Sex Research*, 42.
- Byrne, D. & Kelley, K. (1986). *Alternative Approaches to the Study of Sexual Behaviour*. New York: Lawrence Erlbaum Associates.
- Caldwell, T. (1972). *The captains and the kings: The story of an American dynasty*. Garden City, New York: Doubleday.
- Callahan, M. (Producer), Munter, R. (Writer), & Khroustalev, D. (Editor). (2000). *The 1990s: America's hard drive*. [Video]. (Available from MPI Home Video, Orlando Park, IL).
- Caprio, F. (1953). *The sexually adequate female*. Greenwich. P.64
- Carrere, S., & Gottman, J.M., & Katz, L.F. (1992). How a couple views their past predicts their future: Predicting divorce from an oral history interview. *Journal of Family Psychology*, 5(3-4), 295-318.
- Carroll, P. N. (1982). *It seemed like nothing happened: The tragedy and promise of America in the 1970s*. New York: Holt, Rinehart and Winston.
- Carstensen, L.L., Gottman, J.M., & Levensen, R.W. (1995). Emotional behaviour in long term marriage. *Psychology and Aging*, 10(1), 140-149.

- Caruso, S., Intelisano, G., Lupo, L., & Agnello, C. (2001). Premenopausal women affected by sexual arousal disorder treated with sildenafil: A double blind, crossover, and placebo-controlled study. *Journal of Obstetrics and Gynaecology*, 108, 623-638.
- Cartwright, W. (1983). *Philosophy of science: how the laws of physics lie*. Oxford, New York: Claredon Press.
- Cartwright, B.A. & Collett, T.S. (2004). Landmark maps for honeybees. *Biological Genetics*, 57, (1-2).
- Catania, J. (1987). Help-seeking: An avenue for adult sexual development. Unpublished dissertation. University of California: San Francisco.
- Catania, J., McDermott, L. & Pollack, L. (1986). Questionnaire response bias and face-to-face interview sample bias in sexuality research. *Journal of Sex Research*, 22:210-230.
- Cawood, E. H. H., & Bancroft, J. (1996). Steroid hormones, the menopause, sexuality and well-being of women. *Psychological Medicine*, 26, 925-936.
- Chagnon, N.A. (1988). Life histories, blood revenge and warfare in a tribal population. *Science*, 239. p. 985-992.
- Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology*, 66, 7-18.
- Chesney, A.P., Blackeney, P.E., Chan, F.A., & Cole, C.M. (1981). A comparison of couples who have sought sex therapy with couples who have not. *Journal of Sex & Marital Therapy*, 7, 131-140.
- Chopra, D., & Boteach, S. (Speakers). (2001). *Integrating the masculine and the feminine in the spiritual traditions of Judaism and Vedanta*. (Cassette Recording). Carlsbad, CA: Hay House.
- Chothia, F. 1993 (March 5). "Storm Over School Sex Education." *Weekly Main*, p. 5.

- Christensen, A. (1988). Dysfunctional interaction patterns in couples. In P. Noller & M.A. Fitzpatrick (Eds.). *Perspectives on marital interaction* (pp.31-52). Philadelphia: Multilingual Matters.
- Christensen, A., Heavey, C.L. (1990). Gender and social structure in the demand/withdraw pattern of marital conflict. *Journal of Personality and Social Psychology*, 59, 73-81.
- Christensen, A., & Shenk, J.L. (1991). Communication, conflict, and psychological distance in nondistressed, clinic, and divorcing couples. *Journal of Consulting and Clinical Psychology*, 59, 458-463.
- Christensen, A., & Walczynski, P.T (1997). Communication and satisfaction in couples. In R.M. Sternberg & M. Hojjat (Eds.), *Satisfaction in close relationships* (p. 249-274).
- Cilliers, C. D. (1989). The Role of the school in the Republic of South Africa in the prevention of AIDS - A situation analysis. *South African Journal of Education*, 1:1-6.
- Clatterbaugh, K. (2000). Review essay: Literature of the U.S. men's movement. *Signs*, 25(3), 883-894.
- Clifford, J., & Marcus, G. (Eds.) (1986). *Writing culture: The poetics and politics of ethnography*. Los Angeles, CA: University of California Press.
- Colapinto, J. (2000). *As nature made him: The boy who was raised as a girl*. New York: HarperCollins.
- Cole, C., & Cole, A. (1999). Marriage enrichment and prevention really works: Interpersonal competence training to maintain and enhance relationships. *Family Relations*, 48, 273-275.
- Colegrave, S. (1989). *Uniting heaven and earth*. New York: St. Martin's Press.
- Collaer, M. L., & Hines, M. (1995). Human behavioral sex difference: A role for gonadal hormones during early development. *Psychological Bulletin*, 118, 55-107.
- Constantinople, A. (1973). Masculinity-femininity. An exception to a famous dictum. *Psychological Bulletin*, 80, 389-407.

- Cook, E. (1985). *Psychological Androgyny*. New York: Pergamon Press.
- Cooper, C., R. Hamilton, H. Mashabela, S. Mackay, E. Sidiropoulos, C. Gordon-Brown, S. Murphy, & J. Frielinghaus. (1994). *Race Relations Survey 1993/1994*. Johannesburg: South African Institute of Race Relations.
- Cosmides, L. & Tooby, J. (1987). From evolution to behaviour: Evolutionary psychology as the missing link. In J. Dupre (Ed.), *The latest on the ebst: Essays on evolution and optimality*. (p. 277-306). Cambridge, MA: MIT Press.
- Cowlshaw, B. (2001). Subjects are from Mars, objects are from Venus: Construction of the self in self-help. *Journal of Popular Culture*, 35(1), 169-183.
- Crow, G. (1997). *Comparative sociology and social theory: beyond the three worlds*. Basingstoke: Macmillan.
- Cupach, W. R., & Comstock, J. (1990). Satisfaction with sexual communication in marriage: Links to sexual satisfaction and dyadic adjustment. *Journal of Social and Personal Relationships*, 7, 179-186.
- Cutler, W. B., Garcia, G., & Krieger, A. M. (1980). Sporadic sexual behavior and menstrual cycle length in women. *Hormones & Behavior*, 14, 163-172.
- Dabbs, J.M. (2000). *Heroes, rogues and lovers: testosterone and behaviour*. New York: London, McGraw Hill.
- Dalton, A. (2000). The ties that unbind. *Psychology Today*, 33(1), 12.
- Daly, M., Wilson, M. & Weghorst, S.J. (1982). Male Sexual Jealousy. *Ethnology and Sociobiology*, vol. 3, pp. 11-27.
- Daly, M. & Wilson, M. (1983). *Sex, evolution and behaviour*. Boston: Willard Grant Press.
- Darwin, C. (1903). *The correspondence of Charles Darwin. Vol.1* Cambridge University Press.
- Davis, S. R. (1998). The role of androgens and the menopause in the female sexual response. *International Journal of Impotence Research*, 10 (S-2), S82-83.

- Dean, T. (2000). *Beyond sexuality*. London: University of Chicago Press.
- Delamater, J., & Maccorquodale, P. (1979). *Premarital Sexuality: Attitudes, Relationships, Behaviour*. Madison: University of Wisconsin Press.
- Delamater, J. (2003). *Handbook of social psychology*. Cambridge University Press.
- Dickes, R., & Strauss, D. (1980). Adverse reaction of the apparently healthy partner in response to improvement in the overtly dysfunction partner. *Journal of Sex & Marital Therapy*, 6, 109-115.
- Dillman, D.A. (2000). *Mail and internet surveys: tailored design method*. New York: Wiley.
- Dillon, L.K. Kitty, G., Moser, L.E., Melliar, S., Smith, P.M. & Ramakrishna, Y.S. (1994). A graphical interval logic for specifying concurrent systems. *ACM. Trans Software Engineering Methodology*, 3(12), p. 131-165.
- Donahey, K. M. & Carroll, R. A. (1993). Gender differences in factors associated with hypoactive sexual desire. *Journal of Sex and Marital Therapy*, 19, 25-40.
- Donnelly, D. A. (1993). Sexually inactive marriages. *Journal of Sex Research*, 30, 171-179.
- D'Souza, D. (1991). *Liberal education: The politics of race and sex on campus*. New York: Free Press.
- Duncan, N., & Van Niekerk, A. (2001). Investing in the young for a better future: A programme of intervention. In M. Seedat, N. Duncan, & S. Lazarus (Eds.), *Community psychology: theory, method and practice*. Cape Town, SA: Oxford University Press. P. 325-341.
- Dunn, K. M., Croft, P. R. & Hackett, G. I. (1999). Association of sexual problems with social, psychological, and physical problems in men and women: A cross sectional population survey. *Journal of Epidemiology and Community Health*, 53, 144-148.
- Durden-Smith, J., & Desimore, D. (1983). *Sex and the brain*. New York: Arbor House.

- Dylan, B. (1962). *Blowin' in the wind*. (Song) Warner Bros., Inc.
- Eagly, A.H. (1987). *Sex differences in social behaviour: a social role interpretation*. Lawrence Erlbaum Associates: New Jersey.
- Edwards, S.D., Ngcobo, H.S.B. & Pillay, A.L. (2004). Psychological well-being in South African University students. *Psychological Reports*, 95, 1279-1282.
- Ehrenreich, B., Hess, E., & Jacobs, G. (1986). *Re-making Love: The feminisation of sex*. Garden City, New York: Anchor.
- Elder, G. (1974). *Children of the great depression*. Chicago: University of Chicago Press.
- Ellis, A. (1975). The rational-emotive approach to sex therapy. *Counseling Psychologist*, 5(1), 14-21.
- Ellis, C. & Bochner, A. (1996). *Composing ethnography*. Walnut Creek: Alta Mira Press.
- Ellis, H. (1942). *Studies in the psychology of sex: Vol1 (2): In women*. New York: Random.
- Emlin, S.T. & Oring, L.W. (1977). *Ecology, sexual selection and the evolution of mating systems*. 86, p. 109-112,
- Epstein, N., & Baucom, D. H. (1993). Cognitive factors in marital disturbance. In K. S. Dobson & P. C. Kendall (Eds.), *Psychopathology and Cognition* (pp. 351-385). San Diego: Academic Press.
- Epstein, N., & Baucom, D. H. (1999). *Advances in cognitive-behavioural couple therapy: Assessment and intervention with behavioural patterns and cognitive themes*. Workshop presented at the annual meeting of the Association for Advancement of Behaviour Therapy, Toronto.
- Epstein, N., Baucom, D.H., & Daiuto, A. (1997). Cognitive-behavioural couples therapy In W. K. Halford & H. J. Markham (Eds.), *Clinical handbook of marriage and couples interventions*. (pp. 415-449). Chichester, UK: Wiley.

- Epstein, N., Baucom, D. H., & Rankin, L. A. (1993). Treatment of marital conflict: A cognitive-behavioural approach. *Clinical Psychology Therapy and Experimental psychiatry*, 9, 149-155.
- Erikson, E. (1959). Identity and the life cycle. *Psychological Issues*, 1, 18-164.
- Everaerd, W., & Laan, E. (2000). Drug treatments for women's sexual disorders. *The Journal of Sex Research*, 37, 195-204.
- Faduli, S. (1991). *Backlash: The undeclared war against American women*. New York: Crown.
- Farber, D., & Bailey, B. (2001). *The Columbia Guide to America in the 1960s*. New York: Columbia University Press.
- Farrell, W. (1993). *The myth of male power: Why men are the disposable sex*. New York: Simon & Schuster.
- Fasching, D. (1992). *Narrative theology after Auschwitz: from alienation to ethics*. Minneapolis, MN: Fortress.
- Feldman, H. A., Goldstein, I., Hatzichristou, D. G., Krane, R. J., & McKinlay, J. B. (1994). Impotence and its medical and psychosocial correlates: Results of the Massachusetts Male Aging Study. *Journal of Urology*, 151, 54-61.
- Fincham, F. D., & Breach, S. R. (1999). Conflict in marriage: Implications for working with couples. *Annual Review of Psychology*, 50, 47-77.
- Fincham, F. D., & Bradbury, T. N. (1992). Assessing attributions in marriage: The relationship attribution measure. *Journal of Personality and Social Psychology*, 62, 457-468.
- Fincham, F. D., Harold, G. T., & Gano-Phillips, S. (2000). The longitudinal association between attributions and marital satisfaction: Direction of effects and role of efficacy expectations. *Journal of Family Psychology*, 14, 267-285.
- Fish, L. S., Fish, R. C. & Sprenkle, D. H. (1984). Treating inhibited sexual desire: A marital therapy approach. *American Journal of Family Therapy*, 12, 3-12.

- Fisher, J. (1977). *Handbook of behaviour therapy with sexual problems. Volume 1- general procedures*. New York: Pergamon Press.
- Fisher, W. A., Byrne, D., White, L. A., & Kelley, K. (1988). Erotophobia-erotophilia as a dimension of personality. *Journal of Sex Research*, 25, 123-151.
- Fischer, E., Winer, D., and Abramowitz, S. (1983). Seeking professional help for psychological problems. In Nadler, A. et al., (eds.), *New Directions in Helping: Applied Perspectives on Help Seeking and Receiving*, Vol. 3, Academic Press, New York.
- Fletcher, G.J., Simpson, J.A., & Thomas, G. (2000). The measurement of perceived relationship quality components: A confirmatory factor analytic approach. *Personality and Social Psychology Bulletin*, 26(3), 340-354.
- Footlick, J. (1990, Winter/Spring). What happened to the family? (Special Edition The 21st Century family). *Newsweek*, 114(27), 14-20.
- Foucault, M. (1980). *History of sexuality: an introduction*. New York: Vintage.
- Foucault, M. (1989). *Foucault live (Interviews, 1961-1984)*. (Ed.) Sylvere Lotringer. New York: Semiotext (e).
- Fowers, B. J., & Olson, D. H. (1989). ENRICH Marital Inventory: A discriminant validity and cross-validation assessment. *Journal of Marital and Family Therapy*, 15, 65-79.
- Frank, E., Anderson, C., & Kupfer, D. J. (1976). Profiles of couples seeking sex therapy and marital therapy. *American Journal of Psychiatry*, 133, 559-562.
- Frank, E., & Kupfer, D. J. (1976). In every marriage there are two marriages. *Journal of Sex & Marital Therapy*, 2, 137-143.
- Frank, E., Anderson, C., & Rubenstein, D. (1978). Frequency of sexual dysfunction in "normal" couples. *New England Journal of Medicine*, 299, 111-115.
- Friday, N. (1976). *Spare rib*. P.45. New York: Macmillan.
- Friedan, B. (1963). *The feminine mystique*. New York: Dell.

- Friedan, B. (1981). *The second stage*. New York: Summit Books.
- Freud, S. (1962). *Three contributions to the theory of sex*. New York: Dutton. (Originally published in 1905.)
- Fugl-Meyer, A. R., & Sjogren-Meyer, K. (1999). Sexual disabilities, problems and satisfaction in 18-74 year Swedes. *Scandinavian Journal of Sexology*, 2, 79-105.
- Furman, W., Brown, B. & Feiring, C. (1999). *The development of romantic relationships in adolescence*. Cambridge University Press.
- Gagnon, John, H. (1965). Female Child Victims of Sex Offences. *Social Problems*, vol. 13, pp. 176-192.
- Gagnon, John, H., & Simon, W. (1973). *Sexual Conduct*. Chicago: Aldine.
- Gagnon, J. H., Rosen, R. C., & Leiblum, S. R. (1982). Cognitive and social aspects of sexual dysfunction: Sexual scripts in sex therapy. *Journal of Sex and Marital Therapy*, 8, 44-56.
- Gale Group. (1997). *The 1970s: Era overview: Discovering U. S. history*. (On-line). Available: <http://www.galenet.com/servlet/HistRC/>
- Gale Group. (1998). *Changing sexual morality (1970s)*. *American decades CD-ROM*. (On-line). Available: <http://www.glaenet.com/servlet/HistRC/>
- Gale Group. (2001). Johnson, Virginia E. (1925). *Gale encyclopaedia of psychology (2nd Ed.)*. (On-line). Available: <http://www.findarticles.com>
- Gallup, G. (1970). Chimpanzee self-recognition. *Science*, 167.
- Gambrill, E. D. (1977). *Behavioural modification: Handbook of assessment, intervention, and evaluation*. San Francisco: Jossey-Bass.
- Garte, D. (Producer), Munter, R. (Writer), & Landeros, B. (Editor). (2000). *The 1980s: A decade of decadence* [Video]. (Available from MPI Home Video, Orlando Park, IL)

- Geary, D. (1998). *Male, female: the evolution of human sex differences*. Washington, D.C.: American Psychological Association.
- Gebhard, P. H. (1977). The acquisition of basic sex information. *The Journal of Sex Research*, 13:13-21.
- Gevisser, M. (1993 April 8). Sex in the schoolroom - But it's safer. *Weekly Mail Education Supplement*, p. 1.
- Gilligan, C. (1982, 1993). *In a different voice: Psychological theory and women's development*. Cambridge, MA: Harvard University Press.
- Glatt, A. E., Zinner, S. H., & McCormack, W. M. (1990). The prevalence of dyspareunia. *Obstetrics & Gynaecology*, 75, 433-436.
- Glazer, H. I., Rodke, G., Swencionis, C., Hertz, R., & Young, A. W. (1995). The treatment of vulvar vestibulitis syndrome. *Journal of Reproductive Medicine*, 40, 283-290.
- Gleik, E. (1997). Tower of psychobabble. *Time*, 149(24), 68-73.
- Goetsch, M. F. (1991). Vulvar vestibulitis: Prevalence and historic features in a general gynaecologic practice population. *American Obstetrics and Gynaecology*, 161, 1609-1617.
- Gold, E. P. (1986). Long-term effects of sexual victimization in childhood: An attributional approach. *Journal of Consulting and Clinical Psychology*, 54, 471-475.
- Golden-Biddle, K. & Locke, K. (1997). *Composing qualitative research*. Thousand Oaks: Sage.
- Goldstein, I., Lue, T. F., Padma-Nathan, H., Rosen, R. C., Stern, W. D., & Wicker, P. A. (1998). Oral sildenafil in the treatment of erectile dysfunction. *New England Journal of Medicine*, 338, 1397-1404.
- Goodman, A. (1993). Diagnosis and treatment of sexual addiction. *Journal of Sex & Marital Therapy*, 19, 225-251.
- Gorden, R.L. (1987). *Interviewing: Strategy, techniques and tactics*. Chicago: Dorsey Press.

- Gordon, K. C., Baucom, D. H., Epstein, N., Burnett, C. K., & Rankin, L. A. (1999). The interaction between marital standards and communication patterns: How does it contribute to marital adjustment? *Journal of Marital and Family Therapy*, 25, 211-223.
- Gore, A. (1992). *Earth in the balance: Ecology and the human spirit*. Boston: Houghton Mifflin.
- Gottman, J. M. (1993a). The roles of conflict engagement, escalation, and avoidance in marital interaction: A longitudinal view of five types of couples. *Journal of Consulting and Clinical Psychology*, 61, 6-51.
- Gottman, J. M. (1993b). A theory of marital dissolution and stability. *Journal of Family Psychology*, 7, 57-75.
- Gottman, J. M. (1994). *What predicts divorce? The relationship between marital processes and marital outcomes*. Hillsdale, New Jersey: Lawrence Erlbaum.
- Gottman, J. M. (1999). *The marriage clinic: A scientifically based marital therapy*. New York: W. W. Norton.
- Gottman, J. M., & Krokoff, L. J. (1989). Marital interaction and satisfaction: A longitudinal view. *Journal of Consulting and Clinical Psychology*, 57, 47-52.
- Gottman, J. M., & Levenson, R. W. (1992). Marital processes predictive of later dissolution: Behaviour, physiology, and health. *Journal of Personality and Social Psychology*, 63, 221-223.
- Graham, C. A., Ramos, R., Bancroft, J., Maglaya, C., & Farley, T. M. M. (1995). The effects of steroidal contraceptives on the well-being and sexuality of women: A double blind, placebo-controlled, two centre study of combined and progestogen-only methods. *Contraception*, 52, 363-369.
- Gray, J. (1992). *Men are from mars; women are from Venus*. New York: HarperCollins.
- Gray, J. (1994). *What your mother couldn't tell you and your father didn't know: Advanced relationship skills for lasting intimacy*. New York: HarperCollins.
- Groves, R. (1989). Actors and questions in telephone and personal interview surveys. *Public Opinion Quarterly*, 48, p. 190-205.

- Haavio-Mannila, E., & Kontula, O. (1997). Correlates of increased sexual satisfaction. *Archives of Sexual Behavior*, 26, 399-419.
- Hall, G. (1922). Flapper Americana novissima. *Atlantic Monthly*, 129, 771-780.
- Halpern, C. T., Udry, J. R., Campbell, B., & Suchindran, C. (1993). Testosterone and pubertal development as predictors of sexual activity: A panel analysis of adolescent males. *Psychosomatic Medicine*, 55, 436-447.
- Halpern, C. J. T., Udry, J. R., & Suchindran, C. (1997). Testosterone predicts initiation of coitus in adolescent females. *Psychosomatic Medicine*, 59, 161-171.
- Hamer, D., Hu, S., Magnuson, V., Hu, N., & Pattatucci, A. (1993.) A linkage between DNA markers on the X chromosome and male sexual orientation. *Science*, 261, 321-327.
- Hamilton, W.D. & Zuk, M. (1982). Heritable true fitness and bright birds: a role for parasites. *Science*, 218, p. 341-387.
- Haqq, C. M., & Donahoe, P. K. (1998). Regulation of sexual dimorphism in mammals. *Physiological Reviews*, 78, 1-33.
- Harding, C. (Ed.) (1992). *Wingspan: Inside the men's movement*. New York: St. Martin's Press.
- Harding, C. (Ed.) (2001). *Sexuality- psychoanalytic perspectives*. Philadelphia: Brunner Routledge Press.
- Harlow, H.F. (1962). The heterosexual affection system in monkeys. *American Psychologist*, (17), 1-9.
- Harrison, J., & Heath, R. (1997). Advertising joins the journey of the soul. *American Demographics*, 19(6), 22-27.
- Hartman, L. M. (1980a). The interface between sexual dysfunction and marital conflict. *American Journal of Psychiatry*, 137, 576-579.

- Hartman, L. M. (1980b). Relationship factors and sexual dysfunction. *Canadian Journal of Psychiatry*, 25, 560-563.
- Hawton, K., & Catalan, J. (1986). Prognostic factors in sex therapy. *Behaviour Research and Therapy*, 24, 377-385.
- Heaton, J. (1998). Neural and pharmacological determinants of erection. *International Journal of Impotence Research*, 10 (S-2), S34-39.
- Heaton, J. P. W. (2000). Central neuropharmacological agents and mechanisms in erectile dysfunction: The role of dopamine. *Neuroscience & Biobehavioral Reviews*, 24, 561-569.
- Heavey, C. L., Christensen, A., & Malamuth, N. M. (1995). The longitudinal impact of demand and withdrawal during marital conflict. *Journal of Consulting and Clinical Psychology*, 63, 797-801.
- Hecht, M.L. (1978). The conceptualization and measurement of interpersonal communication satisfaction. *Human Communication Research*, 4(3), 253-264.
- Hedricks, C. A. (1994). Female sexual activity across the human menstrual cycle. *Annual Review of Sex Research*, 5, 122-172.
- Heiman, J. R. (2000). Orgasmic disorders in women. In S. R. Leiblum & R. C. Rosen (Eds.), *Principles and practice of sex therapy* (3rd Ed., p. 118-153). New York: Guilford.
- Heiman, J. R. (2001). Sexual desire in human relationships. In W. Everaerd & E. Laan (Eds.), *Sexual appetite, desire and motivation* (pp. 117-134). Amsterdam: The Royal Netherlands Academy of Arts and Sciences.
- Heiman, J. R., Gladue, B. A., Roberts, C. W., & LoPiccolo, J. (1986). Historical and current factors discriminating sexually functional from sexually dysfunctional married couples. *Journal of Marital and Family Therapy*, 12, 163-174.
- Heiman, J. R., LoPiccolo, L., & LoPiccolo, J. (1981). The treatment of sexual dysfunction. In A. S. Gurman & D. P. Kniskern, (Eds.), *Handbook of family therapy* (pp. 592-627). New York: Brunner/Mazel.

- Heiman, J. R., & LoPiccolo, J. (1983). Clinical outcome of sex therapy. *Archives of General Psychiatry*, 40, 443-449.
- Heiman, J. R., & Meston, M. (1997). Empirically validated treatment for sexual dysfunction. *Annual Review of Sex Research*, 8, 148-194.
- Helenson, R., & Shrivastava, S. (2001). Three paths of adult development: Conservers, seekers, and achievers. *Journal of Personality and Social Psychology*, 82, 995-1010.
- Herbert, J. (1996). Sexuality, stress, and the chemical architecture of the brain. *Annual Review of Sex Research*, 7, 1-43.
- Herek, G.M. & Capitanio, J.P. (1995). Black heterosexuals' attitudes toward lesbians and gay men in United States. *Journal of Sex Research*, 32, p.95-105.
- Hill, G. (1992). *Masculine and feminine: The natural flow of opposites in the psyche*. Boston: Shambala.
- Hite, S. (1976). *The Hite Report*. MacMillan: New York.
- Hoch, Z., Safir, M. P., Peres, G. & Shepher, J. (1981). An evaluation of sexual performance- Comparison between sexually dysfunctional & functional couples. *Journal of Sex and Marital Therapy*, 7, 195-206.
- Hof, L. (1987). Evaluating the marital relationship of clients with sexual complaints. In G. R. Weeks & L. Hof (Eds.), *Integrating sex and marital therapy: A clinical guide* (pp. 5-22). New York: Brunner/Mazel.
- Hofer, M. A. (1996). On the nature and consequences of early loss. *Psychosomatic Medicine*, 58, 570-581.
- Hoffman, D. (Director). WETA/Varied Directions Intl. (Producer). (1991). *Making Sense of the sixties*. Alexandria, VA: Public Broadcasting Service.
- Hollows, J. (2000). *Feminism, femininity, and popular culture*. Manchester, MI: Manchester University Press.

- Holman, T.B., & Li, B.D. (1997). Premarital factors influencing perceived readiness for marriage. *Journal of Family Issues*, 18(2), 124-144.
- Hughes, C. (1994). From field notes to dissertation: Analysing the stepfamily. A.A. Bryman & R.G. Burgess (Eds.). *Analysing qualitative data*. London: Routledge.
- Hurlbert, D. F. (1991). The role of assertiveness in female sexuality: A comparative study between sexually assertive and sexually non-assertive women. *Journal of Sex and Marital Therapy*, 17, 183-190.
- Hurwitz, M. B. (1989). Sexual dysfunction with infertility. *South Africa Medical Journal*, 76, 58-62.
- Huysamen, G.K. (1994). *Methodology for the social and behavioral sciences*. Halfway House, Midrand: Southern Book Publishers.
- Hyde, J. S., DeLamater, J., Plant, E. A., & Byrd, J. M. (1996). Sexuality during pregnancy and the year postpartum. *The Journal of Sex Research*, 33, 143-151.
- Jacobson, N. S., & Christesen, A. (1996). *Integrative couple therapy: Promoting acceptance and change*. New York: W. W. Norton.
- Janssen, E., & Everaerd, W. (1993). Determinants of male sexual arousal. *Annual Review of Sex Research*, 4, 211-246.
- Johnson, B. & Christensen, L. (2000). *Educational research: Quantitative and qualitative approaches*. Boston: Allyn & Bacon.
- Julien, D., Arellano, C., Turgeon, L. (1997). Gender issues in heterosexual, gay and lesbian couples. In W. K. Halford & H. J. Markman (Eds.), *Clinical handbook of marriage and couples interventions* (pp. 107-127). Chichester, UK: Wiley.
- Kalichman, S.C. (1995). *The handbook of sexuality in close relationships*. Boston: Allyn & Bacon.
- Kant, I. (1963). *Kant's "critique of practical reason" and other works on the theory of ethics*. Trans. Thomas Kingsmill Abott. London: Longmans, Green and Company.

- Kaplan, H. S. (1974). *The new sex therapy*. New York: Brunner/Mazel.
- Kaplan, H. S. (1989). *Premature ejaculation: Overcoming premature ejaculation*. New York: Brunner/Mazel.
- Karlin, R. (1997). Illusory safeguards: legitimizing distance in recall with guidelines for forensic hypnosis. *Inferential Journal of Clinical and External Hypnosis*, 45, p.18-40
- Karney, B. R., & Bradbury, T. N. (1995). The longitudinal course of marital quality and stability: A review of theory, method, and research. *Psychological Bulletin*, 118, 3-34.
- Katzenstein, L. (1998). *Viagra: The potency promise*. New York: Brunner/Mazel.
- Keller, E. (1985). *Reflections on gender and science*. New Haven, CT: Yale University Press.
- Keller, M. F., McCullough, J. P., Klein, D. N., Arnow, B., Dunner, D. L., Gelenberg, A. J., Markowitz, J. C., Nemeroff, C. B., Russel, J. M., Thase, M. E., Trivedi, M. H., & Zajecka, J. (2000). A comparison of nefazodone, the cognitive behavioral-analysis system of psychotherapy, and their combination for the treatment of chronic depression. *The New England Journal of Medicine*, 342, 1462-1470.
- Kelley, H. H., Berscheid, E., Christensen, A., Harvey, J., Huston, T.L., Levinger, G., McClintock, E., Peplau, L. A., & Peterson, D. R. (1983). *Close relationships*. New York: W. H. Freeman.
- Kelley, H. H. & Thibault, J. (1978). *Interpersonal relations: A theory of inter-dependence*. New York: Wiley.
- Kemph, B.T., & Kasser, T. (1996). *Social research methods: Qualitative and quantitative approaches*. Sage Publication.
- Keyes, C. L. M., Shmotkin, D., & Ryff, C. D. (2002). Optimizing well-being: The empirical encounter of two traditions. *Journal of Personality and Social Psychology*, 82, 1007-1022.

- Kiecolt-Glaser, J., Newton, T., Cacioppo, J., MacCallum, R., Glaser, R., & Malarkey, W. (1996). Immunological responses in the wife demand/husband withdraw interaction pattern. *Journal of Consulting and Clinical Psychology, 64*, 83-96.
- Kilmann, P. R., Boland, J. P., Norton, S. P., Davidson, E., & Caid, C. (1986). Perspectives of sex therapy outcome: A survey of AASECT providers. *Journal of Sex & Marital Therapy, 12*, 116-138.
- Kilmann, P. R., & Mills, K. H. (1983). *All about sex therapy*. New York: Plenum.
- Kincheloe, J.L. & McLaren, P.L. (1994). Rethinking critical theory and qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds.). *Handbook of qualitative research*. Thousand Oaks: Sage.
- Kinder, B. N., & Curtiss, G. (1988). Specific components in the etiology, assessment, and treatment of male sexual dysfunctions: Controlled outcome studies. *Journal of Sex & Marital Therapy, 14*, 40-48.
- King, T. (1999). Jung and catholic spirituality. *America, 180(11)*, 12-19.
- Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1948). *Sexual behavior in the human male*. Philadelphia: Saunders.
- Kinsey, A. C., Pomeroy, W. B., Martin, C. E., & Gebhard, P. H. (1953). *Sexual behavior in the human female*. Philadelphia: Saunders.
- Kinsey Institute for Research in Sex, Gender, and Reproduction. (2001). History of the institute. *The Kinsey Institute Web Site*. (On-line.) Available: <http://www.indiana.edu/~kinsey/history.html>
- Klages, M. (1997). *Postmodernism*. Retrieved January 2, 2002, from University of Colorado at Boulder English Department Web site: <http://www.colorado.edu/English/ENGL2012Klages/pomo.html>
- Klages, M. (2001). Structuralism/Poststructuralism. Retrieved January 2, 2002, from University of Colorado at Boulder English Department Web site: <http://www.colorado.edu/English/ENGL2012Klages/1derrida.html>

- Klinetob, N. A., & Smith, D. A. (1996). Demand-withdraw communication in marital interaction: Tests of interspousal contingency and gender role hypotheses. *Journal of Marriage and the Family*, 58, 945-957.
- Kite, M.E. & Whitely, B.E. (1996). Sex differences in attitudes towards homosexual persons, behaviour and civil rights: a meta-analysis. *Personality and Social Psychology Bulletin*, 22, p. 336-353.
- Kobak, R., Ruckdeschel, K., & Hazan, C. (1994). From symptom to signal: An attachment view of emotion in marital therapy. In S. M. Johnson & L. S. Greenberg (Eds.), *The heart of the matter: Perspectives on emotion in marital therapy* (pp. 46-71). New York: Brunner/Mazel.
- Koedt, A. (1968). *The myth of the vaginal orgasm: A thesis for future study*. New York: Macmillan.
- Krane, R. J., Goldstein, I., & Saenz de Tejada, I. (1989). Impotence. *New England Journal of Medicine*, 321, 1648-1659.
- Kranz, R., & Cusick, T. (2000) *Gay rights*. New York: Facts on File, Inc.
- Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing*. Thousand Oaks: Sage.
- Laan, E., van Lunsen, R. H. W., Everaerd, W., Heiman, J. R., & Hackbert, L. (2000, June). *The effect of sildenafil on women's genital and subjective sexual response*. Paper presented at the 26th Annual Meeting of the International Academy of Sex Research. Paris: France.
- Lachman, S.J. (1990). *The Challenge of AIDS in the 1990's: South Africa*. Lennon Ltd. South Africa.
- Landy, L. (1996). Quality and quantity or Marcuse's problem ain't been solved yet. *Contemporary Music Review*, 15 (34). Harwood Academic Publishers.

- Laumann, E. O., Gagnon, J. H., Michael, R. T., & Michaels, S. (1994). *The social organization of sexuality: Sexual practices in the United States*. Chicago: University of Chicago Press.
- Laumann, E. O., Paik, A., & Rosen, R. C. (1999). Sexual dysfunction in the United States: Prevalence and predictors. *Journal of the American Medical Association*, 281: 537-544.
- Lassen, C. L. (1995). Resistance versus motivation: Tipping the balance. In R. C. Rosen & S. R. Leiblum (Eds.), *Case studies in sex therapy* (pp. 232-249). New York: Guilford.
- Leary, M. R., & Dobbins, S. E. (1983). Social anxiety, sexual behaviour, and contraceptive use. *Journal of Personality and Social Psychology*, 45, 1347-1354.
- Leiblum, S. R., & Rosen, R. C. (Eds.). (1988). *Sexual desire disorders*. New York: Guilford.
- Leiblum, S., & Rosen, R. (Eds.). (2000) *Principles and practice of sex therapy*. (3rd Ed.) New York: Guilford Press.
- Lennon, J., & McCartney, J. (1967). I am a walrus. (Song) *Sergeant Pepper's lonely heart club band*. (Album) Los Angeles: Capital Records.
- Leo, J. (1998). Mars to Venus: Back off. *U. S. News & World Report*, 124(18), 16.
- Lerner, S. E., Melman, A., & Christ, G. J. (1993). A review of erectile dysfunction: New insights and more questions. *Journal of Urology*, 149, 1246-1255.
- Lesch, K. P., Bengel, D., Heils, A., Sabol, S. Z., Greenberg, B. D., Petri, S., Benjamin, J., Muller, C. R., Hamer, D. H., & Murphy, D. L. (1996). Association of anxiety-related traits with polymorphism in the serotonin transporter gene regulatory region. *Science*, 274, 1527-1531.
- Lessler, J.T. & Holt, M. (1987). Using response protocols to identify problems in the United States Census long form. *Proceedings of the American Statistics Association, Survey Research Methods Section*, p. 262-266.
- Levy, S. (1991). A difference in hypothalamic structure between heterosexual and homosexual men. *Science*, 253, 1034-7.

- Levey, S. (1993) *The sexual brain*. Cambridge, MA: MIT Press.
- Levine, S. B., & Rosenthal, M. (1977). Marital sexual dysfunction: Female dysfunction. *Annals of International Medicine*, 86, 588-597.
- Lewin, J. & King M. (1997). Sexual medicine. *British Medical Journal*, 314.
- Lincoln, Y. & Guba, E. (1999). Establishing trustworthiness. In A. Bryman & R.G. Burgess. *Qualitative research*. (Vol 3.) London: Sage.
- Linehan, M. (1993). *Cognitive-behavioural treatment of borderline personality disorder*. New York: Guilford.
- Lisak, D. (1995). Integrating a critique of gender in the treatment in the treatment of male survivors of childhood abuse. *Psychotherapy*, 32, 258-269.
- Lloyd, S. A. (1990). Conflict types and strategies in violent marriages. *Journal of Family Violence*, 5, 269-284.
- Lock, M. (1998). Menopause: Lessons from anthropology. *Psychosomatic Medicine*, 60, 410-419.
- Locke, H. J., & Wallace, K. M. (1959). Short marital adjustment and prediction tests: Their reliability and validity. *Marriage and Family Living*, 21, 251-255.
- Lopata, H. (1998). *Circles and settings: Role changes of American women*. Albany: SUNY Press.
- LoPiccolo, J. (1983). Challenges to sex therapy. In C. M. Davis (Ed.), *Challenges in sexual science: Current theoretical issues and research advances* (p. 16-22). Lake Mills, IA: The Society for the Scientific Study of Sex.
- LoPiccolo, J. (1992). Postmodern sex therapy for erectile failure. In R. C. Rosen & S. R. Leiblum (Eds.), *Erectile disorders: Assessment and treatment* (p. 171-197). New York: Guilford.
- LoPiccolo, J. (1994). The evolution of sex therapy. *Sexual and Marital Therapy*, 9, 5-7.

- LoPiccolo, J., & Lobitz, W.C. (1972). The role of masturbation in the treatment of orgasmic dysfunction. *Archives of Sexual Behavior*, 2, 163-171.
- LoPiccolo, J., & Stock, W. E. (1986). Treatment of sexual dysfunction. *Journal of Consulting and Clinical Psychology*, 54, 158-167.
- Lloyd, E. A. (1993). Pre-theoretical assumptions in evolutionary explanations of female sexuality. *Philosophical Studies*, 69, 139-153.
- Luria, Z. & Rose, M.D. (1979). *Psychology and Human Sexuality*. Amazon Books.
- MacLaine, S. (2000). *The Camino: A journey of the spirit*. New York: Simon & Schuster.
- Marachino, N. (1999). There's nothing wrong with porn: Part two. *The Adult Webmaster Magazine*. Retrieved April 25, 2002, from [http://www.theadultwebmaster.com/articles/nothing wrong pt2 01.phtml](http://www.theadultwebmaster.com/articles/nothing%20wrong%20pt2%2001.phtml)
- Markman, H. J. (1990). Constructive marital conflict is NOT an oxymoron. Special Issue: Negative communication in marital interaction: A misnomer? *Behavioural Assessment*, 13, 83-96.
- Markman, H. J., Floyd, F. J., Stanley, S. M., & Stroraasli, R. D. (1988). Prevention of marital distress: A longitudinal investigation. *Journal of Consulting and Clinical Psychology*, 478-482.
- Martin, D., & Lyon, P. (1972). *Lesbian/woman*. San Francisco: Glide Publications.
- Martin, J.L. (1987). The impact of AIDS on gay male sexual behaviour patterns in New York City. *American Journal of Public Health*, 77, p. 578-582.
- Martin, K., & Voorheis, B. (1975). *Female of the Species*. New York: Columbia University Press.
- Masters, W., & Johnson, V. (1966). *Human sexual response*. Boston: Little, Brown.

- Masters, W. & Johnson, V. (1979). *Homosexuality in perspective*. Boston: Little, Brown.
- Masters, W. & Johnson, V. (1988). *Crisis: Heterosexual behaviour in the age of Viagra*. New York: Grove Press.
- Masters, W., Johnson, V. & Kolodny, R. (1982). *Human Sexuality*. Boston: Little, Brown.
- Masters, W., Johnson, V., & Kolodny, R. (1992). *Human sexuality* (4th Ed.). New York: Harper Collins.
- May, E.T. (1988). *Homeward bound: American families in the cold war era*. New York: Basic Books.
- McCabe, J. P. & Cobain, M. J. (1998). The impact of individual and relationship factors on sexual dysfunction among males and females. *Sexual and Marital Therapy*, 13, 131-143.
- McCabe, M. P. (1992). A program for the treatment of inhibited sexual desire in males. *Psychotherapy*, 29, 288-296.
- McCabe, M. P. (1993). *Sexual Dysfunction Scale*. Melbourne: Deakin University.
- McCabe, M. P. & Jupp, J. J. (1989). Interrelationships among general arousability, emerging and current sexual desire and severity of sexual dysfunction. *Psychological Report*, 65, 147-154.
- McCarthy, B. W. (1995). Bridges to sexual desire. *Journal of Sex Education and Therapy*, 21, 132-141.
- McCarthy, B. W. (1997). Therapeutic and iatrogenic interventions with adults who were sexually abused as children. *Journal of Sex & Marital Therapy*, 23, 118-125.
- McCarthy, B. W. (1998). Sex in the first two years of marriage. *Journal of family Psychotherapy*, 9, 1-11.

- McCarthy, B. W. (1999). Marital style and its effects on sexual desire and functioning. *Journal of Family Psychotherapy*, 10(3), 1-12.
- McConnell, T. (Ed.) (2001). *American decades (Vol. 9)*. Detroit: Gale Research.
- McDaniel, P. (2001). Shrinking violets and Caspar milquetoasts: Shyness and heterosexuality for the roles of the fifties to Rules of the nineties. *Journal of Social History*, 34(3), 547-568.
- McGaa, E. (1990). *Mother earth spirituality*. San Francisco: HarperCollins.
- McGraw, D. (1995). The Christian capitalists. *U.S. News & World Report*, 118(10), 53-56, 59-60, 62.
- McGuire, M. (1993). Health and spirituality as contemporary concerns. *ANNALS, AAPSS, May*, 144-154.
- McKenna, K. E. (1998). Central control of penile erection. *International Journal of Impotence Research*, 10 (Suppl. 1), S25-S34.
- McLoughlin, W. (1978). *Revivals, awakenings and reform*. Chicago: University of Chicago Press.
- McNamara, E. (1994). *Sex, suicide and the Harvard psychiatrist*. Pocket Books.
- McWilliams, J. (2000). *The 1960s cultural revolution*. Westport, CT: Greenwood Press.
- Mead, R. (1995). Is John Gray from Mars? *New York*, 28(37), 66-69.
- Meeks, B.S., Hendrick, S.S., & Hendrick, C. (1998). Communication, love and relationship satisfaction. *Journal of Social and Personal Relationships*, 15(6), 755-773.
- Mehrabian, A. & Stanton-Mohr, L. (1985). Effects of emotional state on sexual desire and sexual dysfunction. *Motivation and Emotion*, 9, 315-330.
- Meston, C. M., & Frohlich, P. F. (2000). The neurobiology of sexual function. *Archives of General Psychiatry*, 57, 1012-1030.

- Metz, M. E. (1993). *The styles of conflict inventory for personal relationships*. Palo Alto, CA: Consulting Psychologists Press.
- Metz, M. E., & Dwyer, S. M. (1993). Differences in conflict management styles between sex dysfunction, sex offender, and satisfied couples. *Journal of Sex & Marital Therapy*, 19, 104-122.
- Metz, M. E., & Lutz, G. (1990). Dyadic playfulness differences between sexual and marital therapy couples. *Journal of Psychology and Human Sexuality*, 167-182.
- Metz, M. E., Rosser, B. R. S., & Strapko, N. (1994). Differences in conflict resolution styles between heterosexual, gay, and lesbian couples. *Journal of Sex Research*, 31, 293-308.
- Metz, M. E., Pryor, J. L., Nesvacil, L. J., Abuzzahab, F., & Koznar, J. (1997). Premature ejaculation: A psychophysiological review. *Journal of Sex & Marital Therapy*, 23, 3-23.
- Michael, R., Gagnon, J., Lauman, E., & Kolata, G. (1994). *Sex in America: A definitive study*. Boston: Little, Brown & Co.
- Michelson, D., Bancroft, J., Targum, S., Kim, Y., & Tepner, R. (2000). Female sexual dysfunction associated with antidepressant medication: A randomised, placebo-controlled study of pharmacological intervention. *American Journal of Psychiatry*, 157, 239-243.
- Miles, B.M. & Huberman, A.M. (1994). *Qualitative data analysis*. Thousand Oaks: Sage.
- Miller, G. E., & Bradbury, T. N. (1995). Refining the association between attributions and behaviour in marital interaction. *Journal of Family Psychology*, 9, 196-208.
- Miller, N. (2002). *Environmental politics: Interest groups, the media, and the making of policy*. Boca Rotan, FL: Lewis.
- Miller, W. B., Pasta, D. J., MacMurray, J., Chui, C., & Comings, D. E. (1999). Dopamine receptor genes are associated with age at first sexual intercourse. *Journal of Biosocial Science*, 31, 43-54.
- Moir, A., & Jessel, D. (1992). *Brain sex: The real difference between men and women*. New York: Dell Publishing.

- Money, J. (1995). *Gender maps: Social constructionism, feminism, and sexosophical history*. New York: Continuum.
- Money, J. (1988). Commentary: Current status of sex research. *Journal of Psychology and Human Sexuality*, 1, 5-15.
- Money, J. (1985). The conceptual neutering of gender and the criminalization of sex. *Archives of Sexual Behavior*, vol. 14, no. 3, pp. 279-290.
- Morawski, J. (1985). The measurement of masculinity and femininity: Engendering categorical realities. *Journal of Personality*, 53(2), 196-223.
- Morgan, E. (1991). *The 60s experience: Hard lessons about modern America*. Philadelphia: Temple University Press.
- Morgantaler, A. (1993). *The male body*. New York: Dell Publishing.
- Morin, J. (1995). *The erotic mind: Unlocking the inner source of sexual passion and fulfillment*. New York: HarperCollins.
- Morokoff, P. J. & Gilliland, R. (1993). Stress, sexual functioning, and marital satisfaction. *Journal of Sex Research*, 30, 43-53.
- Mosher, D. L. (1979). Sex Guilt and Sex Myths in College Men and Women. *Journal of Sex Research*. 15:224-34.
- Mouton, J. (2001). *How to succeed in your masters and doctoral studies: a South African guide and resource*. Pretoria: Van Schaik.
- Moynihan, R. (2003). The making of a disease: Female sexual dysfunction. *British Medical Journal*, 326, 45-7.

- Myers-Shirk, S. (2001). Sexuality. In M.K. Cayton & P. W. Williams (Eds.) *Encyclopaedia of American Cultural & Intellectual History* (Vol. 2, pp.83-92). New York: Charles Scribner's Sons.
- Nathan, S. G. (1986). The epidemiology of the DSM-III psychosexual dysfunctions. *Journal of Sex & Marital Therapy*, 12, 267-281.
- Newmann, M. (1996). Collecting ourselves at the end of the century. In C. Ellis & A. Bochner (Eds.), *Composing ethnography: Alternative forms of qualitative writing*. (p. 172-198). Walnut Creek, CA: Sage.
- Nicholas, L. J. (1994a). *Sex counselling in educational settings*. Braamfontein: Skotaville Publishers.
- Nicholas, L. J. (1994b). "A Profile of 2,209 UWC First Year Students: Career Interests, Guidance Experiences, Knowledge and Attitudes towards AIDS and Sexuality and Religiosity." An unpublished report: Centre for Student Counselling, University of the Western Cape.
- Norman, K.D. (1989). The sociological interview, in Norman K. Denzin, *The research at*, 3rd edition. Prentice Hall: New York.
- Norusis, M.J. (1993). *SPSS for Windows: Base systems users' guide, release, 6, 0*. Chicago: SPSS Inc.
- Notarius, C.I., Markman, H.J., & Gottman, J.M. (1983). Couples interaction scoring system: Clinical implications. In E.E. Filsinger (Ed.), *Marriage and Family Assessment*. P.117-136. Beverly Hills, CA: Sage Publications.
- O'Farrell, T. J., Choquette, K. A., Cutter, H. S. G., & Birchler, G. R. (1997). Sexual satisfaction and dysfunction in marriages of male alcoholics: Comparison with non-alcoholic martially conflicted and nonconflicted couples. *Journal of Studies on Alcohol*, 58, 91-99.
- O'Leary, K. D., & Curley, A. D. (1986). Assertion and family violence: Correlates of spouse abuse. *Journal of Marital and Family Therapy*, 12, 281-289.

- O'Sullivan, L.F. & Allgeier, E.R. (1998). Feigning sexual desire: Consenting to unwanted sexual activity in heterosexual dating relationships. *Journal of Sex Research*, 234
- Paglia, C. (1997). Feminists must begin to fulfil their noble, animating ideal. Retrieved 3/16/02 from *The Chronicle of Higher Education* website:
<http://chronicle.com/colloquy/97/feminism/46b00401.htm>
- Pascal, E. (1992). *Jung to live by*. New York: Warner Books.
- Pasupathi, M., Carstensen, L.L., Levenson, R.W., & Gottman, J.M. (1999). Responsive listening in long-married couples: A psycholinguistic perspective. *Journal of Nonverbal Behaviour*, 23(2). p.173-193.
- Patten, M.A. (2004). Correlates of species richness of North American bat families. *Journal of Biogeography*, 21, p. 975-985.
- Payze, C. & Keith, T. (1993). Everyday life in South African hostels. In A. Minnaa, (Ed.) *Communities in isolation: Perspectives on hostels in South Africa*. Pretoria: HSRC.
- Pencak, W. (2001). Poststructuralism and postmodernism. In M.K. Cayton & P. W. Williams (Eds.), *Encyclopaedia of American Cultural & Intellectual History* (Vol. 2, pp. 215-224). New York: Charles Scribner's Sons.
- Perper, T., & Comog, M. (1999). Sex in the interstices: The meltdown of idealized selves and partners. *Sexuality and Culture*, 3, 101-115.
- Perusse, D. (1993). Cultural and reproductive success in individual societies: testing the relationship at the proximate and ultimate levels. *Behavioural and Brain Sciences*, 16. 267-322.
- Peterson, V. (2000). Mars and Venus: The rhetoric of sexual planetary alignment. *Women and Language*, 23:2, 1-7.
- Pickering, J. (1997). *The authority of experience: Essays on Buddhism and psychology*. Surrey, TW: Curzon.

- Pietropinto, A. (1986). Male contribution to female sexual dysfunction. *Medical Aspects of Human Sexuality*, 84-91.
- Powis, D. A., & Bunn, S. J. (1995.) Neurotransmitter release and its modulation. *Biochemical mechanisms, physiological function and clinical relevance*. Boston: Cambridge University Press.
- Preston-Whyte, E. M. (1995). "Half-Way There: Anthropology and Intervention-Oriented AIDS Research in KwaZulu/Natal, South Africa." In: Han ten Brummelhuis and Gilbert Herdt, (Ed). *Culture and Sexual Risk: Anthropological Perspectives on AIDS*. Amsterdam: Gordon and Breach Science Publishers.
- Pretzer, J., Epstein, N., & Fleming, B. (1991). The Marital Attitude Survey: A measure of dysfunctional attributions and expectancies. *Journal of Cognitive Psychotherapy*, 5, 131-148.
- Purnine, D. M., & Carey, M. P. (1997). Interpersonal communication and sexual adjustment: The roles of understanding and agreement. *Journal of Consulting and Clinical Psychology*, 65, 1,017-1,025.
- Radner, H., & Luckett, M. (Eds.). (1999). *Swinging single: representing sexuality in the 1960s*. Minneapolis, MN: University of Minnesota Press.
- Rathus, L. *Human sexuality: in a world of diversity*. Boston: Allyn & Bacon.
- Rathus, J. H., & Sanderson, W. C. (1999). *Marital distress: Cognitive behavioural interventions for couples*. Northvale, NJ: Jason Arosen.
- Raush, H. L., Barry, W. A., Hertel, R. K., & Swain, M. A. (1974). *Communication, conflict and marriage*. San Francisco, CA: Jossey-Bass.
- Redoute, J., Stoleru, S., Gregoire, M.-C., Costes, N., Cinotti, L., Lavenne, F., Le Bars, D., Forest, M. G., & Pujol, J.-E (2000). Brain processing of visual sexual stimuli in human males. *Human Brain Mapping*, 11(3), 162-177.
- Reed, J. (1999). *The meaning of Mars and Venus on earth*. Unpublished doctoral dissertation, California School of Professional Psychology – Berkeley/Alameda, U.S.

- Reed, J. (1981, November 2). America shapes up. *Time*, 118(18), 94-98, 103-104, 106.
- Reinisch, J.M., Sanders, S.A., Ziemba-Davis, M. (1988). The study of sexual behaviour in relation to the transmission of human immunodeficiency virus: Caveats and recommendations. *American Psychologist*, 43, 921-927.
- Reiss, Ira L., (1984). "Human Sexuality in Sociological Perspective," pp. 39-50 in K.K. Holmes et al. (Eds.), *Sexually Transmitted Diseases*. New York: McGraw-Hill.
- Reiss, I. L. (1986). *Journey into sexuality: An exploratory voyage*. Englewood Cliffs, NJ: Prentice Hall.
- Rice, S. (1994). Changing our minds: Books that shaped 20th century ideas about sexuality. In: *"Stonewall and beyond: Lesbian and gay culture,"* the online edition of a Columbia University Libraries exhibition held from May 25 to September 17, 1994. New York: Columbia University Libraries.
- Richardson, L. (1990). Narrative and sociology. *Journal of Contemporary Ethnography*, 19(1), 116-135.
- Richmond-Abbot, M. (1992). *Masculine and feminine: Gender roles over the life cycle*. (2nd edition). New York: McGraw-Hill.
- Roffe, M. W., & Britt, B. C. (1981). A typology of marital interaction for sexually dysfunctional couples. *Journal of Sex and Marital Therapy*, 7, 207-222.
- Rogers, W. S. & Rogers, R. S. (2001). *The psychology of gender and sexuality: An introduction*. Philadelphia: Open University Press. Rosenthal, R., & Rosnow, R. L. (1991). *Essentials of behavioral research: Methods and data analysis*. New York: McGraw Hill.
- Rorty, R. (1998). *Achieving our country: Leftist thought in twentieth century America*. Cambridge, MA: Harvard University Press.
- Rosen, R. C. (1991). Alcohol and drug effects on sexual response: Human experimental and clinical studies. *Annual Review of Sex Research*, 2, 119-180.

- Rosen, R. C., Lane, R. M., & Menza, M. (1999). Effects of SSRIs on sexual function: A critical review. *Journal of Clinical Psychopharmacology*, 19, 67-85.
- Rosen, R. C., & Leiblum, S. R. (1992). *Erectile disorders: assessment and treatment*. New York: Guilford Press.
- Rosen, R. C., Taylor, J. F., Leiblum, S. R., & Bachman, G. A. (1993). Prevalence of sexual dysfunction in women: Results of a survey of 329 women in an outpatient gynecological clinic. *Journal of Sex and Marital Therapy*, 19, 171-188.
- Rosenbaum, A., & O'Leary, K. D. (1981). Marital violence: Characteristics of abusive couples. *Journal of Consulting and Clinical Psychology*, 49, 63-71.
- Rosenberg, M. (1965). *Society and the adolescent self image*. Princeton, NJ: Princeton University Press.
- Rosenheim, E., & Neumann, M. (1981). Personality characteristics of sexually dysfunctioning males and their wives. *Journal of Sex Research*, 17, 124-138.
- Rosenthal, R., & Rosnow, R. L. (1991). *Essentials of behavioural research: Methods and data analysis*. New York: McGraw Hill.
- Rosnow, R.L. & Rosenthal, R. (1999). *Beginning behavioural research: A conceptual primer*. Upper Saddle River, New Jersey: Prentice Hall.
- Ross, M. H. (1983). Political decision making and conflict: additional cross-cultural codes and scales. *Ethnology*, vol. 22, pp. 169-192.
- Rotundo, A. (1993). *American manhood: Transformations in masculinity from the revolution to the modern era*. New York: Basic Books.
- Roundinesco, E. (1986). *Histoire de la psychanalyse en France seuil*. Paris.
- Rowe, D. C., Rodgers, J. L., & Meseck-Bushey, S. (1989). An "epidemic" model of sexual intercourse prevalences for Black and White adolescents. *Social Biology*, 41, 1-18.

- Rowland, D. L., & Burnett, A. L. (2000). Pharmacology in the treatment of male sexual dysfunction. *The Journal of Sex Research, 37*, 226-245.
- Rubin, G. (1984). Thinking sex: Notes for a radical theory of politics and danger: *Exploring female sexuality*. Ed. Carole S. Vance. Boston: Paul. p. 267-319.
- Ryff, C.D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology, 57*, 1069-1081.
- Ryff, C.D., & Keyes, C.L.M. (1995). The structure of psychological well-being revisited. *Journal of Personality and Social Psychology, 69*, 719-727.
- Sager, C. J. (1976). Sex as a reflection of the total relationship. *Journal of Sex & Marital Therapy, 2*, 3-5.
- Sanders, S. A., Graham, C. A., Bass, J. L., & Bancroft, J. (2001). A prospective study of the effects of oral contraceptives on sexuality and well-being and their relationship to discontinuation. *Contraception, 64*, 51-58.
- Sandler, J., Meyerson, M, & Kinder, B.N. (1980). Human sexuality: current perspectives. Tempa: Mariner.
- Sbrocco, T., Weisberg, R. B., Barlow, D. H., & Carter, M. M. (1997). The conceptual relationship between panic disorder and male erectile dysfunction. *Journal of Sex & Marital Therapy*.
- Schaap, C. (1984). A comparison of the interaction of distressed and nondistressed married couples in a laboratory situation: Literature survey, methodological issues, and an empirical investigation. In K. Hahlweg & N. S. Jacobson (Eds.), *Marital interaction: Analysis and modification* (pp. 133-158). New York: Guilford Press.
- Schaefer, M. T. & Olson, D. H. (1981). Assessing intimacy: The PAIR inventory. *Journal of Marital and Family Therapy, 1*, 47-60.
- Schiavi, R. C. (1999). *Aging and male sexuality*. Boston: Cambridge University Press.

- Schmidt, F.L. & Hunter, J. E. (1998). The validity and utility of selection methods in personnel psychology: practice and theoretical implications of 85 years of research findings. *Psychological Bulletin*, 124, p. 262-274.
- Schmidt, G. (1988). *Handbook of industrial, work and organizational psychology, vol: Personal psychology*. Sage Publication.
- Schreiner-Engel, P., & Schiavi, R. C. (1986). Lifetime psychopathology in individuals with low sexual desire. *Journal of Nervous and Mental Disease*, 174, 646-651.
- Schreiner-Engel, R, Schiavi, R. C., White, D., & Ghizzani, A. (1989). Low sexual desire in women: The role of reproductive hormones. *Hormones and Behavior*, 23, 221-234.
- Seidman, S. (1992). *Embattled eros: Sexual politics and ethics in contemporary America*. New York: Routledge. SIECUS Report, vol. 8, no, 3, January 1980, Human Sciences Press, New York.
- Seilhamer, R. A., & Jacob, T. (1990). Family factors and adjustment of children of alcoholics. In M. Windle & J. S. Searles (Eds.), *Children of alcoholics: Critical perspectives* (pp. 168-186). New York: Guilford Press.
- Sekaran, U. (1994). *Research methods for business: a skill building approach*. (2nd Ed.), New York: John Willey.
- Seligmann, J. (1990, Winter/Spring). Variations on a theme. (Special Edition: The 21st Century family). *Newsweek*, 114(27), 38-40, 44, 46.
- Sherwin, B. B., & Gelfand, M. M. (1987). The role of androgen in the maintenance of sexual functioning in oophorectomized women. *Psychosomatic Medicine*, 49, 397-409.
- Shifren, J. L., Braunstein, G. D., Simon, J. A., Casson, P. R., Buster, J. E., Redmond, G. P., Burki, R. E., Ginsburg, E.S., Rosen, R. C., Leiblum, S. R., Caramelli, K. E., & Mazer, N. A. (2000). Transdermal testosterone treatment in women with impaired sexual function after oophorectomy. *The New England Journal of Medicine*, 343, 682-731.

- Silverman, D. (Ed.). (1997). *Qualitative research: Theory, method and practice*. London: Sage.
- Simons, J. S., & Carey, M. P. (2001). Prevalence of sexual dysfunctions: Results from a decade of research. *Archives of Sexual Behaviour, 30*, 177-217.
- Skolnick, A. (1991). *Embattled paradise: The American family in an age of uncertainty*. New York: Basic Books.
- Smaling, A. (1992a). Objectivity, reliability and validity. In G.J.N. Bruinsma & M.A. Zwanenburg (Eds.). *Methodology for management specialists: Trends and methods*. Muiderberg: Dick Coutinho.
- Smaling, A. (1992b). Varieties of methodological intersubjectivity – the relations with qualitative and quantitative research, and with objectivity. *Quality and Quantity, 26*, 169-180.
- Smaling, A. (1994a). The pragmatic dimension: Paradigmatic and pragmatic aspects of choosing a qualitative or quantitative method. *Quality and Quantity, 28*, 233-249.
- Smaling, A. (1994b). Lectures presented to the Centre for Research Methodology Winter School, Human Sciences Research Council, Pretoria, July. (Unpublished).
- Smuts, B.B. (1985). *Sex and friendship baboons*. Aldine: New York.
- Snell, W. E., Jr. (1986). The Masculine Role Inventory: Components and correlates. *Sex Roles, 15*, 443-455.
- Snell, W. E., Jr. (1991). *The impact of the masculine role on women's and men's sexual-esteem, sexual-depression, and sexual-preoccupation*. Manuscript in preparation.
- Snell, W. E., Jr., Belk, S. S., & Hawkins, R. C. II. (1986a). The masculine role as a moderator of stress-distress relationships. *Sex Roles, 15*, 359-366.
- Snell, W. E., Jr., Belk, S. S., & Hawkins, R. C. II. (1986b). The stereotypes about Male Sexuality Scale (SAMSS): Components, correlates, antecedents, consequences, and counsellor bias. *Social and Behavioural Sciences Document, 16*, 9. (Ms. No. 2746).
- Snell, W. E., Jr., Belk, S. S., & Hawkins, R. C. II. (1987). Alcohol and drug use in stressful

times: The influence of the masculine role and sex-related personality attributes. *Sex Roles*, 16, 359-374.

Snell, W. E., Jr., Belk, S. S., & Hawkins, R. C. II (1990). Cognitive beliefs about male sexuality: The impact of gender roles and counsellor perspectives. *Journal of Rational-Emotive Therapy*, 8, 249-265.

Snell, W. E., Jr., Belk, S. S., Papini, D. R., & Clark, S. (1989). Development and validation of the Sexual Self-Disclosure Scale. *Annals of Sex Research*, 2, 307-334.

Snell, W. E., Jr., & Finney, P. (in press). Interpersonal strategies associated with the discussion of AIDS. *Annals of Sex Research*.

Snell, W. E., Jr., & Finney, P. (1990). [Reliability and validity of the AIDS Empathy Scale]. Unpublished raw data.

Snell, W. E., Jr., Fisher, T. D., & Miller, R. (1990). Development of the Sexual Awareness Questionnaire: Components, reliability, and validity. Submitted for publication.

Snell, W. E., Jr., Hawkins, R. C. II., & Belk, S. S. (1988). Stereotypes about male sexuality and the use of social influence strategies in intimate relationships. *Journal of Social and Clinical Psychology*, 7, 42-48.

Snell, W. E., Jr., & Papini, D. R. (1989). The Sexuality Scale: An instrument to measure sexual-esteem, sexual-depression, and sexual-preoccupation. *Journal of Sex Research*, 26, 256-263.

Snell, W. E., Jr. (1997). *Measuring multiple aspects of the sexual self-concept: The Multidimensional Sexual Self-Concept Questionnaire (MSSCQ)*. Paper presented at the annual meeting of the Midwestern Psychological Association, Chicago, IL.

Snell, W. E., Jr., Papini, E. (Ed.). (1997). *New directions in the psychology of human sexuality: Research and theory*. Cape Girardeau, MO: Snell Publications.

Snolnick, A. (1991). *Embattled paradise: the American family in an age of uncertainty*. New York: Basic Books.

- Sollie, D. (2000). Beyond Mars and Venus. *Phi Kappa Phi Journal*, 80 (3), 42-45.
- Spanier, G. B. (1976). Measuring dyadic adjustment: New scales for assessing quality of marriage and similar dyads. *Journal of Marriage and the Family*, 38, 15-28.
- Speake, J. (1979). *Dictionary of philosophy*. New York: Basic books.
- Spector, I. P., & Carey, M. P. (1990). Incidence and prevalence of the sexual dysfunctions: A critical review of the empirical literature. *Archives of Sexual Behavior*, 19, 389-408.
- Spradley, J. (1979). *The ethnographic interview*. New York: Holt, Rinehart and Winston.
- Sprecher, S. (2002). Sexual satisfaction in premarital relationships: Associates with satisfaction, love, commitment and stability. *The Journal of Sex Research*, 39 190-196.
- Spence, J., & Helmreich, R. (1978). *Masculinity and femininity: Their psychological dimensions, correlates, and antecedents*. Austin: University of Texas Press.
- Spock, B. (1946). *Baby and child care*. New York: Meredith Press.
- Spradley, J.P. (1979). *The ethnographic interview*. Fort Worth: Harcourt Brace Jovanovich College Publishers.
- Stearns, P. (1979). *Be a man! Males in modern society*. New York: Holmes & Meier.
- Steers, W. D. (2000). Neural pathways and central sites involved in penile erection: Neuroanatomy and clinical implications. *Neuroscience & Biobehavioral Reviews*, 24, 507-516.
- Stephens, T. (1975). *The crimes of empire: a chronology of United States war crimes and torture*. Philadelphia: Saunders.
- Stern, K., & McClintock, M. K. (1998). Regulation of ovulation by human pheromones. *Nature*, 392, 177-179.
- Stets, J., & Burke, P. (2000). Femininity/masculinity. In E. F. Borgatta & R. J. V. Montgomery (Eds.), *Encyclopaedia of Sociology*, Revised Edition. New York: Macmillan.

Stevens, A. (1999). *On Jung*. Princeton, New Jersey: Princeton University Press.

Stoleru, S., Gregoire, M.-C., Gerard, D., Decety, J., Lafarge, E., Cinotti, L., Lavenne, F., Le Bars, D., Vernet-Maury, E., Rada, H., Collet, C., Mazoyer, B., Forest, M. G., Magnin, F., Spria, A., & Comar, D. (1999). Neuroanatomical correlates of visually evoked sexual arousal in human males. *Archives of Sexual Behavior*, 28(1), 1-21.

Stopes, M. (1918). *Married love*. New York: Macmillan.

Stravynski, A., Gaudette, G., Lesage, A., Arbel, N., Petit, P., Clerc, D., Fabian, J., Lamontagne, Y., Langiois, R., Lipp, O., & Sidoun, P. (1997). The treatment of sexually dysfunctional men without partners: A controlled study of three behavioural group approaches. *British Journal of Psychiatry*, 170, 338-344.

Struckman-Johnson, C. & Struckman-Johnson, D. (2002). Sexual coercion reported by women in three Midwestern prisons. *Journal of Sex Research*, 39, p. 1-11.

Stuart, F.M.; Hammond, D.C. & Pett, M.A. (1987). Inhibited sexual desire in women. *Archives of Sexual Behaviour*, (16) 91-106

Sudman, S. & Blair, E.A. (1999). Sampling in the 21st Century. *Journal of Academy and Marketing Sciences*, 27, p. 269-272.

Sullivan, S. (2001). New philosophical directions. In M.K. Cayton & P. W. Williams (Eds.), *Encyclopaedia of American Cultural & Intellectual History* (Vol. 2, pp. 263-272). New York: Charles Scribner's Sons.

Swayer, C. (1994, December 7). Censorship Laws to Be Relaxed. *The Argus*, p. 1.

Sydie, R.A. (1987). *Natural women, cultured men: a feminist perspective on sociological theory*. Open University Press.

Symons, D. (1979). *The evolution of human sexuality*. New York: Oxford University Press.

Taeuber, C. (Ed.). (1991). *Statistical handbook on women in America*. Phoenix, NM: Oryx Press.

- Talmadge, L. D., & Talmadge, W. C. (1986). Relational sexuality: An understanding of low sexual desire. *Journal of Sex and Marital Therapy*, 12, 3-21.
- Tannen, D. (1990) *You just don't understand: Women and men in conversation*. New York: William Morrow, Ballantine.
- Tanner, J.M. (1990). *Foetus into man: physical growth from conception to maturity*. Cambridge: Harvard University Press.
- Taylor, S., Klein, L., Lewis, B., Gruenewald, T., Gurung, R., & Updegraff, J. (2000). Biobehavioral responses to stress in females: Tend-and-befriend, not fight-or-flight. *Psychological Review*, 107(3), 411-429.
- Taylor, T. (1996). (Speaker). (1996). *A history of the U.S. economy in the 20th Century* (Cassette Recording). Springfield, VA: The Teaching Co.
- Terman, L., & Miles, C. (1936). *Sex and personality*. New York: McGraw-Hill.
- Tieger, P., & Barron-Tieger, B. (1995). *Do what you are: Discover the perfect career for you through the secrets of personality type*. Boston: Little, Brown, & Co.
- Tiemey, W. (1998). Life history's history: Subjects foretold. *Qualitative Inquiry*, 4(1), pp. 49-70.
- Time-Life Books. (Eds.), (1999). *Pride and prosperity: The 80s*. Richmond, VA: Time-Life.
- Tolman, D.L., & Kimmel, E. (in press). *A new view on women's sexual problems*. New York: Harrington Park Press.
- Tolman, D.L. (1994b). Daring to desire: Culture and the bodies of adolescent girls. In J. Irvine (Ed.), *Sexual cultures: Adolescents, communities and the construction of identity*. p.250-284. Philadelphia: Temple University Press.
- Toolan, D. (1996). Harmonic Convergence and all that: New age spirituality. *Cross Currents*, 46 (Fall), 369-379.
- Tovey, P. (1998). Narrative and knowledge development in medical ethics. *Journal of Medical Ethics*, 24:1, 176-181.

- Townsend, J. M. (1998). *What women want—what men want: Why the sexes still see love and commitment so differently*. Oxford, New York: Oxford University Press.
- Tullman, G.M., Dornnbush, R.L., Gilner, F.H., Kolodny, R.C., & Tullman, R.L. (1981). The pre- and post-therapy measurement of communication skills of couples undergoing sex therapy at the Masters & Johnson Institute. *Archives of Sexual Behaviour*, *10*, 105-109.
- Udry, J. R., Billy, J. O. G., Morris, N. M., Groff, T. R., & Raj, M. H. (1985). Serum androgenic hormones motivate sexual behavior in adolescent boys. *Fertility & Sterility*, *43*, 90-94.
- Udry, J. R., Talbert, L. M., & Morris, N. M. (1986). Biosocial foundations for adolescent female sexuality. *Demography*, *23*, 217-230.
- Unger, R. (1979). Toward a redefinition of sex and gender. *American Psychologist*, *34*, 1085-1094.
- Usher, J.M., & Baker, C.D. (Eds.). (1993). *Psychological perspectives on sexual problems: New directions in theory and practice*. New York: Routledge.
- Van de Bilt, E., & Kardux, J. (2001). Overview: From the Reagan era to the present. In M.K. Cayton & P. W. Williams (Eds.), *Encyclopaedia of American Cultural & Intellectual History* (Vol. 2, pp. 195-203). New York: Charles Scribner's Sons.
- Vanzetti, N.A., Notarius, C.I., & NeeSmith, D. (1992). Specific and generalized expectancies in marital intervention. *Journal of Family Psychology*, *6*, 171-183.
- Vargo, M. (1998). *Acts of disclosure: The coming-out process of contemporary gay men*. New York: Haworth Press.
- Vohs, K. D., Catanese, K. R., & Baumeister, R. F. (2004). Sex in "his" versus "her" relationships. In J. H. Harvey, A. Wenzel, & S. Sprecher (Eds.), *Handbook of sexuality in close relationships* (pp. 455-474). Mahway, NJ: Lawrence Erlbaum.
- Vonk, R., & Ashmore, R. (1993). The multifaceted self: Androgyny reassessed by open-ended self-descriptions. *Social Psychology Quarterly*, *56*(4), 278-287.

- Walczak, D. (1988). Rationalization and the deprofessionalization of physicians. *Physics*, 67(1), p. 1-22.
- Walsh, C.E. (1991). *Literacy as praxis: culture, language and pedagogy*. Norwood: Ablex, New York.
- Wandersee, W. (1988). *On the move: American women in the 1970s*. Boston: G.K. Hall.
- Watkins, C. (1990). The effects of counsellor self-disclosure: A research review. *The Counselling Psychologist*, 18(3), 477-500.
- Watson, P., Biderman, M., and Boyd, C. (1989). Androgyny as synthetic narcissism: Sex role measures and Kohut's psychology of the self. *Sex Roles*, 21(3/4), 175-207.
- Weiss, J. (1998). Making room for fathers: Men, women, and parenting in the United States, 1945-1980. In McCall, L. & Yacovone, D. (Eds.) *A shared experience: Men, women, and the history of gender*. (p. 349-67.) New York: New York University Press.
- Weiss, J. (2000). *To have and to hold: Marriage, the baby boom, and social change*. Chicago: University of Chicago Press.
- Weiss, R. L., Hops, H., & Patterson, G. R. (1973). A framework for conceptualizing marital conflict, a technology for altering it, some data for evaluating it. In L. A. Hamerlynck, L. C. Handy, & E. J. Mash (Eds.). *Behavior change: Methodology*.
- Weiss, V. (1980). The application of heritabilities in personnel selection. *Swiss Journal of Psychology*, 62, 15-16.
- Weisstein, N. (1970). "Kinde, küche, kirche" as scientific law: Psychology constructs the female. In R. Morgan (Ed.), *Sisterhood is powerful: An anthology of writings from the women's liberation movement* (pp. 228-245). New York: Vintage Books.
- White, K. (2000). *Sexual liberation or sexual license: The American revolt against Victorianism*. Chicago: Ivan R. Lee.

- Whitely, B.E. (2001). Gender role variables and attitudes towards homosexuality. *Sex Roles*, 45, p. 691-721.
- World Health Organization, (1992). WHO Committee on Rabies, eight report. Geneva.
- Wile, D.B. (1993). *After the fight: A night in the life of a couple*. New York: Guildford Press.
- Wincze, J. P., & Carey, M. P. (2001). *Sexual dysfunction: A guide for assessment and treatment*. New York: Guilford.
- Winter, D. (1996). *Ecological psychology: Healing the split between planet and self*. New York: HarperCollins College.
- Wolfe, T. (1976). The "me" decade and the third great awakening. *New York*, 9(34), 26-40.
- Wood, J. (2002). A critical response to John Gray's Mars and Venus portrayals of men and women. *Southern Communication Journal*, 67(2), 201-210.
- Wyche, K. (1999). Interpreting the life narrative: Race, class, gender, and historical context. *Psychology of Women Quarterly*, 23, 232-326.
- Young-Eisendrath, P. (1997). *Gender and desire: Uncursing Pandora*. College Station: Texas A & M University Press.
- Zikmund, W.G. (2000). *Business research methods*. Fort Worth: Dryden.
- Zucker, K. J. (1999). *Intersexuality and gender identity differentiation*. *Annual Review of Sex Research*, 10, 1-69.
- Zukav, G. (1989). *The seat of the soul*. New York: Simon & Schuster.

ANNEXURES

19 June 2005

THE CHIEF EXECUTIVE DIRECTOR

King Edward VIII Hospital

Private Bag XO2

Congella

4013

RE: CONSENT TO CONDUCT RESEARCH

Dear Sir or Madam:

I am currently registered for a PhD degree in Psychology at the University of Zululand, my supervisor is Prof. Steve Edwards. The title of my thesis is, "Improving sexuality in interpersonal relationships". The chief aim of my study is to explore the theoretical and practical investigations into the relationship between sexuality and psychological well-being with special reference to the improvement of sexual functioning in interpersonal relationships. It is in this regard that I am writing to you to seek permission to obtain this sample at King Edward VIII Hospital. I have had a discussion with Prof. J. Moodley, the head of the department of obstetrics and gynaecology who has supported my initiative, but suggested that I write to you to obtain formal consent.

The study will take the form of a biographical questionnaire, which is essentially much uncomplicated. And the use of two questionnaires (the Sexuality and Psychological Well-being Scales) consisting of closed-ended questions and one open-ended question regarding responses/suggestions and recommendations to improving sexuality. The patients' would be requested to participate voluntarily and will be free to withdraw from the study at any stage without prejudice.

This type of study has not been undertaken in South Africa previously, hence it would shed some light on the perceptions of sexuality and psychological well-being. The findings of the study would be made available for perusal to your institution via the dissertation. I am willing to abide by any ethical or other requirements that govern research by your institution.

I thank you anticipating a favourable response.

Sincerely,

Ms Sonia Roopnarain

RESEARCH QUESTIONNAIRE

INSTRUCTIONS: Please complete the following questionnaire as fully as possible by choosing the answers which apply to you and make a cross (X) in the space provided. All information provided to the researcher will be treated in **STRICT CONFIDENCE**.

SECTION A: BIOGRAPHICAL INFORMATION

1. Age

20 and under	
21-30	
31-40	
41-50	
50+	

2. Gender

MALE	
FEMALE	

3. Ethnic Grouping

AFRICAN	
COLOURED	
INDIAN	
WHITE	

4. Home Language

ENGLISH	
AFRIKAANS	
ISIZULU	
XHOSA	
VERNACULAR	
OTHER	

5. Marital status

SINGLE	
MARRIED	
DIVORCED	
WIDOWED	
LIVING WITH PARTNER	

6. Educational Level (tick one)

NO SCHOOLING	
PRIMARY EDUCATION	
SECONDARY EDUCATION	
HIGH SCHOOL EDUCATION	
POST MATRIC (technical/college certificate/diploma)	
UNIVERSITY EDUCATION	

7. Occupation

STATE EMPLOYED	
UNEMPLOYED	
SELF-EMPLOYED	

Open ended question: As a closing suggestion, if you are unhappy with any of your relationships, draft a plan of action to begin dealing with problem areas concerning your sexual life. You may wish to discuss your concerns with a trusted friend or with a counsellor. Don't forget the many fine self-help books in the field of human sexuality available to assist you through issues such as these. Furthermore, what suggestions can you recommend to improve your sexual relationship? In the space provided below please discuss your thoughts and proposed solutions. Thank you for your time and assistance.

SEXUALITY SCALE (SS)

INSTRUCTIONS: The statements listed below describe certain attitudes toward human sexuality, which many different people may have. As such, there are no right or wrong answers, only personal responses. For each item you will be asked to indicate how much you agree or disagree with the statement listed in that item. Use the following scale to provide your responses:

A	=	Agree
B	=	slightly agree
C	=	Neither
D	=	slightly disagree
E	=	Disagree

1. I am a good sexual partner.
2. I am depressed about the sexual aspects of my life.
3. I think about sex all the time.
4. I would rate my sexual skill quite highly.
5. I feel good about my sexuality.
6. I think about sex more than anything else.
7. I am better at sex than most other people.
8. I am disappointed about the quality of my sex life.
9. I don't daydream about sexual situations.
10. I sometimes have doubts about my sexual competence.
11. Thinking about sex makes me happy.
12. I tend to be preoccupied with sex.
13. I am not very confident in sexual encounters.
14. I derive pleasure and enjoyment from sex.
15. I'm constantly thinking about having sex.
16. I think of myself as a good sexual partner.
17. I feel down about my sex life.
18. I think about sex a great deal of time.
19. I would rate myself low as a sexual partner.
20. I feel unhappy about my sexual relationships.
21. I seldom think about sex.
22. I am confident about myself as a sexual partner.
23. I feel pleased with my sex life.
24. I hardly ever fantasize about having sex.
25. I am not very confident about my sexual skill.
26. I feel sad when I think about my sexual experiences.
27. I probably think about sex less often than most people.
28. I sometimes doubt my sexual competence.
29. I am not discouraged about sex.
30. I don't think about sex very often.

PSYCHOLOGICAL WELL-BEING SCALE

The following set of questions deals with how you feel about yourself and your life, and there are no right or wrong answers.

Circle the no that best describes your present agreement Or disagreement with each statement	Strongly Disagree	Disagree Somewhat	Disagree Slightly	Agree Slightly	Agree Somew hat	Strong Agree
1. I tend to be influenced by people with strong opinions	1	2	3	4	5	6
2. I think that it important to have new experiences that challenge how you think about the world.	1	2	3	4	5	6
3. In general I feel I'm in charge of the situation.	1	2	3	4	5	6
4. I live life one day at a time and don't really think about the future.	1	2	3	4	5	6
5. Maintaining close relationships have been difficult and frustrating for me.	1	2	3	4	5	6
6. When I look at the story of my life, I am pleased with how things have turned out.	1	2	3	4	5	6
7. I have confidence in my opinions, even if they are contrast to the general consensus	1	2	3	4	5	6
8. For me, life has been a continuous process of learning, changing and growth.	1	2	3	4	5	6
9. The demands of everyday life often get me down.	1	2	3	4	5	6
10. Some people wander aimlessly through life, but I am not one of them.	1	2	3	4	5	6
11. People would describe me as a giving person, wiling to share my time with others.	1	2	3	4	5	6
12. I like most aspects of my personality.	1	2	3	4	5	6
13. I judge myself by what I think is important, not by the values of what others think is important.	1	2	3	4	5	6
14. I gave up trying to make big	1	2	3	4	5	6

improvements or changes in my life a long time ago.						
15. I am quite good at managing the many responsibilities of my daily life.	1	2	3	4	5	6
16. I sometimes feel as if I've done all there is to do in my life	1	2	3	4	5	6
17. I have not experienced many warm and trusting relationships with others.	1	2	3	4	5	6
18. In many ways, I feel disappointed about my achievements in life.	1	2	3	4	5	6

SEXUALITY SCALE: ISIZULU

1. Ubambo lwakho oluthembekile.
2. Angikhululekile ngokuthinta ezocansi.
3. Ngicabanga ngezocansi.
4. Ngiyazithanda izinto zocansi.
5. Ngikhululekile ngobulili.
6. Ngicabanga ngezocansi ngaphezu kwazo zonke izinto.
7. Ngiziwa ngingcono kakhulu kwezocansi kunabanye abantu.
8. Angeneme ngezocansi.
9. Angiphuphi mayelana nokuphathelene nezocansi
10. Nginokuzingabaza nokuqondene nezocansi.
11. Ukucabanga ngocansi kungenza ngijabule.
12. Ngihlala ngicabanga ngezocansi.
13. Aninasiqiniseko malunga ngezocansi.
14. Injabulo yami itholakala kwezocansi.
15. Ngihlala ngicabanga ngocansi.
16. Ngizibanga njengomuntu onolwazi kwezocansi.
17. Ngizizwa ngingeneme ngezocansi.
18. Ngicabanga ngezocansi izikhathi esinigi.
19. Ngiyazenyeza kwezocansi.
20. Angeneme ngenaba zocansi.
21. Angicabangi ngezocansi.
22. Ngiyaziqhenya ngezocansi.
23. Ngizizwa ngigcolisekile ngempilo yami kwezocansi.
24. Angikaze ngizicabange ezocansi.
25. Angizethembi ngocansi.
26. Ngiyajabha mangicabanga ngezocansi.
27. Ngicabanga kancane ngezocansi kunabanye abantu
28. Ngezinye izikhathi angulwethembi ulwazi lwami kwezocansi.
29. Angidikibele ngocansi.
30. Angicabangi ngocansi ngazonke izkhathi.

CONSENT TO PARTICIPATE IN RESEARCH

You are invited to participate in a research study conducted by Sonia Roopnarain, who is a doctoral student from the Department of Psychology at the University of Zululand. Ms. Roopnarain is conducting this study for her doctoral dissertation. Prof Steve Edwards is her faculty supervisor for this project. This study is funded by the National Research Foundation. Your participation in this study is entirely voluntary. You should read the information below and ask questions about anything you do not understand, before deciding whether or not to participate.

- **PURPOSE OF THE STUDY**

The purpose of this study is to help people with sexual difficulties. We hope to use what we learn from the study to make changes to the program so it will help people who have sexual problems even more than the program already does.

- **PROCEDURES**

If you volunteer to participate in this study, we will ask you to fill out the questionnaires provided.

- **POTENTIAL RISKS AND DISCOMFORTS**

We expect that any risks, discomforts, or inconveniences will be minor and we believe that they are not likely to happen. If discomforts become a problem, you may discontinue your participation.

- **POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY**

It is not likely that you will benefit directly from participation in this study, but the research should help us learn how to improve sexuality in human relationships. This study does not include procedures that will improve your physical disability or general health.

- **PAYMENT FOR PARTICIPATION**

You will not receive any payment or other compensation for participation in this study. There is also no cost to you for participation.

- **CONFIDENTIALITY**

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law.

- **PARTICIPATION AND WITHDRAWAL**

You can choose whether or not to be in this study. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you do not want to answer. There is no penalty if you withdraw from the study and you will not lose any benefits to which you are otherwise entitled.

- **IDENTIFICATION OF INVESTIGATORS**

If you have any questions or concerns about the research, please feel free to contact

Ms. Sonia Roopnarain
Doctoral student
Department of Psychology
University of Zululand
083 791 2888

Prof. Steve Edwards
Professor
Department of Psychology
University of Zululand
035-902 6602

- **RIGHTS OF RESEARCH SUBJECTS**

If you have any questions about your rights as a research subject, you may contact the University of Zululand on 035-902 6603.

I understand the procedures described above. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

Printed Name of Subject

Signature of Subject

Date

Cronbach Alpha Test (Reliability test)

A) Sexuality Scale (SS)

RELIABILITY ANALYSIS - SCALE (ALPHA)

Reliability Coefficients

N of Cases = 100.0 N of Items = 30

Alpha = 0.7857

Interpretation:

Reliability analysis for the questionnaire continuous variables reveals Cronbach's alpha value is **0.7857**, which indicates a satisfactory level of internal consistency and reliability of questionnaire variables.

B) Psychological Well-Being Scale

RELIABILITY ANALYSIS - SCALE (ALPHA)

Reliability Coefficients

N of Cases = 94.0 N of Items = 18

Alpha = 0.8146

Interpretation:

Reliability analysis for the questionnaire continuous variables reveals Cronbach's alpha value is **0.8146**; this is above 0.7 which indicates a satisfactory level of internal consistency and reliability of questionnaire variables.