Group treatment of premature ejaculation: a new model.

Robert Muller
University of Massachusetts Amherst

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GROUP TREATMENT OF PREMATURE EJACULATION: A NEW MODEL

A Thesis Presented By

ROBERT MULLER

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GROUP TREATMENT OF PREMATURE EJACULATION:
A NEW MODEL

A Thesis Presented
By
ROBERT MULLER

Approved as to style and content by:

[Signatures]
Richard Halgin, Ph.D., Chairman of Committee
Alvin Winder, Ph.D., Member
Stephen Blane, Ed.D., Member

Bonnie Strickland, Chairperson
Department of Psychology
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INTRODUCTION

Literature Review

Definition. Premature ejaculation has been recognized as the most common male sexual dysfunction. Despite this fact, there exists little agreement over the criteria for defining an individual as a premature ejaculator. This difficulty seems inherent though when one attempts to operationalize intimate sexual relations into a functional versus a dysfunctional interaction.

Kinsey, Pomeroy, and Martin (1948) did not view quick ejaculation as a problem, certainly it was not abnormal. They state that approximately three-fourths of all males reach orgasm within two minutes after beginning sexual intercourse. Kinsey et al. emphasized that most species of mammals and man's closest relatives among the primates ejaculate instantly upon intromission:

    Far from being abnormal, the human male who is quick in his sexual response is quite normal among mammals, and usual in his species (p. 580).

Despite their pioneering contributions to our knowledge of human sexual functioning, Masters and Johnson's (1970) definition of premature ejaculation is conspicuously problematic. Their own intensive research (Masters and Johnson, 1966) had validated experiential
observations: The human female requires a longer time to be stimulated to orgasm than does the male. Further, the clitoris is the part of a woman's anatomy which is most sensitive to erotic stimulation and is central to orgasmic response. Sexual intercourse, renowned as the ultimate sex act, is not an efficient way to stimulate the clitoris. (See Rotkin 1976 for feminist perspective.) Given this information, it is puzzling, if not disturbing, that Masters and Johnson (1970) consider a male to be a premature ejaculator if he reaches orgasm greater than 50 percent of the time before his female partner does during intercourse. Ron Mazur (1980) maintains that this kind of misinformation leads to the creation of pseudo-problems, with men seeking treatment for a "dysfunction" when, in actuality, they are functioning quite normally.

The criteria of length of time from intromission to ejaculation has been used as a measure of premature ejaculation. Lowe and Mikulas (1975) use an ejaculatory latency criterion of less than three minutes, while Zeiss (1978) employs a five-minute criterion. Is a sexual interaction considered successful if the male can hold off his ejaculation for five minutes and five seconds, while the male is labelled as "dysfunctional" if ejaculation occurs within four and a half minutes after intromission? Also it is possible for a man to inhibit his sexual arousal by employing non-erotic imagery or by actually inflicting pain on
himself. Through these methods, he may be able to pass the "time" test; yet it is doubtful he has experienced much pleasure.

The glaring deficiency in many of the attempts at defining premature ejaculation is an absence of a measure of the quality of sexual interaction. Helen Singer Kaplan (1974) believes the crucial issue is the absence of voluntary control of ejaculation, such that it interferes with the quality of the couple's sexual interaction. Along the same lines, Joseph LoPiccolo (1978) finds it easier to define what is not premature ejaculation: when two partners agree that the quality of sexual interactions is not affected by efforts to delay ejaculation.

**Etiology.** In reviewing the literature on premature ejaculation and from her clinical experience, Kaplan (1974) refutes the notion that there might be a certain personality type associated with premature ejaculation. It is common to all socioeconomic levels, occurs in psychologically healthy men and men with severe psychopathology, and affects men involved in warm, loving relationships as well as pathological ones.

To this writer's knowledge, the most comprehensive investigation of the phenomenon of premature ejaculation was reported in 1943 by Bernard Shapiro. Shapiro (1943) studied 1130 cases of premature ejaculation over more than
twenty years of his medical practice. Careful investigation, both medical and psychological, failed to uncover any direct causal links. Not all men who experienced psychological trauma showed ejaculatory disturbances; some had erectile problems; still others were unaffected. Shapiro proposed that the multitude of clinical manifestations of premature ejaculation must be understood through the combination and reciprocal influence of both somatic and emotional factors.

Our patients suffered from premature ejaculation because they happen to have an inferior ejaculatory apparatus which became the point of least resistance and there the emotional pressure could break through and manifest itself as premature ejaculation. That is, so to speak, like stuttering of the ejaculatory mechanism (p. 377).

Dissimilarities of clinical symptoms and the contrasting pharmacological responses constituted the basis for Shapiro to differentiate two separate forms of premature ejaculation, group A and group B. Group A consisted of men ranging in age from 30 to 55 years old who presented with general neurasthenia, fatigue from mental and physical overexertion, and circulatory or digestive disorders. For these men, normal ejaculation had gradually given way to premature ejaculation. These men also experienced erectile insufficiency along with their ejaculatory difficulties. Shapiro hypothesized that general nervous exhaustion heightened irritability to the point that a small amount of
stimulation triggered the ejaculatory response in these men.

Group B was comprised of men in whom premature ejaculation was present from the first act of coitus. Rarely did their sexual histories contain significant sexual traumas. These men tended to range in age from 18 to 30 years old. Shapiro maintained that these men possessed a characteristically high level of sexual drive and hyper-tonus of their sexual apparatus; that is, they could be provoked to erection by only mild stimulation. Interestingly, Shapiro suggested that heredity may play a role in etiology. He reported that these men tended to have relatives who were also premature ejaculators. To this writer's knowledge, no one has pursued this hypothesis further.

The research on premature ejaculation has focused primarily on the men who might fall into Shapiro's Group B category. This project will focus on premature ejaculation in which there is no erectile difficulty present.

From a psychoanalytical viewpoint, premature ejaculation is considered a neurotic symptom. It is believed that the premature ejaculator harbors intense, but unconscious, sadistic feelings towards his mother which get generalized to other women. Premature ejaculation serves the unconscious purpose of disappointing and humiliating a woman (mother) by depriving her of sexual pleasure,
while keeping conflicted feelings repressed (Kaplan, 1974). Shapiro (1943) found only minimal support for Abraham's explanation that premature ejaculation involves a fixation in childhood at the bed-wetting stage. Shapiro's extensive investigation discovered that 8 percent of the premature ejaculators he studied had a history of enuresis in childhood.

Satisfactory sexual relations require cooperation and communication between the partners. Leon Salzman (1972) proposes that premature ejaculation is best understood within the interpersonal context of the dyadic relationship. He views premature ejaculation as a symptom which clearly involves the use of power and control as it is played out in sexual relations. Premature ejaculation is also viewed as a communication:

It is a technique in interpersonal transaction and is present when the participants are engaged in some form of struggle whether for status domination or the expression of negative and unfriendly feelings (p. 127).

From his clinical experience, Salzman proposes that the man's feelings of anger are intimately connected with premature ejaculation. Anger, when it is not severe enough to inhibit sexual relations, serves to accelerate the process, thus terminating the intimate contact as quickly as possible. In addition to unconscious hostile motives, Salzman suggests that premature ejaculation may serve to prevent the further development of unwanted
intimacy.

Masters and Johnson (1970) stress that the man's first few ejaculatory experiences predispose him to be a premature ejaculator. Many of the premature ejaculators that Masters and Johnson studied had had their first sexual experience with prostitutes. Hoping for a fast "trick," the prostitutes typically attempt to bring their customers to orgasm as quickly as possible. Many early sexual encounters occur in places such as a drive-in, lover's lane, or in someone's house before the parents return. In these situations, rapid ejaculation could be considered adaptive because of the danger of discovery and subsequent punishment. From these experiences, Masters and Johnson believe that premature ejaculation becomes a conditioned sexual pattern which continues to manifest itself in later sexual interactions.

Behavioral theory views premature ejaculation as caused by anxiety and fear which have become conditioned to the sexual response. This anxiety and fear may have developed due to problematic early sexual relations, performance anxiety related to past failures, and/or the association of sexual activity with dirtiness or sinfulness.

Kaplan (1974) disagrees with Masters and Johnson concerning their emphasis on early sexual experience as the key predisposing factor in the development and
maintenance of premature ejaculation. This explanation is not sufficient for there are men who have had these experiences yet do not ejaculate prematurely, while some premature ejaculators did not have this type of early sexual experience.

It is unlikely and probably unnecessary that a consensus can be reached regarding the etiological roots of premature ejaculation. There is much agreement, however, that for whatever reason, the premature ejaculator is unable to perceive accurately his bodily sensations premonitory to ejaculation. For this reason, he becomes highly aroused without full awareness of his increasing bodily excitement. The stage of ejaculatory inevitability is reached rapidly, without experiencing the prolonged pleasure characteristic of the plateau phase of the sexual response cycle. The stage of ejaculatory inevitability refers to the beginning of the contractions of the prostate gland and possibly the seminal vesicles. Beyond this point, the man feels the ejaculate coming, but can no longer exert voluntary control over the process.

The ability to control ejaculation is essential for effective sexual interactions. Given the female partner is usually physiologically slower to respond, the man must be able to tolerate high levels of arousal while engaging in sexual activities which will excite his partner to an equally high level of sexual excitement. Preoccupation
with sexual performance because of past difficulties or unrealistic expectations can create anxiety which may further interfere with the man's ability to monitor his sexual arousal level, thus exacerbating his ejaculatory control difficulties. Secondary impotence due to anxiety stemming from anticipation of sexual inadequacy is often a frequent complication of premature ejaculation.

Men have been socialized to believe that proficiency in sexual relations is the essence of manhood. To be a sexually dysfunctioning male is therefore viewed as a shameful weakness. It is considered equally unmanly to expose or discuss this vulnerability with one's partner. The consequences of premature ejaculation may involve continued but strained sexual relations without appropriate communication or the increased avoidance of sexual activities.

Unwilling to acknowledge his difficulties to others, the premature ejaculator commonly attempts to cover up his "handicap." A number of techniques may be employed. The man may try to distract himself by employing antierotic imagery (i.e., reciting baseball averages to himself) or by actually inflicting pain upon himself (biting his lip or sticking his fingernails into his palm). Another technique used is masturbation shortly before engaging in intercourse. The application of numbing creams or the wearing of extra condoms may also be utilized to inhibit
arousal. Men employing these techniques sacrifice their own sexual enjoyment in order to create the illusion of a "quantitatively successful" sexual performance for their partner. Kaplan (1974) points out that these distracting techniques merely delay arousal, while the ability to control ejaculation once the man is aroused remains unchanged.

**Customary treatment.** Early efforts at treatment of premature ejaculation focused either exclusively on somatic or solely on psychoanalytic therapy. Shapiro (1943) proposed that premature ejaculation was a psychosomatic condition. He treated premature ejaculation (Group B) with sedatives and a retraining program in which the man was encouraged to unlearn faulty ejaculatory habits and adopt correct ones which tended to inhibit ejaculation. Although the length of this treatment averaged approximately two years, the reported 82 percent success rate was quite impressive at this early date. Shapiro, foreshadowing the work of Semans (1956) and Masters and Johnson (1970), stressed the essential role of the female partner in the treatment of premature ejaculation.

The ultimate success depends largely upon the understanding and cooperation of the partner. Much of the anxiety and uneasiness may be overcome by her kindly and helpful attitude, while any display of impatience and resentment will magnify the inhibitions. For this reason, we made it a rule to secure the cooperation of the partner (p. 379).
Psychoanalytic treatment of premature ejaculation has sought to uncover and resolve unconscious conflicts, especially those relating to oedipal issues. The desired intrapsychic change would involve a resolution of a sadistic orientation toward women (mother) and, with its resolution, a concomitant improvement in sexual functioning. O'Connor and Stern (1972) reported a 75 percent success rate treating twenty premature ejaculators through psychoanalysis. The average length of treatment was two years. While others (Kaplan et al., 1974; and Salzman, 1972) incorporate psychoanalytic principles into their treatment strategy, exclusive use of psychoanalytic therapy for the specific treatment of premature ejaculation is rare because of unnecessary cost and length of treatment.

Some behavioral theorists focus on anxiety as the key factor causing premature ejaculation. At the beginning of treatment the client is told that premature ejaculation is the direct result of anxiety learned in previous sexual situations which can be unlearned. The client is then desensitized to anxiety related to sexual situations, especially intercourse. In general, results show that systematic desensitization has aided improvement in ejaculatory control, but is not sufficient to remove the difficulty (Cooper, 1968). In a frequently cited study on the usefulness of systematic desensitization in the
treatment of premature ejaculation, Martin Obler (1973) reports an 80 percent recovery rate. It must be noted, however, that the effect of systematic desensitization was confounded by simultaneous assertiveness and confidence training included in the treatment strategy.

Mellaril and MAO inhibitors have been shown to significantly retard ejaculation. Lazarus (1978) cites the International Drug Rx Newsletter, which recommends the short-term use of Mellaril with tapering dosage after improvement for the treatment of premature ejaculation. Detrimental side effects and the lack of carryover after discontinuation of the medication are primary reasons that pharmacological treatment of premature ejaculation is not popular.

Presently, the most successful and popular treatment of premature ejaculation is based on the technique developed by James Semans (1956). Semans believed that premature ejaculation resulted from an extremely rapid ejaculatory reflex. Semans instructed the man and his partner to engage in exercises that enabled the man to prolong his ejaculatory reflex. The exercises involved the woman's extravaginal stimulation of the penis until the man felt the sensations premonitory to ejaculation. At this point, stimulation is interrupted until the urge to ejaculate dissipates. Stimulation is then resumed and
continued until the man experiences the premonitory sensations once again, at which point stimulation is stopped. As the exercises proceed successfully, lotion or creams are used to simulate the intravaginal environment. This process is repeated until the man reaches the point at which he can tolerate extravaginal stimulation indefinitely. According to Semans, if this can be achieved, normal coitus without premature ejaculation can be expected.

LoPiccolo (1978) hypothesizes that the Semans technique is based on the principles involved in E. R. Guthrie's "crowding of the threshold" process. This procedure involves extinguishing the connection between the stimulus (in this case, minimal stimulation) and the response (ejaculation). According to Guthrie's theory, extinction of response (ejaculation) can be caused by gradually exposing a subject to progressively more intense and prolonged stimulation, but always keeping the intensity and duration of the stimulus just below the threshold for elicitation of the response.

Masters and Johnson (1970) modified and extended the Semans approach for their extensive treatment of premature ejaculation at their Clinic. Using a mixed gender cotherapy team, Masters and Johnson worked intensively for two weeks with 186 prescreened premature ejaculators and their partners, achieving a 98 percent success rate.
Recently, Zilbergeld and Evans (1980) have raised serious questions concerning the legitimacy of Masters and Johnson's outcome results. They harshly criticize Masters and Johnson for "slip-shod methodology," including unspecified category criterion as well as incomplete and vague reporting of results. Also, their carefully selected couples (wealthy, highly motivated, and highly committed) can hardly be considered a typical population.

At the very beginning of treatment, the couple is "assured unequivocally that a complaint of premature ejaculation can be reversed successfully" (Masters and Johnson, 1970, p. 101), that is, if there is complete commitment to and cooperation with the treatment by both partners. At first, the couple is prohibited from engaging in sexual intercourse and they are instructed to engage in sensate focus exercises. These exercises involve the husband and wife taking turns pleasuring (massaging and caressing) each other in a relaxed, intimate manner. Next, the wife stimulates the husband to the point of ejaculatory inevitability. Upon signal from her husband, the wife ceases stimulation and employs the squeeze technique. This procedure involves squeezing the head of the penis for 3 to 4 seconds just below the rim of the glans with sufficient force to cause him to lose his erection partially. The wife waits 15 to 30 seconds, then resumes stimulation.
This cycle is repeated several times with increasing levels of stimulation, either with lubricants or through oral stimulation. Simultaneously occurring along with these exercises are meetings with the cotherapists to monitor the progress of treatment, address questions and concerns of the couple, and most importantly, to deal with resistances to treatment which may inhibit the couple's progress.

If the above exercises have been performed successfully, the couple proceeds to nondemand intromission in the female superior position. The woman mounts the man's penis as he lies on his back. Both partners remain motionless after insertion to allow the man to become accustomed to the erotic sensations of intravaginal containment. If during this time the man feels like he is going to ejaculate, the woman lifts herself off the penis and employs the squeeze technique. After this, the woman again mounts the penis and the cycle is repeated. Gradually as ejaculatory control increases, intercourse is performed with thrusting by the man, then by the woman. Masters and Johnson recommend the lateral coital position as optimal for premature ejaculators, providing the woman with full pelvic movement for maximum stimulation, while the man is able to relax on his side. The most difficult position in which to maintain ejaculatory control is ironically also the most popular, the male superior or missionary position.
Helen Singer Kaplan (1974) emphasizes that the overriding objective in the treatment of premature ejaculation is to get the man to focus his attention repeatedly on the sensations of impending orgasm. Through the use of behavioral exercises similar to those used by Masters and Johnson (1970), the man achieves the therapeutic goal of voluntary control of his ejaculation. Kaplan's treatment strategy differs from that of Masters and Johnson in several different ways. Most notable are Kaplan's use of the stop-start method (Semans, 1956) rather than the squeeze technique, the format of meeting once or twice a week rather than daily for two weeks, and the utilization of one therapist instead of mixed-gender cotherapists. Kaplan's therapeutic sessions with the couple seem to place a greater emphasis on working with the relevant relational issues which contribute to the maintenance of the sexual dysfunction in the couple. It must be remembered that the couples that Masters and Johnson accepted for sex therapy were carefully screened. Only those who were highly motivated and committed to treatment and to their relationship were accepted for sex therapy. It is likely therefore that dealing with relational difficulties and resistances will be a more integral part of most sex therapies when treating a less restricted population.

Due to the relatively straightforward procedures involved in the treatment of premature ejaculation, some
sex therapists have explored the possibility of self-administered treatment of this difficulty. To this writer's knowledge, the self-directed treatment approach was first attempted by Lowe and Mikulas (1975). Ten volunteer couples were given an eighty-page program consisting of a discussion of the phenomenon of premature ejaculation and detailed instructions of Masters and Johnson's (1970) techniques including sensate focus and the squeeze technique. Another component of the treatment program consisted of the therapist contacting these couples by phone twice a week to monitor progress and encourage continued commitment to the outlined program. Results were very impressive. Over an average of three weeks, the mean ejaculatory latency increased from 1.8 minutes before treatment to 37.2 minutes afterwards, while the control group remained unchanged. After this, the control group was allowed to follow the self-directed program. All couples considered, the minimum amount of improvement in ejaculatory control for any one couple was 4.5 minutes.

Robert Zeiss (1978) compared the effectiveness of three different strategies in the treatment of premature ejaculation: totally self-administered, self-administered with phone contacts, and the standard in-clinic couples treatment. Zeiss trained and employed undergraduates as the "sex therapists" for his study. Results indicated that a totally self-administered program without therapist
contact was completely unsuccessful. Under the other experimental conditions which utilized trained paraprofessionals, good results were achieved.

**Group treatment.** In recent years, the usefulness of a group therapy format in the treatment of premature ejaculation has been explored. A group format affords clients the opportunity to share with and receive support from other individuals with similar difficulties. Even in today's "liberated" society, to speak openly about sexuality and sexual problems is a rarity. Among men, a discussion concerning personal sexual difficulties might be considered the most taboo of the taboo.

The safe and supportive context of the group provides men with the opportunity to get help with and speak frankly about what they have always considered their "cursed" weakness. Although there is often resistance to beginning a group, the openness and trusting environment created often is felt as a welcome relief.

Resistance to changing one's attitudes and sexual practices can be influenced in a positive way by peers. Zilbergeld (1975) comments on the important dynamics which occur when one member of the group successfully resolves his problem.

Although there are some feelings of envy, the main result is that others now believe more firmly that change is possible, and they return to working on their own problems with renewed vigor (p. 214).
A group therapy format also provides a therapist or a clinic an efficient, cost-effective use of a therapy hour. Sex therapy is made available to more people and at a reduced cost for clients and the clinic.

Kaplan, Kohl, Pomeroy, Offit, and Hogan (1974) utilized a six-week group therapy format to treat four premature ejaculators and their female partners. As in her recommendation for individual treatment, Kaplan and her Cornell colleagues again emphasize the importance of including the female partner in all aspects of treatment,

... because it is anxiety engendered by the sexual and marital transactions which often seems to distract the husband from abandoning himself to his sexual sensations (p. 446).

The objectives of the group included conveying and discussing the assigned sexual exercises, while the group process was utilized to reveal and resolve obstacles and resistances motivated by either marital conflicts or an individual's intrapsychic issues. Interpretations were made solely to facilitate the implementation of sex therapy. Common themes shared by group members included resistance to treatment motivated by the man's fear of failure, fears of abandonment, and the experience of temporary impotence caused by improving male sexual performance accompanied by excessive demands by the wife. After a four-month follow-up, all four couples reported satisfactory ejaculatory control.
Although it is dangerous to make a causal link between premature ejaculation and orgasmic dysfunction in the female partner, these sexual difficulties frequently occur simultaneously. Golden, Price, Heinrich, and Lobitz (1978) attempted to address this issue by conducting a sex therapy group for couples in which the man was a premature ejaculator and the woman presented with orgasmic difficulties. The authors emphasized the importance of treating both partners to alleviate the false belief that improving the man's ejaculatory control will increase the wife's desire for sex and/or that she will necessarily become more orgasmic. The twelve-week group format included a large didactic component: in the anatomy and physiology of the sexual response, but also in the teaching of communication and sexual skills. Heavy emphasis was placed on homework assignments comprised of behavioral sexual tasks as well as communication exercises. Postgroup self-reports revealed significant changes in amount of sexual activity along with increased communication during sex. Couples reported sexual activities as more pleasurable than before, while separate questionnaires revealed an improved ability to perceive accurately the mate's sexual preferences and pleasures.

Much of the treatment strategy used by Golden et al. (1978) was based on the group format employed by Lobitz and LoPiccolò (1972). Lobitz and LoPiccolo recognized and
addressed what they considered behavioral skill deficits which they viewed as contributing to the sexual dysfunction. The therapists were considered role models: Their own self-disclosures were utilized to disinhibit the clients' anxieties about addressing personal sexual issues. Role playing of sexual situations within the group provided a forum for the clients to get feedback and advice from the therapists and other clients. Clients were expected to take an active role in their own treatment program. In the later sessions, they were expected to conceive of and implement their own homework assignments and, in the end, to formulate a maintenance program. Lobitz and LoPiccolo reported that all six premature ejaculators were treated successfully using these methods.

Zeiss, Christensen, and Levine (1978) had only partial success in treating premature ejaculators within male-only groups. Only the males attended the group sessions; yet they were expected to relay all the information from the meetings to their partners. Women were expected to participate in the assigned sexual exercises at home. The two "groups" consisted of three men and two cotherapists. Having only three clients in a group is not conducive to the development of group process. Also the men selected for the groups varied widely in the severity and duration of their problem. The relatively poor 50 percent success rate after follow-up might be attributable to these two
factors.

The major figures in the sex therapy field, Masters and Johnson, Kaplan, and the LoPiccolos, recognize and lament the difficulties experienced by the premature ejaculator both in his interactions with and in his damaged self-esteem. It is not uncommon for a man to be so troubled by his "unmanly" dysfunction that he avoids engaging in intimate relations rather than risk exposing his vulnerability. Despite this obvious consequence of the dysfunction, none of the above-mentioned sex therapists outline viable treatment programs for men without partners. There are also married men whose wives, for whatever reason, are unwilling to participate in sex therapy. While Masters and Johnson (1970) suggest the use of surrogate partners (but only for the males), this option is not widely available and often prohibitively expensive. Without question, sex therapy without a partner is necessarily limiting; however, at times, it is the only option available, and a welcome one to the partnerless male troubled by premature ejaculation.

Bernie Zilbergeld has been a significant figure in focusing attention on the sex therapy of men without partners. In his book Male Sexuality (1978), Zilbergeld outlines a self-administered treatment strategy for premature ejaculators without partners. He prescribes
a series of masturbatory exercises in which the man stimulates himself to the point of ejaculatory inevitability, then pauses. This stop-start technique is used to develop ejaculatory control. Increasingly high levels of stimulation are provided through the use of subtle adjustments in technique, the use of lubricating lotions, and the employment of erotic imagery.

Zilbergeld (1975) describes an experimental program for the group treatment of sexual dysfunction for men without partners. The major techniques employed in the group were the discussion of the masturbation exercises, self-disclosure, assertiveness training (including role playing), relaxation training, and the examination and the debunking of the male sexual myths. This project explored a variety of differently composed groups of men and assorted therapeutic techniques. Some tentative conclusions reached included the advantage of a homogeneous group (only premature ejaculators) over a heterogeneous one (premature ejaculators and men with erectile dysfunctions). It was proposed that ten sessions focusing on issues specifically relevant to sex therapy (rather than social skills) was sufficient to achieve optimal results. The presence of a female coleader was felt to be highly desirable: Men in the group reported benefiting from hearing a woman's perspective on sexuality and intimacy.
Michael Perelman has successfully treated premature ejaculation using two different group strategies: one in which both members of the couple attend the sessions and one in which just the men attend. Both met twice a week for five weeks. Perelman (1980) reports these groups to be similarly effective in improving general sexual functioning. A supportive, permissive, and educative environment was an essential feature of both groups. In addition, sexual and communicative tasks were prescribed by the therapist in both groups and practiced at home by the couple. In the men-only group, their partners had made a commitment before the start of treatment to participate in these tasks with their mates.

Perelman emphasized the importance of dealing with the resistance created by either member of the couple. These resistances reveal the many factors which interact to contribute to the maintenance of the sexual problem. He cautions that unmanaged resistance may sabotage the treatment.

Paul Fleming (1980) reports the development of a very successful five-session group treatment of premature ejaculation. These men-only groups have been modelled after the preorgasmic groups for women developed by Lonnie Barbach (1974). In the treatment strategy reported upon by Fleming, the leaders combine group therapy and workshop
techniques. A textbook, Zilbergeld's *Male Sexuality* (1975), is used for the program, and homework assignments are given. After setting the tone of the meetings through self-disclosure, the leaders attempt to stimulate discussion about male sexuality by raising sensitive issues and by showing thought-provoking films. The men in the group typically respond well to this approach; they are quite willing and relieved to finally share feelings, ideas, and concerns about their own sexuality and sexual difficulties. During the final meeting, a female staff member talks about female sexuality and answers questions from the men. Fleming characterizes this meeting as a "highlight" for the men which helps to consolidate what they have learned from the program. Fleming claims that 75 percent of the sixty men who have participated in these groups have reported that they now feel completely in control of their ejaculation.

The prognosis for the successful treatment of premature ejaculation through a variety of methods is excellent. Treatment strategies that have achieved the best results are those which have emphasized focusing the man's attention on his bodily sensations premonitory to ejaculation.

Unfortunately, it is likely that a large percentage of the men who experience premature ejaculation will never
seek treatment, remaining silent casualties of a restrictive sex role which discourages risking vulnerability or the exposure of weakness. Unquestionably, these rigid standards of behavior and performance contribute to the maintenance, if not the etiology, of premature ejaculation. Treatment must address and attempt to unburden the man of these deeply ingrained patterns and myths surrounding male behavior and sexuality.

Formulation of Problem and Rationale

Treatment for men troubled by premature ejaculation is available through a wide variety of techniques. The goals of these treatment modalities may range from improving the number of penile thrusts made before ejaculation to achieving insight into unconscious conflict. Although the hypothesized source of anxiety differs in many forms of treatment, most therapists recognize the key role played by anxiety in the manifestation of premature ejaculation. A much less acknowledged fact is that a large amount of the anxiety surrounding sexuality for men today derives from self-inflicted performance pressures adopted as part of their heavily socialized sex role.

A man's sexuality has become equated with his very essence, his manhood. Until recently, a man who experienced erectile difficulties was described as "impotent,"
while a man who could not reach orgasm intravaginally was called "incompetent" in his ejaculation. Males are socialized to believe that their worth is based on the achievement of certain designated goals. Success in the sexual sphere is evaluated by quantitative criteria. A man's rating on the "masoch scale" is based on the number of bed partners that he has "had," the number of orgasms achieved, or, in a more recent perversion of this quantification of success, the number of orgasms produced in the female partner. Men, most often by mutual consent, take on the responsibility for the choreography of sexual activities as the assumed experts, both as directors and performers. Many men also become burdened themselves with the responsibility for both their own and their partner's sexual satisfaction. Masters and Johnson (1970) lament these inherently limiting sex role patterns:

The most unfortunate misconception our culture has assigned to sexual functioning is the assumption, by both men and women, that men by divine guidance and infallible instinct are able to discern exactly what a woman wants sexually and when she wants it. Probably this fallacy has interfered with natural sexual interaction as much as any other single factor. The second most frequently encountered sexual fallacy, and therefore a constant deterrent to effective sexual expression, is the assumption, again by both men and women, that sexual expertise is the man's responsibility (p. 87).

It is unlikely that the attitudes of the liberated, "sexually-demanding" females have contributed significantly to performance pressures felt by modern males, as is
proposed in the concept of the "new impotence" coined by Ginsberg, Frosch, and Shapiro (1972). Rather, it seems that man is his own worst enemy. James Polyson (1978) did a revealing study of college students' attitudes towards sexual dysfunction in men and women. Male subjects judged men who experienced sexual difficulties as having more serious and pervasive psychological problems and as less likely to attain happiness in life than equivalently dysfunctional females. These negative attributions were made only by the male subjects, not the female. To a large degree, performance pressure seems to be a self-imposed restriction reflecting the male's unwillingness to relinquish control, to accept and enjoy less structured and more egalitarian sexual relationships (Gross, 1978).

Men have accepted unrealistic and, in fact, superhuman standards by which to measure their equipment, performance and satisfaction, thus insuring a perpetual no win situation (Zilbergeld, 1978, p. 8).

It is clear that unless these standards and expectations are addressed during treatment, many of these men afterwards will continue to place themselves in "no win situations."

Part of a comprehensive treatment program must help a man to place his "dysfunction" in proper perspective. A treatment program is proposed which serves this function in two ways: first, by organizing a homogeneous group of men to share openly their similar problems previously perceived as one's unique, shameful handicap; secondly, by opening up
for exploration and discussion attitudes concerning sexuality and masculinity. These attitudes, without question, contribute to anxiety around performance during sexual relations and, therefore, interfere with feelings of satisfaction and sexual fulfillment.

Men tend to think that all other men are having a better time sexually than they are, with none of the worries. Zilbergeld (1975) quotes a *Psychology Today* survey in which men guessed that only one percent of their peers were virgins, when in fact 22 percent of the sample were. Men are comfortable speaking with each other about sex when it involves joking or locker-room bravado; however, men are extremely secretive about their own sexuality. To raise a concern or ask a question about sexual matters is to risk being considered less than a man. William Farrell in *The Liberated Man* (1974) laments that man's "main weakness is the expectation of not being weak" (p. 206).

Bringing men together in a group will open their eyes to the fact that they are not alone with their concerns and that men can help each other to deal with sensitive and personal matters such as sexuality. Farrell (1974) points out that men's groups have been successful in combining supportiveness with challenging each other to change. Commonly experienced socialization pressures are highlighted
and discussed in terms of

how these expectations become pressures, how pressures become anxieties, how anxieties give us feelings of powerlessness, and how anxieties about powerlessness, combined with expectations for power, make us fight to be in control (p. 206).

One of the goals of exploring attitudes about sexuality and masculinity will be for men to grant each other "permission" (Annon, 1976) to expand their rigid heterosexual patterns. On the other hand, pressuring men into quickly adopting a new set of "liberated" standards can be similarly oppressive. Nelson and Segrist (1975) in outlining a short-term structured group program for male consciousness raising mention the importance of "group reinforcement of such non-traditional male values as tenderness and gentleness" (p. 2). Suggested activities involve placing individuals in awkward situations which require nontraditional behavior, i.e., holding hands or touching other men, or telling someone whether you like them or do not. This new type of directive pressure seems contraindicated.

Another important component of a successful treatment strategy is the use of behavioral exercises adapted from the work of James Semans (1956) and proven effective by many sex therapists including Kaplan (1974), Zilbergeld (1975), and Perelman (1980). This procedure known as the stop-start technique is used to help the premature ejaculator to more accurately perceive his bodily
sensations premonitory to ejaculation. Increasing the man’s awareness of his bodily excitement will allow him to more accurately monitor his level of arousal, thus enabling him to experience the prolonged excitement of the plateau stage of his sexual response cycle.

Heightened awareness to one's own bodily excitement can improve ejaculatory control. These exercises, however, must not be isolated from an open and supportive therapeutic context. To help men focus and observe their physical reactions to a sexual situation, without a concomitant concentration on and exploration of the man's psychological reactions to the situation, would be inadequate and incomplete. In fact, the assignment of sexual exercises to develop better ejaculatory control without addressing the man’s attitudes and expectations for himself, his partner, and their sexual relations is to collude with him and his anxieties that it is only his "sexual skills" which need to be developed or refined in order for him to have more comfortable and more satisfactory sexual relations.

The proposed group treatment strategy will be a modification of the work done by Zilbergeld (1975). Zilbergeld worked with a group of men without partners. His treatment strategy included the execution and discussion of masturbatory exercises, self-disclosure, assertiveness
training (including role playing), relaxation training, and the debunking of male sexual myths. Assertiveness and relaxation training will not be included in the present treatment strategy. A major difference is proposed in the orientation of the process of the group. Zilbergeld states in his procedure that the basic format of this group was similar to that of behavior therapy groups, "... most of the communications in the group was between group members and one or both of the leaders." The intention of this group will be to encourage the utilization of other group members for information and support, thus promoting group cohesion which has been recognized as an important curative factor of groups (Yalom, 1970). Turning to the leaders for "answers" is a pattern that will be discouraged.

Jack S. Annon (1976) proposed the PLISSIT model to describe the different levels at which a therapist can intervene in the treatment of a sexual problem. These levels start with a superficial level and move towards greater exploration. These levels are: granting Permission, providing Limited Information, making Specific Suggestions, and Intensive Therapy. The therapists and group members will share in the responsibility for addressing these different levels.

The basic premise of creating a group for the exploration of sexual attitudes gives permission to these men to
examine and question their long-held traditional and self-defeating beliefs. Group members, through self-disclosure, will help free other members to share their thoughts, feelings, and pain. Limited information about anatomy, physiology, and the "norms" of sexual behavior will be provided by both therapists and group members. Specific suggestions in the form of behavior exercises will initially be provided by the therapists. Group members, however, will be encouraged to share individual techniques or perspectives which have proven to be successful for them. In his P-LI-SS-IT model, Annon emphasizes that intensive therapy refers to a highly individualized treatment program that may be necessary if the standardized treatment provided is not successful in helping the client reach his stated goals. If after the ten-week treatment group is completed intensive therapy is warranted, then an appropriate referral will be made.

By providing men troubled by premature ejaculation with an opportunity to speak openly about their shared feelings and anxieties about their sexual problems, sexuality, and their male identity, it is hypothesized that certain changes will occur. These men will be more able to view their fantasies, fears, and difficulties around sexuality as "normal," having heard other men express similar thoughts and emotions. The positive group
experience of sharing personal feelings with other men is likely to result in the increased probability that these men will be able to use their male companions as important emotional resources. The exploration and re-evaluation of unrealistic expectations men hold for themselves will encourage an increased flexibility within the man's heterosexual sex role, enabling men to feel more comfort and satisfaction with a wider range of sexual activities. These attitudinal changes are likely to result in decreased anxiety during sexual relations, which will contribute to better ejaculatory control. The performance of the assigned behavioral exercises will have trained the individual to monitor closely his sexual arousal level, which is a key element in developing the ability to control ejaculation.
CHAPTER II
METHODOLOGY

Procedure

The process of recruiting subjects for this study involved placing advertisements in several local newspapers in addition to notifying clinicians and agencies in the area that appropriate referrals were being sought. The advertisement announced the beginning of "a group treatment program with limited openings for men troubled by premature ejaculation."

Upon initial contact with one of the cotherapists, the prospective client was informed of the research component of the project and given a brief description of the goals of the program. If he was still interested at this point, the individual was asked to come into the clinic for a brief assessment interview. The purpose of this initial interview was to determine whether the present treatment strategy was appropriate for this individual's needs and for the optimal functioning of the group. If a man was not accepted for treatment on the basis of this screening interview (i.e., inappropriate referral or serious psychopathology), an appropriate referral would be made. On the basis of this screening interview,
however, all clients seen were judged to be appropriate candidates for the group.

These clients were then notified and asked to return for a more in-depth interview and to fill out a questionnaire. At this time, both the clinical and research components of the project were discussed in greater detail and clients signed informed consent forms (Appendix A). The pretreatment questionnaire (Appendix B) was given first. Following that, this writer engaged the client in an information gathering interview (Appendix C) focused primarily on the individual's sexual history and specific information related to the manifestation of the present problem. The issue of confidentiality within the group and in the research aspects of the treatment project was highlighted, as well as the importance of making a commitment to participate in the ten-week treatment project. After the interview, the client was given a life-history questionnaire (Appendix D) and requested to fill it out at home. Following the ten group meetings, the members were asked to return to fill out the posttreatment questionnaire (Appendix E) and to participate in an open-ended interview (Appendix F) to discuss their group experience.

Subjects

Nine men expressed interest in the group and were
interviewed. One dropped out shortly after the initial assessment, while two others who were expected for the first session changed their minds and chose not to participate in the project. Despite publicizing the group heavily, through alerting local agencies, therapists, physicians, and urologists and advertising in the local newspapers, all of the men who were interviewed had responded solely to the notice in the campus paper. Of the six men who participated in the group, five ranged in age from 20 to 23, while one was 37 years old and the only married individual. At the start of the group, one man was living with a woman but not married, two had ongoing monogamous relationships, one maintained a long-distance relationship, and one was not involved with anyone. Five of the six men who started the group completed the ten-week program.

The Group Format

Sessions were held once a week for one and a half hours on a weekday night. The group met ten times, consecutively except for a vacation break between sessions three and four. There were two therapists, the author and a clinical faculty member, who functioned nonhierarchically as cotherapists. The major goal of the group meetings was to allow these men to explore their feelings about themselves, their sexuality, and their relationships with women
and other men. The group sessions were conducted primarily in an open-ended manner with an interpersonal orientation. Topics of discussion developed out of the concerns which the clients brought to the group. The cotherapists functioned mainly as facilitators of the group process, although on occasion interpretations were made.

While an attempt was made to minimize the amount of structure to the meetings, the integration of the sexual exercises into the group format necessitated some structuring of the sessions. Each group ended with the assignment of specific behavioral exercises designed to promote better ejaculatory control and more satisfactory sexual relations. The exercises and instructions given for each session (Appendix G) were based largely on the work of Bernie Zilbergeld (1978), with an integration of certain techniques developed by Helen Singer Kaplan (1975) and Goldfried and Davidson (1976). The beginning of each session addressed issues or problems raised by the previous week's assignment. Thus, the discussion of the exercises served as a springboard for the exploration of issues relating to sexuality, sexual interactions, and relationships.
In this section, background information on each of the clients is provided. These summaries are based on all the pretreatment contacts: an initial screening meeting, an extensive sexual history interview, in addition to written responses on a life history questionnaire and a questionnaire inquiring about sexual practices, attitudes, and satisfaction. A description of the client and his problem is presented along with relevant family data and psychosocial and sexual history.

The group began with six participating members. In all, nine men had expressed interest in the project and were interviewed. One of the men dropped out of school and moved away from this area a week after his interview. The other two men participated in the entire intake procedure and were expected at the first group session, but did not attend. They were contacted by phone following the first session. One man excitedly related that during the preceding week he and his partner had worked on improving his ejaculatory control with tremendous results. In an exhilarated manner, he expressed his assurance that he no longer had any need to participate in the group. The other individual was an anxious and shy man who stated simply that he had decided to work on this difficulty alone with
his partner. All three men were referred to Bernie Zilbergeld's *Male Sexuality* to assist them with their self-directed treatment. They were also informed that the leaders would be available to them should they have future questions or concerns.

Dan

**Description.** Dan, a 21-year-old single white man, appeared handsome and fashionably dressed. A successful, self-employed businessman, Dan has also been enrolled in several psychology courses at the University in his pursuit of a career in psychology. Though intelligent and perceptive, he was prone to intellectualization. During the pretreatment interactions, it seemed that Dan was making speeches rather than relating to the interviewers. At times, this writer felt Dan was subtly condescending.

He related that he had done much thinking about his sexuality: on his own, in psychology classes, and in his individual psychoanalytic psychotherapy. He wished to participate in the group in addition to attending individual therapy three times a week. Due to the specific nature of the treatment group, it was determined that the two concurrent treatment modalities would not be in conflict. With the assurance from Dan that he had discussed this matter adequately with his individual therapist, Dan was accepted for the group.
Presentation of the problem. At the beginning of the group, Dan was involved in a relationship with a woman, Karen, who was living on the West Coast. They had been involved for one and a half years, including a year spent living together. He described Karen as "passionate, sensitive, and sensible." While they talked a great deal about their relationship, Dan often felt intimidated and overpowered by herassertiveness. Typically Dan acquiesced, reluctant both to challenge Karen or to make known his own needs. This pattern was manifested in their sexual relationship. Dan described his sexuality in the past as goal-oriented (orgasm-oriented). He expressed the desire to incorporate more caressing and cuddling into lovemaking, but Karen was not comfortable with this shift.

Dan had not been satisfied with his ejaculatory control. He reported his average ejaculatory latency as three minutes. While according to most standards his difficulty was extremely mild, Dan was very troubled by his sexual performance. Dan expressed that Karen wanted him to be a sexual "white knight," a role which Dan renounced verbally, yet may have pursued unwittingly through the adoption of heroic sexual standards. The couple had previously tried sexual techniques developed for the treatment of premature ejaculation, but the improvement was not satisfactory. Dan was discouraged about his sexual relationship with Karen; he lamented that sexuality was not
making a significant enough contribution to their relationship.

Dan's involvement with the psychology department brought him into occasional contact with one of the group's cotherapists, Dr. Richard Halgin. Dr. Halgin discussed with Dan the possible difficulties involved in this situation. It was determined that this would not present significant complications for Dan's treatment nor for the other members of the group.

**Family background.** Dan is the youngest of five children from an upper-middle-class Jewish family. He was raised by his natural parents, whom he characterized as two strong-willed people who had a "turbulent, passionate, and loving relationship." He described them identically: both are "very political" and "sensitive, intelligent, and attractive."

Dan was very close to his father during his early childhood. Father's increased attention to his business created a distance between the two which Dan felt still existed. This limited contact with his father frustrated Dan and he hoped that the future would bring more meaningful communication between them. Dan noted that at times his father can be "self-centered and childish."

Dan described a very close relationship with his mother. This closeness lessened when she went to work for
her husband during Dan's early teenage years. She was very dedicated to raising her children and, according to Dan, was constantly putting the concerns of others ahead of her own. Dan's description of this dynamic typified his removed, intellectualized manner: "Her most significant flaw is her propensity towards neurotic anxiety regarding health and safety."

Relevant psychosocial and sexual history. Being the youngest child in his large family had a significant effect on Dan. He was quite precocious, always seeking to relate to his elders. Dan recounted being attached to a number of his parents' friends as role models. He always wanted to grow up quickly. In his family, he was known as "the 64-year-old midget." Dan's internal ambivalence about this surge toward adulthood may have been symbolized by his bed-wetting, which continued until age 8.

Dan received most of his sex education "from the street," the older boys on the block. He regretted that his parents did not take a more active role. He did recall being fascinated by his father's and brother's pornographic magazines at an early age. Sexually, Dan's drive toward adulthood manifested itself in very early and active sex play with the girls in the neighborhood. These experiences occurred between the ages of 7 and 10 and involved the physical exploration of the girls' bodies, followed by
unsuccessful attempts at sexual intercourse. He recalled his humiliation at being unable to "consummate" his experiences, because he assumed that everyone else was doing it. He elaborately recounted the details of these encounters. He spoke of these memories as "frustrating and very painful," yet his affect when describing these experiences was incongruent with those feelings.

During his early teens, Dan continued to pursue unrealistic sexual goals which ended with frustration. He recounted dating girls several years older than he and having his sexual advances rejected. Around this time, Dan discovered masturbation and began to engage frequently in this activity, often using father's pornographic magazines. Dan's first successful experience with sexual intercourse occurred at age 14. He became infatuated with a woman several years older and they got involved in a sexual relationship. This pattern of being involved with older women continued throughout high school and into his first and only year at college. Dan was very dissatisfied with the undisciplined approach to academics offered by this innovative school. He also expressed contempt towards the immature student body, to whom he felt he could not relate.

Hugh

Description. Hugh, a white, 37-year-old, married graduate student in philosophy, resided with Ann, his second wife,
and their 3-year-old daughter. He appeared slightly overweight, of above average intelligence, and had a receding hairline. From the start he seemed to be a brash, provocative individual. During the pretreatment contacts, Hugh was very controlling and responded to questions circumstantially with irrelevant details and anecdotes. He intellectualized considerably, rarely sharing personal feelings.

Hugh anticipated with excitement the unique opportunity to speak openly with other men about sexuality. Another appealing aspect of the treatment for Hugh was that it offered a "straightforward" program of exercises. He shared his disdain for Freud and people who try to "psychologize" all behavior.

**Presentation of the problem.** Hugh's sexual history revealed both premature ejaculation and erectile difficulties with previous partners. In the previous three years, however, he had been troubled only by premature ejaculation. The onset of this symptom coincided with his unplanned marriage to Ann. They married because of a pregnancy. This forced union created a great deal of hostility. Hugh stated that for the first two and a half years of the marriage, there was very little hugging or kissing. They both engaged in extramarital relations, but remained together ostensibly for the good of their daughter. Ironically, this daughter preserved both their togetherness and their separateness.
Their daughter was sharing a bed with her mother, while Hugh was sleeping in another room, reportedly because of his "fitful sleeping patterns." Hugh also related that their child was still breast-feeding at 3 years of age.

Hugh described Ann as having been the victim of a repressive family situation. He noted that within recent years she had been able to enjoy her emerging strength as a woman. She was a nurse who had begun to take courses towards an M.B.A. degree. She was also taking great pride in her motherhood, although from Hugh's description of the situation Ann and the baby tended to be overinvolved.

At the beginning of their relationship, Ann was more invested in their marriage, while Hugh was indifferent. More recently, however, that balance had shifted. Hugh entered treatment with the hope that their relationship could be salvaged, but questioned whether in reality this was possible.

Family background. Hugh is the oldest of two children born to a middle-class, Irish Catholic family. He described his parents' marriage in terms quite similar to his own: "uninspiring . . . no signs of affection though some loyalty." He recalled his mother being reasonably intelligent, concerned, and gregarious, although nervous during his childhood. When Hugh was 17, his mother had a nervous breakdown which left her "intensely depressed" and very
difficult to relate to. He recalled his father's reluctance to hospitalize her despite Hugh's concern that she was "too crazy to be around the house" (e.g., his mother reportedly tried to kill his father on several occasions). Hugh took refuge from his chaotic home by spending a great deal of time with his high school friends.

Hugh characterized his relationship with his father as "always distant but respectful." The father, a lawyer, was portrayed as a duty-bound, quiet individual who appeared not to derive much pleasure out of life. Hugh viewed his father as not a very warm man, and one who tended to overemphasize the laurels of manhood.

Relevant psychosocial and sexual history. Hugh described himself as "somewhat of an outcast" in his early childhood. His teenage years offered limited but more satisfactory peer contact. In high school, he remembered being considered a "weirdo" because he did not participate in traditionally masculine activities. He reported the girls liked him though. Hugh was able to establish a few close friendships, which were important resources during his mother's illness.

Hugh recalled that questions about sex raised considerable anxiety in his parents. Each would redirect Hugh to the other parent. It was primarily through health class in seventh grade and by reading books that he learned about
sexuality. Hugh attended a Catholic high school and, although he denied being affected, he recounted receiving the message that sex was dirty and uncomfortable. One unusual feature of Hugh's sexual history is that he asserted that he had never masturbated to orgasm. Again, he denied that religion was a factor; rather he claimed not to enjoy masturbation. He reported having tried it once and feeling foolish.

Hugh had his first sexual relationship at age 17. He and his partner engaged in sexual interactions quite frequently but without much enjoyment: Hugh consistently ejaculated upon intromission and there was little foreplay or variety involved. At that time, Hugh recalled finding a book on sexual technique which informed and enriched his sexuality.

Hugh went to college at a prestigious Ivy League school. There he developed his interest in philosophy. The male students, he reported, were insensitive and openly sexist. Intimate sharing between men was "unthinkable."

At age 20, Hugh began a relationship with a woman who would become his first wife. Sexually, he experienced considerable difficulty attaining an erection. Interactions at the emotional level were dysfunctional also. She became pregnant and they decided to get married. They divorced two years later. Hugh reported that he has maintained
occasional contact with his son born from this marriage.

Hugh claimed that after his divorce he met the 
"ultimate" sexual partner. He stated that their entire 
relationship consisted of blissful sex, "sometimes making 
love seven or eight times a night." He stressed that as 
a result of this relationship he knew how good sex could 
be, and he wished to recapture this feeling. At this time, 
Hugh held a high position in a popular spiritual movement. 
This involvement necessitated his travelling abroad, thus 
forcing an end to this cherished relationship.

It was overseas that Hugh met his present wife, Ann, 
also a member of this movement. They were both taking part 
in an extremely stressful training program. They became involved and Ann got pregnant. For numerous reasons, they 
were unable to obtain an abortion; so they decided to marry. This coincided with a drastic organizational upheaval within the movement. Hugh, who had been involved 
in the movement for eight years, broke with the movement 
as a result of new oppressive policies. He described this 
break as "traumatic." He felt devastated and depressed for 
over a year following this event. He saw a psychiatrist briefly, who prescribed some pills for his sleeping problems. Hugh's difficulty coping with this event added considerable strain to his already problematic relationship with Ann.
Jack

Description. Jack was a 20-year-old, single, white economics major in his sophomore year at the University. Though tall and lanky, he was very gentle in appearance. His initial shyness diminished as our interaction proceeded; yet he remained soft-spoken and fidgety. His intent, wide-eyed gaze portrayed an air of innocence. He seemed fascinated by the idea that a man's attitudes towards his own sexuality and masculinity might contribute to his dissatisfaction with sexual relations. He reacted to this idea with a naive "Huh, that's interesting; I never thought about that."

Presentation of the problem. Jack had always ejaculated within several seconds after vaginal penetration. He, however, was unaware that this was anything to be concerned about until a year prior to this intake, when his partner yelled at him for ejaculating too quickly.

Jack had been involved with a 19-year-old woman named Sally for the six months prior to seeking treatment. He described her as friendly and quite understanding about his sexual difficulty. Jack related that at times though she would get a little "pig-headed," and he would usually give in to her wishes. On the questionnaire, he wrote that he was uncomfortable making a sexual request of his partner: "I never ask anything except if she wants the
top, and she usually does." Sally, on the other hand, almost always made requests of him. Also he reported the frequency that he orally stimulated her genitals as "almost always," contrasted with her orally stimulating his genitals "almost never."

Jack admitted he feared that because of his premature ejaculation Sally would leave him for another man, a better lover. This "paranoia" may have originated from his first girl friend, who yelled at him, warning that few women would tolerate this. His anxiety was undoubtedly nurtured by Sally, who occasionally asked, "Are you going to last this time?" as they began sexual relations. These factors led to increased anxiety and resentment.

Interestingly, it was Sally's idea for Jack to join the group. He had seen the advertisement but chose not to act. When Sally saw the ad, she showed it to him and told him to check into it. After our initial contact, Jack still had some reservations about the group, specifically his discomfort talking with a group of men about his sexuality. The next day, however, Jack phoned the clinic and enthusiastically expressed his desire to participate in the project. His high level of motivation was demonstrated by his thoughtful and extensive responses on the life history questionnaire.

Family background. Jack is the youngest of three boys
raised by a troubled, working-class Catholic family. There was very little affection shown in the home. The only hugs he got were from his father, an alcoholic who was rarely home. Jack remembered wishing his mother would have encouraged him to do well in school as she did with his older brothers. She had always expressed that Jack would do best working with his hands as a mechanic like his father. He recalled her treating him more like a mainte-
nance man" than her son. Jack sensed that his mother hated men: She conveyed to her sons that they were a "burden" on her.

Jack described his father as more like a friend than a father. He was easy-going and very affectionate when he was sober. At times he would promise to take Jack to the ball game only to get drunk and forget their plans. He was occasionally crude. Jack was told by his father that his mother was a "real dud" in bed. Jack described his parents' marriage this way:

It sucked. They always fought and tried to get us kids to take sides. They never kissed or showed open affection and they even slept in separate beds. They never went out and my father always drank while my mom bitched.

Jack was very hesitant to verbalize affective reac-
tions about his parents. He occasionally expressed "disap-
pointment"; yet he clearly avoided elaboration of his feel-
ings about his troubled family situation. At age 12, when his parents divorced, Jack stayed with his mother and
maintained a friend-like relationship with his father through visitation.

His parents' marriage gave him a dismal impression of what heterosexual life could offer. He turned to his older brothers for direction, but their behavior only caused Jack even greater concern. His oldest brother never went out with girls nor ever showed any interest, while his other brother had a drinking problem in addition to being manic-depressive. Jack worried that he would turn out like them. Jack's family experience certainly failed to provide him with any appropriate role models. Instead, these influences perpetuated feelings of isolation, discomfort with the opposite sex, a negative view of sexuality, and low self-esteem.

Relevant psychosocial and sexual history. It is quite possible that physiological factors contributed to Jack's manifestation of premature ejaculation. First, Jack was born with hypospadius, a malformation of the urethra. This was surgically corrected at birth, and another operation was necessary at age 14 to "remodel" his penis. He reported that the operation left him with small scars on his scrotum. Secondly, Jack had a hernia operation at age 4 which left a big scar. Thirdly, Jack confided that he had been bothered by the small size of his penis.

These factors very likely affected Jack's view of his
own sexuality. In the pretreatment interview, he commented that he was embarrassed to be naked in front of his partners. Jack also reported not feeling relaxed during foreplay, which was usually brief. One might wonder what role his discomfort over his "scarred" genitals and small penis played in his reluctance to proceed leisurely through foreplay and how these might have contributed to a wish for a rapid termination of intercourse and sexual interaction.

Jack recalled enjoying his peer interactions as a child. He enjoyed sports and learning about cars. School, however, held little interest for him, and he was a discipline problem in the early elementary years.

Throughout high school, Jack associated with boys who shared his mechanical interests. This group was not academically oriented: They drank, took drugs, and were viewed as "a bunch of losers." His status as a member of this bad crowd caused uneasiness in the girls whom he had gotten the courage to approach. He rarely dated, stating he had a very low opinion of himself during this time.

Jack considered his move to college to be a significant turning point. He removed himself from a difficult family situation and from friends who were bad influences. He became less shy with girls. He joined a fraternity, met new people, and became more serious about his school work.

Jack's first experience with intercourse occurred
during his freshman year at college. It took place under anxiety-provoking conditions: Jack and this woman were both "cheating" on their respective established partners and had sex in a place where there was significant danger of discovery. Jack experienced premature ejaculation at that time and continued to be unable to satisfactorily control his ejaculation throughout his limited sexual experience. One of his partners berated him for ejaculating prematurely. From that point on, Jack became extremely anxious about his sexual performance. He described his current six-month involvement with Sally as the most serious heterosexual relationship of his life.

Mitchell

Description. At the time of the initial interview, Mitchell was a 23-year-old single white man, who was both bartending and taking classes at the University. He appeared short and stocky. His short curly hair, protruding ears, very round face, and anxious but vacant gaze combined to make him look somewhat odd in appearance. Mitchell seemed quite introverted, interacting tentatively with the interviewers. His description of his lifestyle indicated a rather schizoid existence.

Mitchell appeared to be of slightly below average intelligence, with minimal insight into his life situation. From his recapitulation of recent experiences, it seemed
that his judgment had been faulty at times. It seemed clear, however, that he was determined to become part of the treatment group, stressing that his difficulty with ejaculatory control contributed significantly to his discomfort in heterosexual interactions. He seemed also to be seeking the interpersonal contact that the group would offer.

Presentation of the problem. Mitchell has had limited sexual experience. At the time of our initial contact, he was not involved in a relationship with a woman.

During Mitchell's first attempt at intercourse, which occurred at the end of high school, he ejaculated upon intromission, and subsequently continued to be troubled by involuntary ejaculation immediately after vaginal penetration. Mitchell had investigated the phenomenon of premature ejaculation. He felt disheartened when the book he read reportedly linked this difficulty with deep psychological problems. He also had employed sexual exercises developed for the treatment of premature ejaculation; although the lack of a consistent partner had prevented Mitchell from benefiting fully from these techniques.

While Mitchell was unquestionably troubled by premature ejaculation, he acknowledged that his primary difficulty involved establishing a satisfactory intimate relationship. He felt strongly though that improved
ejaculatory control would enhance his self-esteem and help diminish the considerable anxiety which surrounded his interactions with women.

Family background. The historical information which Mitchell provided for the project was vague and sketchy. Further inquiry into his ambiguous written comments could not be made due to Mitchell's late completion of the life history questionnaire (one week before he dropped out of treatment). This situation may have resulted from both Mitchell's ambivalence about participating in the project and the painful nature of the details of his childhood.

Mitchell is the oldest of three children in a Roman Catholic family. His parents got a divorce at age 7, at which point he continued to live with his mother. Mitchell remembered a great deal of tension existing between his natural parents, including frequent, violent fights. Mitchell mentioned that his uncle played a significant role as a father figure early in his childhood.

Mitchell's descriptions of his parents on the life history questionnaire were very brief, superficial, and confusing. When asked to describe his mother, he wrote: "extroverted, reads a lot, hard working, private." He characterized their relationship as "very detached, I grew up alone," but gave no more details than those six words. When Mitchell was 10 years old, his mother remarried.
Mitchell's statements about his stepfather were even more limited. He portrayed their relationship as "friendly, but not close." The only other information provided was that he was a "veteran" and was "very working class." Again, it was unclear whether the nature of Mitchell's emotional involvements were so limited or whether his motivation or comfort writing about these relationships was the issue.

**Relevant psychosocial and sexual history.** Mitchell recalled being quite withdrawn as a child. He was "very introverted" and was often alone, never really having any friends. This situation was aggravated by his family's constant moving; during one period they moved seven times in eight years. This presented Mitchell with the difficult task of constantly being the "new kid in town." He was small and skinny. He vividly recalled being tormented by the other children, rarely being accepted. These painful times left him "very vulnerable to rejection." The scars left by his childhood could be detected in his tentative, anxious interpersonal style. The impact was revealed also in his response to the question: "What do you like in a friend?" to which Mitchell replied, "Stability, trust, someone to count on."

During his teenage years, Mitchell's physical growth helped him feel more comfortable interacting socially with
others. He became involved in sports and began to develop friendships. He was short-tempered though. Bitterness from previous bullying episodes now left him anxious to prove that he could no longer be pushed around.

Mitchell recounted that sex was a taboo subject in his home. Both his parents were quite conservative. Mitchell stated that he was not bothered by this because, unlike the other boys, as a teenager he was not concerned with chasing girls: "I was still trying to get my character together."

Mitchell discovered masturbation at age 14 and engaged in that activity frequently, although he felt uncomfortable about it. His interest in the opposite sex began to develop late in his high school years, but he was too shy to approach girls for a date. His first experience with intercourse occurred on his graduation day from high school. He ejaculated prematurely; the experience was brief and disappointing.

Mitchell spent his first year in college living with a group of men who drank a lot and neglected their academic responsibilities. He "went along with the crowd," which eventually necessitated his dropping out of school after one year. Mitchell was able to obtain a job as a dishwasher, but maintained a seclusive existence. He worked hard and eventually was promoted to bartender. His life,
however, consisted of little besides working, sleeping, and watching television.

At age 21, Mitchell began socializing more. He became very attached to a woman he had been dating for several weeks. He considered this his first serious heterosexual relationship. He apparently was considerably more invested in the relationship than she. After a short time she broke up with him and moved away, leaving Mitchell "devastated" by the loss. Mitchell sunk quickly into an extended period of depression and isolation: "one and a half years of self-imposed recluse." His life consisted of working sixty hours a week, drinking after work, overusing marijuana, sleeping late, then running.

Six months prior to the intake, Mitchell developed a friendship with Kate. They became quite close, although not sexually. Mitchell shared much of himself with her: speaking openly about his painful childhood years and the depressing recent times. Although Kate moved away after several months, this relationship significantly bolstered Mitchell's self-confidence. He became less withdrawn and more motivated to change his present situation. He credited Kate for giving him the courage to seek out this treatment group.

Murray

Description. Murray was a 23-year-old single white man
who at the time of the first interview had been living with his partner, Eileen, for five months. Murray's initial appearance was quite striking: tall, quite slender, with a bright green streak dyed into his brown hair. The green streak, he explained, was a statement of his independence from the established ways of our culture. He described himself as politically minded and active. His somewhat bizarre appearance contrasted sharply with his quiet, insightful, and sensitive manner.

He expressed excitement about talking openly with a group of men about sexuality, to share feelings and tensions which had long been "locked up inside." It was evident that Murray had done much thinking about "men's issues"; he expressed the belief that it was important to challenge traditional masculine roles. His sensitivity and candor in talking about extremely personal issues were evidence of his comfort with relating in a way nontraditionally masculine.

At the time of the initial interview, Murray was employed delivering pizzas. He had completed three years of schooling at a small Midwestern liberal arts college, but took a leave of absence before completing his degree requirements. He moved to this area in order to be with his girlfriend, who was attending college nearby.

Presentation of the problem. Murray stated that he had
experienced premature ejaculation since he first became sexually active at age 17. This difficulty was continuing to cause strains in his present relationship. Murray and his current partner, Eileen, had been dating for thirteen months and had lived together for the previous five months. Eileen was described as determined, loving, emotional, intelligent, and stubborn. She was described as being very expressive of her needs, pain, and anger. Murray remarked that he and Eileen placed a premium on communication.

Murray reported that their sexual relations had been a source of great frustration for both of them. Murray asserted that he was preoccupied with fulfilling Eileen's sexual desires, thus neglecting to focus on his own sexual sensations. Eileen had been able to reach orgasm through manual stimulation. They rarely engaged in sexual intercourse; this was attributed to both tension surrounding intercourse due to Murray's premature ejaculation and their differing work schedules. Most of their sexual contact involved manual caressing and pleasuring; although they often found this to be enjoyable, part of this pattern of relating sexually served as an avoidance of intercourse.

Murray described Eileen as being understanding around his sexual difficulty. Shortly prior to the intake, however, she had begun to express her exasperation with just
talking about the problem rather than doing something more concretely to change the situation. Both hoped the treatment project would serve this function.

**Family background.** Murray is the oldest of two children raised in a middle-class Jewish family. He described his parents' relationship as loving, although not overtly physical, and intensely interdependent. Murray portrayed his mother as intelligent, warm, witty, and very devoted to her family. She played an active role encouraging Murray to learn and discover new areas of interest. At age 15, he rebelled against his mother's involvement, labelling her as "overbearing." This separation-promoting reaction resulted in some distance between them for several years.

Murray described his father as very quiet, shy, and intelligent. His father, an immigrant from Eastern Europe, had a strong sense of responsibility and a need for financial security. From his description, it seemed apparent that Murray wished he had had a closer relationship with his father. He lamented that they never spent much time together. Murray sensed his father loved him but showed it in indirect ways (e.g., sending him clippings from the *New York Times*). His father felt uncomfortable with physical contact between them and would "flinch at an embrace." Murray learned to play sports from his father but remarked that it was his grandfather who taught him
"machismo." He loved his grandfather and greatly enjoyed doing mechanical projects with him.

Relevant psychosocial and sexual history. Murray required a hernia operation at age 6 months, leaving him with a large scar near his genitals. He admitted concern and anxiety about this disfigurement in the past, though he subsequently became less self-conscious about it. Murray reported that he had been intermittently troubled by ulcerative colitis which first appeared at age 13, with physical distress manifested primarily during times of tension. Murray reported having recovered from a bout just prior to the initial interview.

As a child, Murray enjoyed playing sports, doing well in school, and being in a leadership role. He received his sex education from school rather than his parents. His interest in sexuality began in the early teens, although he had very few sexual experiences in high school. Murray was popular and was considered "Joe Wonderful" in sports and schoolwork. Despite this, he skipped his last year of high school and went off to college, reasoning that he hated Philadelphia.

It was during freshmen year at college that Murray's first sexual experiences occurred. During his first encounters, he ejaculated upon being touched on the penis. With experience, his ejaculatory control improved only
slightly, to the point where he ejaculated immediately upon intromission. This difficulty plagued him throughout his college years. He was extremely "frustrated" and "embarrassed." He questioned his adequacy as a lover and a man, because he "couldn't climb into the saddle and fuck a woman's brains out."

After several "unsuccessful" sexual interactions, Murray went into a long period of abstinence from sex. This coincided with a withdrawal from interpersonal contact. He encountered difficulty adjusting to the anonymity of college life after being an academic and athletic standout in high school. Murray admitted that he reverted to becoming an avant-garde intellectual to retreat from social interaction, fearing the rejection of others.

During his junior year, he became more withdrawn and stopped attending classes. He recalled that his colitis was very bad during this time. He spent the following year at school "doing drugs and playing frisbee," again choosing not to attend classes. At the end of that year, Murray negotiated a leave of absence. He then moved to Boston where he renewed a relationship with Eileen, who had been his "childhood sweetheart." Feelings of closeness were quickly rekindled and, after travelling together for the summer, Murray moved to this area to live with her.
Wally

Description. Wally was a 22-year-old single white man. A history major in his second year, Wally spent considerable time playing guitar. He appeared likable and of above average intelligence, yet was noticeably anxious. He responded to questions with short, succinct replies, intermittently flashing a fragile smile which faded quickly to reveal taut facial muscles. As the interview proceeded, it became apparent that Wally was attempting to suppress large amounts of anger.

Presentation of the problem. Wally had been troubled by premature ejaculation fairly consistently for the past six years. He first ejaculated prematurely at age 16 after he discovered his girl friend sleeping with someone else. He wished to humiliate her, "to get even," so he forced her to have sex with him immediately after this other man left. He recalled wanting to make her feel "as if she'd been gang-banged." He ejaculated immediately upon entering her vagina. As he related the details of the incident, he expressed no regrets or guilt feelings, rather only added that his girl friend felt guilty for having cheated on him.

At the time of the interview, his current relationship with Pam had existed for ten months. From his description of her and their relationship, it was unclear why he was involved with her. He characterized their sex
life as "horrible"; yet later he stated, "The sexual aspects are what the relationship is based on."

Early in their relationship, Wally would anticipate the "intolerable" humiliation of premature ejaculation and would avoid sexual interactions. Anger appeared to be an important dynamic in their relationship. Pam had been expressing her displeasure at Wally's premature ejaculation and was seen by Wally as being frank and demanding about her own sexual needs. Wally reported that his arduous attempts to satisfy her through oral stimulation were often unsuccessful. He was unable to satisfy her with his tongue or penis. Wally literally pounded his fist on the table when he described his infuriating ineffectiveness.

Wally hoped the group would help him feel less embarrassed about his sexual difficulty and less worried about his performance so that he might enjoy sexual relations.

Family background. Wally is the youngest of three children from a middle-class Episcopalian home. He experienced several different home environments during his childhood. From birth to seven he lived with his natural parents, from 8 to 11 with his natural mother, and from 12 to 17 with his father and stepmother. He claimed to remember little about his natural parents' relationship, although he did relate that there was little affection between them and
they slept in separate beds. Their divorce, he recalled, was "very unhappy for both of them," but he minimized his own reaction to it.

Wally described his mother in a brief, removed, and somewhat condescending manner. He felt he and his mother loved each other despite not spending much time together. He regretted having taken her for granted before the divorce; afterwards they were closer. He portrayed her as a "good person," although "she took a long time to grow up, not really being on her own until age 40."

Wally described his father as "very bright," but "unmotivated" and "going nowhere." He was very domineering during Wally's childhood. Wally related that his father practiced "mental cruelty, telling me I was a shit, etc. I was treated as a subhuman with no right to an opinion." Wally recalled being forced by his father to call his stepmother "Mom." He stated that his father was an alcoholic who often denied difficult financial and emotional realities. Wally reported that his relationship with his father improved considerably once he went off to college and was no longer dependent on him.

Relevant psychosocial and sexual history. While Wally was reluctant to discuss his feelings about his parents' divorce, he did acknowledge the negative effect of frequent moves during his early teenage years. Friendships had to
be terminated and new ones developed. Wally reported that this process was especially problematic because of his "extreme shyness" as a child.

Wally recalled that his interest in sex began in eighth grade. He had experienced a nocturnal emission, enjoyed it, and began to masturbate frequently. He developed a group of friends who were similarly fascinated with sex. He learned more about sex from these friends, and a competition developed to see who would shed his virginity first.

Wally was involved in numerous sexual relationships during his early high school years. Although he characterized them as meaningless emotionally, Wally stated he remained in these relationships for their sexual component. In his later years in high school, Wally was involved for one and a half years in what he described as a "sadistic" relationship. He and his girl friend made each other miserable, and sex was horrible. He recalled getting angry and violent when she did not reach orgasm; "hatred came from the sexual act." It was this girl whom he tried to humiliate following her unfaithfulness. The misery of that relationship, he reasoned, was better than being alone. During this "confusing time," Wally participated in a brief homosexual relationship. He recalled this being motivated by his wish to feel close to someone. Afterwards, he felt
somewhat guilty about this encounter.

After high school graduation, Wally took some time off from academic work. Living at home with his father, he worked occasionally painting houses. He remembered feeling depressed much of the time and drinking a lot, although he denied drinking was ever a problem for him. During this time of searching and confusion, Wally became interested in a cult religion, but quickly dropped it. He saw a psychiatrist for a year and found this experience quite helpful.

During his junior year at college, Wally met his present girl friend Pam. As mentioned earlier, their relationship became quite strained, much of the discomfort, according to Wally, derived from their frustrating sexual interactions. After a short time, Wally began to date an old girl friend, Alice. Sexual relations were very satisfying with her. Alice was described as more understanding than Pam, whom Wally described as "intimidating." For several months, he slept with Pam for six nights and Alice on the other night of the week. Although Wally believed Pam's jealousy was irrational, shortly prior to the intake he had agreed to stop seeing Alice and concentrate on their relationship.
CHAPTER IV

GROUP SESSIONS

The next section provides a detailed review of the ten group meetings. The major content areas of each session are delineated and the progress of each client is monitored. A comprehensive description of each session is presented to provide the reader with a thorough account of the group process. This manner of presentation is an adaptation and expansion of the format used by Lonnie Barbach (1980).

Session 1

The first session began with the therapists delineating the rules and regulations of the group: Issues of promptness and confidentiality were discussed; also the necessary commitment to participation in both the group discussions and homework exercises was emphasized. The members were requested to introduce themselves to others, relating a sense of themselves outside of the sexual sphere. This activity prompted Wally to make a key tone-setting remark: He admitted that he had held a "preconception that this group was going to be a losers' club . . . but you guys all look pretty normal." There was relieved laughter after this comment, which facilitated other members to express their hopes and fears concerning the
group. Several members acknowledged the uniqueness of this type of gathering of men and the resulting anxiety. Dan seemed to be somewhat self-congratulatory when he spoke of the "courageous element involved in the pain of tackling this problem."

Hugh identified himself as considerably older than others. He lamented that he could no longer make love several times a night like when he was younger. He raised the issue of age and his expansive sexual experience as if to imply that the circumstances surrounding his difficulty were unique. The latter comment sparked competitive responses from Dan and Wally, who prided themselves on their extensive sexual experience.

Dan appeared to be vying for a leadership role or special status in the group from the start. He made it clear that he had spent much time exploring sexuality issues in a number of forums and that he had previously done exercises quite similar to those to be assigned. He also established the fact that he had an academic connection with "Richard" (referring to Dr. Halgin) outside the group.

The discussion then turned to the two empty chairs in the room. Members hypothesized reasons for the two men's absence. Dan wondered whether prolonged feelings of isolation had become too established to overcome. Murray
thought their absence was understandable, acknowledging that "it's difficult to confront things about yourself that you don't like."

Although Wally was an active and spontaneous participant, he appeared anxious and intense, often sitting with his arms folded tightly across his chest. Wally stimulated discussion by admitting his "irrational" but pervasive fear of losing his partner due to his inadequacy as a lover. Jack dejectedly confessed that "sex has become work" because of the anxiety that has developed about his performance. He also related strongly to the "paranoid" feeling expressed by Wally that his partner might leave him for another man, a better lover.

Mitchell sat quietly throughout much of the group, an anxious but alert observer. After listening to others describe fairly elaborate sexual histories, Mitchell volunteered that he was a "late bloomer." He was clearly the least active member of the group. Although Hugh, on the other hand, spoke quite often, his thoughts and the manner in which he expressed them served to set himself apart from the group.

Murray expressed enthusiasm about being in a men's group. He seemed more willing than others to share personal experiences and feelings, rather than discussing a topic in abstraction. He played an important role in
facilitating discussion by personalizing and expanding upon issues raised by others.

The group ended with a discussion of the therapists' announced ban on intercourse. The first exercise was given along with a reiteration of the importance of diligent adherence to the assigned tasks.

**Exercise:** (all) relaxation techniques, self-body exploration.

**Summary.** The first session began somewhat slowly. After the therapists delineated the rules and regulations for the group, members began tentatively to talk about themselves and their situations. Humor was used by members as well as the therapists to alleviate some of the tension. Gradually, the men were able to overcome their initial anxiety and share their thoughts more openly. The members seemed to inspire each other to speak about certain topics. Although there was much discussion about sensitive issues, there was little interaction among members. Rarely did one member ask another a facilitative question; this was done mostly by the leaders in this first session.

**Session 2**

The leaders opened the group with the announcement that the two men absent the previous week had been contacted and had communicated their intention not to
continue with the project. Dan wondered whether there was something about pregroup procedures (i.e., interviews, questionnaires) which was upsetting. This comment inspired others to air their feelings about the research component of the project. Dan and Murray complained that filling out forms felt bureaucratic and was an impersonal way to gather information about sexuality. Jack, Wally, and Mitchell expressed uneasiness about the videotaping. Wally complained that the fee felt like an additional burden. Hugh proclaimed that his feelings contrasted with the consensus of the group, saying he felt comfortable with the forms, the interview, and the videotaping. Murray acknowledged that he felt "unburdened" by the interview and reflected that the pregroup procedures helped to create a sense of commitment to the group.

There was a variety of responses to the previous week's exercise. Dan, Jack, and Murray felt awkward doing the self-body exploration. Jack also mentioned he was experiencing difficulty finding private time at the fraternity house for the assignments. Wally again challenged the therapists, ridiculing the exercises as "useless" and "silly." Hugh, on the other hand, seemed genuinely surprised and pleased by his very positive exercise experience.

Several of the men then engaged in a discussion about the self-defeating aspects of a "success" orientation towards sexuality. Dan insisted that failing was inevitable
in life and sexuality and, if this part of the experience was not talked about, it would be a major loss for the person and the group. Hugh challenged Dan, retorting, "That's like saying, if you don't get cancer, you're missing something." The two exchanged subtle put-downs. There was tension between them, but it was quickly laughed off.

Murray continued the discussion by commenting that dissatisfaction often results from distorted expectations. Men, he lamented, are brought up to feel that their sexual interactions should be like "James Bond, achieving sexual conquests without any problems and which leave the women exhausted from having orgasms." Dan concurred, highlighting the troublesome myth created by the media that satisfactory sexual relations are easy. In reality, he insisted, sex is "completely the opposite; it's very complex and it's very subtle and problematic." While Dan spoke at some length about sex-role pressures, his manner seemed rehearsed, and he revealed little of his own feelings.

The issue of performance anxiety within the group was raised, but its existence was unequivocally denied by all. The members insisted that trust and respect were assured by virtue of the fact that they all admitted sharing a common problem.

Hugh diverted the discussion when he introjected a new topic, the issue of his and other men's feelings of
"insane jealousy." Although he spoke mostly in general terms, Hugh did allude to feeling rageful when his wife had shown interest in other men. Mitchell, who had been extremely quiet, suddenly became very engaged. He admitted that he shared Hugh's deep and rageful feelings at times. Surprisingly, he then revealed that he had experienced a very painful childhood. His family moved repeatedly, and these adjustments were very difficult. He was psychologically and physically tormented by other children. As Mitchell grew, he responded violently to any challenge. He confessed that situations which evoke jealous reactions revive childhood feelings of rejection and inadequacy and trigger violent responses. Mitchell felt these early experiences contributed to a tendency to distance himself from others.

An awkward silence followed Mitchell's dramatic self-disclosure, which occurred near the end of the session. Members tentatively questioned him about factual aspects of his past and plans for the future. Gradually, supportive comments were made, including the recognition that for Mitchell participation in the group involved taking a risk to be trusting of others. Murray, continuing to display his sensitivity, was the first member to respond empathically to Mitchell. In contrast, Dan in his interactions with Mitchell seemed to convey a condescending attitude.

Jack spoke very little during the session. Wally's
participation differed markedly from his behavior during the first group. He spoke rarely, and, when he did, his comments were tinged with anger and resentment. Wally remained silent during discussions of topics which were known by the therapists to be particularly salient for him.

**Exercise:** (all) focused-attention masturbation, introduction to stop-start technique.

**Summary.** The members expressed themselves much more freely than they had the previous week. Several lively discussions of "men's issues" developed, during which traditional values were questioned. Topics such as success-orientation and performance anxiety were discussed; yet the possibility of their existence within the group's interactions was denied. Dan was helpful in initiating discussions about the group, its structure, and its goals. This was a crucial session for Mitchell. With his very personal self-disclosures, he exposed to the group some of the pain he experiences. This also was the first instance in which the group focused its attention on one member for a prolonged period of time.

**Session 3**

Mitchell contacted the clinic forty-five minutes before the group was to begin. His message stated that an
emergency had arisen which necessitated his missing that evening's session. This information was conveyed to the group at the start of the meeting. The members expressed their concern and the question arose as to the appropriate response to Mitchell's message. Hugh, in a surprising display of sensitivity, cautioned that Mitchell appeared to be the "most delicate" of the members and any contact with him should be handled with care. Murray felt that contacting Mitchell would be a caring gesture and suggested that one of the group members call him. Dan agreed, commenting that this might be an opportunity to define the members as "friends." There was a consensus that a phone call would be an appropriate expression of concern, and Murray eventually took on the responsibility for that contact.

Wally initiated a discussion of the exercises. In contrast to the previous week, Wally expressed his enjoyment of the masturbatory exercises. The assignment gave him permission ("doctor's orders") to masturbate without guilt. He had previously believed that masturbation was solely a teenage activity. Dan spoke glowingly about his experience. Maintaining a high level of arousal without ejaculating eventually led to a new, very powerful sensation: "I felt it not only in my penis, but in my entire body as I'd fantasized how a female orgasm is experienced."
When the focus shifted to Jack, he revealed that his girlfriend had ridiculed him for doing the masturbation exercises. Dan pointed out Jack's partner's insensitivity and began to advocate that he be more assertive. Jack denied being upset by the incident, acknowledging only that he was "a little bummed out." A heated dialogue ensued, with Hugh and Dan debating how Jack could best handle his situation. Jack appeared rather bewildered that he had provoked such an intense exchange. When asked how he felt about the discussion, Jack shrugged his shoulders and replied only, "I don't know, a lot is being said very quickly."

Murray, who maintained a rather low profile throughout the session, admitted feeling troubled by an imbalance in his love relationship. He experienced difficulty asserting his own needs, while often acquiescing to the requests of his partner. The opportunity to focus on his own pleasure during the masturbatory exercises was found to be helpful.

Hugh, in typical fashion, deflected the conversation when he was asked about his own experience. Dan and Murray were persistent, however, and confronted Hugh with his avoidance of self-disclosure. Hugh minimized the significance of the masturbatory exercises, insisting that his difficulty with ejaculatory control was limited to intercourse with Ann. Hugh did admit, however, that hostility
between Ann and himself was probably a significant contributing factor in his sexual difficulty.

Wally picked up on this theme by admitting that he possessed a "resentment of women in general," and therefore felt little desire to satisfy them. When he experienced premature ejaculation and his partner was still aroused, he felt pressured and angered by what he experienced as her insatiable sexual appetite. Wally then related an incident which had occurred during the preceding week. One night, his girl friend asked him to make love to her. Wally, who had been drinking that afternoon, felt intruded upon by her request; he lost control and began to hit her. He admitted being shaken by the severity of his reaction. He understood the anger and resentment as representative of anger at himself "cause I can't cut it sexually." This inadequacy was exposed each time he had sexual relations. The group sat in tense silence as Wally related his feelings. As he finished, he quickly deflected the group's focus by wondering whether others shared his feelings.

It appeared that Wally was requesting verification that his feelings and behavior were understandable and acceptable. The members obliged by acknowledging their occasional feelings of inadequacy and resentment. Feelings of inferiority in comparison to other men were shared: For Dan, Hugh, and Jack this created a constant fear that each man's partner would leave him for a superior lover.
Due to the upcoming vacation week, two sets of exercises were given. This marked the first instance in which the men with partners were assigned different exercises than those men who did not have participating partners.

Exercise: (all) masturbation with subtle adjustments

Exercises assigned for vacation week:
(with partner) sensate focus
(without partner) subtle adjustment
masturbation with lubrication

Summary. A sense of cohesion seemed to be emerging in the group. Members began to offer support and suggestions to each other, while also taking risks to challenge one another. A sense of trust appeared to have developed which enabled Wally and, to a lesser extent, Jack to share very personal and distressing occurrences with the group.

Three days after this meeting, Jack called the clinic. He sounded quite dismayed and confessed that he had done something very bad. He disclosed that he and his partner had broken the "abstinence rule" to which the group members were asked to adhere. His distress and guilt over this "transgression" were surprising, and revealed an intense involvement with the group.

(Vacation Week)
Mitchell was welcomed back to the group. His previous absence, he explained, was due to the death of his best friend's mother. Mitchell had decided it was more important to stay with him than attend the group. In addition to this, Mitchell confessed that the preceding two weeks had been "weird": He had been very preoccupied, which resulted in his failure to pick up the exercise assignments that had been left for him.

As the discussion proceeded, it became apparent that only Wally and Hugh had done most of the assigned exercises. Dan related details of his visit with his girlfriend in California. She had made it clear to him during his visit that she was unwilling to participate in the exercises. Dan described their interactions as "complicated" because of the recent months spent apart. Although he admitted wanting support from her, he minimized his own disappointment, saying her reaction was understandable given the circumstances.

Jack explained that his partner refused to participate with the exercises after reading the instructions. Sheepishly, he also confessed that she had pressured him into having intercourse despite the agreed upon ban. He apologized for his action and expressed his dismay that he had let the group down.
Several members pondered their partner's uncooperative-ness. From that topic, Hugh and Dan launched into an intellectualized discussion about female sexuality. During this time, Mitchell, who had been silent since the opening minutes, was observed to be staring blankly into space. One of the therapists interrupted the flow of the conversation to inquire about Mitchell's nonparticipation. Mitchell smiled inappropriately, while remarking that he had been under a great deal of pressure recently. He denied any connection between his past personal disclosure and his subsequent distancing from the group. He insisted that he felt great and was merely physically frazzled because of work, school, and a weekend of "heavy partying." Mitchell's remarks were followed by an awkward silence, the lengthiest in the group's short history.

A sense of depression filled the room; an interpretation linked this feeling with the recognition of the complexity of issues involved in the manifestation of this problem. Dan asserted that he had observed a sense of depression throughout the entire group and proposed that the vacation had affected people's feelings of closeness; a sense of continuity and trust had been lost. Dan himself appeared noticeably more sedate and less loquacious than in previous sessions. This more humble posture may have resulted from his disappointing visit with his girl friend in California and the realization that he was really a
member of the partnerless segment of the group. Hugh abruptly punctured the pensive atmosphere by highlighting the concomitant role of physiological factors and psychological ones involved in sexual functioning.

The therapists acknowledged the discomfort involved in doing exercises focused on an activity which created feelings of inadequacy, but re-emphasized the importance of adhering to the exercise schedule. This prompted Murray to reveal his difficulty admitting his need for help or making demands on his partner. Jack readily acknowledged similar inhibitions. He then began to express his distress over his partner's resistance to participation. The group actively encouraged Jack to express more affect about his situation, but he was reluctant to explore his feelings further.

Hugh, who had been relatively quiet for most of the session, remarked that perhaps a homogeneous group (only men with partners) would be more appropriate for him, since he and his wife were able to do the exercises without struggling. Hugh was very pleased with the exercises, which had expanded his pattern of sexual interaction to include more foreplay and caressing. He portrayed his relationship as harmonious, in contrast to the problematic relationships being discussed in the group, yet alluded to his wife's interest in another man and their daughter's intrusiveness into their intimacy.
Wally boasted that his situation was different also. "Contrary to everyone else," his relationship was getting closer, and he announced that he was now living with his partner. Apparently bolstered by increased confidence in his relationship, Wally seemed more relaxed and spontaneous in his interactions with others during this session.

The group decided that in the interest of cohesiveness all members should be doing the same exercise each week (when possible). When Jack was asked whether maintaining the abstinence rule (from intercourse) would adversely affect his relationship, he proclaimed that he would definitely not deviate from the prescribed exercises regardless of the consequences. Based on the sentiment expressed in the group, the assignment that was given was comprised of an exercise from the previous week, along with a condensed version of the new exercises.

Exercise: (with partner) manual stimulation (stop-start) of penis by partner (without partner) masturbation (stop-start) with fantasy.

Summary. The fourth group was characterized by discontinuity and disillusionment. The week of vacation seemed to have weakened the sense of involvement with the group. The exercises had been neglected by most. There was little
cohesion; members who were pleased with their relationships felt disconnected from those who were experiencing difficulty. Members also seemed unsure how to respond to Mitchell, who had returned to the group but was quite withdrawn.

Session 5

Neither Mitchell nor Hugh were present at the start of the group. Murray mentioned having seen Mitchell on his way to softball practice earlier that afternoon. Murray began discussion by expressing anger at his partner for being domineering; he also deplored feeling as though the relationship revolved around her schedule and needs. Jack, who seemed to admire Murray, initiated a dialogue and revealed that he was troubled by very similar dynamics in his relationship. This was the first instance that Jack had initiated an interaction with another member. During this time, Hugh entered the room but was barely acknowledged, as the discussion continued without a pause.

Wally joined in, describing a problematic imbalance in his relationship also. He indignantly characterized his girl friend as a selfish and withholding person, whose ideal sexual interaction involved Wally masturbating her to orgasm. From this cutting description of his partner, it was apparent that the "honeymoon" period (after moving in together) had ended.
Hugh spoke up for the first time: He portrayed his situation as different than the other members' due to his age and extensive sexual experience. He explained that his predicament was that he had been spoiled by a past "perfect" sexual partner, with whom he would make love "four or five times a night." His present wife, in comparison, was passive and dull. Hugh managed to slip in a brief apology for being late, explaining that he had been babysitting and his wife had been delayed with a school-related activity. One of the therapists wondered whether this incident and past latenesses reflected Hugh's inability to make a demand on Ann which would enable him to get to the group on time. Infuriated by this comment, Hugh retorted that psychologists who thought all behavior was intentional were "psychotic."

Dan was able to tell Hugh that he felt distracted by his late arrival. A question arose within the group which paralleled the vital relational issues discussed earlier, that is, "How much could we demand from each other within the group?" This sparked Dan to wonder aloud about Mitchell. Dan and Murray felt that his absence indicated his desire to drop out, a final step in his gradual withdrawal from the group. Dan acknowledged that Mitchell's revealing disclosures may have left him feeling vulnerable and anxious in the group. Hugh introjected and expressed a desire to return to the previous topic of negotiating
personal needs within a relationship. Dan angrily confronted Hugh for trying to divert attention from a significant group issue, Mitchell's absence. Murray attempted to intercede; he expressed that he missed Mitchell's input and Mitchell was letting the group down by not attending: "The issue is we're all in this together and he's flaking out." In his defense, Hugh insisted that Mitchell was obviously a sensitive individual who took his responsibility to the group seriously.

At that moment (approximately forty-five minutes into the session), the door opened and Mitchell appeared, dressed in his softball uniform. He looked rather strong and healthy and greeted the group with a boisterous "Hi" which prompted Hugh to exclaim, "You let me down!" Mitchell calmly explained that he had been at softball practice and had lost track of the time. When members expressed their concern and questioned whether he was anxious about returning to the group, he ignored them and instead crowed: "I had a good practice; I'm in a great mood; . . . How are we tonight?" He admitted that his broad, silly smile, which members had commented on, resulted from several postpractice beers.

The inappropriateness of Mitchell's behavior was disconcerting. Several members laughed along with him, perhaps relieved to see him apparently in good spirits.
Murray, however, silenced the uneasy laughter when he took exception to Mitchell's cavalier attitude. Hugh then informed Mitchell that earlier he had argued on his behalf, and now felt foolish. Strengthened by the previous confrontations, Dan reprimanded Mitchell for trivializing his commitment to the group by arriving late and shifting the focus to softball and drinking. Mitchell insisted that softball was a big part of his life and stated that he was one of the team leaders.

Little time remained and experiences with the previous week's exercises had not yet been discussed; so the therapists initiated a shift in focus. Mitchell, however, immediately grabbed the spotlight again. He announced that he had had the best sexual experience of his life. He detailed the encounter and credited his incorporation of the assigned exercises as the key to his flawless ejaculatory control. He denied any link between this recent success and his weakening commitment to the group. Instead, he claimed he was eager to share this incident with the group to instill hope and to verify the effectiveness of these techniques.

The session ended with other members sharing their experiences with the exercises. Of note, Jack related that he had asserted his needs with his partner and had very positive results. Hugh characteristically deflected attention from himself by focusing on his wife's "spectacular"
orgasm in his description of his exercise experience and then by relating an anecdote about a friend. He did add, however, that he was beginning to realize that his relationship with Ann did indeed affect their sexual interactions. Wally complained that his partner did not appear to enjoy manually stimulating him; this affected his ability to relax and enjoy himself. Wally appeared reflective after he was reminded of his parallel resentment towards manual stimulation of his partner and the possible consequences of that for her.

Exercise:  (with partner) "quiet vagina" (intercourse without movement)  
(without partner) masturbation (subtle adjustments) with fantasy.

Summary. The fifth session marked a significant point in the group's development. Issues of commitment to the group and its members were discussed explicitly. Several members felt secure enough to confront each other about attitudes or behavior which they found objectionable. The confrontation of significant "group issues," the commotion created by Mitchell's late arrival, along with the necessity of exploring each man's exercise experience combined to produce a session which felt hectic yet dramatically valuable. It should be noted that a review of the videotape of this session revealed inconsistencies in Mitchell's account of
this incident which cast serious doubts as to the veracity of his experience. Unquestionably, Mitchell wished to impress the members of the group and perhaps, as was interpreted, demonstrate his ability to control various aspects of his life.

Session 6

Mitchell was missing at the start of the session but arrived after several minutes. Jack opened by proudly relating that he had been very successful with the "quiet vagina" exercise: He was able to maintain ejaculatory control intravaginally for fifteen minutes. Although he acknowledged that he still needed work, Jack was extremely pleased with his progress. Wally remarked that he had done the partnerless exercises. He then reluctantly revealed that his girlfriend had moved out after only one week. He denied feeling angry about this sudden turnabout, but then proceeded to berate her for being irrational and unstable. Wally reflected that he had tolerated this problematic relationship because he was "terrified of being alone."

Murray articulated that the group and the assigned exercises had combined to bring relational issues into sharp focus and had put considerable strain on members' relationships. Dan admitted feeling envious of the members who had participating partners. He hoped to renew his own
relationship during the summer, when he would be visiting California. He acknowledged the risk this temporary move involved, which also included leaving his intensive individual psychotherapy of three years' duration.

Mitchell conceded that because of relative inexperience with serious relationships, he often felt unsure of how to participate in the group. He added, however, that he was able to do the exercises for those with participating partners. He then recounted in a confusing manner a sexual interaction with a woman whom he had just met. He did not feel comfortable asking this new partner for her cooperation with the exercises, so he "tricked her," incorporating the new techniques during sex without her knowledge. Hugh and Jack were impressed and amused by Mitchell's deception, while Dan felt it would be stressful to do the exercises without the support of a partner.

Hugh mentioned that the exercise reminded him of a practice which existed in India, a spiritual event involving intercourse without ejaculation for an extended period of time. This type of technique, Hugh declared, was "more sane" and "less intimidating" than rapid thrusting until ejaculation. Ignoring inquiries about his own experience and feelings, he continued his oration on the philosophy of sexuality and spirituality. Finally, one of the therapists confronted Hugh on his avoidance of talking about himself. He appeared taken aback by the comment, but then
quickly assured the group that he was bothered by only two things: Physiologically, his orgasm was not as powerful as he wished and, socially, he could no longer make love several times a night.

The following interaction took place immediately after Hugh's comment:

Dan: I'm having a real hard time; you're speaking in the past or the hypothetical, yet I get this image of sex with Ann as mechanical and unsatisfactory. I sense there's pain you're not letting yourself feel. . . . You've consistently said, "My only problem is I can't do it two or three times a night" (other members nodding) --

Murray (interrupting): Can I ask, what's wrong with having just one orgasm a night?

Dan: Yeah, what's the difference if you're having six orgasms if you're not enjoying the one you got?

A heated battle ensued in which Dan and Murray attempted to persuade Hugh that emotions played a significant role in experiencing sexual pleasure. Hugh acknowledged that emotions are one part of sexuality, but held firmly to his assertion that orgasm was a purely physical sensation. Dan replied that he was angered by Hugh's separation of sex into the emotional and the physical because Dan had been working on the integration of his sexual experience. Murray, now at the edge of his seat, commented on Hugh's intellectualized and stubborn style of relating:

Murray: I think it's a defense, having been through years of intellectual jerking off (makes masturbation
motion over his head). I used to do it as a way of diverting attention from myself.

Hugh: The intellect has its place. I think you two guys (Dan and Murray) are just constituted very differently than me.

Murray: I'm not so sure. I've been into a heavy spiritual rap and a mystical rap and I think that stuff can be valuable, but a lot of the stuff you're saying has come out of my mouth and it's frustrating when someone asks you a question and you just go "out there." I feel like shaking you sometimes.

For quite some time, Dan, Murray, and Hugh dominated the discussion. When asked what others thought about what was occurring, Jack and Mitchell responded that they felt lost, while Wally accused Hugh of overemphasizing his age and ignoring the detrimental effects of his problematic marriage on his sex life.

As the session drew to a close, a summarizing interpretation was made: Much of the group had focused on Hugh, trying to "shake" him in some way, and it was apparent that Hugh had a very difficult time letting people in, either to get to know him or to let them affect him. Hugh rejected this observation as biased by a world view which held the expression of emotion in the highest esteem. The therapist continued, underscoring that this issue was of primary importance in the group, that is, how much can members take from each other and be affected by one another. He pointed to recent incidents in which this similar dynamic was observed in the behavior of Jack and Dan. Dan hesitantly admitted that it was difficult for
him to "take" from others and linked this pattern to his inability to focus on his own pleasure during sexual relations.

As the session ended, Hugh walked across the room and shook hands with both Dan and Murray; they exchanged smiles and pats on the back and left the room together.

Exercise: (with partner) partner thrusting (stop-start) in female-on-top position
(without partner) masturbation in maximally arousing environment

Summary. The sixth session was intense and emotional. Spurred by a confrontation from the therapists, the group expressed its increasing annoyance with Hugh's evasive interpersonal style. Members took risks, giving both angry and caring feedback. Hugh was the central figure in this session. He was predominantly defensive in reaction to the confrontation he received; yet towards the end of the meeting, he appeared to soften somewhat. He also seemed genuinely relieved when he learned that other members were not making love several times a night. Dan, Hugh, and Murray seemed to establish themselves as the core of the group, with the other members apparently willing to remain on the periphery.
Session 7

The session began with Hugh missing; Dan expressed concern that he might have been scared off after being confronted last week. Jack, who had been more verbal in recent meetings, announced that he had broken up with his girl friend. Reflecting on his relationship, he had determined that his partner had manipulated him and he felt unable to express his individuality. Upon questioning, it was apparent that little processing of these vital issues had occurred within his relationship. He then confessed that the final blow occurred when his partner announced her intention to go out with another man. Jack reluctantly admitted that he was "pretty crushed" and related that, in a rare moment of assertiveness, he had walked out on her. He expressed satisfaction about the resolution for the relationship, yet felt discouraged that his progress with the exercises would be halted.

Wally revealed that after his recent breakup he had telephoned an old girl friend and renewed ties. After one very successful and pleasant experience with intercourse, he felt extremely dismayed when he encountered difficulty the following time. He recognized that the techniques were working, yet seemed to detest needing to alter his sexual style in any way.

At that moment, Hugh barged into the room, making
considerable noise as he took his seat. He explained that he had been given a surprise birthday party by some friends and had difficulty leaving. When asked, he assured the members that he had no discomfort about returning to the group.

Dan informed the group that he had had a negative experience with the exercise, masturbation aided by the use of erotic literature. He expressed anger at the leaders for assigning an exercise that reminded him of the disturbing childhood memories which he associated with his father's graphic pornographic magazines. He then described his precocious strivings toward adult sexuality, including attempted intercourse during sex play at age 7. He characterized these memories as "painful" and "frustrating"; yet he related these events in a removed manner, even smiling occasionally as if proud of his unusual past.

Dan's comments led into a discussion of feelings about erotic magazines. Ambivalence was expressed: Several men acknowledged and condemned the oppressive objectification of women involved, yet confessed to finding them arousing.

Thirty-five minutes into the session, Mitchell still had not spoken. With a bemused expression on his face, he swivelled in his chair and chomped on a wad of gum. He rarely appeared interested in the discussion and was
observed to be staring blankly into space for extended periods of time; yet none of the members attempted to interact with him. Finally, one of the therapists contacted him. Mitchell reoriented himself, then quickly assured the members that he had been listening but simply did not feel like talking. He continued that he was presently having intercourse regularly, although he kept his partner uninformed about the group and practiced the exercises "secretly." In recent weeks, Mitchell had reported being with several partners; yet before this time he had encountered difficulty meeting women. It was also noted that his reports of increased heterosexual relations contrasted with his recent withdrawal from others in the group. These observations were shared with Mitchell, and the therapists admitted being perplexed by these circumstances. Mitchell replied with vague responses: He attributed these occurrences to "a change in attitude" and to "taking one day at a time."

In an apparent attempt to rescue Mitchell, Hugh remarked that he was pleased to see Mitchell was enjoying his life more. Hugh continued that he too was feeling better about his life and relationship. He credited the group for helping to improve communication with his wife and reported feeling optimistic about his marriage "for the first time ever."
Murray initiated a discussion about the frustration experienced by not being able to bring a partner to orgasm, especially via intercourse. The anatomy of female sexuality was discussed, specifically the lack of stimulation received by the clitoris during intercourse. Despite this knowledge, members confessed that they still felt like inadequate lovers if intercourse failed to satisfy their partners. Wally noted that for him this frustration often turned into anger. They also complained that additional pressure derived from the expectation that the man alone must "figure out" how to satisfy the woman.

As the session drew to a close, the observation was made again that Mitchell seemed disconnected from the group. Dan and Murray both related that they had been concerned about Mitchell, yet felt reluctant to challenge another member after the previous week's intense session. Dan, Murray, and Hugh expressed their concern and interest in Mitchell's current situation. Mitchell admitted feeling "a little out of it" during the meeting. His responses to inquiries from others were vague and circumstantial, prompting Murray, at one point, to express his confusion and implore Mitchell to be more specific. At the end of the session, the leaders contacted Mitchell, requesting to speak with him briefly alone.
Exercise: (with partner) intercourse in side-to-side position
(without partner) create exercise to suit individual needs

The therapists, concerned that Mitchell might be deeply troubled, met with him briefly after the session. Mitchell verbalized interest in continuing with the group, despite his apparent indifference, which, he admitted, might have resulted from drinking a few beers before the meeting. He denied feeling depressed; on the contrary, he insisted he had just decided to join the service and felt good about the change.

Summary. The seventh session re-established a benevolent ambience to the group. Members shared similar feelings on issues such as performance pressure and erotic magazines; there was little confrontation. Mitchell's inattentiveness and vague manner created a low level of tension throughout the session as members seemed unsure how to respond to him. When interactions did occur, they were tentative and felt tediously awkward.

Session 8

Mitchell was not present as Dan began the session be-moaning the impending termination of the group. He said that the group had increased his sensitivity to himself
both emotionally and physiologically and had helped him become less goal-oriented in his sexuality. Hugh related that his sexual interactions no longer revolved around his orgasm. Hugh commented that this new perspective on sexuality was attained after much thought and a necessary reorientation of his masculine self-image. He then shared childhood memories of being harassed by his father for doing anything "feminine."

Wally continued to be perplexed by his inconsistent ejaculatory control: At times he needed to withdraw frequently, while other times, with the same woman, it was unnecessary to employ any control techniques. He related that he was not reaching orgasm intravaginally by choice. This decision he attributed to an increased emphasis on caressing and the fact that his partner did not use birth control. One of the therapists judged that it was imperative to warn Wally of the dangers incumbent in the withdrawal method of contraception. Allowing that his attitude might be irresponsible, Wally replied indifferently that he was not concerned that a pregnancy might occur— not to him. Shaking his head vigorously, Hugh immediately assured Wally that "it can happen to people like you; it happened to me twice!" Upon further questioning, it became clear that Wally held little affection for his new partner; in fact, he considered her a nag and confessed to "using" her until he found someone more satisfying. Wally appeared
extremely uncomfortable during this time, fidgeting nervously in his chair and avoiding eye contact with other members.

It was observed that a premium was being placed on delaying ejaculation as long as possible. The group was informed that an upcoming assignment involved attempting to ejaculate as quickly as possible. Dan underscored that it was his attitude which affected his enjoyment of sexual experience rather than its longevity. He insisted that maintaining a rigid view that lengthy caressing was the "only way" to have sex would be as restrictive as some of the troublesome patterns and beliefs previously held by group members. A discussion developed about the process of lovemaking, focusing specifically on the issue of what occurred after they ejaculated.

Jack informed the members that he was reunited with his girlfriend, yet they were still struggling. The group had helped him realize that he needed to negotiate his own needs into the relationship, but this had created friction.

Murray, who had been more quiet than usual, expressed guilt over not having done the assigned exercises. He related that he had been preoccupied this week with planning an upcoming move with his partner to a large city. He admitted feeling frustrated with his present lack of direction and was anxious to change his situation. Jack, who had a connection in the city, quickly offered Murray a job
possibility. Murray seemed mildly interested and expressed his gratitude at the offer.

After Murray finished speaking, there was a lull in the process, at which point the issue of Mitchell's absence was raised. Contrasting views of Mitchell were expressed. Hugh recalled that he had spoken to Mitchell two weeks ago and he seemed "on top of the world." Hugh proposed that perhaps Mitchell felt that he had mastered his problem and, therefore, no longer needed the group. Dan commented that Mitchell seemed to have a need to impress the group. He wondered whether Mitchell's beer drinking may have served to "fortify" him against the anxiety of coming to the group. Wally snarled that he thought Mitchell was a "bullshit artist" who didn't take the group seriously. Murray recalled his observation that Mitchell appeared scared and upset the previous week, yet was unable to talk about it. He remembered feeling frustrated with Mitchell, but was reluctant to "get on him" about it.

As the session drew to a close, the members expressed their hesitation about Mitchell returning to the group. Wally expressed some of the group's ambivalent and unacknowledged anger towards Mitchell when he remarked, "I'd welcome him back . . . but I wouldn't want to open myself up to him." This prompted Dan to declare that he resented the large amount of time and energy that had been focused on Mitchell without results. Dan felt that if Mitchell
returned he would unfairly distract the group from proceeding with its tasks. Dan acknowledged that Mitchell needed help, but questioned whether this group was the appropriate place for him. Hugh challenged Dan's view and insisted that Mitchell had indeed changed for the better during recent weeks. As the group ended, Dan had been the only one to verbalize directly that he would prefer that Mitchell not return.

Exercise: (with partner) intercourse in male-on-top position (without partner) exercise which has previously difficulty

Summary. The eighth group was somewhat disjointed; there were periods of uneasiness and of silence. Members began the process of termination: Many reflected on their progress and discussed the effects of the group on their relationships. There was a marked change in Hugh's participation this week. On the whole, he was considerably less hostile and more empathic towards others. While Hugh appeared to be making an effort to "join" the group, Murray seemed to be disengaging, and Mitchell was absent. Members seemed relieved at the opportunity to vent their feelings about Mitchell.

Mitchell was contacted by phone the following day.
He acknowledged that a number of confusing things were occurring in his life which he needed to sort out. He gratefully accepted an invitation to meet with cotherapists.

He arrived at the clinic on time and appeared alert, although somber. He explained that he had recently decided to drop out of school, unable to handle the coursework in addition to working thirty hours a week at the restaurant. He planned to return to his parents' home next year and finish school at the state university near their home. He claimed that his confusion resulted from his struggle with a career decision (whether or not to join the air force). He denied that other aspects of his life were troubling him and, when asked, assured the interviewers that his drinking was not problematic.

A referral for individual therapy was suggested and discussed. Mitchell felt his present difficulties revolved around career rather than personal issues. Mitchell was informed of a resource center which provided both career and personal counseling. He expressed interest in continuing participation in the group, although admitting this was partially out of obligation. He thanked the therapists for their time and stated that he would attend the next session.

Session 9

Mitchell was not present as the meeting began. The
therapists informed the group that they had met with Mitchell the previous week, at which point he had expressed his intention to attend this meeting. Hugh added that he also had seen Mitchell during the preceding week. He noted that Mitchell had seemed apprehensive about returning to the group, yet expressed his desire to do so.

Hugh announced that it would be necessary for him to leave the session a half hour early. He explained that their babysitter had to leave early and his wife, who was "under a tremendous amount of pressure," was occupied writing an important paper. Hugh then began to discuss the triangular conflicts prevalent in their home. His wife and 3-year-old daughter were described as extremely involved with each other: They slept in the same bed and the daughter was still being breast-fed. Hugh claimed his daughter threw jealous tantrums whenever he and his wife were physically affectionate. He described his daughter as "instrumental" in their relational problems. When asked why his daughter was allowed to interfere with his marriage, Hugh became defensive: He assured the group that his marriage was improving and that both his wife and daughter were becoming more self-assured.

The topic shifted to a discussion of the exercises. Murray related that his partner, Eileen, had objected to having intercourse, insisting that it was not pleasurable for her. After a lengthy talk, they made a "new commitment
to make intercourse better," a more mutual interaction. Dan recalled feeling rejected when his partner had previously raised a similar concern about intercourse. Dan shared that having his partner rub her clitoris during intercourse proved to be a very comfortable and mutually satisfactory arrangement.

Jack joined the discussion; he sighed that he had decided to get back together with his girlfriend. Much to his dismay, however, she refused to have intercourse with him. He sounded quite discouraged, and presented himself as helpless to change the situation. He lamented that she never showed any interest in his activities or friends and sadly wondered aloud if he was a "boring" person. A sullen, uncomfortable silence followed Jack's question to the group. Murray, however, acknowledged that it felt awful to feel "boring" and shared that he had held similar worries when he first started seeing Eileen. He implored Jack to negotiate this issue with his partner and insisted that it was not necessary to surrender his own interests for the relationship.

Wally had been very quiet and appeared somewhat preoccupied. He acknowledged feeling worried that he might fail a course which would prevent him from graduating. He stated that he had been inundated with work the preceding week and was unable to do the exercises with his partner.

Hugh's increased involvement with the group became
evident when he suggested a postgroup picnic for members to reunite and meet each others' partners. Hugh also demonstrated his greater awareness and concern for others by inquiring about Dan's noticeably more reserved posture during the session. Dan seemed pleased to have his participation missed. He related to the situation Wally had described, increased school pressures as the semester drew to a close. Dan described a dynamic in his relationship in which he struggled to avoid becoming overinvolved with his partner's personal problems. It appeared that Dan was also attempting to minimize his care-taking tendencies within the group by maintaining a peripheral involvement in this session.

At that point, Hugh, who had stayed almost ten minutes later than he had originally planned, left the room. The therapists encouraged Wally and Jack to share their feelings about having sporadically participating partners. Both responded that they found it very difficult to be alone and missed the intimate sharing that a relationship with a woman offered. Dan intellectualized briefly about how men need "mothering" and seek out a substitute for the original mother figure. Becoming more personal, Dan admitted his longing for a secure relationship where he could feel connected and nurtured. Murray heartily related to Dan's search for a safe, holding relationship. As the conversation continued, both Dan
and Murray confessed to occasionally playing "mother and baby" with their partners. The interpretation was made that the group had been a safe, caring place where intimate sharing had occurred and that there seemed to be a sadness about the approaching end of this experience. Several members acknowledged that the group had helped them open up in other aspects of their life. Sadness was expressed that the closeness and trust that had developed would soon end.

**Exercise:** (with partner) intentional "quickie"
   (intercourse)
   (without partner) intentional "quickie"
   (masturbation)

**Summary.** The ninth session felt somber and disconnected at the start. Mitchell did not attend the meeting despite his prior assurance that he would. Hugh had characterized his need to leave early as an effort to help out his overwhelmed wife, and this seemed to cut off any possible confrontation about his premature departure. Several members expressed that their attention had recently been concentrated on events outside of the group, and it appeared they had a difficult time finding time for the exercises and feeling connected to one another in the group. After Hugh left, however, there seemed to be a shift. Wally and Jack were drawn out and the group pulled into a tighter circle,
with members sitting on the edge of their chairs. Discussion focused on the longing for a safe, caring environment, which, in fact, the group had been. After this interpretation, members expressed their sadness at the group's dissolution.

**Session 10**

The group began with neither Mitchell nor Dan present. Dan had sent word with Wally that he was finishing up a paper and would be several minutes late. Murray announced that he met Mitchell on the street the previous week and had told him that the group was concerned about him. Mitchell shared that he was struggling with some major life decisions; he also added that he might attend the last meeting.

At that point, Dan entered the room. In addition to this being Dan's first lateness, it was also the first time he had come to group unshaven and less than meticulously dressed. He apologized for being late, then immediately related to the group that he had had a very difficult semester. He finished by expressing his regrets that the group was ending, since he felt he was just beginning to make headway.

Hugh raised the idea that the group should have been labelled as a "male sexuality" group rather than "premature ejaculation." Several members agreed, acknowledging that
the group dealt with broader issues than ejaculatory control. Hugh mentioned that there seemed to be a developing fad of sado-masochism and wife-swapping among his friends. He contrasted this trend with the more mature and fulfilling emphasis on subtlety which was advocated by the group.

Dan declared that the most important component of the group was that it provided a rare opportunity for men to get together to talk. The support, he maintained, was crucial, and this he would regretfully lack during the upcoming summer. Hugh proudly shared that the previous week he had talked frankly about sex with a male friend for the first time in his life. Hugh remarked that having spoken personally about sex in the comfortable setting of the group enabled him to relate this way elsewhere. Murray agreed wholeheartedly, stating that he too felt more comfortable communicating directly about sex. Hugh expressed his appreciation to the other members for dealing with such a delicate topic so openly.

Murray noted his own progress, yet compared the end of the group to graduation from first grade; still a long way to go. Wally admitted that although the exercises were somewhat effective, there were a number of disappointments associated with the group: His relationship ended and he now felt more confused about what he wanted from a relationship. Wally reflected that the group helped solve
some of his problems, while exposing others of which he had not been aware.

A discussion of the "quickie" exercises was initiated by Hugh, who was pleased by his longevity. Dan adamantly criticized the exercise as regressive. He was angered that the leaders assigned an exercise which reminded him of a disturbing past pattern of speedy masturbation with release as the only goal.

Jack recalled that when he entered the group he had thought the problem would be cured by the end; he now realized that this difficulty was more complicated than he had imagined. He acknowledged having difficulty talking openly with others, as he had never been in a group before. On the whole, he felt it was a very positive experience.

Hugh remarked that the group had made him realize that he and his wife had to work at having satisfactory sexual relations. He noted that he and Ann had to overcome the myth that sex must be spontaneous.

Several members commented that their sexual relations had become less orgasm-centered. Dan, modifying his previous stance, acknowledged that the "quickie" exercise did serve to highlight the idea that one must allow flexibility in sexuality: Sex could be quick and powerful or long and tender.

As the final session drew to a close, an awkward silence developed. Members had spent much of the session
reviewing their progress outside of the group, but seemed hesitant to talk directly to other members. Dan was able to speak of support systems and how he valued the group experience. Hugh agreed, remarking that the exercises could have been found in a book but the group was the essential component. Murray, Dan, Hugh, and Jack, followed by the therapists, made brief comments, thanking each other for their contribution to their very positive experience, while Wally remained silent.

Summary. The members reviewed their experience in the group. Most comments were positive and highlighted how the group promoted change in several aspects of their lives as well as their sexuality. Wally and Dan expressed more ambivalent feelings about their experience. The therapists advised that during the next year members should continue to incorporate the techniques they had learned into their sexual relations. The members agreed that the exercises had been secondary and that the sessions themselves had been the most meaningful part of the group experience. Most of the discussion was generalized; only towards the end of the session did interaction become more personal, and then only briefly.
In the following section, the experience and progress of each client are reviewed, and an evaluation and discussion of the group as a whole are provided. The analysis of the data obtained is, for the most part, qualitative. While Bronfenbrenner (1977) and Gibbs (1979) have argued that a preoccupation with laboratory precision often leads to a loss of touch with the human element in the problem under investigation, they also maintain that an overindulgence into one individual's subjective experience similarly yields insignificant results. Zeiss's (1978) research on premature ejaculation offered a caricature of the former type of error: He gave each couple a stopwatch with which to measure their ejaculatory latency. The unstructured, anecdotal work presented by Pleck and Sawyer (1974) and Farrell (1974), on the other hand, demonstrate the deficiencies of an undisciplined use of the qualitative mode. The purpose of this project was to explore the utility of a new group model for the treatment of premature ejaculation. A qualitative description and analysis of the process permitted data to be gathered related to the numerous predetermined hypotheses. This approach allowed maximum flexibility: The unique experience of each client was appreciated, while an attempt was made to determine the
significant common effects of the group.

Irvin Yalom (1970) remarked that clients' reports were a rich and relatively untapped source of information regarding the effects of group therapy. It seemed essential to enter the experiential world of the client and incorporate their observations about progress and outcome into our analysis of the results of this project. Clients' comments about each other, as well as their remarks and suggestions about the group and the therapists, were valued greatly and are included in the discussion of the results. Lieberman, Yalom, and Miles (1973) emphasized that client reports "constitute the most immediate, and often the most poignant data about group effects" (p. 93). They also discovered that the therapists and the members often disagreed on which participants benefited most.

A truly comprehensive appraisal of outcome must include the therapist's clinical impressions. While a client may have reported a specific improvement (e.g., increased comfort communicating with men about sexuality), clinical observations are employed to either verify or refute these claims. The therapist's impressions and observations must be guided by what Erikson (1964) called "disciplined subjectivity." Reviewing each group on videotape assisted the therapists in this pursuit. It was essential that the therapists were in touch with their emotional
reactions so they did not interfere with their therapeutic and perceptive abilities. In fact, when monitored properly, these emotions can be of great benefit to the clinician. Erikson (1964) emphasized that "the evidence is not all in" until the clinician is able to utilize his own emotional responses.

In this section, client reports as well as clinical impressions of the results of the group are provided. This information is supplemented by pre and posttreatment questionnaire data. Significant shifts in attitudes and behavior are noted.

**Clients**

Dan.

**Questionnaire and interview.** Dan viewed the opportunity to talk openly with a group of men about sexuality, problems, fears, and mates as the most valuable aspect of his experience. During his postgroup interview, he stressed the reassuring nature of this process and labelled the experience as "pivotal" to how he wishes to interact with men and his mates in the future. Dan recognized his own tendency to avoid sharing personal feelings and asserting his own needs: His reluctance to "take" in a relationship was evident in his interactions within the group. His shifting responses to items in the posttreatment questionnaire reflected Dan's increased comfort adopting a "passive"
role in sexual interactions and his greater willingness and comfort with communicating both positive and negative messages to his partner. In his interview, Dan proudly noted that his ability to comfortably and spontaneously express anger at the leaders in the final session had been a critically significant incident for him.

Responses on the questionnaire along with Dan's comments during the interview indicated clearly that he was no longer worried about his performance and felt much more in control of his ejaculatory process. He reflected that he had gained much insight into this problem, realizing that his anxiety about his sexuality derived predominantly from the discrepancy between his performance and the unrealistic expectations he possessed. Dan's report that he had acquired an increased sexual repertoire was substantiated by shifts in posttreatment questionnaire responses. Although he expressed frustration at having very limited partner participation during the group, Dan felt his increased flexibility would allow him to incorporate the control techniques he had learned whenever necessary: "If I feel not in control, I'll know what to do and that's reassuring."

On the pretreatment questionnaire, Dan viewed his sexual practices and performance as similar to his estimation of that of other men on 52 percent of the items. This figure dropped sharply to 15 percent after the group. Of
the twenty-six items on which he perceived a postgroup difference, Dan viewed himself as more potent and more egalitarian (nontraditional) in his sexual relations on 92 percent of these questions as opposed to 21 percent previously. While some important shifts in self-perception may have occurred, this new striking imbalance seemed to indicate that Dan idealized his own experience within the group and reinforced an already somewhat grandiose self-concept. This grandiosity was manifest in Dan's condescending attitude to other members at times, reflected in his final comment that an important component of the group was that it allowed him to work on the "latent therapist" in him, helping him to develop his empathic and facilitative abilities.

Observations on progress. Although Dan described the group as an "enriching" experience and demonstrated a significant shift in his responses to the questionnaire, the manifestation of these changes within the group was more difficult to observe. During the early weeks, Dan seemed to be making an effort to be the ideal client and create the ideal group. His bold intentions, however, conflicted with the realistic limitations of the group and his own ambivalence: He was unable to follow through on his own suggestions for extending the closeness and trust that was developing among the members.

His loquacious and intellectualized manner
temporarily gave way to a more humble posture after Dan returned from a disappointing visit with his girl friend in California. He seemed sad and angry both about his partner's rejection of him and his subsequent perception of a reduction in his stature within the group. Despite his ability to facilitate the expression of these emotions in others, he was unwilling to do so himself. Dan seemed determined to establish himself as a leader in the group and he was, in fact, quite perceptive in his observations of group process and in his interactions with other members. He helped initiate and facilitate discussions of pertinent topics; yet his self-disclosure often possessed a removed and rehearsed quality. Murray, in his postgroup interview, concurred: He observed that although Dan constantly challenged Hugh's non-emotional posture, Dan, ironically, had quite similar difficulties speaking personally about his own experience.

Dan greatly valued the support the group offered; he expressed sadness at the anticipated void during the summer. It is likely that this sense of loss also derived from feelings relating to an upcoming three-month break from his individual therapist. Although the therapists had doubted Dan's benefit from the group, Dan claimed that it had been quite helpful to him. It may be that the experience felt significant because it provided the opportunity for
Dan to share his thoughts on sexuality, feel positively about himself because of his leadership role, and establish bonds with a group of men.

Hugh.

Questionnaire and interview. Hugh was quite enthusiastic about his experience in the group. A major consequence of the experience, highlighted by Hugh in his interview and evident in his changing responses to items on the questionnaire, was the evolution of a new orientation towards sexuality: one which de-emphasized ejaculation and expanded previously rigid sexual interaction patterns. He admitted that he learned much about subtlety in sexuality, responding very positively to exercises which increased his sensitivity towards himself:

It's natural to do things to yourself that are pleasurable--I thought, how strange that I have never touched this part of my body in this way before in my entire life (strokes the back of his thigh).

Adopting this new perspective, Hugh noticed a "deepening sensitivity" to his wife in many aspects of their relationship. He credited the group with forcing him to communicate more with his partner, which resulted in improving his troubled marital situation. He confided that he felt optimistic about his marriage for the first time ever.

Hugh stressed that the group provided an invaluable
opportunity to speak frankly with other men about sexuality. Prior to the group, he admittedly felt uncomfortable speaking with another man about a sexual difficulty. According to his reply on the posttreatment questionnaire, he now felt "very comfortable" with this. This response was validated by his disclosure that he had recently initiated a conversation about sexuality with a male friend, something he had never done before.

During the postgroup interview, Hugh reported that his ejaculatory control had definitely improved, along with his self-confidence. His responses to the questionnaire items reflected this greater confidence in his sexual performance, indicated that he now felt more relaxed and fulfilled after sex, and, interestingly, showed that Hugh now held a more positive body-image.

Observations on progress. After the initial assessment, there had been some concern as to whether Hugh was an appropriate candidate for the group. His abrasive, controlling manner demonstrated his difficulty with mutual interactions, while his steadfast prejudice against "psychologizing" signalled his disdain for introspection. He was accepted for the group and antagonized members with this behavior throughout the early weeks.

His age and sexual difficulty seemed to be experienced as humiliating narcissistic injuries. His argumentative and intellectualized manner served to maintain
a distance between himself and other members and minimize feelings of vulnerability. A turning point, however, occurred in the sixth session when he was confronted on his evasive and impersonal style. While anger was expressed, it was done empathically. Several members were able to relate personally and effectively to him and his experiences and, for the first time, it appeared that Hugh began to allow others to get close to him. He also seemed genuinely relieved when other members assured him that the expectations he held for his sexual performance were unrealistic, if not ludicrous.

Hugh's participation in the group changed remarkably after this session. He seemed to make an effort to "join" the group rather than oppose it; he was more empathic with others and more open, disclosing more personal material, including his difficulties with his wife and daughter and memories of a strained relationship with his father. These observed differences were confirmed by Murray, in his post-group interview, who felt Hugh was the member who most benefited from the group experience.

In the last few groups, Hugh seemed to go through a real change. The week after people confronted him, he came back and was talking a lot more personally. It seemed like it really had a profound effect on him. I was really impressed.

It was evident from these observations, as well as his own appreciative comments, that the group experience had a very positive impact on Hugh and seemed to promote change in
several aspects of his life.

Jack.

**Questionnaire and interview.** A comparison of responses on the pre and posttreatment questionnaires indicated changes along several dimensions which paralleled Jack's own appraisal of his group experience. One major consequence of the group was revealed in the posttreatment interview: Jack decided to stop dating his girlfriend. The group, he stated, had helped him realize that he had control over his life and that he was not getting what he needed from that relationship. He acknowledged that he was still bothered by a real lack of self-confidence, but felt more able to speak up for himself, especially in the final weeks of the group.

A strengthened self-image and increased assertiveness were apparent in Jack's responses to questionnaire items after the group was completed. Jack responded that he felt "comfortable" making a sexual request of a partner, while prior to the group experience, he was "uncomfortable" doing so. He reported feeling increased ease in "saying no" to a partner: refusing her sexual advances and asking her to stop doing something that is no longer exciting him. His greater self-confidence was also reflected in a more moderate, less self-deprecating reaction to a rejected sexual advance or a disappointing sexual interaction. An
interesting indirect effect was a shift in responses to certain items on the questionnaires which indicated an improvement in body-image.

During the interview, Jack reported that his ejaculatory control had improved, although he lamented that sporadic partner participation prevented him from deriving maximum benefit from the exercises. He felt less concerned about his sexual performance, no longer dreading intercourse and the inevitable embarrassment of ejaculating prematurely.

Perhaps most significantly, Jack seemed to gain a more realistic perspective on himself and his sexuality.

I'd never really talked with a bunch of guys before and I had a lot of misconceptions: like you're really screwed up if you have a problem like this... I'd never heard anyone ever talk about this problem; so I thought I was the only one on campus with this problem.

He discovered that the troubles he had considered unique to him were shared by others: "Hearing those guys talk made me realize I'm not crazy." While responses on the pretreatment questionnaire indicated that Jack felt quite inadequate in comparison to his own estimation of other men's sexual relations and performance, his postgroup responses showed a striking reduction in this perceived discrepancy. Previously held exaggerations and misconceptions of other men's potency (i.e., other men "almost always" achieve simultaneous orgasms with their partners) were
corrected. He initially viewed himself as similar to other men on only 45 percent of the thirty-three items; however, this percentage rose to 79 percent after the group experience.

The knowledge that his problems and concerns were shared by other men was reassuring. He found it "interesting" to hear other members talk about relationships and sexuality in ways he had "never thought about before"; yet it seemed to be overwhelming at times. Jack recalled often feeling like "the little kid on the block." While these new concepts may have been too much for Jack to assimilate at the moment, Wally revealed in his postgroup interview that he and Jack would walk together after each group at which time Jack would excitedly share "thoughtful" reflections on what had transpired in the group.

Jack reflected that it had taken a lot of courage for him to participate in the group, but he was very glad he had. He expressed sadness at the group's ending.

Observations on progress. Participation in the group did seem to be a significant event in Jack's life. His shy, nonverbal style and restricted exposure to nontraditional ways of relating and thinking made the group a strange, intimidating place during the early weeks. As the supportive environment allowed Jack to open up, he became very engaged. The members encouraged the expression of his
affect and his needs both within the group and in his relationship. He appeared to look to Murray as a role model in this respect. He demonstrated a more self-assured manner during the middle phase of the group, although he became more withdrawn towards the end as pressures within his relationship mounted. Jack acknowledged his problem with chronically low self-esteem; the possibility of individual therapy was discussed, and Jack expressed serious interest. As his postsession talks with Wally indicated, the exposure to new ways of thinking and relating reverberated strongly within Jack and is likely to result in continuing integration of these concepts along with their progressive effects on his attitudes and behavior.

Mitchell. Mitchell was the only member of the group not to complete the treatment program. His termination occurred after the seventh session; therefore, he did not take part in the posttreatment interview which provided an opportunity for the client to discuss his personal experience in the group. Without direct input from Mitchell the discussion of his experience must be derived solely from the therapists' clinical impressions and speculations.

In retrospect, Mitchell was more seriously disturbed than initially thought. During initial interactions, he seemed anxious and guarded; yet this posture was observed in other clients at first and, therefore, was attributed
primarily to situational rather than characterological factors. Mitchell appeared to enjoy the camaraderie of the group but seemed unsure of how to participate appropriately. During the second session, his sudden disclosure of painful childhood memories stunned the group, and perhaps surprised Mitchell too. He became the focus of attention for the remainder of that group. Perhaps Mitchell could not tolerate being in such an anxiety-provoking environment, because he missed the following session and, when he returned to the group, maintained a peripheral involvement.

During the remainder of his participation in the group, he fluctuated between a withdrawn dissociated presentation and periods of almost hypomanic grandiosity. Although Mitchell denied extensive drinking, it was suspected on several occasions that he may have been "medicating himself" through the use of either drugs or alcohol. It became obvious that Mitchell possessed a need to impress the members of the group: He boasted of his prowess as a softball player and a lover. He seemed exhilarated as he informed the group of a highly successful sexual encounter he had had, crediting the incorporation of the assigned techniques as crucial to his ejaculatory control and consequent pleasure. While this may indeed have occurred, his vague and inconsistent presentation cast suspicion on the veracity of his story.

During private meetings, Mitchell did acknowledge
feeling tense and confused about his life, yet insisted these difficulties were limited to career issues. It may be that the braggadocio which characterized a part of Mitchell's confusing presentation was a defensive attempt to deny pressing feelings of inadequacy and loss of control.

When Mitchell did not return for the last three groups, the therapists sent him a letter offering their availability should need arise and provided referrals for both personal and career counseling.

Murray.

Questionnaire and interview. Murray stated that he had a very pleasant and positive experience with the group. He found it reassuring to talk openly with other men about sexuality, sexual problems, and relationships. The exploration of sexual values helped Murray to become more aware of his own views. Based on pretreatment information and his contributions in the group, it was clear that Murray was a very sensitive man who was quite nontraditional in his sexual attitudes and practices even before this experience. In the postgroup interview, Murray remarked that it was satisfying to see his attitudes affirmed as positive by the group.

Murray noted that the group experience had helped him be more assertive both interpersonally and sexually. He began to question the established interaction patterns he
had with his partner. Previously, he acquiesced to her demands; however, following the group he felt more comfortable challenging her and standing up for himself and his needs.

Murray felt he had gained a considerable amount of control over his ejaculation. Although he occasionally still experienced difficulty, he felt more comfortable and in control: "It's no longer like there's me and then there's this penis acting independently of me." He also felt more able to integrate control techniques into lovemaking. Crediting the group, Murray expressed relief that he was no longer troubled by severe anticipatory anxiety prior to intercourse. Murray viewed the exercises as providing a valuable structure for increasing his sensitivity to his own sexuality and working on improving sexual interactions with his partner. He maintained, however, that the experience of talking with other men was the component of the group of primary importance.

Observations on progress. Murray was an extremely valuable member of the group. His willingness to personalize and expand upon issues raised by other members often led to meaningful discussions and interactions. His open and empathic style served the significant function of modelling nontraditional male behavior within the group.

A predominant issue for Murray throughout the group
was a struggle to assert his needs within his relationship with Eileen. Despite his claim that he had difficulty asserting himself in interpersonal situations, Murray displayed the ability to sensitively and effectively confront other members on several occasions. He credited the group with helping him be more assertive with Eileen; yet, from his descriptions, it sounded as though Murray had developed an exaggerated posture. He proudly claimed to be initiating more fights with her recently. He seemed belligerent and unreasonable with her at times, as if he felt there was only room for one of them to get their needs met within the relationship. As the group proceeded, Murray's reports of this type of interaction diminished. It was clear that Murray was quite anxious negotiating his relationship with Eileen. In the last few sessions, it was observed that Murray appeared to slightly withdraw from the group. Murray admitted feeling preoccupied during this time with an upcoming move with Eileen and the subsequent significant transition in his life and relationship.

In Murray's case, it was not necessary for members to challenge his already progressive attitudes towards sexuality and masculinity. The group, however, did serve the important function of affirming these views as positive and providing him with support. Prior to the group, Murray reported that he and Eileen had constantly discussed their
feelings about his premature ejaculation problem. Unfortunately, the communication alleviated only a small portion of their frustration and had not improved the situation significantly. The exercises successfully provided this very verbal couple with a much needed structure in which to work on a difficulty which has chronically troubled them.

Wally.

Questionnaire and interview. Wally felt that the group experience had helped him become more aware of his own sexual needs. He confessed that previously he had been extremely anxious about pleasing his ex-partner, Pam; his fear of failure filled him with "sheer terror." During the postgroup interview, Wally stated that he had recently adopted a new attitude towards sexual relations, one in which he felt increased comfort with "demanding more physically from my partner." In his relationship with Pam, he had been angered by her demands and expectation that he be a "James Bond" type of lover. The group, he asserted, influenced his breakup by helping him to realize that he did not need to fulfill a certain role.

Wally's new attitude seemed to reflect several different trends. It is likely that the group did help to liberate Wally from restrictive sex-role expectations. The group clearly supported Wally's assertion of his own needs.
within his relationship; however, Wally's responses also indicated an increased comfort in asserting his anger. His comments seemed to reflect lingering bitterness towards Pam and his resentment towards all women. A comparison of Wally's postgroup questionnaire responses to those given before the group experience substantiated his stated willingness to take a more active role in sexual relations; however, this activity seemed to be at the expense of his partner's pleasure. He felt more comfortable expressing negative comments to his partner and being directive, while he came to feel less comfortable complimenting her. His replies also predicted that in the future he would be less likely to orally stimulate his partner's body or her genitals.

As the postgroup interview proceeded, Wally became more open. He noted that his premature ejaculation contributed to a "strong self-hatred" which he sometimes turned against his partner, as in the incident when he struck Pam. He admitted being frightened by his propensity to lash out violently. The issue of individual psychotherapy was discussed, and Wally stated he intended to pursue this option in the near future.

Wally felt his ejaculatory control had definitely improved, although he still lamented not having "total mastery" over it. Even at the end of the interview, he demonstrated that he still maintained unrealistic sexual
expectations: He expressed his resentment at needing to incorporate any control techniques, stating, "I don't want to have the urge to ejaculate." He wondered whether hypnosis might be helpful for further treatment. While this inquiry may indicate a reluctance to accept his own limitations, it may also reflect Wally's developing sense that others can be trusted and can offer help to him.

Observations on progress. Participation in the group seemed to be a particularly difficult experience for Wally. He often appeared extremely tense and serious; it was obvious he held much inside. In some instances it was clear from Wally's pregoup interview that he had very similar concerns to those being discussed; yet he would choose not to share his experience. This usually occurred around issues which might further expose Wally's anger, over which he maintained tenuous control. He frequently denied feeling angry about a situation, even though he appeared to be seething.

He seemed to resent demands being placed on him both sexually and emotionally. This was clearly expressed in his resentment of Pam; yet there appeared to be a parallel situation in the group. For example, in an early group meeting he expressed his indignation that there was a fee charged for the group in addition to the requested cooperation with the research component of the project. He appeared especially anxious when he would become the focus
of attention in the group. He seemed to resent the group’s expectation that he share his feelings and interact freely with others. He would bristle when inquiries were made of him; yet his brief and incomplete responses and withholding style often made questioning necessary. He also lacked empathy; he rarely expressed concern for or interest in the other members.

Throughout the group, Wally had been much more comfortable focusing on his progress with attaining ejaculatory control than on more interpersonal issues. In the last session, he reflected that he had come to the realization that his problem with premature ejaculation was more complicated than he had previously thought, involving both relational and internal issues. The group, he remarked, had also made him question his goals and expectations for relationships. While the immediate effect of these new concepts was admittedly confusion, Wally’s comments indicated that the group experience did seem to have a significant beneficial effect—influencing him to begin a major reorientation of his rigid view of sexuality and relationships.

The Group

Outcome summary. Based on the posttreatment questionnaires and interviews and clinical observations from sessions, it was evident that the group impacted significantly upon the
lives of its members. While each individual reacted uniquely, there seemed to be certain common effects of the experience for those who completed the group. All of the members spontaneously commented on the reassuring perspective they had gained from talking with other men about very personal issues. An improvement in ejaculatory control was reported by every client; they universally added that they felt comfortable employing the control techniques which they had learned, when necessary. Their questionnaire responses indicated decreased performance anxiety, an expanded sexual repertoire, and predictions of more non-genital sexuality in the future. With the exception of Hugh, the members highlighted the group's essential role in increasing their ability to focus on and enjoy their own sexual pleasure. These same men reported that the group had encouraged them to assert their own interpersonal and sexual needs within their relationships.

The members of the group unanimously proclaimed that the most significant aspect of the experience was the reassuring nature of hearing other men share difficulties and concerns about sexuality and relationships which they previously worried were uniquely their own. The group did become a safe and supportive environment in which the members were able to explore and have challenged their expectations and attitudes concerning masculinity and
sexuality. The secrecy which surrounds sexuality, along with unattainable standards for male behavior depicted by the media and honored by our culture (Farrell, 1974; Zilbergeld, 1978) have contributed to the formation and perpetuation of distorted attitudes and perceptions. Prior to the group, for example, these men viewed themselves as disproportionately poorer lovers than others: Hugh felt inadequate because he could not make love two or three times a night, and Jack thought he was the only premature ejaculator among the 14000 men on campus.

Their posttreatment questionnaire and interview responses offered strong confirmation of the expectation that, after undergoing this type of experience, these men would be more able to view their fears, fantasies, and difficulties around sexuality as more normal. It was not surprising to see a concomitant reduction in performance anxiety. The group sessions along with the assigned exercises helped these men re-examine and expand their predominantly rigid interpersonal and sexual attitudes and interaction patterns. Sexually, this increased flexibility served to deflect the focus of sex away from intercourse and alleviated much pressure which had become associated with this activity. Postgroup responses to the questionnaire and interview substantiated clients' reports that greater comfort and satisfaction with a wider range of sexual activities had developed, thus confirming a second
expectation. Although the follow-up data is presently not available, it was expected that improved ejaculatory control attained through the performance of the assigned excercises would be more likely to be maintained due to attitudinal changes, decreased performance anxiety, and an expanded sexual repertoire.

Advantages of a new group model. It is clear that a group treatment mode inherently provides conditions for therapeutic growth which are not available in individual sex therapy models (Semans, 1956; Masters and Johnson, 1970; Kaplan, 1974). The conditions which characterize most group treatment models for sexual difficulties (Barbach, 1970; Zilbergeld, 1975; Perelman, 1980) include the opportunity to witness honest expression of emotionality in others, to recognize similarities to others, and to give and receive support. Working individually or with the couple, on the other hand, may perpetuate feelings of isolation and the need for secrecy around sexual matters. While perhaps more intimate details may be uncovered sooner in an individual session, the client's support system remains limited. Jack Annon (1976) advises the individual therapist whenever appropriate to assure the client that others share similar feelings and problems. The effect of these statements, however, seems incomparable to the powerful and reassuring impact of hearing disclosures from peers within
a group. Most troubling is the clinical experimentation with self-directed techniques (Lowe and Mikulas, 1975; Zeiss, 1978) which further isolate the individual and focus completely on the physical manifestation of the symptom. Only minimal, if any, phone contact occurs between client and therapist (sometimes a paraprofessional) and no attempt is made to address attitudinal or interpersonal issues relating to the difficulty.

It is not the purpose of this paper to detail the advantages of a group model over an individual one (see Yalom 1970). More specifically, the author would prefer to focus on a comparison between the newly developed group model described in this thesis and previous group models used in the treatment of premature ejaculation.

Past efforts to treat men in a group for premature ejaculation have been primarily leader-centered, quite structured, and behaviorally oriented (Zilbergeld, 1975; Zeiss et al., 1978; Fleming, 1980; and Perelman, 1980). The fundamental difference between the model presented here and previous treatment efforts was the model's open-ended, client-based, interpersonal orientation. Its goals were more broadly scoped. It had been hoped that through interactions with fellow members clients would come to see themselves more as others do. This interpersonally oriented format provided clients with the unique growth-promoting opportunity to discover, express, and accept
themselves in intimate relation to others in the group (Berzon, Pious, and Farson, 1963). Defenses and problematic ways of relating which contributed to both sexual and interpersonal difficulties were observed and interpreted in each client's behavior within the group. Attempts were made to work with the clients' concerns about being accepted by partners, performance anxiety, and unrealistic expectations, by exploring those issues in the "here-and-now" (Yalom, 1970) of the group sessions.

While this model and the previous behavioral models both incorporate sexual exercises (Semans, 1956; Zilbergeld, 1975) and the exploration of attitudes towards sexuality and masculinity as components of treatment, because of the differing orientations and goals, the process within the group sessions varied considerably.

Past models have utilized a quasi-workshop format: Leaders educated members about sex and the human body (Perelman, 1980), led discussions debunking sexual myths which they had presented to the group (Zilbergeld, 1975), and structured discussion around certain thought-provoking films they brought to the group (Fleming, 1980).

Zilbergeld (1975), the originator of that model, described the format of his group as similar to that of a behavior therapy group: The majority of the communications and interactions in the group occurred between group members
and one or both of the leaders.

It was the intention of this model to maximize the use of members for support, information, and feedback to fellow group members about both interpersonal and sexual matters in order to promote group cohesion, an important curative factor in groups (Dickoff and Latkin, 1963; Yalom, 1970). This increased responsibility allowed these men, who admittedly felt like "losers," to help each other and feel useful. Clients were responsible for generating topics which were most salient for them. This differed from previous models which plugged clients into a standardized group format with role playing or social skills training or had them debunk myths which originated from the leaders.

Previous group models have stressed the importance of initial therapist self-disclosures for setting a personal tone in the group and for "getting the ball rolling." After much careful thought, it was decided that the therapists could be most helpful to the group members by maintaining the posture of participant-observers, remaining as "objective" as possible in order to best comment on the ongoing process. The sessions were a forum for the members' thoughts and feelings; the therapists' comments reflected observations about the clients and their interactions both outside and within the group sessions. The
therapists, in keeping with the interpersonal orientation of this model, participated considerably less often than the leaders in the behavioral groups. For these reasons, there was no self-disclosure from the therapists, revealing their own philosophies, issues, or difficulties with sexuality. This, by no means, appeared to inhibit the expression by clients of personal and sensitive material. Murray and Dan helped the group get off to a rapid and productive start by speaking openly about sensitive issues and generating discussions about relevant topics. Hugh, in his posttreatment interview, commented that had the therapists "established too much authority at the beginning, people might not have opened up as much."

The delegation of responsibility and control to the members served to reinforce the principle that this was "their group." Cohesion itself has been found to be of therapeutic value (Dickoff and Latkin, 1963). By the third session, it was apparent that bonds were forming among the members. The existence of group cohesion, defined as attraction to the group and associated efforts to participate actively in the group therapy venture, was demonstrated by the perfect attendance of the five members who completed the group and confirmed by their enthusiasm in posttreatment interviews. Members were able to establish a trusting environment within which they felt free to talk and were listened to, shared emotional experiences, offered
each other both support and confrontation, and were able to reduce feelings of loneliness and isolation. While the therapists at times facilitated these interactions, they were predominantly initiated and conducted by the group members themselves.

Hugh and Jack, the two individuals who seemed most positively affected by the group experience, appeared to be significantly influenced by comments by other members rather than the therapists. This confirms findings (Berzon, Pious, and Farson, 1963; Yalom, 1970) which have maintained that the main mechanisms of therapeutic effectiveness in group therapy reside in the interaction among its members. While Hugh's anti-authority issues often caused his interactions with the leaders to develop into struggles for control, he was able to be reached successfully by his peers in the group during the pivotal sixth session. The increased trust and interest in interactions with others that resulted was clearly observable during the latter sessions. Similarly, Jack received crucial support and encouragement from members, which enabled him to assert himself noticeably more during the sessions and in his relationship with his partner. Also, he acquired the invaluable perspective that his concerns and problems were shared by other men.

Had discussion been limited to topics solely related to sexuality and had the group's activities been directed
by the leaders, it is doubtful that the group's influence on Hugh and Jack would have been as dramatic. The format of the group was established to allow clients to share whatever they felt was most salient for them, and this occurred. Discussions covered a broad spectrum of topics: relationships with parents, past lovers, present girl friends, male friends, and each other; attitudes about work, school, sex, and religion; and emotions such as envy, vulnerability, love, and hate.

In the final session, Wally confessed that he felt more confused about his situation than prior to the group. He realized that his sexual difficulty was not as simple and clear-cut as he had previously perceived; rather it was influenced by other emotional and interpersonal factors. According to Schafer (1973), an important change that can occur during effective short-term therapy is that the client develops "a more comprehensive idea of the scope, multiplicity, and complexity of his problems" (p. 138). While it is likely that this occurred for all clients to some degree, Wally, in particular, seemed to arrive at a somewhat discouraging yet more accurate perception of his own life circumstances after the group experience.

It had been hypothesized that this new group format would increase the future likelihood that members would come to view other men as appropriate resources for their emotional concerns and would feel more comfortable engaging
in intimate discussions with them. Support for this hypothesis was seen even before the completion of the group: Both Murray and Hugh reported initiating discussions about sexuality with male friends for the first time ever.

Afterthoughts and Recommendations

The membership of this group was drawn from a college community: Two were undergraduates, two were part-time students, one was a graduate student, and one was working in the area and involved with a student. At the start of the group, four members were involved in "steady" relationships, one maintained a long-distance relationship, and one had no partner. In anticipation of the instability inherent in college relationships, the group format was designed to be able to accommodate transitions in relationship status and the consequent heterogeneity within the group. Zilbergeld (1975) had recommended working with a homogeneous population, and Perelman (1980a) predicted having both men in relationships and partnerless men in the same group would be "disastrous." As it turned out, four members of the group underwent changes in relationship status during the course of treatment. Fortunately, this model allowed for flexibility, a progression of exercises was available for both men with and without partners, and,
contrary to prior cautions, the group ran quite smoothly. In fact, most members in the postgroup interviews mentioned that hearing people talk about their different situations was a helpful aspect of the group. Hugh, the only married member, was the sole individual to comment that the heterogeneity of the group was distracting.

By dint of being male in our culture, the majority of what was talked about in the group had relevance for all the members. On the whole, the development of group cohesion was not adversely affected by the diversity within the group. The foundation for this sense of cohesiveness was formed during the early weeks of the group when all members were performing the same exercises. It is possible, however, that Mitchell's concern about being partnerless within the group may have exacerbated his general feelings of anxiety and isolation. It may have contributed to Mitchell's acting out, his reported sexual exploits and drinking, and his subsequent withdrawal from the group. Again, it should be noted that in working with a college population where relationships are often transient and commitments tenuous, it seems advisable that a group treatment model contain a format which can accommodate both men with partners and those without.

This model provided a secure bastion within which to focus on "male issues" around sexuality, work, and
relationships and provided an opportunity for these men to experience one another in an interpersonally oriented group psychotherapy setting. There did not exist, however, a forum to speak to or hear from the men's partners. Similarly, there was no support system for these women to discuss their feelings about the project and the sacrifices involved. Almost every member, either during the group or in the posttreatment interview, mentioned that he wished there existed a group similar to this one for partners. While unquestionably this indicated positive regard for their experience, they also may have been signalling a request for help in handling their partners' reactions to the project.

Working with men only, their reports about difficulties in their relationship and with the exercises were necessarily biased. Kaplan (1974) and Perelman (1980) both emphasize the importance of dealing with the couple's resistance to the exercises directly and efficiently in order to obtain maximum results in sex therapy. This was clearly a shortcoming of the approach described in this thesis. While an effort was made to monitor the progress of every member during each session, the exercises were considered secondary to focusing on the process of each member within the group. Both time constraints and the priorities established for the model necessitated that the leaders at times were less than vigilant in their
handling of the "sex therapy-proper" aspects of the treatment.

Time constraints not only impinged upon an in-depth monitoring of the sexual exercises but also, at times, inhibited the group's ability to engage comfortably in extended personal discussions. It was felt that weekly sessions for ten weeks was an appropriate time frame. The format of twice a week for five weeks, as used by Perelman (1980), would seem to put unreasonable demands on the couple to comfortably perform and process two sets of exercises each week and, for the man, to engage in and process properly his group experience. Future groups may wish to avoid interrupting the ten-week sequence with a vacation week, although the disruption did bring into focus some important process issues.

Extending the length of each session from one and a half hours to two hours does seem to be indicated. The necessity of monitoring each member's exercise progress and explaining the exercises for the following week, as well as dealing with various relationship crises, often caused the ninety-minute sessions to feel somewhat hectic. Two-hour sessions would alleviate some of this pressure, allow for more in-depth processing, and facilitate group cohesion. For the same reasons, it is heartily recommended that groups consist of six or seven members. Any larger number would likely dilute the experience for those involved, and
any fewer would not leave an appropriate margin of safety in case of drop-outs.

It was the philosophy of the leaders to let the members of the group be the primary sources of support, feedback, and confrontation to each other. While support and feedback of a neutral type were given easily, members appeared reluctant to challenge one another. When this occurred, it was usually inspired by a comment by one of the therapists. In the posttreatment interviews, several members commented that they had been significantly affected by remarks made by the therapists. They also suggested that the therapists should have made a greater attempt to draw out the "quiet members" of the group. While it was the desire of the therapists to delegate the primary responsibility of the group to its members, perhaps future therapists using this model might emphasize this philosophy more strongly throughout the pregroup meetings and highlight this issue more frequently during sessions. It is also likely that this model can tolerate therapists taking a slightly more active role in modelling an empathic style of confrontation with its members without endangering its principles and philosophical orientation.

Research in the area of human sexuality is a delicate and difficult task. Caution must be taken when comparing the effectiveness of different treatment models (whether
between two different studies or within the same project), because this exercise makes the questionable assumption that these group populations are in fact comparable. The idea of including a no-treatment control group in the research design, although basic to experimental methodology, raises a host of ethical concerns. Further, therapists repeatedly using the "same model" are likely to modify their technique slightly and obtain varied results depending upon the unique composition of individuals in treatment.

While group therapy appears to be a promising mode of treatment for sexual difficulties, many questions still remain. In order to begin to arrive at some tentative conclusions concerning the significance of particular variables, it seems inevitable that certain methodological compromises may have to be made and certain questionable assumptions accepted. Large numbers of groups must be done, their process carefully studied and reported, and consistent observations of specific trends noted. Variations of models should be explored. The amount and type of therapist activity should be studied along with its effect on group dynamics. The issue of heterogeneity versus homogeneity deserves further scrutiny, more specifically a focus on the interaction of this factor with the developmental status of the group population. The utility of occasional meetings between the therapist, each client,
and his partner throughout the course of the group should be investigated. This option might provide support for the partner and enable the therapists to tackle resistance more directly.

An important measure of the more lasting effects of each treatment model could be attained through careful follow-up studies of clients. Yalom's (1970) comment that clients' reports are a rich and relatively untapped source of information regarding their group experience still appears to hold true. Unquestionably clinicians and researchers must increase their efforts to better use this invaluable resource. They must also adhere to the principle of "disciplined subjectivity" (Erikson, 1964), which should guide the formation and utilization of their own clinical impressions. While several recommendations for changes in format have been proposed for further investigation, it is firmly believed that the model presented in this thesis offers exciting potential for the effective and cost-efficient treatment of premature ejaculation, as well as other sexual difficulties.
REFERENCES


Zeiss, R. A., Christensen, A., & Levine, A. G. Treatment for premature ejaculation through male-only groups. *Journal of Sex and Marital Therapy*, (Summer) 1978, 4(2), 139-143.


INFORMED CONSENT

This project will involve participation in ten, one and a half hour group meetings to be held ten Tuesday evenings beginning March 3rd. The group will consist of a small number of men, like yourself, who wish to achieve greater control of their ejaculation. There will be two co-leaders who will instruct the men in sexual exercises to be done in the privacy of one's own home. These exercises have been researched thoroughly and when used properly have been consistently effective. An important feature of the group will be the exploration of issues concerning one's own concept of sexuality and masculinity which may contribute to an individual's sexual difficulty and dissatisfaction with sexual relations.

We are interested in studying the effectiveness of our treatment approach. We would like to obtain some information regarding your current sexual practices and attitudes towards sexuality. For this, we would like you to fill out a questionnaire. An individual interview to gather more specific information will take place. At this time, we will also give you a life history questionnaire to fill out at home. Another questionnaire and interview will follow the ten weeks of group meetings to investigate the effectiveness of this treatment.

We firmly believe that all aspects of this project are important and urge you to participate fully in all of them in order to benefit most from the treatment experience. If, however, at any point you wish to discontinue participation in the project, you may do so without penalty.

This project is being conducted for both treatment and research purposes. It is possible that for professional purposes, material from the interviews, questionnaires, and group meetings may be included in a presentation about this treatment approach. Please understand that your name, the names of the other people, and any other identifying information will be altered or disguised to protect your rights of privacy and confidentiality.

Please feel free to ask any questions or raise any concerns you may have about the project with us at this time or at any time throughout the the course of treatment. Thank you.

Rob Muller
Richard Halgin, Ph.D.

I have read and understood the above document and am willing to participate in this project.

(name) (date)
APPENDIX B

Pretreatment Questionnaire

Name ____________________________  Today’s Date __________________________

Date of Birth __________________________

Below are a list of behaviors which may occur during sexual relations. We would like you to answer the following three questions about each of the listed behaviors based on your own sexual experience.

A) How comfortable are you with it?

B) How often does it occur for you?
1. Almost never (0-5%)  2. Occasionally (5-35%)  3. Fairly often (35-65%)  4. Usually (65-95%)  5. Almost always (95-100%)

C) On the average, how often do you estimate it occurs for other men?
1. Almost never (0-5%)  2. Occasionally (5-35%)  3. Fairly often (35-65%)  4. Usually (65-95%)  5. Almost always (95-100%)

After each listed behavior, please answer the above three questions by circling the number which best describes your experience.

1) Initiating sexual relations yourself
   A. How comfortable are you with it?  1  2  3  4  5
   B. How often does it occur for you?  1  2  3  4  5
   C. On the average, how often do you estimate it occurs for other men?  1  2  3  4  5

2) Having your partner direct sexual activities
   A. How comfortable are you with it?  1  2  3  4  5
   B. How often...for you?  1  2  3  4  5
   C. How often...for other men?  1  2  3  4  5

3) Telling your partner that what she is doing feels pleasurable.
   A. How comfortable are you with it?  1  2  3  4  5
   B. How often...for you?  1  2  3  4  5
   C. How often...for other men?  1  2  3  4  5

4) Asking your partner to stop doing something because it is no longer exciting to you.
   A. How comfortable are you with it?  1  2  3  4  5
   B. How often...for you?  1  2  3  4  5
   C. How often...for other men?  1  2  3  4  5

Comments, if any:

157
A) How comfortable are you with it?
   4. Comfortable       5. Very comfortable

B) How often does it occur for you?
   1. Almost never (0-5%)  2. Occasionally (5-35%)  3. Fairly often (35-65%)
   4. Usually (65-95%)  5. Almost always (95-100%)

C) On the average, how often do you estimate it occurs for other men?
   1. Almost never (0-5%)  2. Occasionally (5-35%)  3. Fairly often (35-65%)
   4. Usually (65-95%)  5. Almost always (95-100%)

<table>
<thead>
<tr>
<th>Question</th>
<th>Comfortable</th>
<th>Uncomfortable</th>
<th>Neutral</th>
<th>Comfortable</th>
<th>Very comfortable</th>
</tr>
</thead>
<tbody>
<tr>
<td>A) How comfortable are you with it?</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>B) How often does it occur for you?</td>
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<tr>
<td>C) On the average, how often do you estimate it occurs for other men?</td>
<td></td>
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</table>

5) Experiencing difficulty achieving and/or maintaining an erection.
   A. How comfortable are you with it?
   1 2 3 4 5
   B. How often...for you?
   1 2 3 4 5
   C. How often...for other men?
   1 2 3 4 5
   Comments, if any:

6) Ejaculating involuntarily before you are able to get your clothes off.
   A. How comfortable are you with it?
   1 2 3 4 5
   B. How often...for you?
   1 2 3 4 5
   C. How often...for other men?
   1 2 3 4 5
   Comments, if any:

7) Ejaculating involuntarily during foreplay when unclothed.
   A. How comfortable are you with it?
   1 2 3 4 5
   B. How often...for you?
   1 2 3 4 5
   C. How often...for other men?
   1 2 3 4 5
   Comments, if any:

8) Ejaculating involuntarily shortly after inserting your penis into the vagina.
   A. How comfortable are you with it?
   1 2 3 4 5
   B. How often...for you?
   1 2 3 4 5
   C. How often...for other men?
   1 2 3 4 5
   Comments, if any:

9) Thinking non-sexual thoughts in order to delay ejaculation.
   A. How comfortable are you with it?
   1 2 3 4 5
   B. How often...for you?
   1 2 3 4 5
   C. How often...for other men?
   1 2 3 4 5
   Comments, if any:
### A) How comfortable are you with it?
1. Very uncomfortable
2. Uncomfortable
3. Neutral
4. Comfortable
5. Very comfortable

### B) How often does it occur for you?
1. Almost never (0-5%)
2. Occasionally (5-35%)
3. Fairly often (35-65%)
4. Usually (65-95%)
5. Almost always (95-100%)

### C) On the average, how often do you estimate it occurs for other men?
1. Almost never (0-5%)
2. Occasionally (5-35%)
3. Fairly often (35-65%)
4. Usually (65-95%)
5. Almost always (95-100%)

10) Physically causing yourself pain (i.e., biting your lip) in order to delay ejaculation.
   - How comfortable are you with it? 1 2 3 4 5
   - How often...for you? 1 2 3 4 5
   - How often...for other men? 1 2 3 4 5
   - Comments, if any:

11) Masturbating before intercourse in order to delay ejaculation.
   - How comfortable are you with it? 1 2 3 4 5
   - How often...for you? 1 2 3 4 5
   - How often...for other men? 1 2 3 4 5
   - Comments, if any:

12) Talking to your partner about a sexual difficulty.
   - How comfortable are you with it? 1 2 3 4 5
   - How often...for you? 1 2 3 4 5
   - How often...for other men? 1 2 3 4 5
   - Comments, if any:

13) Talking openly to a male friend about a sexual difficulty.
   - How comfortable are you with it? 1 2 3 4 5
   - How often...for you? 1 2 3 4 5
   - How often...for other men? 1 2 3 4 5
   - Comments, if any:

14) Talking with a group of men about a sexual difficulty.
   - How comfortable are you with it? 1 2 3 4 5
   - How often...for you? 1 2 3 4 5
   - How often...for other men? 1 2 3 4 5
   - Comments, if any:
A) How comfortable are you with it?
4. Comfortable  5. Very comfortable

B) How often does it occur for you?
1. Almost never (0-5%)  2. Occasionally (5-35%)  3. Fairly often (35-65%)
4. Usually (65-95%)  5. Almost always (95-100%)

C) On the average, how often do you estimate it occurs for other men?
1. Almost never (0-5%)  2. Occasionally (5-35%)  3. Fairly often (35-65%)
4. Usually (65-95%)  5. Almost always (95-100%)

15) Refusing sex after your partner makes sexual advances.
   A. How comfortable are you with it?  1 2 3 4 5
   B. How often...for you?  1 2 3 4 5
   C. How often...for other men?  1 2 3 4 5
   Comments, if any:

16) Having your partner refuse sex after your sexual advances.
   A. How comfortable are you with it?  1 2 3 4 5
   B. How often...for you?  1 2 3 4 5
   C. How often...for other men?  1 2 3 4 5
   Comments, if any:

17) Having sexual contact without it leading to orgasm by either you or your partner.
   A. How comfortable are you with it?  1 2 3 4 5
   B. How often...for you?  1 2 3 4 5
   C. How often...for other men?  1 2 3 4 5
   Comments, if any:

18) Making a sexual request of your partner.
   A. How comfortable are you with it?  1 2 3 4 5
   B. How often...for you?  1 2 3 4 5
   C. How often...for other men?  1 2 3 4 5
   Comments, if any:

19) Your partner making a sexual request of you.
   A. How comfortable are you with it?  1 2 3 4 5
   B. How often...for you?  1 2 3 4 5
   C. How often...for other men?  1 2 3 4 5
   Comments, if any:
A) How comfortable are you with it?
1. Very Uncomfortable
2. Uncomfortable
3. Neutral
4. Comfortable
5. Very comfortable

B) How often does it occur for you?
1. Almost never (0-5%)
2. Occasionally (5-35%)
3. Fairly often (35-65%)
4. Usually (65-95%)
5. Almost always (95-100%)

C) On the average, how often do you estimate it occurs for other men?
1. Almost never (0-5%)
2. Occasionally (5-35%)
3. Fairly often (35-65%)
4. Usually (65-95%)
5. Almost always (95-100%)

20) Oral stimulation of your partner's genitals
A. How comfortable are you with it? 1 2 3 4 5
B. How often...for you? 1 2 3 4 5
C. How often...for other men? 1 2 3 4 5
Comments, if any:

21) Having your genitals stimulated orally.
A. How comfortable are you with it? 1 2 3 4 5
B. How often...for you? 1 2 3 4 5
C. How often...for other men? 1 2 3 4 5
Comments, if any:

22) You kissing the sensitive (non-genital) areas of your partner's body while she is passive.
A. How comfortable are you with it? 1 2 3 4 5
B. How often...for you? 1 2 3 4 5
C. How often...for other men? 1 2 3 4 5
Comments, if any:

23) Your partner kissing the sensitive (non-genital) areas of your body while you are passive.
A. How comfortable are you with it? 1 2 3 4 5
B. How often...for you? 1 2 3 4 5
C. How often...for other men? 1 2 3 4 5
Comments, if any:

24) Intercourse in the male-superior position.
A. How comfortable are you with it? 1 2 3 4 5
B. How often...for you? 1 2 3 4 5
C. How often...for other men? 1 2 3 4 5
Comments, if any:
A) How comfortable are you with it?
1. Very uncomfortable  
2. Uncomfortable  
3. Neutral 
4. Comfortable  
5. Very comfortable 

B) How often does it occur for you?
1. Almost never (0-5%) 
2. Occasionally (5-35%) 
3. Fairly often (35-65%) 
4. Usually (65-95%)  
5. Almost always (95-100%) 

C) On the average, how often do you estimate it occurs for other men?
1. Almost never (0-5%) 
2. Occasionally (5-35%) 
3. Fairly often (35-65%) 
4. Usually (65-95%)  
5. Almost always (95-100%) 

<table>
<thead>
<tr>
<th>25</th>
<th>Intercourse in the female-superior position.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>How comfortable are you with it?</td>
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<tr>
<td></td>
<td>1</td>
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<tr>
<td>B.</td>
<td>How often...for you?</td>
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<td>1</td>
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<tr>
<td>C.</td>
<td>How often...for other men?</td>
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<tr>
<td></td>
<td>1</td>
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<tr>
<td>Comments, if any:</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>26</th>
<th>Intercourse in the side to side position.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>How comfortable are you with it?</td>
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<td></td>
<td>1</td>
</tr>
<tr>
<td>B.</td>
<td>How often...for you?</td>
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<td></td>
<td>1</td>
</tr>
<tr>
<td>C.</td>
<td>How often...for other men?</td>
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<tr>
<td></td>
<td>1</td>
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<tr>
<td>Comments, if any:</td>
<td></td>
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<table>
<thead>
<tr>
<th>27</th>
<th>Changing position during intercourse.</th>
</tr>
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<tbody>
<tr>
<td>A.</td>
<td>How comfortable are you with it?</td>
</tr>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>B.</td>
<td>How often...for you?</td>
</tr>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>C.</td>
<td>How often...for other men?</td>
</tr>
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<td></td>
<td>1</td>
</tr>
<tr>
<td>Comments, if any:</td>
<td></td>
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<table>
<thead>
<tr>
<th>28</th>
<th>Your partner reaches orgasm through intercourse.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>How comfortable are you with it?</td>
</tr>
<tr>
<td></td>
<td>1</td>
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<tr>
<td>B.</td>
<td>How often...for you?</td>
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<td></td>
<td>1</td>
</tr>
<tr>
<td>C.</td>
<td>How often...for other men?</td>
</tr>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Comments, if any:</td>
<td></td>
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<table>
<thead>
<tr>
<th>29</th>
<th>Your partner reaches orgasm through stimulation other than intercourse.</th>
</tr>
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<tbody>
<tr>
<td>A.</td>
<td>How comfortable are you with it?</td>
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<td>1</td>
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<tr>
<td>B.</td>
<td>How often...for you?</td>
</tr>
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<td></td>
<td>1</td>
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<tr>
<td>C.</td>
<td>How often...for other men?</td>
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<td></td>
<td>1</td>
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<tr>
<td>Comments, if any:</td>
<td></td>
</tr>
</tbody>
</table>
A) How comfortable are you with it?  
1. Very uncomfortable  
2. Uncomfortable  
3. Neutral  
4. Comfortable  
5. Very comfortable  

B) How often does it occur for you?  
1. Almost never (0-5%)  
2. Occasionally (5-35%)  
3. Fairly often (35-65%)  
4. Usually (65-95%)  
5. Almost always (95-100%)  

C) On the average, how often do you estimate it occurs for other men?  
1. Almost never (0-5%)  
2. Occasionally (5-35%)  
3. Fairly often (35-65%)  
4. Usually (65-95%)  
5. Almost always (95-100%)  

30) Although your partner does not have an orgasm, she feels  
satisfied after sexual relations.  
A. How comfortable are you with it?  
   1  2  3  4  5  
B. How often...for you?  
   1  2  3  4  5  
C. How often...for other men?  
   1  2  3  4  5  
   Comments, if any:  

31) Sexual contact ends even though you are aware that your  
partner does not feel satisfied.  
A. How comfortable are you with it?  
   1  2  3  4  5  
B. How often...for you?  
   1  2  3  4  5  
C. How often...for other men?  
   1  2  3  4  5  
   Comments, if any:  

32) Sexual contact ends after both you and your partner  
feel satisfied.  
A. How comfortable are you with it?  
   1  2  3  4  5  
B. How often...for you?  
   1  2  3  4  5  
C. How often...for other men?  
   1  2  3  4  5  
   Comments, if any:  

33) Reaching simultaneous orgasm with your partner.  
A. How comfortable are you with it?  
   1  2  3  4  5  
B. How often...for you?  
   1  2  3  4  5  
C. How often...for other men?  
   1  2  3  4  5  
   Comments, if any:  

Below are some statements concerning how you view your sexuality. Please indicate to what degree you feel each of the following statements is true of you by circling the number that best describes your view.

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I am satisfied with my sexual partner.</td>
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<tr>
<td>2</td>
<td>I am satisfied with the variety in my sex life.</td>
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<td></td>
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<tr>
<td>3</td>
<td>I am bothered by the size of my penis.</td>
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<tr>
<td>4</td>
<td>I feel relaxed and fulfilled after sex.</td>
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<tr>
<td>5</td>
<td>I do not enjoy foreplay before intercourse.</td>
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<tr>
<td>6</td>
<td>Sex does not last long enough for me.</td>
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<tr>
<td>7</td>
<td>I am satisfied with the physical condition of my body.</td>
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<tr>
<td>8</td>
<td>I worry about my sexual performance.</td>
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<tr>
<td>9</td>
<td>My partner and I have good communication.</td>
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<tr>
<td>10</td>
<td>I am bothered by my inability to control ejaculation.</td>
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APPENDIX C

Pretreatment Interview

I. General information
A. Present occupation? (If student: year? major?)
B. Who were you raised by? (Are parents still alive?)
C. Position in family?

II. Early development
A. As a child, what was the attitude toward sex in your home?
   1. How were questions about sex handled?
B. Sex education
   1. How was it done? by whom?
   2. When did you first learn about conception and reproduction?
   3. How old were you when you had your first wet dream?
      a) Had you been told in advance about it?
C. Religion: What role, if any, did religion play in your developing attitudes towards sexuality?
D. 1. What role did affection play in your home?
   2. What was your parents attitude towards sex?
      a) with each other?
      b) toward your developing sexuality?

III. Beginnings of sexuality
A. At what age did you first masturbate to orgasm?
   1. How often did you engage in this?
   2. How did you feel about doing it?
   3. Were you ever discovered?
B. When did you first become interested in members of the opposite sex?
   1. At what age did you begin to date?
   2. Did you date different people or did you have a steady relationship?
   3. How did you feel about your masculine identity at the time?
   4. What was the attitude of your friends to girls and sex at this time?

IV. Early sexual experiences
A. What types of sexual activities did you engage in?
   1. Under what conditions?
   2. How did you respond sexually?
   3. How did you feel about these activities? (about yourself?)
4. Was emotional involvement necessary before you engaged in sexual activities?
B. When was your first experience with intercourse?
   1. How did you respond sexually?
   2. How did your partner respond?
   3. How did you feel afterwards?
   4. What kind of contraception was used? Whose responsibility was it?

V. Later sexual experiences
A. Did things change for you sexually when you went to college?
   1. Did you ever participate in any "one night stands"?
      a) How did you feel about them?
      b) How did you respond sexually?
   2. What was the attitude of your friends to women and sexuality?
B. Have you ever had any experience with prostitutes?
   1. What are your thoughts about it?
C. Have you ever had V.D.?
D. Did you ever have intercourse that resulted in pregnancy?
   (If so)
   1. What was the result?
   2. How did you feel about it?
   3. How did your partner feel about it?

E. How do you feel about homosexuality?
   1. Have you ever engaged in a sexual activity with someone of the same sex?
      a) How did you feel about it?
      b) How do you feel about it now?
   2. If not, have you ever thought about engaging in a sexual activity with someone of the same sex?

VI. Current relationship
A. Describe your relationship with your partner.
   1. How do you feel about it?
   2. Are you satisfied with the amount and type of physical affection?
B. Does your partner experience sexual difficulties of any kind?
   1. For how long?
   2. What is her attitude towards sex?
C. Do you see your sexual difficulties affecting other aspects of your relationship?
D. What other areas of your relationship are currently troubling you?
VII. Work
A. How does your work affect your relationship and sexual relations?
B. How does your partner's work affect your relationship and sexual relations?
C. (if children) How do you feel your children affect your relationship and sexual relations?

VIII. Nature of sexual difficulty
A. Why did you come in for sex therapy at this time?
B. How would you describe the sexual problem you've been experiencing?
   1. How long has this been a problem?
   2. Type of contraception presently used?
   3. What are your ideas on how or why this problem developed?
C. How have you handled this difficulty in the past? (books, different techniques?)
D. Have you ever talked to anyone about this before?
E. How have your partners reacted in the past? Helpful, cooperative?
F. How has your present partner responded?

IX. Premature ejaculation
A. After stimulation begins, how long does it take you to have an orgasm? (inside or outside of the vagina)
B. How often do you have sex with your partner? intercourse?
C. Have you noticed any pattern? Does premature ejaculation occur under certain circumstances and not others?
   1. What have you found influences your ejaculatory control?
      a) alcohol?
      b) drugs?
      c) condoms?
D. Do you enjoy foreplay? What usually takes place?
E. What do you do after ejaculation?
F. How often do you masturbate?
   1. How do you feel about it?
   2. How often do you think other men masturbate?
   3. Do you have control of ejaculation during masturbation?
G. What have you tried to delay ejaculation?
H. Ever see medical doctor for this? Any previous therapy experiences?
I. Are you on any medication?
X. Conclusion of interview
   A. Is there anything else that you would like to tell me about your background that you feel bears on your sexual life?
   B. How would you like things to be different after therapy?
APPENDIX D

Life History Questionnaire

Please fill in the following information as completely as possible. If you need additional space for any answer, continue on the back of the page. PLEASE WRITE AS NEATLY AS POSSIBLE. Thank you.

I. General Information

Name:
Address:
Telephone:
Present Occupation:
(if student, put year and major)
Income from employment:
With whom are you now living? (List each person's name and their relationship to you)

Do you live in a house, apartment, room, etc. (specify)?
Do you share a room with another person (first name)?

II. Personal Data

Date of birth: Place of birth:
Current religious affiliation:
How seriously do you practice it?
Was this the faith in which you grew up? If not, what was your former religious affiliation and for what reason did you change?

Describe any intense religious experiences you may have had and your age at the time:
Was bed-wetting a problem? Age stopped?
Any problems or delays relating to developmental milestones (i.e. talking, walking)?

Childhood illnesses and your age at the time?

Adult illnesses and your age at the time?
Name:

Any recurrent or chronic physical problems and your age?

Any accidents (nature, results, your age)?

Any surgery (nature and your age)?

III. Educational Background

<table>
<thead>
<tr>
<th>Schools attended</th>
<th>Age range</th>
<th>Approximate Grade</th>
<th>Degree obtained</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Nature of employment</th>
<th>Your Age</th>
<th>Length of time</th>
</tr>
</thead>
</table>

Here you ever in the Armed Services?

Reason for joining?

Dates:
Name:

V. Family of origin

Were you raised by your natural parents, adoptive parents, other (specify)?

Mother. Name:
Age: Place of birth:
Occupation(s):
Education:
Living? _______ If no, your age at her death:
Current residence:
Describe your mother:

What was your relationship with your mother like growing up (specify any changes and your age at the time)?

Give any other pertinent information about your mother not covered above:

Father. Name:
Age: Place of birth:
Occupation(s):
Education:
Living? _______ If no, your age at his death:
Current residence:
Describe your father:

What was your relationship with your father like growing up (specify any changes and your age at the time)?

Give any other pertinent information about your father not covered above:

Parent's marital history

<table>
<thead>
<tr>
<th>Currently living together?</th>
<th>If no, your age when any of the following occurred: Separated</th>
<th>Divorced</th>
<th>Mother remarried</th>
<th>Father remarried</th>
</tr>
</thead>
</table>

Parent with whom you lived:

How would you describe your parents' marriage?

If you had stepparent(s), briefly describe your relationship with them:

Your brothers and sisters. (List all of the children of your parents in order from oldest to youngest, including yourself, and the age of each.)
With which of your siblings do you get along best?
With which do you have the poorest relationship?
Give any information about your siblings that you consider important:

Were there any major changes in the financial status or lifestyle of your family as you were growing up (specify and indicate your age at the time)?

VI. Current relationship (if any)
Name of partner:
Age: Place of birth:
How long have you been involved in this relationship?
Are you living together? If yes, for how long?
Partner's occupation:
Partner's education:
How do your parents feel about the relationship?
How do her parents feel about the relationship?
How would you describe your partner?

What is the nature of your commitment to your partner?
(If married) Date of marriage:
How long did you know your spouse prior to marriage?
How long were you engaged?
How did you meet?

How would you describe your relationship prior to marriage?
Name:

Names and ages of children, if any:

Is there any information about your children which you consider of major importance?

If separated or divorced, please describe the reasons for and your feelings about your divorce or separation.

VII. Social History

What was the nature of your relationships with other children outside the family before the age of 12?

Did you have a best friend? First name? Sex:
Duration of friendship? Your age range at the time?
Describe any special relationships you may have had with adults other than your parents as you were growing up:

What was the nature of your relationships with other young people outside the family after the age of 12?

Did you have a best friend? First name: Sex:
Duration of friendship: Your age range at the time:
Who was your favorite hero when you were a child?

What did you want to be when you grew up (indicate any changes and your approximate age at the time)?

Do you recall what your parents wanted you to be?
Name:

Describe any extracurricular activities in which you participated as you were growing up:

At this point, what type of career do you foresee yourself pursuing?

What is the nature of your current relationships with others your own age?

Do you prefer casual or intimate relationships with others your own age?

What do you like in a friend?

What are your favorite leisure time activities?

List below, and on the back of this sheet if necessary, your major life experiences and your age when they occurred. Include anything that you feel had a profound or important effect on you.
VIII. History of significant sexual partners
(Start with the first one and proceed to present)

<table>
<thead>
<tr>
<th>First Name</th>
<th>Your age</th>
<th>Length of relationship &amp; approx. frequencies</th>
<th>Emotional feelings toward partner</th>
<th>Your typical sexual response</th>
<th>Partner’s typical sexual response</th>
</tr>
</thead>
</table>

Comment on characteristics of less significant sexual experiences:

Thank you very much for your cooperation.
APPENDIX E

Posttreatment Questionnaire

Below are a list of behaviors which may occur during sexual relations. We would like you to answer the following three questions about each of the listed behaviors based on your own sexual experience.

A) How comfortable are you with it?
   4. Comfortable  5. Very comfortable

B) Based on your recent experience, realistically how often would you estimate that this will occur for you in the near future?
   1. Almost never (0-5%)  2. Occasionally (5-35%)  3. Fairly often (35-65%)
   4. Usually (65-95%)  5. Almost always (95-100%)

C) On the average, how often do you estimate it occurs for other men?
   1. Almost never (0-5%)  2. Occasionally (5-35%)  3. Fairly often (35-65%)
   4. Usually (65-95%)  5. Almost always (95-100%)

After each listed behavior, please answer the above three questions by circling the number which best describes your experience.

1) Initiating sexual relations yourself
   A. How comfortable are you with it?  1  2  3  4  5
   B. How often will it occur for you in the future?  1  2  3  4  5
   C. On the average, how often do you estimate it occurs for other men?
      Comments, if any:

2) Having your partner direct sexual activities
   A. How comfortable are you with it?  1  2  3  4  5
   B. How often...for you in the future?  1  2  3  4  5
   C. How often...for other men?
      Comments, if any:

3) Telling your partner that what she is doing feels pleasurable.
   A. How comfortable are you with it?  1  2  3  4  5
   B. How often...for you in the future?  1  2  3  4  5
   C. How often...for other men?
      Comments, if any:

4) Asking your partner to stop doing something because it is no longer exciting to you.
   A. How comfortable are you with it?  1  2  3  4  5
   B. How often...for you in the future?  1  2  3  4  5
   C. How often...for other men?
      Comments, if any:

The posttreatment questionnaire is identical to the pretreatment questionnaire (Appendix B) with the exception of a change of wording in question B for each of thirty-three behaviors listed.
APPENDIX F

Posttreatment Interview

I. Personal experience
   A. For you personally, what was the value of the group?
   B. What changes, if any, do you see resulting from the group?
      1. Do you expect these changes to be lasting? (Why?)
   C. How, if at all, do you feel your attitudes have been affected?
      1. Towards sexuality?
      2. Towards your partner or other women?
      3. Towards masculinity?
   D. How do you feel about your present ability to control your ejaculation?
      1. On the average now, after penetration, how long is it before ejaculation occurs?
      2. Is this an improvement?

II. Perception of the group experience
   A. Pick one incident or interaction which occurred within the group sessions which had a particularly significant impact on you.
      1. How were you affected?
   B. What was participation in the group like for you?
   C. What was your motivation for continued attendance?
   D. How did you see yourself fitting in with the group?
      1. What role, if any, do you think you played?
      2. What, if anything, do you feel you learned from others in the group?
   E. What about the group was not helpful?
      1. How did you feel about the therapists' participation?
      2. Do you have any suggestions for improvements or changes?
   F. Evaluate the exercises. How did or didn't they work for you?

III. Perception of others' experience
   A. Who in the group do you feel was affected positively by the experience? How?
   B. Who in the group do you feel was not helped by the group? Why not?
IV. Follow-up
   A. What unfulfilled expectations did you have?
   B. What do you still need?
   C. Would you be willing to participate in a follow-up aspect of this project six months from now?
APPENDIX G

Weekly Exercise Assignments

Exercises for Week #1
Total time required 25-35 min.
Two times a week

This week's tasks involve three exercises designed to help you become more aware of your body.

Conditions:
1) Try to find a time and place where you can be assured of privacy.
2) If possible, do these tasks when you are through with all your responsibilities for the day.
3) Take a shower, then get into bed without any clothes on. Make the conditions in your room as comfortable as possible.
4) Important: Read through each exercise twice carefully and completely before proceeding. This will help to avoid consistent interruption of the flow of the exercise in order to consult the directions.

Exercise A - Becoming aware of your breathing (Time required 2-3 min.)
- Lie on your back with your knees drawn up until your feet rest flat on the mattress. Get as comfortable as you can.
- Close your eyes and let the weight of your body sink into the bed.
- Now become aware of your breathing. Is it shallow, quick, deep?
- If it is shallow or quick, try to take slow and deep breaths.
- Breathe deeply for several minutes. Notice all the details of how your chest and belly move as the air flows through your nose and mouth, and down into and out of your lungs.

Exercise B - Learning to relax the muscles of your body (Time required 7-10 min.)
1) Start with your left hand. Clench it tightly into a fist and study the tension in your hand and your arm. Hold that tension for approximately 10 seconds.
   - Now let go, relax, let the muscles become loose. Let your fingers spread out comfortably.
   - Let the bed support the weight of your arm and hand.
   - Notice the difference between the tension and the relaxation. Enjoy the contrast.
2) Do the same with your right hand... (Hold tension for 10 sec.)
   - Now let go, relax...
3) Clench both hands into fists and bring them towards your shoulders, tightening your bicep muscles. (10 sec.)
   - Now let go, relax, let your arms drop down again by your sides...
4) Next, your shoulders. Bring them up towards your ears. Hold them there. (10 sec.)
   - Now let go, relax...
5) Now, move to your toes. Curl them into the balls of your feet as tightly as you can.
-Now let go, relax...

6) Next, press your legs together as tightly as you can.
-Now let go, relax...

7) Now tighten up your stomach muscles.
-Now let go, relax...

8) Now do your face: clench your jaws together, wrinkle your face, and close your eyes tightly.
-Now let go, relax...

9) Now try to get in touch with your pelvic muscles. This can be done in two ways. One way is by contracting your buttocks as if you are in danger of having a bowel movement but need to keep it in until you can get to a bathroom. Another way is to stop and start the flow several times next time you urinate.
-Simply squeeze and release these muscles 15 times in rapid succession.
(These exercises known as kegel exercises may contribute to better ejaculatory control. They have also been used to help prevent future prostate difficulties. Kegel exercises (up to 60 a day) can be done anywhere while driving a car or sitting in a class.)

10) Finally, tense up your entire body. Hold it.
-Now let go, relax. Let the weight of your body sink into the bed.

Exercise C - Body self-exploration (Time required 15-25 min.)

This last task involves exploring the sensitive areas of your body, other than your penis. You may feel somewhat uncomfortable with this task. Let your mind and body relax, try to enjoy yourself and your body.

1) Sit up in bed. Prop your back up against the wall using some pillows.
-Starting with your feet, touch and stroke all the parts of your legs: Run your fingers and hands along your ankles, calves, knees, and thighs.
-Vary the types of strokes and pressures.
-Try very light touches, circular movements, both long and short strokes.
-Go slowly and experience the sensations.
-Be aware of how and where you most like to be touched.

2) Now lie on your side.
-Stroke the backs and insides of your thighs.
-Run your hand along the curves of your buttocks, your hip, and your lower back.
3) Now lie on your back. Slowly and gently explore the rest of your body (with the exception of your penis).
- Caress your belly, sides, chest, arms, armpits, neck, and face.
- Touch and fondle your scrotum. Which parts of it are most sensitive?

Although this exercise is not intended to produce arousal or erection, it sometimes does. Whatever happens in this regard is fine. Should you become aroused, just enjoy it. Do not masturbate while doing this exercise, however.
Exercises for Week #2
(Time required 20-35 min. - 3 times a week)

This week's exercises involve focusing attention on your penis in order to help you recognize the point of ejaculatory inevitability ("the point of no return") - this is the point at which you must stop stimulation in order to prevent ejaculation. Conscious perception of the sensations leading to a reflex (i.e., urination) are prerequisite for learning voluntary control.

Day 1

Exercise A (5 min.)
Discover the sensitive areas of your penis using the same methods used in last week's exercises. (Do not worry about arousal at this time; just enjoy the sensations.)
- Stroke your penis slowly and gently, vary the type of stroke and the pressure.
- Stroke the different parts: the shaft, the head, the underside, etc.
  * If you find yourself close to orgasm before the time is up, stop stimulating yourself, wait a minute or so until the urge to ejaculate subsides, then resume the exercise.

Exercise B (15 min.)
Masturbation for 15 minutes without ejaculation.
- Do not use fantasy. Close your eyes and focus all your attention on your erotic sensations as you become highly aroused.
- When you feel you are about to ejaculate - STOP stimulating yourself.
- The urge to ejaculate will subside in anywhere from several seconds to two minutes. You may experience a partial or complete loss of erection, this is common and nothing to worry about.
- When the desire to ejaculate has subsided (wait at least 15 seconds), resume masturbation.
- You will probably have to stop a number of times when you first do this exercise. After you have done this for 15 minutes, masturbate to ejaculation. Focus your attention of your bodily sensation prior to ejaculation and during ejaculation.

Day 2

- Do Exercise A
- Do Exercise B
  * If you feel confident of your control and need only 2 or 3 stops during the fifteen minutes of Exercise B, then go on to exercise C.

Exercise C (15 min.)
Follow the same procedure described in Exercise B except that you now use a lubricant. You may try a few and discover the one you like best (baby oil, Intensive Care lotion, KY jelly, etc.).

Day 3

- Do Exercise A
- Do Exercise B
- Do Exercise C

Possible Problems
1. If you ejaculate before the 15 min. is up in Exercise B or C:
   a) You may be letting yourself get distracted from your bodily sensations - focus your attention on your penis.
b) You may be practicing "brinksmanship", stopping only a split second before reaching the point of ejaculatory inevitability. Nothing useful is gained by this practice. Waiting until the last second can increase anxiety, resulting in unnecessary ejaculations. Stop anytime you are feeling good and excited.

2. You may find that you need to stop again as soon as you resume masturbating. This means that you are not allowing sufficient time for the ejaculatory urge to diminish. Take longer stops.
Exercises for Week 3 (3/17-3/24)
(Time required 15 min. - 3 times a week)

The exercise for this week involves masturbating continuously for 15 minutes, controlling your arousal level by making subtle adjustments in your pleasuring techniques.

Day 1
Exercise A - (15 min.)
Focusing on your penis, masturbate for 15 minutes without ejaculating and without stopping.
-When you reach high levels of excitement, make changes in your masturbatory techniques to decrease your arousal level.
Changes made may include:
- Slowing down the pace
- Changing the amount of pressure you are applying
- Varying the site of maximum stimulation (i.e., stimulating only the shaft and not the head)
- Changing the type of stroke (i.e., using shorter strokes or circular motions)
- You might try relaxing or tensing your pubic muscles (try one change at a time. Find out what works best for you, then stay with it.)

- These subtle adjustments need to be made a bit sooner than would be necessary if you were stopping. (If you make them too late, you should stop in order to prevent ejaculation.)
- When the urge to ejaculate has subsided, you should assume the more arousing type of stimulation.

Days 2 and 3 (15 min.)
If Exercise A has gone smoothly, repeat the exercise this time using a lubricant. You may find this exercise considerably more difficult; if so, go slowly, relax, make your adjustments sooner.
Exercise for Vacation Week (3/24-3/31)

Day 1 (40 min.)

Exercise A

This is the first exercise to be done with your partner. It involves gently caressing and stroking each other's body. In this particular exercise, touch all parts of her body except her genitals and nipples. Similarly, your partner should stroke all parts of your body with the exception of your genitals. You will take turns pleasuring each other's body. Negotiate with your partner who will go first. (The following directions are given for the case in which it is decided that the woman will pleasure the man first. If you decide to do the exercise in the opposite order, simply reverse the names in the directions.)

- The man should lie on his stomach. The woman should then begin to caress him as gently and tenderly as she can.
- Start with the back of his head, his ears, his neck.
- Go slowly down his back and sides.
- Down his buttocks and the insides of his thighs.
- Gently stroke his legs and feet.

*The receiver must concentrate on his feelings. Don't worry if your partner is getting bored or tired. Stay with your feelings when you are the receiver. Give your partner feedback: tell her if something feels unpleasant, if she is doing it too fast or too lightly. Similarly, if something feels good, tell her. Feel free to show her how you'd like to be touched.
- When you have had enough of the back, turn over.
- Your partner should stroke your front in a similar manner.
- Start with the head and face, then neck.
- Slowly and sensitively caress his chest, belly, sides, and arms. Do not touch his penis at this time.
- Next touch his thighs, legs, and feet.
- Do it until you and he have had enough.

- Then switch. Now it is her turn to be pleasured. Now you pleasure your partner in the same way. Skip the nipples, clitoris, and vaginal entrance. Just concentrate on caressing the rest of the body.

Day 2 and 3 (40 min.)

Exercise B

This exercise involves gentle, teasing stimulation of the genitals, the objective of which is to produce arousal, but not orgasm. Again, this exercise will involve taking turns. Negotiate who will go first. Communicate with your partner, tell or show each other what types of stimulation feel most pleasurable.

Instructions for the woman:
- Find a comfortable position for yourself, your partner should be lying on his back.
- Do as much of the general body caressing as you need to arouse your partner. Then play with his penis. Play gently with the tip, shaft, and testicles for a while.
- Then go to another sensitive part of his body, and then back to his genitals again.
- Use your fingers or lips as you and he please. *(This is not a masturbation exercise. If, however, the man should feel the urge to ejaculate, he must tell you so that you can shift your stimulation to a less sensitive area of his body.)*
Instructions for the man:

- First, play with her whole body. Caress her until she begins to become aroused. Then fondle her breasts, kiss and gently pinch her nipples.
- Then play with the pubic hair around her clitoris. Do not touch her clitoris right away.
- Stimulate the area around the vaginal entrance.
- Then touch her clitoris lightly. Then move to other sensitive areas of her body, then back to her clitoris.
- Be as gentle and sensitive as you can. Use your fingers or lips as you and she please. Your partner should be giving you feedback as to what types of stimulation are most pleasurable to her.
Exercise for Week #4
(Time required 1 hour - two times a week)
(With Participating Partner)

This exercise involves your partner manually stimulating your penis using the stop-start method to control ejaculation.

**Important:** 1) Your partner should understand that these exercises need to be executed exactly as described and that you are in control when the exercises are being done. You must let her know a) what type of stimulation to use b) when to stop and c) when to resume.

2) You should be very clear about your willingness to satisfy her manually or orally either before or after doing the exercise.

**Day 1**

**Exercise A**
- Get as comfortable as possible before beginning the exercise.
- Start the "session" with expressions of physical affection - holding, hugging, kissing, etc.
- Both of you should be naked as you begin the exercise.
- Your partner is to stimulate your penis with her hand in ways that are most arousing to you.
- Keep focused on your penis, when you approach the point of ejaculatory inevitability - tell your partner to stop stimulating you.
- Allow sufficient time for the urge to ejaculate to diminish before asking her to resume stimulation.

**Day 2**

If you were able to last for 15 min. with no more than two or three stops during exercise A and feel confident of your control, do the same exercise except that your partner uses lotion, oil or some form of lubrication on her hand.

*If you do not feel confident of your control, repeat Exercise A. Relax, go slowly, try taking longer and sooner stops, focus your attention on your penis and not your partner during this exercise.

Exercise for Week #4
(Time required 20 min. - three times a week)
(If partner is unavailable or non-participating)

**Exercise A**
Using the stop-start method, masturbate for 20 min. while fantasizing having sex with a partner. Start the fantasy with the first touch or kiss and go through all the steps that might occur in this imagined sexual interaction. Remember you are to fantasize an entire sexual encounter - not just intercourse. You may not get through an entire sexual encounter in one session. This is fine. Next time you do the exercise, start the fantasy where you left off the last time.

- As part of the fantasy, see yourself needing to stop sexual contact with your partner and doing so.
- When you stop in the fantasy, stop masturbating.
- When the urge to ejaculate has subsided, resume the fantasy and the masturbation.
- Be sure to include some scenes of needing to stop during intercourse.
- You should stop masturbating:
  a) in order to prevent ejaculation (fantasize yourself letting your partner know that you would like to stop temporarily in order to prolong the sexual excitement).
  b) when, in the fantasy, there is a time that there would not be any stimulation occurring (i.e., as you walk across the room to lock the door).
Be sure to stop masturbating at the same time you stop sexual contact in your fantasy.

You may have difficulty maintaining control during certain fantasized situations (i.e., penetration or rapid thrusting). If so, try exercise B...

**Exercise B**

Instead of masturbating to a fantasy of a whole sexual encounter, fantasize only the scene that gives you trouble.
- Relax, masturbate slowly, get into the fantasy as fully as possible, while at the same time remaining aware of your level of excitement.
- Stop before you need to, both in your fantasy and in your masturbation.
- Go over that scene again and again. As you feel more comfortable try to stop when, rather than before, you need to.
- When you feel in control of the difficult scene, return to Exercise A and incorporate this scene into the larger fantasy.
Exercise for Week #5
(Time required - 20 min. three times a week)
(if partner is unavailable or non-participating)

Exercise A
This exercise is identical to last week's masturbation with fantasy exercise except that instead of stopping stimulation when you reach the point of ejaculatory inevitability, this time make subtle adjustments in your pleasuring techniques in order to control the urge to ejaculate.

As with the previous week's exercise, should certain scenes cause you considerable difficulty in controlling ejaculation, isolate that scene and fantasize it over and over while masturbating. Then incorporate that scene back into the larger fantasy.

-If you are able to achieve good control the first time you do this exercise, you may wish to use lubrication on your hand on the second day and/or third day.

Exercise for Week #5
(Time required - 1 hour two times a week)
(With Participating Partner)

Exercise A
This exercise involves maintaining your penis inside the vagina without any movement for 15 minutes.

- Lie on your back. Your partner should sit on your legs.
- Let your partner stimulate you to erection.
- Then let her rub your penis gently around the outside of her vagina. Be aware of your arousal level and make any necessary adjustments.
- Get accustomed to having your penis around her vagina. *(It is essential for minimizing anxiety that birth control precautions be taken prior to insertion of the penis into the vagina.)*
- When you feel confident of your control of your ejaculation, then - and only then - should she slowly insert your penis into her vagina.
- Relax and focus on the sensations of your penis being quietly held inside her vagina. There should be no movement by either you or your partner. 
- Without any stimulation, the firmness of your erection may diminish. If this occurs, ask your partner to contract her pelvic muscles or to move slightly - just to keep your erection firm.
- Should you feel you are losing control, you may either ask your partner to get off or try to incorporate the breathing and relaxation techniques which have proven effective for you.
Week #6
(When partner is unavailable or non-participating)
(Time required - 20 min. - 3 times a week)

Exercise A
This week's exercise involves increasing the erotic stimulation present
during masturbation through the introduction of your choice of erotic materials:
a book, a magazine, a vibrator or whatever else you've found has helped to increase
your arousal level. Use lubrication if you wish. Use subtle adjustments in
masturbation techniques to help regulate your urge to ejaculate.
-If you experience difficulty during this exercise, when you repeat it
  concentrate on the picture, scene, or type of stimulation which gave you the
  most difficulty.

Week #6
(With participating partner)
(Time required - 1 hour - 2 times a week)

Exercise A
This week's exercise is similar to last week's exercise, except that it
involves your partner thrusting slowly upon your instructions.
-You should be on your back. Have your partner rub your penis around her
  vagina.
-When you feel comfortable and confident of your control, your partner
  should insert your penis into her vagina.
-Remain "quiet" for the first few minutes. Then when you feel confident
  of your control, ask your partner to begin moving very slowly.
-You should instruct your partner how much and how fast she should thrust.
-If you feel the urge to ejaculate, ask your partner to stop moving.
  Then ask her to resume when you are ready. Attempt to do this for 15
  minutes without ejaculating.

Day 2
Try the same exercise only this time, when you feel confident, begin moving
or thrusting slowly yourself. Communicate to your partner when you wish to slow
down or stop. Try to do this for 15 minutes without ejaculating.
Week #7

(When partner is unavailable or non-participating)

(Time required - 3 times a week for 20 min.)

Create an exercise designed for your specific needs. Work on maintaining ejaculatory control in situations which have given you the most difficulty in previous exercises.

Week #7

(With participating partner)

(Time required - 2 times a week for 1 hour)

Exercise A

- Start this exercise in the same manner as you have for the previous two weeks: You on your back with your partner inserting your penis when you feel confident of your control.

- From this position, you will move into intercourse in the side-by-side position: While still inside your lover, roll to one side until she is lying on her side on the bed. You should roll up on one side so that you are facing her. (Your penis may or may not remain inside of her - if it comes out - guide it back in).

- Once you are on your sides, you probably will want to shift your arms and legs around in order to get as comfortable as possible.

- When you are comfortable, ask your partner to begin thrusting slowly. Try to relax - if you are very uncomfortable or tense it is difficult to focus on your arousal level and difficult to control your ejaculation.

- If you are confident of your control, you should begin thrusting also. Take your time. Tell your partner when you need her to stop. Integrate the "quiet vagina" concept in order to help you control your ejaculation.
Week #8

(If partner is unavailable or non-participating)

(Time Required - 20 min. three times a week)

Continue to work on those exercises which may have given you difficulty in the past. Use whatever method of stimulation you have found most arousing.

Week #8

(When partner is participating)

(Time Required - 1 hour twice a week)

Exercise A

This week's exercise involves attempting intercourse in the male-on-top position. This position is recognized as the most difficult position in which to maintain control. You should not attempt this position if you are feeling "on the brink" of orgasm.

- Start the exercise by rubbing your penis around your partner's vagina in this position. When you feel confident of your control, with your partner's help, guide your penis into her vagina.
- Get accustomed to being inside her in this position for a few minutes (the "quiet vagina"). Then proceed with thrusting slowly.
- If you feel the urge to ejaculate, stop, slow down or withdraw depending on how excited you are.
- If you are stopping quite often, take longer stops, relax, talk with your partner, then continue.
- Attempt to control your ejaculation while having intercourse in this way for 15 min., then proceed as you wish (keeping in mind the techniques you have practiced).
### Week #9
(When partner is unavailable or non-participating)
(Time required - two times during week)

**Day 1**
Focusing in on your body, especially your penis, masturbate to orgasm as quickly as possible. Try to ejaculate even faster than you did before starting the group. Do everything you can think of which you feel may bring you to a quick ejaculation (i.e., certain types of breathing, muscle tension or stimulation).

Have fun during this exercise.

**Day 2**
Now try to delay your ejaculation for 15 min. while masturbating under highly arousing conditions. Use subtle changes in masturbatory technique to avoid ejaculation before it is desired.

### Week #9
(When partner is participating)
(Time required - two times during week)

**Day 1**
The purpose of this exercise is to attempt to ejaculate as quickly as possible during intercourse, even faster then you did before starting the group. Concentrate on your bodily sensations and do what it takes to bring yourself to orgasm as quickly as you can during intercourse. Enjoy the experience.

If you are able to do this, you may feel a tendency to apologize - this is not necessary. Feel good that you have acquired increased control of your ejaculatory process. Express your appreciation to your partner and see if she would like you to do something fun for her.

**Day 2**
Now try to delay your ejaculation during intercourse.
- Enjoy some caressing and foreplay with your partner.
- When you begin to have intercourse, do so using a position which has given you control difficulties previously.
- When you feel yourself approaching the point of ejaculatory inevitability, switch to a different position for intercourse in which you feel more confident of your control.
- If switching positions is not sufficient to diminish the urge to ejaculate or you switched too late, you may need to use the stop-start method of control also.