THE TRAINING OF SEX THERAPISTS IN SOUTH AFRICA
A MULTIDISCIPLINARY APPROACH

by

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A B S T R A C T

The high incidence of divorce and marital breakdown in South Africa warrants attention and organised prevention.

There is no correlation between this high divorce rate and existing facilities or utilisation of these facilities.

For the past fifteen years the writer has been involved in training of Marriage Guidance Counsellors and treatment of marital couples in distress. During this time limited facilities, the inability of some couples to utilise existing facilities and the resultant family disruption has become evident.

In an effort to assess the most important needs of couples in distress and the ability of consultants in the helping professions to assist these couples this research was initiated.

Previous findings that sexual dissatisfaction is one of the main reasons of marital breakdown has been confirmed as well as the fact that it is often a mere symptom of various difficulties and poor marital communication.

It was also found that different needs regarding sex education and sex therapy exist in our multicultural society and that thorough recognition of these specific needs is required to offer meaningful assistance.

Following this multicultural evaluative investigation which included a multi-disciplinary enquiry, data was summarised and a tentative training programme suggested.

Final conclusions are not provided. Qualitative data to assist the practitioner has been summarised and a continuous feedback loop of evaluation and improved programme planning initiated in accordance with the requirements of illuminative action research.

To my mother - who sent me into this world
without "incapacitating hang-ups".

To my husband - who is perfecting the art.

To my children - a blessing from above.

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CHAPTER 1

INTRODUCTION

1. STATEMENT OF THE PROBLEM

In South Africa one in every three marriages ends in divorce[1] - the number of these divorced couples where marital breakdown was mainly caused by sexual difficulties is not known. However, local research[2] confirmed in many parts of the Western world[3] indicate that sexual difficulties may well be the most important single factor finally resulting in divorce.[4]

According to the most recent research completed in South Africa, only very small numbers of medical practitioners and other professionals are able and/or willing to offer sex therapy.[5]

The writer has been actively involved in the selection and training of Marriage Guidance Counsellors and the counselling of marital couples over a period of 15 years.

During this time experiential and experimental findings supported the evidence that sexual dissatisfaction in marriage can be compared to the problem of alcoholism in society[6] and should be accepted as one of the most important causes of marital distress often resulting in divorce.

In view of the complexity of the marital relationship and ethical, cultural and religious differences regarding heterosexual behaviour in our varied South African population, only a minimal number of suitably trained professionals see themselves sufficiently equipped to deal with this problem.[7]

We have no institutes of Human Sexuality or Sex Clinics in South Africa[8] and facilities for sex therapy in rural areas are non-existent and negligible in urbanised centres.[9]

At the Child and Adult Research Institute of the University of Durban-Westville t writer has counselled and treated White, Indian, Coloured and a small number of Black clients since 1980, whose marital relationships and parenting abilities have been severely affected by unresolved sexual difficulties or long term sexual dissatisfaction.[10]

When the medical consultant attached to this Institute conducted a pilot study regarding the training of sex therapists, the tremendous needs for facilities and training were confirmed by various professional groups, consultants and clients. Their responses prompted the initiation of this research.

2. MAIN OBJECTIVES

The main objectives of this research were to assess whether a need for well trained sex therapists does exist, whether there are any existing facilities for clients to obtain sex therapy and, if required, to suggest a tentative training programme.

Fox[11] stated that the effectiveness of a learning programme should be measured in terms of the fulfilment of the programme objectives.

Lawton[12] defined programme evaluation as the measurement of success in programme planning. Knowles[13] referred to basic and educational needs that should be considered. He suggested that both must be taken into consideration by the educator as well as specific interests of individuals and groups.

In the process of evaluation, specific sources of information were therefore isolated and evaluative questions formulated to gain the required knowledge regarding final achievement of these objectives.

3. SPECIFIC RESEARCH QUESTIONS

In accordance with the research model presented in Chapter 5 the following questions were asked to gain required information about prospective and existing sex therapy clients and consultants involved in offering sex therapy.

3.1 The Sex Therapy Clients

3.1.1 Who are they?

3.1.2 What are their most important needs?

3.1.3 What information is available regarding the clients' needs?

3.1.4 Is it possible to categorise these needs?

3.2 The Consultants and Sex Therapists

As far as the "therapists'" needs and their ability to satisfy the clients' needs were concerned the following questions were asked.

3.2.1 Who are they?

3.2.2 Are they able to satisfy the clients' needs?

3.2.3 Are they able to assess these needs objectively?

3.2.4 Is their training adequate?

3.2.5 Do they utilise existing facilities?

3.2.6 Is it possible to examine the outcome of training in the cognitive, affective and psycho-motor domains?

4. THE PROCESS OF EVALUATION APPLIED IN THIS RESEARCH

The marital relationship and marital difficulties cannot be adequately examined by utilising a linear cause ——→ result approach. Evaluative illuminative action research was therefore selected as the only suitable paradigm where the value of the research will be determined by the extent of improvement it may bring about in the practices of those engaged in the research.

For this reason a selected existing population has been investigated and it is not known whether this group would represent a random sample from any known total population. Lateral extensions of generalisations may therefore not apply but vertical extensions do apply as will be confirmed in Chapter 6. In this qualitative research no effort was made to translate data into statistical verifiable terms as this could merely have resulted in limiting the depth and quality of these findings.

Investigations regarding heterosexual and marital relationships where intervening variables and intangible responses are so well presented and complicated therapeutic responses form too great a part of the whole training process, reduction for the sake of statistical significance could not be considered.

The research model presented in Chapter 5 was developed by the writer to indicate broad but clear outlines. As indicated, sources were isolated to determine the training objectives to be achieved and allowances were made for dynamic changes which occurred as a result of these findings. An evaluation of the client's needs and the therapist's ability to satisfy these needs was completed and the training programme was investigated within wider organisational structures.

Evaluative observation took place and sources were isolated initially in phase one. During a pilot study efforts were made to assess clients' and counsellors' needs and a content analysis of case histories was completed

In the second phase, needs were translated into training objectives. Systematic selective enquiry of this second phase included group discussions with consultants and multiprofessional teams as well as an analysis of specific data regarding training requirements.

In the third phase the training programme was investigated and Bloom's Taxonomy of Educational Objectives as simplified by Burns[14] was utilised for the purpose of systematic evaluation. Data collecting methods will be discussed in detail in Chapter 6.

Finally, a training programme was suggested merely initiating a process to review the changing needs of the clients and up-date the training for sex therapists continuously.

5. OUTLINE OF THIS RESEARCH

A theoretical overview is presented in Chapter 2 where it is indicated that the ancient Greeks and the Vedic Cultures 15 000 years before Christ drew up very specific instructions for satisfactory sexual functioning.

The development of Sex Clinics in Germany, their partial destruction and the value of material that was retained are indicated and an overview of the Marriage Guidance Movement is provided. Finally a summary is given regarding modern approaches in Sex Therapy with reference to its implications for the training of sex therapists.

In view of our varied population and the necessity for the therapist to have a practical knowledge about clients from different cultures, sex, ethics and culture are discussed briefly in Chapter 3 with specific reference to the Christian and Hindu cultures,as these groups were mainly represented in our client sample. Biblical views and marital customs were included and personal discussions with theologians are quoted in this Chapter.

Sexual dysfunction and the marital relationship with some specific references to male and female sexuality were discussed in Chapter 4.

The Freudian myth that sexual satisfaction depends on maturity as rejected by Kinsey[15] Masters and Johnson[16] and Fisher[17] was viewed with more sympathy recently by Singer,[18] Kaplan,[19] Vincent[20] and Renshaw[21] who concluded that the physio-psychological aspects effecting sexuality cannot be viewed adequately from any "isolated" frame of reference.

Throughout this work adequate and improved sexual functioning within the marriage has been the main emphasis. The writer has taken note of an ethical approach advocated equally by general practitioners and Ministers of Religion[22] that sex therapy should mainly be offered to marital couples whose marital relationship is good or where prognosis for sex and marital therapy is good.

Sexuality of single people and others outside marriage were only considered peripherally in this research and the need for further investigations regarding many other aspects of sexuality has certainly become most obvious during the course of this work.

Chapter 4 ends with a summary indicating the effects of sexual dysfunction within the marital relationship and the implications this may have in the training of sex and marital therapists.

The methodological approach in this research is explained in Chapter 5 as well as the aims and methods of illuminative evaluation. The needs of clients and therapists as confirmed during a pilot study are summarised and the research model is presented and clarified. Finally the data collectin procedures are discussed and limitations of this research indicated.

In Chapter 6 the findings are tabled and discussed, knowledge obtained about the needs of clients and therapists are summarised and some details provided about the couples included in this investigation.

A final conclusion is offered in view of both experimental and experiential findings obtained during the course of this evaluative research.

In Chapter 7 a tentative training programme is suggested and strategies in programme planning indicated. Bloom's simplified taxonomy as adapted by Burns[23] is utilised and applied to the research findings and educational needs of adults are illuminated. A task analysis completed prior to the actual programme is presented and a specific programme suggested to initiate a continuous feedback loop of evaluation and improvement as indicated in the research model.

EXPLANATORY NOTES AND REFERENCES TO CHAPTER 1

1. Personal interview: Information obtained from the Director of the Mental Health Society, Durban.

2. Olivier, L. Die Voorkoms, Aard en seksuele disfunksie onder die Blankes, Kleurlinge, Indiers en Swartmense in R.S.A. Paper Read at the National Psychology Conference Bloemfontein, 1982.

3. Mace, D. Success in Marriage , New York, 1958.

4. Masters, W. and Johnson, V.C. Human Sexual Inadequacy , Boston, 1970.

5. Olivier, L. See Note 2.

6. Robertiello, R.C. The Decline and Fall of Sex , Journal of Sex Research 1976, 12, 70-73.

7. Uken, J.M. The Orgasmic Woman, Johannesburg, 1983.

8. See Note 7.

9. Personal Interviews: Confirmed by groups of black District Nurses and Social Workers during this research.

10. The Child and Adult Research Centre at University of Durban-Westville has a consultancy service for parents and also accepts couples for marital therapy.

11. Fox, D.J. The Research Process in Education , London, 1969

12. Lawton, D. Educational Theory and Curriculum Planning, New Yo 1973.

13. Knowles, M.S. The Modern Practices of Adult Education, New York 1972.

14. Burns, R.W. New Approaches to Behavioural Objectives, Iowa, 1977.

15. Kinsey et al — Sexual Behaviour in the Human Female , Philadelphia, 1953.

16. Masters and Johnson — See Note 4.

17. Fisher, S. — The Female Orgasm , London, 1973.

18. Singer, I. — The Goals of Human Sexuality , London, 197

20. Vincent, C. — Sexual and Marital Health , London, 1973.

21. Renshaw, D. — Human Sexuality , Symposium in Johannesburg, 1976.

22. Structured Research Interviews. See Chapter 6.

23. See Note 14.

CHAPTER 2

THEORETICAL OVERVIEW

1. INTRODUCTION

According to old texts of the Vedic and Post Vedic periods,[1] the development of the science of human sexuality together with the Sciences of Law, Medicine, Etymology and Astronomy, received full acknowledgement in the shaping of ancient civilization and cultures.[2]

In the precise and elaborate descriptions of the life of a person specific prescriptions regarding food, amusements, recreations and clothes were given. These included charms and aphrodisiacs as well as prayers to be offered specifically for virility.

To the Western scholar, who has only recently been able to gain access to these, it is inconceivable that so much has been obscured for centuries. The detailed knowledge relating to human sexuality, sexual dysfunctions and the application of various heterosexual techniques are far more precise than those of the ancient Greeks.[3]

In the West however, as recent as five hundred years ago, broad areas of nature and especially of human nature were still closed to any scientific investigation. For example, the interior of the human body could not be explored, not even after death. Knowledge of the human anatomy was gained by reading Aristotle or Galen, and by dissecting the "lower" animals, or by defying the taboo and making private arrangements with a hangman or graveyard custodian.[4] Even in those days, however, exceptions were made for particular projects. Artists engaged in portraying St. Bartholomew, who had been flayed alive, were permitted to examine the interior of a

body in order to achieve verisimilitude. St Bartholomew, carrying his skin over his shoulder, became a popular subject for painters and sculptors.[5]

The existance of double standards of morality to this day seem to be as old as man. Two tendencies developing out of a dualistic Weltanschauung perceived spirit and matter either as totally incompatible or inseparably identified.[6] Confronted by extremes of rabid asceticism or autonomian eroticism it is understandable that Stoicism became the final answer for many people eventually.[7]

Fortunately considerable progress toward scientific freedom has been made since then. The burden of proof has become scientifically orientated. Most people today would no doubt agree that any scientific inquiry is permissible for its own sake, in the absence of compelling ethical objections to it.[8]

However, as will be discussed in Chapter 6 the reluctance of professionals to apply knowledge about human sexuality and the often deliberate avoidance to offer assistance still exist.[9]

In view of this it is not surprising that official consultation services in the West were only started in the 20th Century in Germany. Even then, progress was slow because of problems encountered from many individuals and power groups within some societies.[10]

To this day sexual inhibitions and taboos within and across cultures affect lay public and professionals, clients and consultants.

It may well have contributed to the slow awakening following the Middle

Ages and Victorian Era to the establishment of Sex clinics in 20th Century Europe.

2. MAGNUS HIRSCHFELD AND HIS CONTRIBUTION TO HUMAN SEXOLOGY

In 1919, Magnus Hirschfeld[11] founded the first Institute of Sexual Science in Berlin. This was followed by the establishment of a number of "Leagues of Sexual Hygiene" in Germany, Austria, Denmark, Sweden and some other countries. These consultation services under the auspices of the League for Sexual Hygiene continued to develop rapidly until the early thirties. The main emphasis was on sexual education and counselling with a mere awareness of other needs. By the late thirties there were more than a thousand marriage guidance centres in Germany and Austria. However, all of them were closed in the wake of the Nazi regime.

Of these, it was Hirschfeld's institute in Berlin which showed the best progress, and which might even today serve as a prototype for a University Department of Sexology. Reflecting the interdisciplinary approach of its founder, the Institute was devoted to four major areas of research: Sexual Biology, Sexual Pathology (medicine), Sexual Sociology, and Sexual Ethnology. Its library housed over 20 000 volumes, 35 000 photographs, large numbers of objects and works of art. In addition, 40 000 confessions and biographical letters were on file. The staff consisted of Hirschfeld himself, an archivist, a librarian, four secretaries, and various assistants.[12] Among the Institute's many activities, three are especially noteworthy: A large premarital counselling

practice, the first of its kind in Germany; regular public lectures and discussions on sexological topics and a medico-legal service for expert testimony, especially in criminal cases.[13] In all of these areas Hirschfeld also trained young scholars and scientists, such as the gynaecologist Ludwig Levy-Lenz and Josef Hynie, later professor of Sexology in Prague.[14] However, the Institute had visitors from many countries. In short, it was an important cultural asset not only for the city of Berlin, but also for the whole country and, indeed, the world.

However, on May 6, 1933, a little more than three months after Hitler had come to power, the Institute was ransacked by a Nazi mob and its books and papers publicly burned. The next day, a Nazi newspaper proclaimed:

> Energetic Action Against a Poison Shop - German Students Fumigate the "Sexual Science Institute"
>
> Detachment X of the German student organisation yesterday occupied the 'Sexual Science Institute' which was controlled by the Jew Magnus Hirschfeld. This institute which tried to shelter behind a scientific cloak..., was an unparalleled breeding-ground of dirt and filth... A whole lorry-load of pornographic pictures and writing as well as documents and registers have been confiscated... The criminal police will have to deal with a part of the material found.[15]

This surprisingly early attack on sexology has led to speculation of its motives. The anti-semitic impulse was clearly presented, but Levy-Lenz, who had been on the staff at the time, ascribed the official vandalism to the fact that many prominent Nazis had been patients, and that the Institute "knew too much" about the party leadership.[16] It is therefore also possible that the real goal of the operation was the retrieval of some specific files or papers,

as the involvement of the criminal police may indicate. The German sexologist Hans Giese reported after the war that some of the material was turned over to the Berlin Police Museum, where it was later destroyed in bombing raids. Hirschfeld himself is said to have brought back from the Nazis part of his own collection while residing in France. This material was then allegedly plundered after his death in Nice.[17] Nothing more specific is known, but accordir to Haeberle the Institute for Sex Research in Bloomington, Indiana now has in its possession a large box of unpublished papers, some of which clearly came from Hirschfeld's Institute.[18]

In addition to his work at this Institute, Hirschfeld could also be described as the father of International Scientific Congresses.[19]

The first Conference on Sexology was held in Germany in 1921 attended by Scientists from Tokio, Peking, Moscow, Copenhagen, London, Rome and San Francisco. This Six Day Conference was followed by four International Conferences and in 1932 The World League for Sexual Reform was founded in Copenhagen during the Fourth International Conference. Havelock Ellis, Hirschfeld and Forel were the first presidents.

However, after the Germans seized control, other countries became cautious and finally the League was resolved when Hirschfeld died.

In spite of current beliefs, Freud was an unimportant figure in Sexology at that stage and psychoanalysis merely a part of the extensive field of Sexology.[20] The leading figures were Hirschfeld, Block, Moll and Max Marcuse; often described as the father of Sexology.

Unfortunately much of the wealth of their contributions have been lost to posterity, although the New York Herald Tribune did refer to Hirschfeld as the "Einstein of Sex" (May 16, 1935) in his obituary.

However, if it would only become aware of its past, Sexology might find the confidence to proceed on a broader front. Let us remember that Sexology, as conceived and named by Block, was Sexualwissenschaft, an enterprise that, by definition, combined the natural and human sciences. The German word Wissenschaft has, to this day, escaped the reduction in meaning to only one kind of knowledge that the English word "science" has suffered. Bloch, Moll, and Hirschfeld always meant the whole spectrum of possible human insights.[21] Thus, when Bloch defined Sexology, he called it "the study (Wissenschaft) of the phenomena and effects of sexuality, in the relation to the physical and psychological, on the individual and social level." And he added: "This definition does justice to the peculiar double quality of the sex drive, its biological and cultural side."[22] Indeed, Bloch, in spite of his medical training, upheld the primacy of the anthropological-ethnological over the medical-clinical approach. In his view, the sexologist was called upon to find the "sexual elementary ideas of mankind."[23] Furthermore, he was the first to insist on the connection between human sexuality and human work.[24]

This looking back to the roots of Sexology also involved a new understanding of the whole scientific, cultural, social, and political context in which they were embedded. After all, the Vienna of Friedrich S. Krauss, Sigmund Freud, Bugen Steinach, and Wilhelm Reich was also the Vienna of Mahler, Schönberg, Weininger, Wittgenstein, Schnitzler, Karl Kraus and the young, unemployed Adolf Hitler.

Berlin, in Hirschfeld's lifetime, changed from a quiet, almost rural Prussian town into the large German capital and hectic metropolis. According to Haeberle, Hirschfeld as well as Block, Mall and Max Marcuse through the most extraordinary scientific advances, technological innovati

cultural breakthroughs, social upheavals and political changes. Berlin was the city of Bismarck and Bebol, Rosa Luxemburg and Walter Rathenau, Fontane and Döblin, Max Reinhardt, Brecht, Weill, and Piscator, the great film companies and the small cabarets; it was Kaiser Wilhelm's imperial residence and the heart of "Weimar culture". All of this had its impact on our pioneers. It constituted the climate in which Sexology was conceived and could grow.[25]

3. THE MARRIAGE GUIDANCE MOVEMENT AND MARRIAGE GUIDANCE IN SOUTH AFRICA.

Today we are also living in an era of rapid and continuous change. The diversity of demands made on every individual increases almost daily.

The "transience" of human relations result in superficial contact with many people and only a small number of intimate friends.

The extended family in rural society with each member contributing to the economic family unit is disappearing fast.[26]

With less experience regarding living together of different age groups as in the extended family, inter-personal demands family members are making on one another are, nevertheless, intensified.

The materialistic urbanised society is highly competitive but also individualistic. Satisfaction of primary needs is taken for granted and the needs for power, prestige, security and possessions are ever increasing. This has brought with it a new morality based on situational considerations.

All these factors are causing intensification of interpersonal needs. It affects the marital relationship and reinforces confusion and conflict regarding male and female roles in marriage. Yet, as a result of this, the needs for companionship and full satisfaction of both

primary and secondary needs in marriage have become greater than ever before.

A further complication regarding husband/wife roles and parenthood has been caused by the awareness of the danger of over-population. Procreation in the Western World has always, until now, come first, satisfaction next. Today this order is almost reversed. This has caused the so-called 'sexual revolution'. Attitudes have greatly changed in recent years. Concern about population has gone into reverse. According to Mace[27] over-population of the earth has become the greatest single menace to our human future. Sex in marriage has therefore come to be accepted as a means of meeting a great variety of needs within the marriage partners. It offers very meaningful emotional reassurances, is accepted to provide mutual enjoyment and recognised as a very important form of recreation.

The apparent emphasis regarding needs for sexual satisfaction found elsewhere and confirmed in this research is merely a symptom confirming the overall change of emphasis in hetero-sexual relationships.

Continuous and rapid overall change adds to the complexity in our society and is causing marital problems and inter-personal complications hitherto unknown to us.

Yet, education for living and preparation for marriage receive limited attention. Furthermore, resources to offer assistance and clarification to those whose marriages are at risk are minimal, usually confined to voluntary workers, and a small group of professionals taking an active part.[28]

3.1 Marriage Guidance in Britain

In Britain, the first Marriage Guidance Council was established in 1938. In response to the growing concern about the increasing divorce rate, a small group of clergy, magistrates, doctors and social workers established an agency to help people in marital difficulties. The work was undertaken by volunteers and was carried out with more courage than expertise.

The early records show that those pioneers initially saw themselves primarily as a referral service, diagnosing problems under such headings as legal, medical, psychiatric or contraceptive, and guiding clients to the appropriate sort of help.[29]

The early counsellors were spurred on by what the first chairman, Dr. Herbert Gray, termed a sense of compulsion, not with a clear idea of how they were to achieve aims, but "as nobody else was trying, they had no choice." [30]

In the same year, a council on Family Relations was set up in the United States. Both movements in Britain and the United States had broadly the same principles and purpose. The post-war years witnessed rapid expansion in the number of Marriage Guidance Councils in Britain and in 1947, recognition was given by the Denning Committee on Matrimonial Procedures, which recommended financial support from public funds. The Home Office made the first grant in 1948 to the National Marriage Guidance Council, the Family Discussion Bureau and the Catholic Marriage Advisory Council, established independently by the Catholic Church. The National Marriage Guidance Council and the Catholic Marriage Advisory Council reserved their status as voluntary organisations, with the Home Office continuing grants in aid providing approximately two-thirds of their income.

The former Family Discussion Bureau continued to provide a marriage counselling service using voluntary counsellors and with national coverage. The small number of full-time staff was occupied mainly with training, supervision and administrative duties.

The methods of counselling have been developed greatly since the pioneer days, borrowing in particular from Psychiatry and Social Case Work practice. Close links were established between the Marriage Counselling Agency and the University of Tavistock, particularly with the Institute of Marital Studies, which contributed substantially to the training of tutors and supervisors.

3.2 David Mace and Marriage Guidance in the United States

In 1947, David Mace, the Secretary of the Marriage Guidance Council in London, who promoted marriage guidance counselling all over the world, went to the United States to accept an appointment as a lecturer in the Medical School at the Drew University, New York. It was estimated that 632 schools and universities in the United States offered courses in marital and family aspects by 1948. According to the Section Report on Marriage and Family Counselling, there were also 300 active Marriage and Family Counselling Centres functioning in forty of the forty-eight states in 1948.[31]

The Oxford Conference of the International Union of Family Organisation held in the early fifties stimulated a world-wide awareness of the need for guidance. In 1953, Professor David Mace was chosen as Chairman of a permanent International Commission on marriage guidance, which was the Marriage Guidance Movement.

3.3 The Marriage Guidance Movement in South Africa

In South Africa the Second World War coincided with accelerated urbanisation, resulting in community and family disruption and an increased divorce rate. Various voluntary agencies, municipalities and church groups were concerned about this. As a direct follow-up of a conference held in Cradock in the Cape Province in 1947, under the auspices of the Afrikaanse Christelike Vroue Vereniging, bureaux were inaugurated to investigate family and marital difficulties in South Africa.

In the same year, the Matrimonial Conciliation Board was opened by the Johannesburg Municipality under the Chairmanship of the Director of Social Affairs. This was followed by similar organisations in Cape Town, Port Elizabeth and Pretoria.

In 1954, David Mace was invited by the Family Welfare Conference Committee in Johannesburg to discuss Marriage Guidance in South Africa.

The Mayor of Johannesburg, Counsellor C.J. Patmore, organised a "Mayor's Family Life Week" in May 1954, to synchronize with Professor and Mrs. Mace's visit to Johannesburg. Over 500 delegates were invited to attend this conference.

As a direct result of this conference the South African National Council for Family Organisations was formed in October 1954. This Council, presently known as FAMSA, was inaugurated as the National Body, centralising all the existing marriage guidance bureaux in South Africa.[32]

4. THE MARITAL RELATIONSHIP AND SOCIETY - IMPLICATIONS FOR TRAINING

The need for continuous readjustment to a rapidly changing society has a marked affect on the marital relationship. Fletcher[33] and Hemming[34] have confirmed marked changes in marital expectations and causes of marital dissatisfaction during the last decade.

This change from institutional needs to companionship needs is confirmed by Walker and Chester[35] in their investigation about areas of marital dissatisfaction in marriage. According to the findings following the evaluation of questionnaires sent to 1 251 British wives, the main complaint was the inability of husbands to show love and physical affection.

This inability to show love and affection at a time when interpersonal needs are reinforced by environmental change was confirmed by Goldin[36] who completed extensive research on marital problems in Rhodesia. He confirmed that sexual dissatisfaction and feelings of rejection were amongst the most frequent problems often resulting in divorce in Rhodesia.

Where procreation has been the main aim in previous decades and sexual need satisfaction said to be of secondary importance,[37] Mace maintains that it now serves additional ends in marriage; it brings about satisfaction of other individual needs of husband and wife and it provides mutual enjoyment that we now recognise to be a very important form of recreation.

The essential emotional reassurance, especially where mutual interests and verbal communication are limited, cannot be replaced by any other "form of recreation" but a satisfactory sexual relationship. This has been confirmed in this research and experienced by both professional

and voluntary workers who have found that the physical relationship is a very true projection of the total marital relationship.[38]

In addition to societal changes and local stress situations Mace[39] maintained that the change of the female role succeeded in emancipating the female intellectually but not emotionally. According to him this in itself causes inhibitions in the sexual relationship affecting marital adjustment.

Sexual inhibition as a result of the emancipation of women was confirmed by Pietropiento and Simenaer[40] According to their findings, emancipation of the wife has caused such insecurity within their husbands that it affected both the husbands' sexual needs and their need for companionship. According to them 34% of the males in the United States wanted their women to be more active sexually, 61,2% thought that sex was a very important pleasure while 40,3% have enjoyed sex more than ever in the past five years.

This acceptance of sexual gratification as an end in itself, in contrast to procreation only, has been accepted more realistically in other cultures. South Pacific Islanders accept the enjoyment openly, while, to the Indian peasants, sex is esteemed as a great event in which sorrow may for a time be forgotten.[41]

It has been indicated that the sexual relationship symptomises the overall level of communication in marriage. Sociologists and family therapists emphasise the need for communication. During a lecture to the marriage guidance counsellors of FAMSA in Johannesburg in July 1974, Margaret Mead confirmed that the lack of communication has become the most important single factor of discontent in marriage.[42]

Masters [43] confirmed that dissatisfaction and unsuccessful communication are symptomised by a lack of sexual satisfaction. He maintained that about half of all married couples developed sexual difficulties in marriage.

The unwillingness to acknowledge this and an inability to handle difficulties related to sexual dissatisfaction result in many unhappy marriages. The sad fact is that we are so ignorant, we are largely blundering in the dark.[44]

This "blundering in the dark" also affected some professionals and trainee-therapists because of their own feelings of inadequacy to handle the problem of sexual adjustment adequately during counselling. In cross-cultural counselling these limitations are often more marked and a thorough knowledge about the client's background becomes essential as well as acceptance of this background.

In the training process, individual counselling of trainees was therefore required to enable them to overcome their own inhibitions regarding sexual relationships and to prevent them from projecting their own attitudes, thus affecting rapport and objective evaluation of their client's most important needs. Knowledge about possible individual pathology affecting the marital relationship and also the client-counsellor relationship is essential. However, careful clarification of many interpersonal variables affecting the psycho-sexual relationship is only possible when the therapist or counsellor is able to empathise without emotional involvement.[45]

Gerdes and Phillips [46] and Mace [47] emphasised the importance of self-knowledge for both client and counsellor and the ability to accept limitations regarding their own knowledge and skills in offering effective assistance.

Referral to other agencies where additional problems such as alcoholism, drug addiction, psychiatric illness and physical handicaps affect the marriage is often essential and should take place as soon as possible.

Ethical considerations regarding confidentiality and co-therapy with staff of other agencies should be considered and the client's full co-operation be obtained prior to any formal referral or initiation of any specific plan of treatment.[48]

Two of the most frequent areas of concern of marriage guidance counsellors have been treatment of sexual difficulties, and preparation for divorce when there is no hope for reconciliation.

Because of the main aim of the Marriage Guidance Society to improve marital relationships the writer has often been approached to intervene and assist Marriage Guidance Counsellors to overcome their own ambivalence and anxiety when they are dealing with clients where reconciliation is impossible and divorce the only solution. In addition medical practitioners and some gynaecologists do not have time, interest or required knowledge to handle interpersonal and functional difficulties effectively.[49] These aspects will be discussed further in Chapter 6.

Today we have one divorce for every three marriages in S.A.[50] In spite of this, some therapists and counsellors still find it difficult to accept responsibility for divorce guidance, in contrast to their conventional frame of reference. It has been emphasised that the willingness and ability to accept a divorce and make a successful readjustment is often the only prerequisite to a happy second marriage. When a client makes it clear that all hope of reconciliation has failed the counselling need not stop but a change of course may well be indicated.[51]

5. REQUIREMENTS OF COUNSELLORS AND THERAPISTS OFFERING ASSISTANCE

The growing awareness of the specialised field of knowledge required for marriage counselling and sex therapy as emphasised by Masters and Johnson[52], Mace[53], Kaplan[54] and others, should result in the expansion of training facilities for both medical and other practitioners in the helping professions.

In this research, where the needs of clients, therapists and counsellors were analysed in an effort to finally suggest improvement in training, the counselling of clients provided in-depth information about needs of both clients' and therapists' ability to utilise skills and knowledge obtained in training.

The importance of establishing a workable rapport between team members as well as clients will be continuously emphasised throughout this research. A complete situation is evaluated when attending to clients. The client, the therapist or counsellor and the organisation are all intimately involved and contribute values and constraints to the counselling process especially in a multiracial country.[55]

Sex therapy differs from traditional techniques in that it combines psychotherapy with modification of sexual behaviour. Although modern sex therapists confirm their focus on improving sexual functioning, the total structure of the problem is also dealt with in sex therapy.[56] However, only to the extent that it is necessary to relieve the sexual target symptom and also to insure that the disability will not recur. Psychodynamic and transactional material is interpreted and neurotic behaviour is modified, but only if these are directly operative in impairing the patient's sexual functioning or if it offers obstacles to the progress of treatment.

Usually sex therapy is completed when the couple's sexual difficulty is relieved. This does not mean that treatment is terminated as soon as the patient manages to have intercourse on one or two occasions. Treatment is ended, however, when the dysfunction is relieved and when the factors which were directly responsible for the problem have been identified and resolved sufficiently to warrant the assumption that the patient's sexual functioning is reasonably permanent and stable.[57]

6. RECENT TRENDS IN THE APPLICATION OF SEX THERAPY

In the United States the last two decades have brought remarkable advances in the knowledge of human sexuality. These data are in the process of being assimilated into the main body of psychiatric thought, which is being greatly enriched thereby. Increased understanding of sexuality has recently resulted in new approaches and innovations regarding the treatment of sexual difficulties. These developments promise relief to many persons with distressing sexual problems who were previously thought to be beyond help.[58]

In the past, sexual dysfunctions were regarded as manifestations of serious psychopathology and were considered with therapeutic pessimism. They were believed to be amenable, if at all, only through the lengthy and costly treatment procedures that are based on the psychoanalytic model. Recent reports of the work of Masters and Johnson and of some behaviour therapists in the USA and in England provide compelling reasons for re-evaluating this traditional position.

Evidence now suggests that sexual problems, while they may well be manifestations of profound emotional disturbance or mental illness, are not invariably so, but also commonly occur in persons who function

well in other areas and have no other psychological symptoms. In many cases, sexual dysfunctions may have their roots in the more immediate and simpler problems which were ignored until recently, such as the anticipation of failure to function, real or imagined demands for performance, and fear of rejection and humiliation by the partner.

Many patients who suffer from sexual problems respond rapidly and favourably to treatment methods which are designed to modify such immediate obstacles to sexual functioning. In fact, it appears that for many patients the new brief forms of intervention are far more effective than the traditional psychiatric approaches.[59]

Apart from this difference in the focus of intervention, sex therapy differs from traditional forms of treatment in two respects: First, the objectives of sex therapy are essentially limited to relief of the patient's sexual dysfunction; second, sex therapy is distinguished by its use of sexual and communicative tasks as an integral part of treatment.[60]

The objectives of the two traditional forms of treatment for sexual disorders, psychotherapy and marital therapy, are comprehensive. Psychoanalytic treatment attempts to reconstruct the patient's personality by fostering resolution of his unconscious conflicts. Similarly marriage therapy tries to improve the quality of the couple's total relationship by helping them resolve previously unrecognized destructive transactions. Within the context of psychotherapy or marital therapy, sexual symptoms are seen as reflections of underlying conflicts and problems and improvement is viewed as a product of the resolution of these more basic issues.

The aim of sex therapy, on the other hand, is much more limited and is concerned primarily with improving sexual functioning, according to Kaplan. However, during sex therapy intrapsychic and transactional conflicts are almost invariably dealt with to some extent. Indeed, improvement of the sexual dysfunction is usually impossible without such intervention. However, the fact remains that all therapeutic maneuvers are mainly directed towards the primary objective of sex therapy: The overall improvement of sexual functioning.[61]

When individuals undergo psychoanalysis, marital therapy or even most forms of behaviour therapy, the therapeutic process is conducted almost entirely in the office. The therapeutic transactions almost exclusively explore interactions which occur between the doctor and the patient or couple. In contrast, sex therapy relies heavily on erotic tasks which the couple conducts at home for its therapeutic impact. "It is the integrated use of systematically structured sexual experiences with conjoint therapeutic sessions which is the main innovation and distinctive feature of sex therapy".[62]

The fact that sex therapy as such is most difficult to obtain in South Africa has recently been confirmed by Olivier[63] and others, confirming limited facilities and poor quality of available services. This will be discussed again in Chapters 5 and 6.

7. TRAINING REQUIREMENTS AND RESEARCH IN SEX THERAPY

In accordance with the model presented in Chapter 5, an analysis of clients' needs, therapists' needs and organisational requirements was attempted, to enable the writer to identify some specific objectives without which training will be a mere trial and error effort.

An overview of organisational facilities throughout the world indicate a variety of areas that receive special attention in planning of learning programmes. In Britain, the syllabus content has altered since the publication of the findings of Masters and Johnson.[64] This project to investigate marital and sexual dissatisfaction brought about an awareness within the counsellors and therapists of their limited knowledge regarding physical adjustment in marriage. Special courses were organised to overcome this difficulty and to offer counsellors and therapists the knowledge and skills required to deal with this.

In Holland special emphasis on community training schemes takes place in contrast to conventional marriage guidance practices elsewhere.[65]

In Australia, selection and training of Marriage Guidance Counsellors is the responsibility of the state and substantial grants are available for this purpose. Counsellors are selected after a two year non-residential training period and they are either rejected, found to be in need of more training or accepted as associate counsellors. In Melbourne, through the writing up of cases followed by a prepared outline of interviewing processes, special efforts are made to develop recording of data and a critical self-analysis of trainee counsellors. During initial interviews they are viewed by tutors through a one-way screen. Supervision interviews are arranged each fortnight for an hour. Methods of training include lecture discussions, role play, case history discussions, audio and video taped interviews and joint counselling sessions. To increase self-awareness, a special four day workshop is organised in Canberra once a year for active counsellors and tutors, according to the Executive Director of the Victoria National Marriage Guidance Council.[66]

Tyndall[67] reported that development of training of Marriage Guidance Counsellors has been slow in Luxemburg, Cyprus and Iceland. Although European countries are in need of state finances, with the exception of Scandinavia, these countries still prefer to function as autonomous bodies.

Professional people with special qualifications or experience are mainly responsible for counselling in Switzerland, Austria and Italy while Sweden and Denmark employ only social workers as marriage guidance counsellors.

In South Africa, F A M S A has been active since 1954 and according to Mace "too many formal lectures, a theoretical approach and Rogerian techniques dominate training".[68] Group techniques are utilised in urban areas, since the early seventies and mainly professional people have been selected for counselling. There are no University chairs in Sexology or Institutes of Human Sexuality as in many European Countries, the United States and Britain.

Improvement of training facilities and developing counselling techniques continue to be matters of international concern. However, little has been done regarding research into the marriage guidance counsellors' specific needs for efficient training. The notable lack of any clearcut aims or criteria of effectiveness in the field of marriage and sex counselling might have contributed to this limitation.[69]

Although complete answers and final training programmes cannot be offered in the human sciences, and any study will fall short of the ideal, it was nevertheless attempted. "Life is the art of drawing sufficient conclusions from insufficient premises".[70]

The crucial factor that should determine whether or not research is carried out in a particular area should not be the ease of devising a study of methodological perfection, but the importance to the researcher and the community of the field of study. "Marriage, like it or not, is still a very important area of social life, and its stability is seen as essential to the maintenance of society by many people."[71] On this basis, this research was attempted in an effort to make a useful and practical contribution and perhaps to initiate change successfully.

According to the literature, careful selection and efficient initial training as well as ongoing in-service training has been accepted as most desirable in this field and confirmed by a review of recent research findings.

In view of these requirements, illuminative evaluation described in Chapter 5 will be utilised fully, taking into account the wider contexts in which innovations in training sex therapists and sex counsellors are functioning. The primary concern of the writer will be with description an interpretation rather than measurement and prediction.[72]

In Chapter 3 some ethical and cultural aspects of human sexuality will be discussed.

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CHAPTER 3

SEX, ETHICS AND CULTURE

1. A HISTORICAL OVERVIEW

At the very core of being human, sexuality can be viewed properly only within the context of the whole person and the whole of human life. Behind any attitude or moral opinion on sex lies a particular anthropology, a particular view of the meaning of life, of human nature and destiny. Sexuality should not be studied in isolation. Unless it is seen as integrated into the whole of human life with all its relationships, sexuality can too easily degenerate into a naive biologism.[1]

Despite differing emphases that may have distinguished Platonic, Aristotelian, and Stoic conceptions, it was a common conviction of classical antiquity that the human species should be viewed primarily as biological beings, that is, from the standpoint of human reason.[2]

Along with this prevailing rationalism, classical anthropology was often characterized by dualism, explicit in Plato, implicit in Aristotle. Rationality constituted the essentially human and identified the human with the divine. Matter was regarded as the principle of individuation and hence of separation. The body was an encumbrance, identified if not with evil then at least with inferiority, a prison that prevented the truly human and good in man, the spirit, from returning to where it belongs. Here biblical anthropology differed sharply from that of classical Greece.[3]

As the word sin is foreign to the tongue of the Hellenic people, their morality was only concerned with what was unjust to others, with offences against the state and with crime.

Fascination with the sexual was not made alluring by being shrouded in a veil of mystery or branded as sinful and forbidden, therefore the erotic is the key to the understanding of the Greek culture generally. To penetrate the natural beauty of Greek morals it is necessary to set oneself free from prejudice often caused by present day attitudes.

The intimate relationship between sex and morality from antiquity was clearly exhibited by Licht.[4] According to him the Greek concept of the sky, Uranus, penetrating the earth with warmth and moisture through which earth brings forth every living thing, is the most basic sexual act of nature.

There is hardly a Greek legend where the erotic did not form the centre or at least the background. The birth of Orion, lustful Pan and Narcissus pining away for love of his own image sadly leaving Echo behind, all include both religion and mythology, "saturated by the erotic".[5]

Always dignified by the desire for beauty, the early Greeks' sexual life developed in overflowing force but apparently also in enviable healthiness. This is confirmed by the almost total absence of any awareness of sexual perversions in the life of the ancient Greeks, and the emphasis in their ethical theories on human sexuality and its eternal beauty.[6]

2. SEX AND MORALITY

The beginnings of mediaeval ethical speculation can be found in Christian Theology. The Bible also takes a unitary view of human nature. Humans are whole living bodies, not solely incarnated spirit, or Cartesian ghosts in a machine.[7]

In biblical theory it is not the rationality or immortality of the soul that constitutes greatness or uniqueness of human beings but the fact that man has been created in the image and likeness of God.[8] The original meaning of human likeness to the Creator was most likely the human participation in God's dominion over creation. Only later, under the influence of Hellenistic philosophy, was the likeness interpreted as immortality.[9] The most important implication of being created in the divine image, however, is relatedness to God. Humanity in the Bible is never seen as autonomous. It is always in relationship to God that people are viewed, their actions judged and achievements evaluated. As a consequence, both Scripture and Christian tradition take serious cognisance of human sinfulness in contrast to the Hellenes.

Virtues and values, above all, faithful and unselfish love, pertain to every sphere of Christian life, not the least of which is human sexuality. This peculiar juxtaposition of the doctrines of creation, universal sinfulness and grace, constitutes the hallmark of Christian anthropology.

Paradoxical as biblical anthropology is in itself, the Christian view of human nature involved still further tensions when the convictions of Jerusalem were joined with the philosophies of Athens. Conflicts occurred that have yet to be fully resolved. The polar tensions that mark contemporary attitudes toward sexuality are related to the very roots of ancient attitudes regarding sex, ethics and morality.[10]

According to Thomas[11] morality involving the modification of the conduct of the individual in view of the presence of others, is already highly

developed in the tribal stage. Here life has demanded the most rigorous regulation of behaviour in order to secure the organisation and the process essential to success.

In tribal existence morality applicable to males was said to have a larger element of the contractual while female morality was measured against her personal adjustment to men.

Hazzlit in his attempts to find foundations of morality finally concluded that social co-operation is the essence of morality as practised by the individual from day to day.[12]

In a different vein, Raphael, in his discussion about moral obligations, maintains that we must legislate for ourselves as moral agents but as moral subjects we are to some extent bound by legislation of the community of moral agents. We have no prerogative or moral judgement; in that respect, all men are equal.[12]

The process of moral evaluation becomes especially difficult in actions that involve both good and evil effects. In the past these decisions were usually made on the principle of double effect interpreted with a "narrowly behavioural or physical understanding of human activity".[13] Contemporary theologians are once again insisting that any attempt to evaluate the moral object of an action apart from motive and circumstances is necessarily incomplete and inadequate. It is the whole action including circumstances and intention that constitutes the basis for ethical judgment. This is not to say that the concrete act is not an important consideration. It is simply to insist that the genuine moral

meaning of particular individual acts is most accurately discerned not solely from an abstract analysis of the biology of the act but necessarily including the circumstances as well as intention that surround the action.[14]

Finally in an effort to relate sexual desire and ethical concerns Paul Ramsey[15] and Engelbrecht[16] emphasise the need to distinguish between Agape, the selfless concern for well being of another, and Eros, the selfcentered desire to possess the object of love. Both affecting, to this day, therapeutic approaches especially in marriage and sex guidance counselling.

3. SEX AND RELIGION

In view of the research sample where the majority of clients are Protestant Catholics or Hindus we are concentrating on these religious groups in our discussion of sex and religion.

3.1 Modern Protestant and Catholic Views

In a very frank discussion about the ethics of sexuality, Engelbrecht [17] refers to the individual and collective conscience arguing that intimacy at this level is a matter between God and the individual concerned.

According to Engelbrecht many distorted views especially regarding human sexual needs can be related to the Latin Proverb: Corruptio optimi pessima.

He poses the question: When does "corruption of the best" occur, and indicates that man may be the slave of the collective conscience in addition to his own individual con-scientia. The existence of many public moralists may therefore affect both individual and society.

He concludes by emphasising the individual conscience and confirms that the church does not judge intimate affairs.[17]

This refreshing tone confirmed by past and present day theologians are in accordance with developments in human sexuality, in medicine, psychology and other helping professions illustrated by present trends and professional attitudes.

In search for an answer towards a theology of human sexuality Thomas[18] concludes that the following seven values: Selfliberation, other-enriching, honesty, faithfulness, social responsibility, life serving and joyous actions, are of particular significance in human sexuality. These are in contrast to frustration, destruction, dishonesty, instability, promiscuity and irresponsibility where integrative growth are seriously abused.

All agree that the final level of moral evaluation is the individual concre decision. It is the individual conscience responsive to principles, values and guidelines that remains the ultimate subjective source for evaluating the morality of particular sexual expressions.

Within the wide boundaries embracing life it is acknowledged that good and bad, sacred and evil are often mere labels identifying the attitudes of the person appplying these. Eventually they may realise that "human sexuality is as sacred as holy communion."[19]

Sniping at new Puritanism where the body has been alienated and seen as evil, following the notion that the body imprisons the soul, New Testament Paul is often misread, according to Heuer[20] and as a fruit of the reformation sometimes falsely quoted by some "sadistic moralists".

Within this wholeness-of-man concept where reason cannot be separated from feeling or conscience, the Christian male accepts marriage as the ordination of priesthood in his own home, following the example of Christ as the lover of his bride, the church. However this remains a conce difficult to accept without distortion and subjectivity.

3.2 The Virtue of Chastity

In the recent past, most moral treatises on human sexuality opened with a definition of chastity as the virtue that regulates sexual passion. Typical of such definitions is the following: "Chastity is the moral virtue that controls in the married and altogether excludes in the unmarried all voluntary expression of the sensitive appetite for venereal pleasure." The latter was often referred to as "perfect chastity" and consisted of "abstinence from all expression of the sensual appetite both in the external act and internal thought, desire and complacency."[21]

Such an understanding of chastity makes a virtue of the denial, repression, and submersion of all human sexuality outside the context of marriage and procreation. This approach is reasonable if the purpose of human sexuality is seen as primarily procreative. Vatican II, however, officially and explicitly rejected such a view as incomplete. It was felt that it could not serve as an adequate basis for a theology of human sexuality. The 1975 Vatican Declaration on Sexual Ethics accentuates the positive role of chastity.

The virtue of chastity, however, is in no way confined solely to avoiding the faults already listed. It is aimed at attaining higher and more positive goals. It is a virtue which concerns the whole personality, as regards both internal and external behavior.[22]

To give expression to the fuller understanding of human sexuality as reflected in this study, it is necessary to define the virtue of chastity in broader and more positive terms. Chastity may be defined, therefore, as that virtue which enables a person to transform the power of human sexuality into a creative and integrative force in his or her life. It facilitates the fullest realization of one's being as male or female and encourages the integration of self with others in the human community. Chastity makes possible both intrapersonal and interpersonal development calling for an active response to the possibilities that human sexuality offers. The repression, submersion, or denial of these possibilities is as much a deviation from virtue as is the mindless pursuit of sensual pleasure as the ultimate goal of life. "Insensitivity is as unspiritual as is promiscuity."[23] The task of developing one's sexuality into a creative and integrative force in life makes the acquisition of the virtue of chastity a constant challenge. Some of the conditions conducive to the fostering of chastity would include the following according to Paolillo: [24]

1) A clear and accurate knowledge of the basic facts and meaning of human sexuality;

2) a positive acceptance of one's sexuality as God-given and fundamentally good; this implies a rejection of views that regard human sexuality as tainted, the source of sin, beneath human dignity, or a less honourable aspect of being human;

3) a proper respect and reverence for human sexuality as a means of interpersonal communication and not merely a biological, physical, genit or emotional reality;

4) a recognition that the pursuit of chastity calls one to a life-long process of openness to the challenges and risks that human sexuality involves; thus, patience and perseverance are important allies, if chastity is to be pursued;

5) a religious appreciation of the fact that the grace of the Almighty underlines e thrust toward fulfilment and perfection; hence, the recognition that a deeply spiritual life will prove a source of much needed strength and motivation for the pursuit of the virtue of chastity;

6) the creative integration of human sexuality is not accomplished without struggle; a healthy dose of asceticism and self-descipline must necessarily accompany the effort to be sexually sensitive and responsive, especially in moments calling for restraint and non-expression as the most effective means of achieving creativity and integration.

Chastity calls one to a generous pursuit of that creative growth toward integration that is the purpose of human sexuality. This remains true for any way of life, that is, for the married, unmarried, celibate, or homosexual. Different states of life may call for a different expression of this basic gift of human sexuality, but in no way of life is it to be dismissed as non-existent or unimportant. The task remains of discovering the most effective way to utilize the force of human sexuality in each state of life so as to bring about a creative growth toward integration.

3.3 The Bible and Marital Sexuality

"It is not good that the man should be alone. I will make him a helpmate" (Gen 2:18).

The expressions used in the Genesis account of Eve's creation - "helpmate," "bone of my bones and flesh of my flesh," "two in one flesh" - eloquently summarise the biblical vision of marriage as a complete and total sharing by the spouses of their life in common. It is not merely a defen of Eve as a being identical in nature and truly equal to man that this passage

indicates, but rather a recognition of marriage as a free and full commitment of partners to share in the mutual task of building the future.[25]

To see here a confirmation of the full modern understanding of personal relationship in marriage may be an exaggeration, but the Bible clearly points to a community of life between man and woman based on equality, total sharing, mutual respect and support.

Other passages in the Old Testament highlight even more explicitly the perso dimensions of the husband-wife relationship. The touching biblical accounts of the love between Abraham and Sara, Elkanah and Hanna (1 Sam 1:1ff), Tobias and Anna, Tobias and Sara, and David and Bathsheba give ample evidence of the Israelite appreciation of this aspect of human sexuality. Further illustrations can be found in the earthy but eloquent description of love expressed in the Canticle of Canticles as well as in the legal provisio that allowed a newly married Israelite a full year of freedom from military and business obligation "to be happy at home with his wife whom he has taken (Dt 24:5; 20:7).

St Paul concretely acknowledges the need for wholesome sexual expression between husband and wife and cautions against periods of prolonged abstinence (1 Cor 7). He emphasizes the equality of husband and wife in their marital relationship and warns against any manipulative or explorative behaviour. On the one hand, Paul reflects the understanding of his time when he describes the husband-wife sexual relationship in terms of rendering a mutual debt and as a remedy against temptation. This fails to do justice to the role of sexuality in fostering mutual love and growth. On the other hand, he reveals the depth of the commitment that is to exist between husband and wife when he dares to compare the husband and wife relationship to the faithful love that Christ lavishes upon the Church.

Significantly, although children are always seen as a blessing, nowhere does the New Testament single out the procreative responsibility of husband and wife as deserving special attention. This is simply taken for granted.

Paul does not counsel asceticism or self-denial out of contempt for the body; he is no Gnostic nor a Hellenistic dualist. His advice on marriage is very much influenced by his imminent expectation of the Parousia: "The appointed time had grown very short..... The form of this world is passing away" (1 Cor 7:29, 31). In the light of Corinth's notorious reputation for sexual excesses, Paul's counsel appears to be a realistic and practical attempt to obviate difficulties that could create a serious threat to marital fidelity.

In short, the Bible clearly places the greatest emphasis on the responsibili of spouses to love one another in mutual and lasting fidelity. It is far more concerned with this overall thrust and direction than with moralizing about specific forms of sexual behavior. Marital sexuality is viewed in the context of its ability to serve and enrich the mutual relationship of the spouses.

3.4 The Church and Sexuality

Quite in contrast to the New Testament, dominant emphasis has been given to the procreative rather than the personal aspect of sexuality in the historical development of Church teaching and attitudes. This emphasis on the procreative dimension led eventually to the evaluation of marital sexuality primarily in terms of openness to procreation and only secondarily in terms of mutual love and support. The unitive aspect of sexuality in marriage was never denied or excluded but rather subordinated to the procreative task.

The moral manuals of the recent past reflected this emphasis in their development of an elaborate theology of marital sexuality that gave the overriding priority to the procreative purpose. Any sexual expression that frustrated procreation, e.g., contraception, masturbation, or sodomy was regarded as intrinsically evil and a serious violation of moral law.[26] As long as procreative integrity was secured, all other sexual expressions between marriage partners, including oral sex, were not regarded as seriously sinful.[27] Any reasonable cause, e.g. fostering of love or relief of concupiscence justified such expressions and rendered them moral and virtuous. Pure pleasure-seeking was not considered a justifying reason in itself, but even if sensual gratification were the only motive, such activity was never regarded as more than venially sinful.

An interesting difference of opinion seems to have existed as to whether orgasm in the female apart from procreation could be said to constitute pollution in the same sense as seminal emission in the male; female secretions in orgasm were not viewed as essential for procreation in the same way that male semen was required.[28] Such precise and intricate distinctions indicate the seriousness with which most theologians of the past considered the procreative purpose of human sexuality. Their careful statements regarding sexual pleasure in the context of married life reveal some appreciation of the importance of this aspect of human sexuality, but it was seen most often as a remedy against concupisc or a means of preserving fidelity. Thus, they concluded, a spouse whose partner was in danger of incontinence could not morally refuse the marriage debt even for fear that the children might be born defective or stillborn, or that the family might be forced to live a life of abject poverty.[29] The conviction was supported with the theological argument that even if the foetus were stillborn or aborted and died in original sin without the opportunity for heaven, this condition would be better than not to have existed at all.[30]

Instances of a more positive view of sexual intercourse as a means of fostering love, enhancing mutual growth, and deepening commitment are decidedly rare in moral theological writings of the past and they are always subordinated to the primary concern for ensuring procreative integrity. Procreation constituted the primary purpose of human sexuality and allowed no compromise. It is not surprising that in such a context birth control was eventually regarded as the most frequent violation of marital chastity. It was recognized that one could sin by refusing to render the "marriage debt," but this was less often confessed as serious sin because of various "justifying" circumstances.

3.5 Recent Trends

The beginnings of the 20th century witnessed a return to the biblical appreciation and emphasis on the interpersonal dimension of human sexuality in the context of marriage. Pius XI reflected this developing trend in his Encyclical on Christian Marriage when he stated that:

"This mutual inward molding of a husband and wife, this determined effort to perfect each other can, in a very real sense, be said to be the chief reason and purpose of matrimony, provided matrimony be looked at not in the restricted sense as instituted for the proper conception and education of the child, but more widely as the blending of life as a whole and the mutual interchange and sharing thereof."[31]

He was able to make such a statement as if he was speaking from a context in which the procreative purpose remained primary.

It remained for Vatican II, however, to culminate this movement by giving official Church recognition to the personal dimension of human sexuality as being of no less importance than the procreative. The implications

of this decision can hardly be overestimated. The Council's deliberate rejection of the centuries-long tradition that regarded the procreative end as supreme, necessitates a thorough rewriting of the theology of marital sexuality found in the moral manuals. The chapter on marriage in Vatican II's Constitution on the Church in the Modern World provides the basis for a contemporary Catholic theology of marital sexuality. One of the fundamental principles of this renewed theology of marital sexuality is the recognition that the very essence of marriage as enunciated by the Council calls for a mutual commitment to responsible partnership.[32]

Characteristic of this responsible partnership is a commitment to continuing mutual growth, as Vatican II made very clear. The role of sexuality in realizing this vision of marriage is briefly but beautifully described in the Council's reflections on conjugal love. The importance and uniqueness of the spouses' sexual expression of their mutual love are strongly emphasized.[33]

According to Kosnik et al serious reflection on this theology of responsible partnership indicates that much more attention must be given to this personal dimension in any evaluation of what constitutes wholesome sexual behavior for the married. Compare Naidoo, Engelbrecht and Heuer.[34]

3.6 Marriage, Sex and Hinduism

In the same vein as both protestant and catholic theologians conclude, Rhadakrishna says:[35] "To look upon sex as something unclean or indecent is a sign of moral perversion".

The Hindu of today, like the Christian, looks upon sex life as sacred, exalting the householder (family) status. Sexual abstinence is not seen as an absolute virtue, however, the highest ideal is said to be that of

non-attachment, in sex, as in all other matters, thus enabling the individual to use the relations when valuable and forgo them without trouble.

Marriage is seen as a social charter for the establishment of a legitimate family rather than a licence for sexual intercourse.

3.6.1 The Marital Ceremony

The Hindu ideal of marriage is essentially a fellowship between a man and a woman who seek to live creatively in a partnership for the pursuit of the four great objects of life: Dharma, artha, kama, and moksa. Its purpose includes the generation of children, their care and nurture, and co-operation in a better social order; but its main aim is the enrichment of the personal of husband and wife, through the fulfilment of their needs for a permanent comradeship, in which each may supplement the life of the other and both may achieve completeness.

The ideal has come down from Vedic times, and is preserved in the elaborate marriage ritual which is in force even today. The marriage ceremony marks the beginning of the great opportunity for the development of an emotional maturity, in which the sense of justice; of understanding, of consideration and the forbearance of others are born. It can be simplified, since the essential rites by which the ideals are impressed on the couple are only few.[36]

The first stage is the pānigrahana, where the bridegroom holds the bride by the hand and leads her thrice round the fire, reciting the appropriate verses. Oblations are offered to Pūsan, Bhaga and Āryaman, who are the presiding deities over prosperity, good luck and conjugal fidelity, respectively. The parties touch each other's heart, and pray that they may be one in heart and mind, though two in bodies. "May you never admit

heart; may you prosper in your husband's house, blest with his life and cheerful children." They ascend a stone and offer a prayer that their mutual love be as firm and steadfast as the stone they tread on. At night the polar star and Arundhatī are shown. The bridegroom is enjoined to be as steady as the polar star, and the bride as faithful as Arundhatī.[37] In the saptapadi ceremony, the bride and the bridegroom take seven steps together, and pray that their married life may be full of love, brilliance, opportunities, prosperity, bliss, progeny and holiness. The husband address the wife thus: "Having completed seven steps, be my companion. May I become your associate. May none interrupt my association with you. May such as are disposed to promote our happiness confirm your association with The husband and the wife take vows that they will further each other's hopes and desires in the spheres of religion, love and worldly prosperity.[38] The ceremony concludes with a prayer that the noble union be indissoluble. "May the universal gods join our hearts; may the waters join our hearts. May Mātariśvan, Dhātar and Dvestri together bind us close.[39] The woman is blessed to be a good wife with her husband alive. At the end of the saptapadi ceremony, the bride passes into the family of the husband. Marriage may be regarded as complete with it. Others argue that consummation is necessary. For three days after the marriage, the two are to sleep in different beds, but in the same room, and practise strict celibacy. This is to indicate that self-control is essential in married lif The bride and the bridegroom approach their marriage with lives that are chas They guard their chastity, and offer it as a tribute to the mate at the time of the marriage. No other gift can quite compensate for the loss of this.[40]

The position of the wife is an exalted one. She is to be the head of the household, bearing full sway over the father-in-law and the mother-in-law, over her husband's sisters and others. She is the effective partner in life. She should not be discarded in religious duties, business matters and the emotional life. All religious acts should be performed together.[41]

The Epics, the Smrtis and the Dharma Sastras mention eight forms of marriage, whi include relics of earlier stages that have survived into the later. Many of these can be traced to the period of the Reg Veda.[42]

3.6.2 South African Indian Attitudes Regarding the Heterosexual Relationship

According to Naidoo [43] the twenty one year history of Indians in South Africa has until very recently been a history of imported values and social morals. By this is meant that the Indian community appears to be developing a new set of social morals which although still Indian in character are very much an indigenous phenomenon for South Africa's Indian community.

However, all social values for the Hindu Indian community have their history their very roots in three specific traditional sources: The Vedas, The Pura and Ancient Laws. Present day sex attitudes in the Indian community can still be traced to Manu and Kantilya, the law givers versed in Hindu Law as authorised by scriptures.

The institution of Marriage was well established in Rig Vedic times. Social attitudes concerning sex were then firmly rooted and indulgence allow only to those entering the marital state - householders state - in the Hindu traditional "stages of life," which will be described briefly.

3.6.3 Ashrama Dharma (Life Stages)

So far as the individual's needs were concerned, it was reasoned that for one's life to be lived well and in accordance with rules recognized as morally good and valuable, the individual needed to achieve his objectives in at least four stages during the course of his life.

The first stage was that of studentship, which began when he was able to leave home to acquire an education. Brahmacharya-the stage of studentship,

required that he had to go to a guru and receive his education, which originally meant learning to read the Vedas.

This is followed by a stage as householder, Grahastha, where family responsibilities were fulfilled. Raising a family and caring for its needs was an obligation accepted by many. This was done in many ways as an obligation to one's ancestors, and there was no redemption of the obligations until one had raised a family. This having been done, the man would withdraw to a forest to meet the needs of the third stage of life.

This was Vanaprastha. At this stage one would contemplate life's meaning and, through study of scriptures and religious discipline, discover and fulfil spiritual obligations.

Finally, it would be expected to renounce the world and live as a recluse by entering Sannyasa ashrama. At this stage one dedicates oneself to spiritual service and prayer and contemplates spiritual growth and endeavou to live a spiritually rewarding life.

The two aspects of Dharma discussed by Naidoo as indicated should be consid together. Varnashrama Dharma is the combined effort of professional abilit and station in life aimed at achieving righteousness in thought and action. Where the caste system is seen as a vertical division of society into a number of groups ranging probably from four to four hundred, and perhaps eve entering into some kind of conflict with each other, the horizontal division of these groups into four stages ensures a unitary stratification obviating rigidity and abuse. The first ashrama or station in life is the stage of studentship, in which a student was recognised for what he was; a student, belonging to no caste, allowed no sex, no wealth, and having a firm commitment to his Gurukul, the institution where he got his education.

At the time of his graduation he is given the choice of going to the next stage, Grahastha, in which he became a householder or proceeded to the third stage in which he became a Vanaprasthin. As a householder he is allowed to marry, raise a family, observe caste rules, gain wealth and participate in every social duty required of him in society.

If and when he became a Varnaprasthin, he studied scripture and observed religious rules with care. This stage of life again allowed him no sex, no accumulation of wealth, no caste and only pure contemplation, study and teaching.

"In the last stage of life when one became a sannyasin or parivrajaka - a travelling teacher, one observed the rules of no wealth, no sex, no caste. One taught freely or gave freely to society of one's learning and experience and chose only to contemplate God's existence." [44]

Thus caste rules were obeyed when one was a householder, the stage of life wherein one accommodated human weaknesses and subsequently weaknesses in society.

In addition to these the cardinal virtues summarised by Naidoo as purity, selfcontrol, detachment, truth and non-violence had to be observed by all people.

Vivaha, is the marriage ceremony which marks the entry of a young man into the life of a "householder". Vivaha according to Naidoo implies sustenance; sustaining religious as well as secular duties. As the Christian husband "ordained into the priesthood of his own home", as indicat the Hindu husband undertakes to live his life in such a way as to protect the well being of his home, family and country. This is regarded as his moral and religious duty.

3.6.4 The Hindu Woman and her Role in Marriage

For women marriage became an obligation mainly in Budhist times. For this reason, the Smirtis, a class of religious literature, exalts the state of marriage.

Although women are seen as subordinate to men in some parts of India, the literature emphasises the equality of sexes especially in traditional Hindu religion.

L. Jaccoliot the celebrated French author of the "Bible in India," maintains that: "India of the Vedas entertained a respect for women amounting to worship; a fact which we seem little to suspect in Europe when we accuse the extreme East of having denied the dignity of woman, and of having only made of her an instrument of pleasure and of passive obedience." [45]

Long before the civil laws of the Romans, which gave the foundation for the legislation of Europe and of America, were codified by Justinian, the Hindu laws of Manu were closely observed and strictly followed by the members of Hindu society in general. Many of the Oriental scholars, having compared the digest of Justinian and the Mosaic laws of the Old Testament with the Hindu laws, have arrived at the conclusion that the code of Manu was related to them as a father is to his child. Yet the Hindu law-givers only repeated and codified the ethical principles which were inculcated in the Vedas. Following the teachings of the Vedas, the Hindu legislator gave equal rights to men and women by saying: "Before the creation of this phenomenal universe the first-born Lord of all creatures divided his own self into two halves, so that one half should be male and the other half female."[46] This illustrati has established in the minds of the Hindus the fundamental equality of man and woman. Just as the equal halves of a fruit possess the same nature, the same properties in equal proportion, so man and woman, being the equal halves

of the same substance, possess equal rights, equal privileges, and equal powers.

The same idea of equality was most forcibly expressed in the Rig Veda (Book hymn 61, verse 8). The commentator explains this passage thus: "The wife a husband, being the equal halves of one substance, are equal in every respect therefore both should join and take equal parts in all work, religious and secular." No other Scriptures of the world have ever given to the woman such equality with the man as the Vedas of the Hindus. According to Swami Abhedananda the Râmâyana describes the exemplary character of Sitâ, the heroine. She was the embodiment of purity, chastity and kindness, the personification of spirituality. She still stands as the perfect type of ideal womanhood in the hearts of the Hindu women of all castes and creeds She is worshipped as an Incarnation of God, as Christ is worshipped among the Christians. India is the only country where it is believed that God incarnates in the form of a woman as well as in that of a man. "A woman's body," says Manu the law-giver, "must not be struck hard, even with a flower, because it is sacred." It is for this reason that the Hindus do not allow capital punishment for women.[47]

The position of women in Hindu religion can be understood better by that unique idea of the Motherhood of God, which is nowhere so strongly expressed and recognized as in India. The mother is so highly honored in India that the Hindus are not satisfied until they see divinity in the form of earthly mother. They say that one mother is greater than a thousand fathers, therefore the Hindus prefer to call the Supreme Being the Mother of the Universe. The Divine Mother is greater than the "Creator" of other religions. She is the Producer of the Creator, or the First-born Lord of all creatures. According to Muller there is no other country where every liv mother is venerated as an incarnation of the Divine Mother, where every village has a guardian mother who protects all as her own children.[48]

4. NON-MARITAL SEXUALITY

From all this it seems clear that no society has ever been completely indifferent to the sexual behaviour of its members. Sex has not been viewed as a purely private affair between two individuals. In most cultures, sexual activity has been regulated at least to some extent.[49] This fact of experience is explained by the radically social nature of human existence, particularly the social dimension of sexuality. Sexual behaviour has implications and significance for society. The universal means by which societies have legitimated, regulated and institutionalized the sexual relations of their members, are marriage and the family, as indicated.

This relationship between sex and marriage has not always been recognized as absolute, however.[50] Marriage was originally a family event rather than a religious or civil affair. Certain values lay behind the Old Testament sexual mores, however, and these evolved from concern for property rights to personal rights. The basic value of human dignity was foremost in Jesus' teaching, exemplified in his stand on marital fidelity and divorce. He rejected the treatment of women as chattel. Jesus' personalism was continued by St. Paul's emphatic condemnation of prostitution, which was representative of every form of depersonalized and depersonalizing sexual activity.[51] Immanuel Kant's maxim is closer in spirit to Christian morality and piety than to rationalist ethics: "So act as to treat humanity, whether in your own person or in that of any other, always at the same time as an end, and never merely as a means."[52]

Examination of the argumentation, therefore, would seem to warrant the conclusion that "moralists" have not yet succeeded in producing convincing proof as to why in every case sexual intercourse must be reserved for marriage.[53] Their difficulties in doing so do not constitute a license

for promiscuity, however. Rather, they give us reason to pause and consider each case more carefully, and not to regard every exception to the norm as immoral.

4.1 A Cross-Cultural Summary of Current Approaches to the Morality of Non-Marital Sexuality.

In current literature, one can discern a variety of approaches to the morality of non-marital sex. These can be summarised under the following five headings:

1) All directly voluntary sexual pleasure outside wedlock is grievously sinful.[54]

   The reasoning advanced for this position is that even the smallest amour of this pleasure is an inducement to indulgence in the fullest amount of it and this would be fatal to the human race.

2) Every genital act outside the context of marriage is immoral.[55]

   The reason advanced for this stance is that sexual intercourse finds meaning only in a stable marriage sustained by a conjugal contract guaranteed by society. This position reflects a genuine concern for the societal implications involved in human sexual expression, and certainly these should not be lightly dismissed. Its insistence, however, that a valid marriage contract ultimately legitimates sexual intercourse tends to identify and confuse the moral and legal orders. Although this formulation may reflect what should exist in the ideal order, it does not do full justice to the imperfect ambiguous real world in which we live. The conjugal contract and civil recognition do not always guarantee a genuine mutual commitment.

3) Premarital intercourse is wrong but preceremonial intercourse may be moral.

This approach attempts to draw a sharper distinction between the inner mutual consent that constitutes the existential bond of marriage and the external manifestation of this commitment before society. It contends that these two moments for various reasons should be more properly termed preceremonial rather than premarital. Manning[56] carry this line of reasoning a bit further suggesting that since marriage is a process, there may be a point at which sexual intercourse becomes an appropriate commitment of the partners' intent, even prior to the formal exchange of vows.

Some of the objections raised against this approach are:

a) It too easily identifies the intention to marry with the existential marriage bond itself, which is not always indicative of total commitment.

b) By exaggerating the importance of sexual intimacy in the growth of their relationship, it interferes with the principal task of the the engaged parties, namely, to get to know each other's strengths, weaknesses, and interests.[57]

c) It has a naïve supposition that sexual consessions will only be claimed by engaged couples.

4) Sexual intimacy may be an appropriate expression of the quality and depth of a relationship, whether marriage is intended or not.[58]

Exponents of this position argue generally that the unitive and procreative aspects of sexuality are not inseparably united, and either purpose may justify sexual expression provided it is not destructive of individuals or community. They view moral norms as

relative and strongly defend the freedom of mature individuals to set aside the rule and act in accordance with their own judgment in the best interest of the parties involved and of society.[59]

5) Sexual experience including intercourse is a natural human function which serves functions other than procreation or expression of intimacy.[60]

This position maintains that sexual expression is an important and healthy human experience because it provides enjoyment, enrichment, and a release of tension. Even apart from any expression of intimacy or intent to procreate, physical pleasure is an important part of human experience. According to this humanist approach, "The satisfaction of intimate body responsiveness is the right of everyone throughout life".[61] Some maintain that intercourse is the healthiest and most beneficial expression of human existence and "the individual should seek to have healthy orgasms in accord with his needs.[62]

In the light of our understanding of human sexuality presented here, it seem clear that the extreme positions (1 and 5), which reject every deliberate experience of sexual pleasure outside the marriage context or which exalt sexual experience purely in terms of physical enjoyment and release of tension, simply do not do justice to the rich and profound meaning of human sexuality. It also seems abundantly clear that one cannot categorize every act of intercourse as equally immoral regardless of circumstances or relationship. There is a vast difference between the deliberate exploitation of others, as in prostitution, and an act of sexual intercourse that expresses a growing commitment of persons to one another.[63]

Previous generations had many fears about unwanted pregnancy and anxiety about the sinfulness of premarital sex. Young people today do not

feel the same fear or measure of anxiety.[64] Traditional norms have become questionable, and social pressures to ensure adherence have decreased considerably. This is not to say that young people are more promiscuous. On the contrary, a young man's first sexual encounter fifty years ago was likely to have been with a prostitute; today it is likely to be with someone with whom he can have a loving relationship.[65]

Studies indicate that sexual behavioural patterns are changing. More college students, particularly college girls, engage in premarital intercourse than their counterparts did twenty years ago.[66] But indiscriminate sexual activity has not increased. Even though marriage is not commonly considered a prerequisite for sexual intercourse, there seems to be a strong emphasis on a loving relationship and some measure of mutual commitment before sexual involvement.

5. CONCLUSION

As indicated in this chapter by illustrating a few examples, standards of morality and immorality differ widely from one culture to another, between groups within similar cultures and from one person to another. In some societies kissing is prohibited in public while in others public coitus is performed as part of religious ceremonies.

There are no universal patterns in marriage or sexual behaviour. Marriage can be between two people of opposite or similar sexes, or as in primitive tribes, between more than two people in a system of polygamy.

Across cultures similar modes of intimacy exist within marriages. Clinebell[67] refers to various intimacies such as: sexual-creative - crisis - work - intellectual - emotional - spiritual and commitment - intimacy. In contrast to couples living together in loneliness these areas are said to have the potential of drawing the marriage together.

In search of answers regarding reasons for marriage as such, Frame[68] maintains that people select mates on the basis of complementarity i.e. a logical man may choose an emotional wife or identification on the basis of similar needs.

Behaviour therapists see marriage in terms of sequences of rewarding and negative behaviour between partners. Conventional psychoanalysts, however, stress the discrepancy between conscious and unconscious demands. Finally Whittaker believes that the usual roles of social behaviour do not apply to intimate relationships, that fairness is not appropriate, consistency is impossible and factual honesty not relevant - "all is fair in love and war and marriage is both."[69]

Margaret Mead[70] observed that "every known human society exercises some explicit censorship over behaviour relating to the human body, especially as that behaviour involves or may involve sex. There is no known society where regulation of these is left wholly to individual or to spontaneous social activity.

Most societies seem to have two problems: How to keep sexual activity out of forbidden channels that will endanger the bodies and souls of others or the orderly co-operative processes of social life and how to keep it flowing reliably in those channels when it is necessary if children are to be conceived and reared in homes where father and mother are tied together by the requisite amount of sexual interest.

In spite of differences, all societies develop their own public, ethical and moral standards, regarding the sexual practices of their members, for the same basic reasons as outlined in this chapter.

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5. See note 4.

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Immanuel Kant claimed that love is a morally unrealiable motive with t exception of human conscience, which, he claimed, made an act morally good. However it does not guarantee resulting acts to be virtuous. Consider 13th Century churchmen burning heretics at the stake or Nazis preserving the purity of the Aryan race by killing thousands of Jews. In contrast David Hume the 18th century Scottish philosopher felt that virtue was found in useful personality traits. Perhaps the main "virt of this theory is the fact that it explains the importance we attach t virtue and vice.

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"Ek wil gaag twee spreuke in Latyn aanhaal: Corruptio optimi pessima, die bederf van die beste bring die slegste voort. Maar wanneer is dit 'n corruptio? Hier kom die gewete van die mens te pas-sy "conscientia"sy medewete met God sy skepper. Maar nie alleen die gewete van die enkele mens nie maar ook die gewete van die gemeenskap waarin hy hom bevind. Tog kan die kollektiewe gewete hier baie skynheilig en tirannies wees. Ek vermoed dat baie publieke moraliste ook sadiste is. Wat ek dus in gedagte het is dat ons in weerwil van die sterk stem van die kollektiewe gewete 'n baie groot ruimte moet laat vir die enkele gewete "De intimis ecclesia non iudiat", dis die tweede Latynse spreuk! Die kerk oordeel nie oor die innerlike sake nie. Wat die seksuele betref sou ek dit so wil stel: "De intimis non iudicamus." Ons oordeel nie oor die intieme lewens van ander nie.

17. See 16.

18. See 14.

19. See 15.

20. During a Workshop on Sex and Religion at University of Durban-Westvill in 1982 Prof. N.A.C. Heuer, Head of the Department of Pastoral Counselling at University of Durban-Westville referred to the "ordination of priesthood"; (p. 5) explained the erroneous accusations against Paul and the New Testament; (p. 4) and discussed the origin of "perfect chastity" and its applicability to positive utilisation of human sexuality in our time.

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27. This attitude was notpeculiar to Israel. The 4th century A.D. biograp of Pythagoras (6th, 5th century B.C.) recounts the advice of Pythagora to women: "If you come from your marital consort, it is a divine privilege even on that very day to visit the holy shrines; but by no means, of course, if you are coming from forbidden intercourse." H. Schelkle, Theology of the New Testament: Morality, translated by W.A. Jurgens (Collegeville, Minn.: Liturgical Press, 1970), 3:265.

28. Recent evidence from Ugarit shows that even the prohibition of transvestism (Dt 22:5) and of intercourse with animals (Lev 18:23) must be seen as motivated by opposition to the sacred cult of Canaan rather than as expressing a biblical sexual ethic. Prof. Cyrus Gordon in an article discussing "Ugarit and Its Significance," (Arts, The Journal of the Sydney University Arts Association, 9 (1974):26-27).

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30. de Vaux, R. Ancient Israel (New York: McGraw-Hill, 1961), 1:40.

31. Kosnik, A. and others. Human Sexuality, New Directions in Catholic Thought. Search Press, London. Printed by Billing and Sons, 1977.

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33. The biblical Word of God often urges the betrothed and the married to nourish and develop their wedlock by pure conjugal love an undivided affection. Many men of our own age also highly regard true love between husband and wife as it manifests itself in a variety of ways depending on the worthy customs of various peoples and times.

McKenzie, J.L. A Theology of the Old Testament (New York : Doubleday, 1974), p. 207.

34. Naidoo, T. The Hindu Way . P.O. Box 40002, Red Hill, 4071, Natal.

Heuer and Naidoo during personal discussions and Engelbrecht in his letter. During discussions all confirmed the necessity of wider acceptance and individual understanding regarding ethical considerati in marriage.

35. Rhadakrishnan, S. Religion and Society. George Allen and Anwin Ltd. Rushton House, London, 1966.

36-38. Rhadakrishnan, S. See note 35.

39. Rhadakrishnan, S. Compare the Christian formula: "I take thee to be my wedded wife, to have and to hold for this day forward, for bett for poorer, in sickness and in health, till death us do part;... and thereto I plight thee my troth." with the responsible partnership commanded by the Catholic Church: "Thus, a man and a woman, who by th

marriage covenant of conjugal love "are no longer two but one flesh" (Mt 19:6), render mutual help and service to each other through an intimate union of their persons and of their actions. Through this union they experience the meaning of their oneness and attain to it with growing perfection day by day.

40. Rhadakrishnan explains: "Hindu tradition insists on brahmacarya and respect for the honour of womanhood. When Rama and Laksmana were wandering in their quest for Sita, Sugirva placed before them the ornaments which were dropped as a trail by Sita, for identification. Rama's eyes were dimmed with tears, and so he asked Laksmana to look at the ornaments and identify them. Laksmana says that he cannot identify them. Laksmana says that he cannot identify the keyuras and the kundalas as he does not know them, but he can readily recogni the nupuras, the anklets, for he has seen them daily while prostrating at Sita's feet.

41. Vivekananda describes how Ramakrishna was willing to sacrifice his mission in life, for the sake of his duty to his wife. "I have learr he said to her, "to look upon every woman as Mother. This is the only idea I can have about you. But if you wish to draw me into the world, as I have been married to you, I am at your service." If Ramakrishna followed the choice of his life, it was, therefore, with the consent of his wife.

42. See Rhadakrishnan, S. p. 165-168 for an excellent summary of various forms of marriage that existed.

43. Naidoo, T. See note 34.

44. For a discussion about these virtues see pages 33-34 Naidoo.

45. Swami Abhedananda <u>India and Her People</u> Ramakrishna Vedanta Math. Calcutta, 1968.

Quoting L. Jaccoliot, French author of <u>The Bible in India</u>. p. 169

46. See note 45.

47. p. 267 According to Abhedananda no other scriptures have acknowledged the woman as equal to the extent of the Vedas of the Hind

48. Compare Prof. F. Max Muller "Life and Sayings of Ramakrishna." Scribner and Sons, New York.

The treatment of woman, according to Hindu religion, will be better understood from some of the quotations from the laws of Manu and other law-givers. Manu says:

1. "The mouth of a woman is always pure." V, 130.
2. "Women must be honored and adorned by their fathers, husbands, brothers, and brothers-in-law, who desire their own welfare." III,
3. "Where women are honored, there the Devas (gods) are pleased; but where they are dishonored, no sacred rite yields rewards." III, 5
4. "Where female relations live in grief, the family soon wholly perishes; but that family where they are not unhappy ever prosper III, 57.
5. "In like manner, care must be taken of barren women, of those who have no sons, of those whose family is extinct, of wives and widows faithful to their lords, and of women afflicted with disea VIII, 28.
6. "A righteous king must punish like thieves those relatives who appropriate the property of such females during their lifetime." VIII, 29.
7. "In order to protect women and Brahmins, he who kills in the caus of right commits no sin." VIII, 349.
8. "One's daughter is the highest object of tenderness; hence, if on offended by her, one must bear it without resentment." IV, 185. (Compare this with the statements of the missionaries that the Hin religion sanctions the killing of girls.)
9. "A maternal aunt, the wife of a maternal uncle, a mother-in-law, a a paternal aunt, must be honored like the wife of one's spiritual teacher; they are equal to the wife of one's spiritual teacher." (In India, the wife of a spiritual teacher is regarded as a living goddess.)
10. "Towards the sister of one's father and of one's mother and towar one's elder sister, one must behave as towards one's mother; but the mother is more venerable than they." II, 133.

11. "But the teacher is ten times more venerable than the sub-teacher, the father a hundred times more than the teacher, but the mother a thousand times more than the father." 11,145.

12. "A chaste wife, who after the death of her husband constantly remains chaste, reaches heaven, though she have no son, just like those chaste men." V,160. (Compare this with the statements of the missionaries that Hindu widows are cursed by their religion.)

13. "In that family where the husband is pleased with his wife and the wife with her husband, happiness will assuredly be lasting." III, 60.

14. "Offspring, the due performance of religious rites, faithful servi highest conjugal happiness, and heavenly bliss for the ancestors a one's self, depend upon the wife alone." IX, 28.

15. "Let mutual fidelity continue till death; this may be considered as a summary of the highest law for husband and wife." IX, 101

49. Roy, Rustum and Delly Honest Sex (New York: New American Library, 1968), chap. 8.

50. Vermeersch, A. De Castitate, Rome: Gregoriana, 1919, n. 304. The fact that Catholic moralists continued, even after him, to cite the Old Testament as forbidding premarital intercourse, indicates how little attention moralists often paid to critical scriptural exegesis i the past. Cf. B Schlegelberger, 23, n 11.

51. Haring, B. What Does Christ Want (South Bend, Indiana: Ave Maria Press, 1968).

52. Kant, I. Critique of Practical Reason, p.141 Translated Lewis White Beck (New York: Bobbs-Merrill, 19

53. Thomas, L and Moreada, N. eds. Love, Marriage and Morlas. New York:Readers Digest Life Value Series, 19

54. Davis, H. Moral and Pastoral Theology. Sheed & Word Vol. II, 1936.

According to him it is grievously sinful in the unmarried deliberately to procure or to accept even the smallest degree of true venereal plea secondly, it is equally sinful to think, say or do anything with intent of arousing even the smallest degree of this pleasure.

55. The recent Vatican Declaration on Sexual Ethics seems to favour such a position:

> Today there are many who vindicate the rights to sexual union before marriage, at least in those cases where a firm intention to marry and an affection which is already in some way conjugal in the psychology of the subjects require this completion, which they judge to be connatural. This is especially the case when the celebration of marriage is impeded by circumstances or when this intimate relationship seems necessary in order for love to be preserved.

However recently this has been overuled by "Catholic from Rome" doctrir which states again that every genital act must be within the framewor of marriage. "The Star" Johannesburg, 2/12/1983.

56. Manning, F. The Human Meaning of Sexual Pleasure and the Morality of Premarital Intercourse - Part Thre The American Ecclesiastical Review 166 (May, 1 p. 317.

57. Sex and Morality : A Report Presented to the British Council of Churc (Philadelphia: Fortress, October 1966), p. 31.

58. Haring, B. Medical Ethics, edited by L.J. Gabrielle (Notre Dame, Ind.: Fides Publ., 1972), p. 90.

59. "The Study Document on Sexuality and the Human Community" presented to the United Presbyterian Church in the United States of America seems to reflect this position when it states:

> In place of the simple, but ineffective and widely disregarded standard of premarital virginity, we would prefer to hear our Church speak in favour of the more significant standard of responsibly appropriate behaviour. Responsibly appropriate behavior might be defined as sexua expression which is proportional to the depth and maturity of the relationship and to the degree to which it approaches the permanence of the marriage covenant.

In its attempt to offer guidance for single adult persons, the study further states:

> Sexual expression with the goal of developing a caring relationship i an important aspect of personal existence and cannot be confined to the married and about-to-be married.

60. Kirkendall, L. A New Bill of Sexual Rights and Responsibiliti The Humanist 36 (Jan/Feb 1976):5.

61. Borowicz, E. Choosing a Sex Ethic (New York: Schocken Book: 1969), p. 54.

62. Hamilton, E. Sex Before Marriage (New York:Bantam Books, 1: p. 35.

One advocate of this position offers the following guidance for enjoyin sex at an early age:

> If intercourse is to be practicable at all for these young adults, th must be able to guarantee the following conditions:
>
> 1) that they will not conceive an unwanted child;
> 2) that, should they fail in their use of birth control methods, they will be able to handle the problem of an unplanned pregnancy
> 3) that they can provide an aesthetically satisfying environment for the flowering of their sexual love, such as a safe place for love-making without fear of interruptions or police intervention;
> 4) that they must be free from feelings of guilt. In other words, t must be able to tell themselves, with conviction, that what they doing is in accord with what they believe to be right; otherwise, the sexual experience itself can be overshadowed by their fears.

63. Ramsey, P. A Christian Approach to the Question of Sexual Relations Outside of Marriage, The Journal of Religion, 45 (1965): 109.

64. Saldahna, S. American Catholics Ten Years Later, Critic, (1975):18.

65. Murdock, G.P. Our Primitive Contemporaries, New York, 1934

66. Andrew Greeley The Catholic Priest in the United States: Sociological Investigations, The National Opi Research Center, University of Chicago (Washin D.C.; The USCC, 1972), p. 101.

67. Clinebell, H.J. Growth Counselling for Mid Years Couples. Philadelphia, Fortress Press, 1977.

68. Frame, J.E. A Critical Commentary of the Epistles of St. Paul to the Thessalonians. Clark, Edinburgh, 1972.

69. Carl Whittaker during a Family Therapy Workshop, Durban, R.S.A., 1982. Verbal statement

70. Mead, M. Male and Female; A Study of the Sexes in a a Changing World. Harmondsworth, Penguin Books, 1962.

CHAPTER 4

SEXUAL DYSFUNCTION AND THE MARITAL RELATIONSHIP

1. INTRODUCTION

The delicate and complex sexual responses of men and women of "husband and wife in the marital relationship depend on the integrity of multiple determinants".[1]

There still remains much that we do not know about sexuality. However, significant data are beginning to emerge also regarding the social and psychological determinants of sexual behaviour.

Dr Albert Kinsey was extremely careful in selecting interviewers for his research projects. He explained to a rejected psychologist: "You do not really want to do sex research, look at your attitudes. You say masturbation is immature, premarital and extramarital intercourse harmful to marriage, homosexualtiy abnormal and animal contacts ludicrous. You already know all the answers, so why waste time on research". [2]

During the course of this research some practitioners were encountered who, in a similar vein, approached sexual problems with viewpoints based on their own biases and experiences. This will be discussed in Chapter 6. Many professionals, notably social workers, psychologists and some medical practitioners have more discomfort in open free discussion with clients about sex than they are apt to acknowledge. [3]
During personal interviews with faculty and Department heads at Universities and Medical Schools this was confirmed.[4] In addition Olivier (1982) confirmed that South African gynaecologists, psychologists, psychiatrists, urologists and general practitioners either ignore or refer patients in need of sex therapy rather than accepting them for treatment.[5]

The almost total absence of research in South Africa regarding human sexuality and sex therapy, may well reinforce this tendency of avoidance, affecting both clients and consultants.

As indicated in our literature overview, sexual problems constitute a major cause in the high divorce rate and marital stress throughout the world.[6]

As this has again been confirmed in this research, see Chapter 6, sexual dysfunctions within the marital relationship will be discussed briefly and its implications for training in later chapters.

It is necessary to distinguish between sexual variations or so called deviations and sexual dysfunctions. According to Kaplan et al, sexual variations are not amenable to sex therapy, which was specifically developed to treat sexual dysfunction. In contrast to the "deviant" person, the dysfunctional patient suffers from inadequate sexual responses and he does not enjoy sexual intercourse.

It should also be stressed that the writer has become very aware of the need for objective adequate knowledge regarding the normal physiological aspects in human sexuality and its implications within marriage and for improved heterosexual experiences.

With the exception of prescribed handbooks, throughout the world, there i overawareness of dysfunction, deviance, disturbance and pathology in research and literature, often with a total absence of adequate guidance and education regarding normal sexual functioning.[7]

Especially in third world countries, and for many South Africans, education is required and guidance often more relevant and preferable

to therapy as such. This has been confirmed especially during follow-up group discussions as will be discussed in later chapters.

However, any investigation regarding training of sex therapists, will be inadequate without attention to sexual difficulties, especially those most prevalent and affecting the marital relationship.

The most frequent forms of sexual dysfunctions described by Brecher and others[8] as "psychosomatic disorders which make it impossible for the individual to have or enjoy coitus", will be presented briefly.

2. SPECIFIC SEXUAL DYSFUNCTIONS OF MALES AFFECTING THE MARITAL RELATIONSHIP:

According to the literature and confirmed by practitioners regarding males, the three most prevalent syndromes causing sexual and heterosexual difficul are: erectile dysfunctions, retarded and premature ejaculations.[9-9.2]

2.1 Erectile Dysfunctions:

Hormonal, vascular and neural mechanisms may affect erections and medical and neurological examinations are indicated especially in "primary impotence".[9.1] Some practitioners still prefer to distinguish between primary secondary impotence. The former when an erection has never been obtained while the latter is described as situational impotence. Organic causes of primary impotence is well described by Cooper, Feldman and David and Blight.[9.2.3]

In contrast to the conventional psychoanalytic view that erectile dysfunction was indicative of underlying psychopathology, the recent discovery of the effects of performance anxiety causing sexual dysfunction has been a significant advance in this field.

However, intrapsychic and dyadic difficulties can still not be ignored and "joint therapists' in accordance with systems-theory formulations have repor a high rate of success. In addition to these, appliers of systematic desensitization within the behaviouristic paradigm also claim impressive resu

The importance of erectile dysfunction and its effect on the marital relationship has received much attention, especially where fear of failure symptomised other affective marital responses. The emancipation of the wife apparently reinforced some difficulties. These include: The female dominant position in coitus; the husband's inability to provide materially in accordance with the couple's or the wife's demands; ambivalence regarding the husbands feelings; guilts following an extramarital sexual experience; all may result in erectile dysfunction often causing a vicious circle of negative reinforcement.[10]

According to these researchers, suggested forms of treatment of erectile dysfunctions whether hormonal, psychoanalytic, behavioural or marital therapy all have well earned claims to success.

However, Coopers "symptom-focused forms of treatment" and the rapid and impressive success rate of conjoint treatment of husband and wife incorporating a multi-model approach also experienced by the writer, can be described as the main present trend. The 80% success rate claimed by Masters and Johnson [11] who have recorded most impressive results with almost similar procedures have been confirmed by local clinicians, sex therapists, and patient responses. [12]

2.2 Premature Ejaculation

Clinical experience in South Africa [13] and elsewhere confirm that this is the most common male sexual "dysfunction".

The problem of a valid criterion still exists and the only reliable definition would seem to confirm the male's absence of voluntary control over the ejaculating reflex according to Ansari [14], Kaplan et al. Ejaculation prior to penetration often results in husbands seeking assistance.

Causes, according to the literature, do often include anxiety, a high level of stimulus response [15]; or conditioned responses.

A person may become conditioned to pre-ejaculation during developmental years and cannot alter this "pattern".

According to recent findings, treatment of any variation of the Seman's method [16] result in excellent and rapid ejaculatary control. There is little doubt about the value of this treatment but adequate diagnoses of the marital relationship and additional guidance and/or therapy is essential.

2.3 Retarded Ejaculation

According to Feldman and Barnett et al[17] this refers to continuous retardation of ejaculation or a total inability to ejaculate. Masters and Johnson et al reported a low incidence and also refer to partial ejaculatory incompetence.

Although organic causes are rare it has to be remembered that some antipsychotic and other drugs may result in "dry ejaculations" and the possible presence of any neurological impairments should be eliminated prior to treatment.

Psychosomatic causes include aggression against the female or low trust relationship while fear of failure in general constitute an important area of causative factors [17.1]

deeply frustrating and disappointing for the woman. Although some women seem to be able to accept this state of affairs without rancour, many others develop a strong antagonism toward sex and an intense hostility toward their husbands. Often this situation also evokes feelings of self-hatred and depression, which are exasperated by the woman's feeling that she is hopelessly trapped in the situation. Typically such women are afraid to openly refuse to have sex with their husbands. Instead, they use subterfuge to avoid intercourse - they may plead illness or fatigue, or deliberately provoke a quarrel before bedtime. [21]

Husbands also vary greatly in their reaction to their wife's inability to respond sexually. Many men accept their partner's lack of response as a matter of course, because it conforms with their culturally-induced expectations. Indeed, for some, their wife's sexual unresponsiveness is a source of gratification on some level. Other husbands who are insecure attribute their wife's problem to their own inadequacies or experience her lack of responsiveness as a personal rejection. In order to counteract these feelings, such men may put pressure on their wife to 'perform' which, of course, further inhibits her response.[22]

To a great extent, gender differences in psychological reaction to sexual dysfunction may be culturally determined. In most societies the male is expected to perform sexually; consequently, a sexual dysfunction in a man is universally regarded as pathological. Women are not subject to the same pressures to perform, and in many cultures are not expected to be sexually responsive. In many segments of our own society the view persists that the woman's role in sexuality is to give man pleasure and bear children. Thus, even today, male physicians and clergymen frequently assure those women who complain of their inability to experience orgasm that their lack of response is perfectly normal, and advise them to accept and adjust to their inorgastic state.[23]

FIGURE 1

A CLASSIFICATION OF FEMALE SEXUAL DYSFUNCTION

MAIN TYPE OF DISORDER	SPECIFIC SUBTYPES OF DISORDER	GENERAL SUBTYPES OF DISORDER
Lack of Sex Drive	None	1. According to the history of the dysfunction. (a) primary (b) secondary 2. According to the circumstances of occurence (a) absolute (b) situational (i) coital (ii) masturbatory (iii) random (iv) other (e.g. oral-genital, anal intercourse) 3. According to affect associated with sexual stimulating (a) with feelings of aversion; (b) without feelings of aversion.
Sexual Anaesthesia	1. Vaginal (a) total (b) partial 2. Clitoral. (a) total (b) partial	
General Sexual Dysfunction	1. Orgasmic 2. Inorgasmic	
Orgasmic Dysfunction	1. Repeated Mounting Arousal 2. Inability to maintain arousal 3. Only slight arousal	
Vaginismus	1. Severe enough to prevent vaginal penetration (a) orgasmic (b) inorgasmic 2. Slight enough to allow penetration (a) orgasmic (b) inorgasmic	
Dyspareunia	1. Due to vaginismus (a) orgasmic (b) inorgasmic 2. Without vaginismus (a) orgasmic (b) inorgasmic	

We should not be unduly shocked by this attitude. Actually, it is not sexual abstinence, per se, but rather the individual's negative psychological attitude toward sexual deprivation which produces emotional problems.[24] Many women who seem to have good marriages and seem well-adjusted in other spheres spend a lifetime with their husbands without ever responding to them sexually. For that matter, there are also many priests who, presumably, abide by their vows to remain continent in life. Apparently, then, if an individual consciously renounces erotic gratification and is strongly motivated to accept a non-sexual life, and consequently is not enraged and disappointed by the deprivation, it is possible to sublimate and supress one's sexual cravings without visible psychological damage.

This is not to imply, however, that the sequelae of general sexual dysfunction in women are always benign. On the contrary, it may have extremely adverse effects, both on the woman's mental health, and on the quality of her marriage and family life, Kaplan et al.

3.2 Specific Female Dysfunctions

For the purpose of discussion a classification of female dysfunctions, designed by Mrs R Keech, Assistant Director of the Durbaa Branch of FAMSA is presented in Figure 1. Conditions may overlap or interchange with various individuals.

The dual presence of local vasocongestive and the orgastic component which is primarily muscular has to be kept in mind in any overview of female sexuality. Hartman and Uken however, in comparison to the male sexual response found that the female response seems relatively less vulnerable

to physical factors [23] and ongoing individual or group therapy also according to the writer's experience often yield encouraging results.

3.2.1 Sexual anaesthesia

This condition is seen by some as a "hysterical conversion symptom," occurs in those females who indicate that they are incapable of erotic responses. Psychotherapeutic intervention for this group seems advisable, however, etiological factors are often complicated and manifold.

3.2.2 General Sexual Dysfunction

As indicated, unresolved conflicts regarding sexuality, marital disturbances and unconscious guilts are mentioned repeatedly in the literature as related etiological factors. Marital and individual therapy have been found to have moderate success rates.

According to psychoanalytic formulations unconscious conflicts about sexuality cannot be ignored, however these patients often also suffer from physical impairments of the vasocongestive component of the sexual response. She may or may not be inorgastic. Hence the term frigidity is often used to generally describe many specific symptoms of dysfunction or the initial symptom described by the patient.

3.2.3 Orgastic Dysfunction

There is considerable confusion in the literature about the question, whether orgasm is necessary to sexual satisfaction and marital happiness in women. While a number of writers are convinced that lack of female orgasm is a basic cause of chronic tension, frustration, and psycho-physiological complaints as well as marital unhappiness, other writers insist that many women are sexually satisfied without orgasmic experience. Some writers seem to hold both views simultaneously.

For example, Kinsey, on the one hand, emphasizes that female orgasm should not be used as the sole criterion of the amount of satisfaction in sexual relations since "considerable pleasure may be found in sexual arousal... and in the social aspects of a sexual relationship." Yet practically all of Kinsey's data in this area are in terms of orgasm. Similarly, Chesser [24] suggests that a distinction is necessary in women between sexual satisfaction in general and orgasm in particular. He writes: "There are those married women whose sexual satisfaction consists essentially in giving pleasure to their husband without achieving a sexual climax themselves; others rarely obtain sexual pleasure on a genital level at all". Later on, however, he refers to the "outstandingly important influence" of female orgasm and sexual satisfaction on sexual intercourse and marital happiness.

C.R. Adams [25] studied the marital and sexual adjustment of 150 wives at Pennsylvania State University, divided into three groups, low, intermediate and high in terms of sexual responsiveness. He concluded that marital happiness depends to a considerable extent on sexual adjustment, which, in turn, depends considerably on sexual responsiveness. "But, if most other factors are favourable," he adds, "a wife may be happy in marriage even though she is quite unresponsive sexually. Conversely, if most other factors are not favourable, a wife may be unhappy in marriage even though she is very responsive sexually."

Hannah and Abraham Stone [26] mention that even if a woman does not attain an intense climax she may nevertheless derive a great deal of satisfaction from sex. They then add, however, that if orgasm is not reached, "the relief is not complete, and the woman may remain for some time in an unsatisfied and restless condition. Repeated experiences of this kind may eventually lead to various physical or emotional disturbances."

Joan Malleson [27] rejects the idea that orgasm in the wife is essential to sexual satisfaction. She describes the "joys" in sex that many women experience without ever having orgasm, and refers to the large number of women who live their lives in harmony and health without orgasm. Yet she also states that, ideally, the woman should achieve an internal vaginal orgasm for complete fulfilment, and adds that unless clitoral stimulation of the wife is provided by the husband, "extraordinary suffering can be caused in some cases."

Wallin's conclusions [28], from his study of 540 wives, are similarly ambiguous. On the one hand, he interprets his findings as consistent with those from Terman's [29] study of 750 wives, namely, that for many women intercourse can be a satisfying and enjoyable experience without orgasm; yet, at the same time he concludes that frequency of orgasm in wives is clearly associated with completeness of relief in intercourse and that intercourse without orgasm is associated with frustration and unsatisfied desire.

Other workers, state quite unequivocally that female orgasm may be unrelate to sexual satisfaction or marital happiness. Mace [30], describes wives who never experience orgasm and are not at all bothered by this lack unless they are told that something is wrong with them. He writes:

"It is a mistake to think that these women are cold and unresponsive by nature. On the contrary, they are often deeply affectionate and capable of giving and receiving tender love. It is just that, for them, the mechanism of orgasm doesn't work. This does not necessarily deter them, however, from enjoying sex relations with their husbands. In their quiet way they respond to the warmth and intimacy and closeness of the sexual embrace."

Davis [31] simply states that orgasm has nothing to do with a woman's health or normality. Although it may enrich her life, she "may also be very happy without it." Otto [32] says essentially the same thing: "Numerous women have satisfactory enjoyment in normal heterosexual intercourse, even if they do not reach the orgasm." "Many women never have orgasm," says Haveman [33] "yet greatly enjoy every act of sexual psychological satisfaction."

In sharp contrast, still other researchers are convinced either that: (1) lack of orgasm in women is associated with neurotic and psychosomatic disturbances; or (2) female orgasm is necessary for sexual fulfilment. Several hold both of these views and perhaps the most outspoken of these is Reich.[34] In his book "The Function of the Orgasm," he develops the thesis that all kinds of psychological disturbances and somatic symptoms result from "the damming up of biological energy and undischarged sexual energy." For Reich, the failure to reach orgasm was the basic cause of psychophysiological and behavioural disorders in human beings.

Van de Velde [35], in his classic "Ideal Marriage", is another worker who insists on the importance of orgasm in the female; he refers to the harmful effects of unrelieved tension by stating: "It is at the present time impossible to estimate how much imbalance of mind and nerves, and misery in marriage, are due to this and the deprivation of complete relaxation in coitus. But I am profoundly convinced of its frequency and importance, as of the underestimate (or neglect) of this factor by doctors and laymen alike." Brown and Kempton [36] refer to lack of orgasm as one of the central and widespread problems of female sexual frustration: "The mounting tension and excitement of intercourse would be intolerable were it not for the promise that orgasm will provide an outlet for the accumulation of nervous energy in waves of pleasurable sensation. When this expectation is not fulfilled, the wife remains bitterly disappointed..

Isabel Hutton [37], a physician, points out that when a woman is unable to reach an orgasm her sexual organs may remain in a more or less chronic state of congestion, for a period of hours, with harmful effects. Oliver [38] says essentially the same thing and also feels that a sizable percentage of complaints of insomnia by women otherwise free from illness or disease may be due to lack of orgasm - even though the women themselves may not be aware of this. Sophia Kleegman [39], a gynaecologist, is convince that the woman who experiences arousal repeatedly without orgasm "is a candidate for many gynaecological problems."

Lack of orgasm may be related to marital maladjustment. As early as 1929 Hamilt found that 73 per cent of the women whose marriages terminated in divorce did not have orgasms during the first year of their marriage.

Kirkendall[41], Weiss [42], and Appel[43] have also reported studies that indicate the importance of sex in marital adjustment. Hollis reports on a study of thirty-four couples who were seen for marriage counselling. Eight of the wives reported a satisfying sexual adjustment and of these, nineteen said they were more or less unable to respond sexually. Locke[44] studied 181 wives who were happily married and 210 who were divorced, relative to various factors including the enjoyment of sex. He found that 90 per cent of the former compared to 53 per cent of the latter enjoyed sex relations. Appel[45] reports that out of 222 married clients seen at the Marriage Council of Philadelphia, 72 per cent showed significant concern about sexual problems.

Clarity regarding this has only been recent following decades of "psychoanalytic clitorial-vaginal orgasm hypotheses". Since Masters and Johnson's research, where clitorial orgasm has been accepted as

crucial to female orgasm the awareness of enormous differences between females has continued to expand. With the exception of the involuntary inhibition of the orgastic reflex, which seems to be the only general or essential pathology, individual differences in the pathogenesis of this condition are varied and no specific "pattern" observed. Primary and secondary orgasmic dysfunctions occur according to Feldman et al who also describes orgasm as "an impairment of a woman's capacity for genital sensory pleasure and related emotional experience".

The following causes are mentioned by most researchers:

3.2.3.1 Obsessive focussing on erotic sensation prior to orgasm

3.2.3.2 Ignorance regarding female sexuality and physiology

3.2.3.3 Subconscious avoidance of sexual enjoyment

3.2.3.4 Problems regarding emotional security and assertiveness

3.2.3.5 Anxiety related to loss of control

3.2.3.6 Masters and Johnson et al maintain that the bio-physical and psychosocial systems operative in the heterosexual relationship may reinforce "negative signals" causing orgasmic dysfunction.

3.2.4 Vaginismus

This is described as a "discrete clinical entity" characterised by a conditioned spasm of the vaginal entrance. It could be severe enough to prevent intercourse. Researchers agree about the psychogenetic etiology of vaginismus where defective psychosexual development is often associated with sexual infantilism. Physical pain during intercourse, guilts, aggression, incest and rape are frequently quoted as causative factors by both clinicians and researchers.[46]

In view of the fact that pelvic examination is essential to confirm the pressence of vaginismus this will clearly be confined to a medical examination, at least initially.

Although vaginismus are relatively rare it has a devastating psychological effect on both husband and wife.

Avoidance of all sexual encounters to prevent physical pain and mental anguish often result in severe marital stress and individual anxiety.

Thus a phobic tendency to total avoidance often complicates therapy. The male has been known to develop secondary impotence as a result of this.[47]

In addition to the mentioned causes and effects many remote causes may result in this condition found in both slightly neurotic to severely disturbed females whose initial marital relationships range from excellent to deeply troubled.

Treatment includes the essential extinction of the conditioned vaginal response by gentle insertion of graduated rubber catheters into the vagina having corrected any possible pain producing elements at first.

Relaxation has to be obtained simultaneously by pharmacotherapy, hypnoses, behavior therapy and/or deep muscle relaxation. In addition insight producing techniques are employed and couple therapy usually offered either at a later stage or at the onset of treatment depending on the therapist or consultant.[48]

'Sex therapy which combines in vivo desensitization of the spastic vagina with conjoint therapy appears to constitute the treatment of choice for this disorder. Moreover, when this procedure is carried out within the context of the marital relationship, the opportunity exists to extend the

benefits of therapy beyond relief of the specific symptom by helping the couple develop a better sexual relationship and work out other interpersonal problems.[49]

3.2.5 Dispareunia

Olivier has distinguished between dispareunia with and without vaginismus and summarises possible causes of the second group.

3.2.5.1 Infections

3.2.5.2 Low level of estrogen

3.2.5.3 Use of some deodorants

3.2.5.4 "Dry vagina"

3.2.5.5 Guilts related to intercourse

3.2.5.6 Penetration anxiety

3.2.5.7 Aggression towards the sexual partner.

According to Feldman et al a small group of males also suffer from this condition.

4. SEXUAL DYSFUNCTION IN BOTH PARTNERS

The most frequent dysfunctions encountered in both partners include premature ejaculation of the husband with some degree of orgastic dysfunction of the wife.

In contrast to expectations of married couples, improvement of one partner does not necessary result in improved sexual functioning of the other partner. The one symptom often reinforced the other partner's dysfunction and unless the interpersonal and subsequent conditional behaviours are evaluated and adequately handled, unsatisfactory sexual activity will contir

A similar combination of dysfunctional symptoms is impotence and vaginismus where the wife sometimes blames her impotent husband when, in fact, her own difficulty has resulted in her husband's impotence. Conjoint treatment is often indicated and, as in many instances, coitus will be "prohibited" by the therapist initially, while other forms of stimulation are practised and encouraged. To this effect the love questionnaire presented in table 3 has been found very useful in conjoint therapy especially.[50]

4.1 SEXUAL DYSFUNCTIONS AND MARITAL DISCORD

Growing evidence indicates that, contrary to psychoanalytic concepts of psychopathology, a sexual dysfunction need not be evidence of deep and severe psychopathology within an individual or a manifestation of severe pathology within the marital system.[51]

Whether to use this specific goal-directed form of treatment when both marital discord and sexual dysfunctions are present or to pursue a therapeutic programme of broader marital or individual therapy is a perplexing decision. It is essential to develop some guidelines for determining when it is feasible to treat the dysfunction directly and when factors of marital discord necessitate other therapeutic alternatives.

Marital discord may be defined as the existence of strife or a lack of harmony between spouses. It may be mild to very severe, constant or episodic. The couple may engage in heated fights and physical violence, or each mate may be distant from the other as they lead parallel lives, never touching in intimacy. The manifestations of marital discord are infinite, but the most common complaints are usually symptomatic of the unconscious aspects of the couple's relationship, of their deeper disappointments and frustrations, and are not necessarily the basic etiological factors that cause the marital discord.[52]

Greene lists lack of communication, constant arguments, unfulfilled emotional needs, sexual dissatisfaction, financial disagreements, in-law trouble, infidelity, conflicts about children, domineering spouse and suspicious spouse, in that order, as the ten most common complaints of husbands and wives who seek marital counselling.

Sexual dissatisfaction, the fourth most frequent complaint in Greene's study, may be related to most of the others. For example, one might expect that a spouse who complains of lack of communication, constant arguments, or unfulfilled emotional needs is not likely to report that sex is satisfactory in all respects.[53]

5. IMPLICATIONS FOR SEX THERAPISTS

Although there are many different individual approaches to the new brief therapy of sex dysfunctions, most have in common the assignment of sexual tasks and the utilization by the therapist of the couple's response to the tasks. The tasks, in addition to their conditioning or deconditioning and learning aspects, are used to open communication, elicit reactions and develop a sense of working together by the couple. The accomplishment of this requires a very specific kind of cooperation between partners that may be thwarted by discord.

It is essential that task instructions be followed and not sabotaged.[54] To accomplish this and to move toward healthy realization of each spouse's sexual potential, partners must be able to meet certain requirements of cooperation: First, to put aside their fights and hostility for a period of a few weeks so that these negative components do not determine significant actions; second, to accept one another as sexual partners; and third, to have a genuine desire to help one another and themselves. In addition, a fourth condition requires that one or the other spouse often put his own gratification aside for several weeks and the fifth that he

participate in maintaining a sexually non-demanding ambience. Those couples who meet the first three criteria usually have no great difficulty in meeting the fourth and fifth and even enjoy their temporary role.[55]

Acceptance of these criteria should prevent misuse of sex in power struggles between spouses. When the couple is not capable of this level of cooperation, and if their actions and feelings are overdetermined by their hostility toward each other, treatment of the sexual dysfunction is not likely to be successful.[56]

In this chapter specific sexual dysfunctions were presented in accordance with recent research findings. The writer agrees with Dr Sapire who maintained that sexual problems in a happy marriage may cause 10% difficulties, however, in an unhappy marriage it constitutes 90% of the difficulties often resulting in divorce.[57]

Vague reference to limited sexual responses and a tendency, in the helping professions as indicated, to concentrate on interpersonal aspects no longer meets the clients' needs or the test of time.

Knowledge of specific dysfunctions is essential especially for non-medical professionals to prevent vague references to "general difficulties in sexual adjustment" of becoming an excuse for consultants when marital counselling fails.[58]

Sexual difficulties in marriage, in addition to these specific dysfunctions may also reflect inadequate knowledge; it may be a mere symptom of severe marital breakdown or a combination of psycho-social and physical difficulties as indicated. Knowledge of these dysfunctions once diagnosed treated should not to be seen as a panace for all the problems of modern marriage. However, a lack of specific knowledge of these could certain result in inadequate counselling,[59] and often unnecessary suffering.

CHAPTER 4

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1) Primary impotence caused by educational and developmental problem
2) Mechanical impotence following diabetes, prostraectomy, fractures damaging the urethra and obstructions.
3) Organic impotence i.e. spinal injuries, schleroses, congenital abnormalities and vascular problems.
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CHAPTER 5

THEORETICAL INVESTIGATION - THE RESEARCH PARADIGM

1. INTRODUCTION

This research finds itself firmly on the premise of illuminative research as an innovation. Innovation is now a major educational priority. its impact is felt throughout the world.[1] Curricula are restructured, new devices introduced, forms of teaching permutated.

More recently innovation in conjunction with evaluation has rapidly developed a legitimacy and importance of its own. The 'evaluator' has emerged as a new and influential figure. In short, both innovation and evaluation have become 'big science'.[2]

More generally within educational research there are two distinct 'paradigms', a term used by T.S. Kuhn[3] as an overarching concept similar in meaning to 'world-view', 'philosophy', or even 'intellectual orthodoxy'. A paradigm prescribes problem fields, research methods, and acceptable standards of solution and explanation for the academic community it embraces. Each has its own strategies, foci and assumptions. Dominant is the 'classical' or 'natural science'[4] paradigm, which utilizes a hypothetico-deductive methodology derived from the experimental and mental-testing traditions in psychology. Almost all evaluation studies have resided within this traditional paradigm.

More recently, a growing number of empirical studies have been completed outside the agricultural-botany framework, and relate instead to social anthropology, psychiatry, and participant observation research in sociology.[5] Such research can be thought of as representing a second and contrasting parad with a fundamentally different research style and methodology from that of

mainstream educational research. Parlett outlined an approach to evaluation that belongs to this alternative, or 'social anthropology' paradigm. For the purpose of clarification of this research a brief summary of his approach is given here.

1.2 TRADITIONAL EVALUATION AND THE NATURAL-SCIENCES PARADIGM

The most common form of natural-sciences type evaluation is presented as an assessment of the effectiveness of an innovation by examining whether or not it has reached required standards on pre-specified criteria. Students - rather like plants - are given pre-tests (the seedlings are weighed or measured) and then submitted to different experiences (treatment conditions). Subsequently, after a period of time, their attainment (growth or yield) is measured to indicate the relative efficiency of the methods (fertilizers) used. Studies of this kind are designed to yield data of one particular type, i.e. 'objective' numerical data that permit statistical analyses. Isolated variables like I.Q., social class, test scores, personality, profiles and attitude ratings are codified and processed to indicate the efficiency of new curricula, media or methods.

Recently, however, there has been increasing resistance to evaluations of this type.[6] The more notable shortcomings may be briefly summarized as follows:

1.2.1 Educational situations are characterized by numerous relevant parameters. Within the terms of the natural-sciences paradigm these must be randomized using very large samples, or otherwise strictly controlle The former approach entails a major data collection exercise and is expensiv in time and resources. It also runs counter to the need, widely acknowledge for evaluation, before large scale application, rather than after it. The latter procedure - of strict control - is rarely followed. To attempt to simulate laboratory conditions by 'manipulating educational personnel' is

not only dubious ethically, but also leads to gross administrative and personal inconvenience. Even if a situation could be so unnervingly controlled, its artificiality would render the exercise irrelevant: rarely can 'tidy' results be generalized to an 'untidy' reality. Whichever approach is used, there is a tendency for the investigator to think in terms of 'parameters' and 'factors' rather than 'individuals' and 'institutions'. Again, this divorces the study from the real world.

1.2.2 The methods used in traditional evaluations impose artificial and arbitrary restrictions on the scope of the study. For instance, the concentration on seeking quantitative information by objective means can lead to neglect of other data, perhaps more salient to the innovation, but which is disregarded as being 'subjective', 'anecdotal', or 'impressionistic'. However, the evaluator is likely to be forced to utilize information of this sort if he is satisfactorily to explain his findings, weight their importance, and place them in context.

1.2.3 Research of this type, by employing large samples and seeking statistical generalizations, tends to be insensitive to local perturbations and unusual effects. Atypical results are seldom studied in detail. Despite their significance for the innovation, or possible importance to the individuals and institutions concerned, they are ironed out and lost to discussion.

1.2.4 Finally, this type of evaluation often fails to articulate with the varied concerns and questions of participants, sponsors, and other interested parties. Since classical evaluators believe in an 'objective truth' equally relevant to all parties, their studies rarely acknowledge the diversity of questions posed by different interest-groups.

These points suggest that applying the natural-sciences paradigm to the study of innovations is often a cumbersome and inadequate procedure. I am not, of course, arguing here against the use of experimental longitudinal or survey research methods as such. Rather, for the reasons suggested, it is true that they are often inappropriate, ineffective, or insufficient for project evaluation purposes. Too often the evaluation falls short of its own tacit claims to be controlled, exact and unambiguous. Rarely, if ever, can educational projects be subject to strict enough control to meet the design's requirements. Innovations, in particular, are vulnerable to manifold extraneous influences. Yet the traditional evaluator ignores these. "He is restrained by the dictates of his paradigm to seek generalized findings along pre-ordained lines. His definition of empirical reality is narrow. One effect of this is that it diverts attention away from questions of educational practice towards more centralized bureaucratic concerns." [7]

1.3 ILLUMINATIVE EVALUATION AND THE "SOCIAL-ANTHROPOLOGY" PARADIGM

Although traditional forms of evaluation have been criticized by many others in this way, little attempt has been made to develop alternative models. The model utilised here, in illuminative evaluation,[9] takes account of the wider contexts in which educational innovations function. Its primary concern is with description and interpretation rather than measurement and prediction. It stands unambiguously within the alternative "anthropological" paradigm. The aims of illuminative evaluation are to study the innovatory project; how it operates; how it is influenced by the various situations in which it is applied; what those directly concerned regard as its advantage and disadvantages; and how intellectual tasks and academic experiences are most affected.[10] It aims to discover and document what it is like to be participating in the scheme, whether as therapist or client; and, in addition to discern and discuss the innovation's most significant features, recurring concomitants, and critical processes. In short, it seeks to address and to

illuminate a complex array of questions: 'Research on innovation can be enlightening to the innovator and to the whole academic community by clarifying the processes of education and by helping the innovator and other interested parties to identify those procedures, those elements in the educational effort, which seem to have had desirable results'.[11]

1.4 ORGANIZATION AND METHODS OF ILLUMINATIVE EVALUATION

Illuminative evaluation is not a standard methodological package but a general research strategy. It aims to be both adaptable and flexible. The choice of research tactics follows not from research doctrine, but from decisions in each case as to the best available techniques: the problem defines the methods used, not vice versa. Equally, no method (with its own built-in limitations) is used exclusively or in isolation; different techniques are combined to throw light on a common problem. Besides viewing the problem from a number of angles, this 'triangulation'[12] approach also facilitates the cross-checking of otherwise tentative findings

"At the outset, the researcher is concerned to familiarize himself thoroughly with the day-to-day reality of the setting or settings he is studying. In this he is similar to social anthropologists or to natural historians. Like them he makes no attempt to manipulate, control, or eliminate situational variables, but takes as given the complex scene he encounters. His chief task is to unravel it; isolate its significant features; delineate cycles of cause and effect; and comprehend relationships between beliefs and practices, and between organizational patterns and the responses of individuals."[13] Since illuminative evaluation concentrates on examining the innovation as an integral part of the learning milieu, there is a definite emphasis both on observation at the practical level and on interviewing participating instructors and students.

Characteristically in illuminative evaluation there are three stages: Investigators observe, inquire further, and then seek to explain. Obviously the three stages overlap and functionally these stages interrelate. The transition from stage to stage, as the investigation unfolds, occurs as problem areas become progressively clarified and re-defined. The course of the study cannot be charted in advance. Beginning with an extensive data base, the researchers systematically reduce the breadth of their enquiry to give more concentrated attention to the emerging issues. This 'progressive focusing' permits unique and unpredicted phenomena to be given due weight. It reduces the problem of possible data overload; and prevents the accumulation of a mass of unanalysed material

Within this three-stage framework, an information profile is assembled using data collected from four areas: Observation; interviews; questionnaires and tests; documentary and background sources. The application of these in this research will be discussed further under data collecting procedures in this chapter.

Illuminative evaluation thus concentrates on the information-gathering rather than the decision-making component of evaluation. The task is to provide a comprehensive understanding of the complex reality surrounding the program: in short, to 'illuminate'. In his research, therefore, the evaluator aims to sharpen discussion, disentangle complexities, isolate the significant from the trivial, and to finally suggest a tentative training programme.

2. MAIN OBJECTIVES OF THIS INVESTIGATION

The main purpose of this research is to investigate the desirability of the training of sex therapists in South Africa.

A secondary objective is to assess the availability of facilities and the utilisation of these by clients and consultants in the helping professions.

3. THE PILOT STUDY

3.1 Needs of Therapists

During 1982 an initial training course was offered to a small group of medical practitioners, social workers, psychologists, educationists and occupational therapists at the University of Durban-Westville. This was organised by the panel doctor of the Child Guidance and Research Centre who is a general practitioner with a special interest in human sexuality.

Apart from group discussions, seminars and participation in a woman's group as initial training of group counselling skills, a number of couples were observed during initial and ongoing counselling sessions. This was followed by a brief period of experiential training in conjoint counselling; both male and female trainees interviewing a married couple seperately and/or in a group of four.

These couples were referred, mostly by medical practitioners, specifically for sex therapy enabling the trainees to initiate sex counselling as from the first encounter.

After completion of the orientation course the trainees were assigned to work in pairs and efforts were made to vary occupation, sex and culture.

I.e. a Muslim (Asian) general practitioner worked with a Roman Catholic (White) Social Worker etc.

Special efforts were made to obtain sufficient information about the different cultural backgrounds of the clients. This was made easier by the multicultural trainee therapist group who provided useful cross cultural information during subsequent discussion groups.

Furthermore, an interesting observation was made during every session, irrespective of cultural similarities or differences, regarding initial information required by the trainee therapists of various disciplines.

Throughout the year the medical practitioners concentrated their enquiries on interpersonal issues of clients while the psychologists, social workers and educationists concentrated on physical aspects.

This was discussed during follow up group sessions and as a result of this experience the first hypothesis was formulated: Trainee sex therapists have a tendency to project their own limitations regarding required areas of skills, experience and knowledge by emphasising that specific area during their initial enquiry session with their clients.

As a result of this, rapport and prognoses could be negatively affected especially in a one-to-one situation.

This awareness of areas of limited knowledge and skills will be discussed in more detail later .[14]

3.2 Needs of Clients

With the exception of a small group of clients mostly in the main urban Centres of South Africa who are directly referred to "specialists" in sex therapy this facility does not exist.[15]

The majority of people in South Africa with sexual dysfunctions or minor sexual problems may approach their General Practitioners, Family Planning Clinics, Marriage Guidance Societies or Ministers of Religion.[16]

However, both experimental and experiential research confirm that many couples and individuals with sexual difficulties receive no assistance whatsoever.[17] The second hypothesis can be formulated as follows: Physical and mental stress often relate to sexual difficulties, but, as a result of limited knowledge and facilities, treatment cannot be obtained.

To substantiate the above hypothesis the following incident occurred during a final group session at the Child Guidance and Research Centre of the University of Durban-Westville during 1982.

A group of mothers whose 10 year old boys were receiving remedial tuition while they received group therapy discussed childbirth and sexual difficulties during a group session. Without any direct questioning the groupleader reported that 8 of the 10 mothers informed her that the child attending remedial sessions was born in spite of active and in some cases repeated attempts at abortion.

This was followed up with individual interviews during which time severe ignorance regarding the reproductive processes, pregnancy, birth and sexuality was noted. As a result of this, a sex education programme has been planned to offer to all parents whose children attend the centre.

During subsequent interviews with other race groups the same level of ignorance and inhibitions resulting in various forms of individual and family stress was confirmed.

4. THE RESEARCH MODEL

Having completed the first stage of this illuminative evaluation namely the observation by the investigator with specific reference to the clients' and the therapists' needs, as indicated by the model presented in Figure 2, the second stage of further enquiry was undertaken.

In this second stage prior to translation of needs into training objectives to be achieved, in depth investigations were completed to gain a thorough knowledge about the clients' and therapists' needs.

During structured interviews and small group discussions, which will be discussed shortly, information was obtained to analyse the knowledge, skills and experiential requirements as indicated.

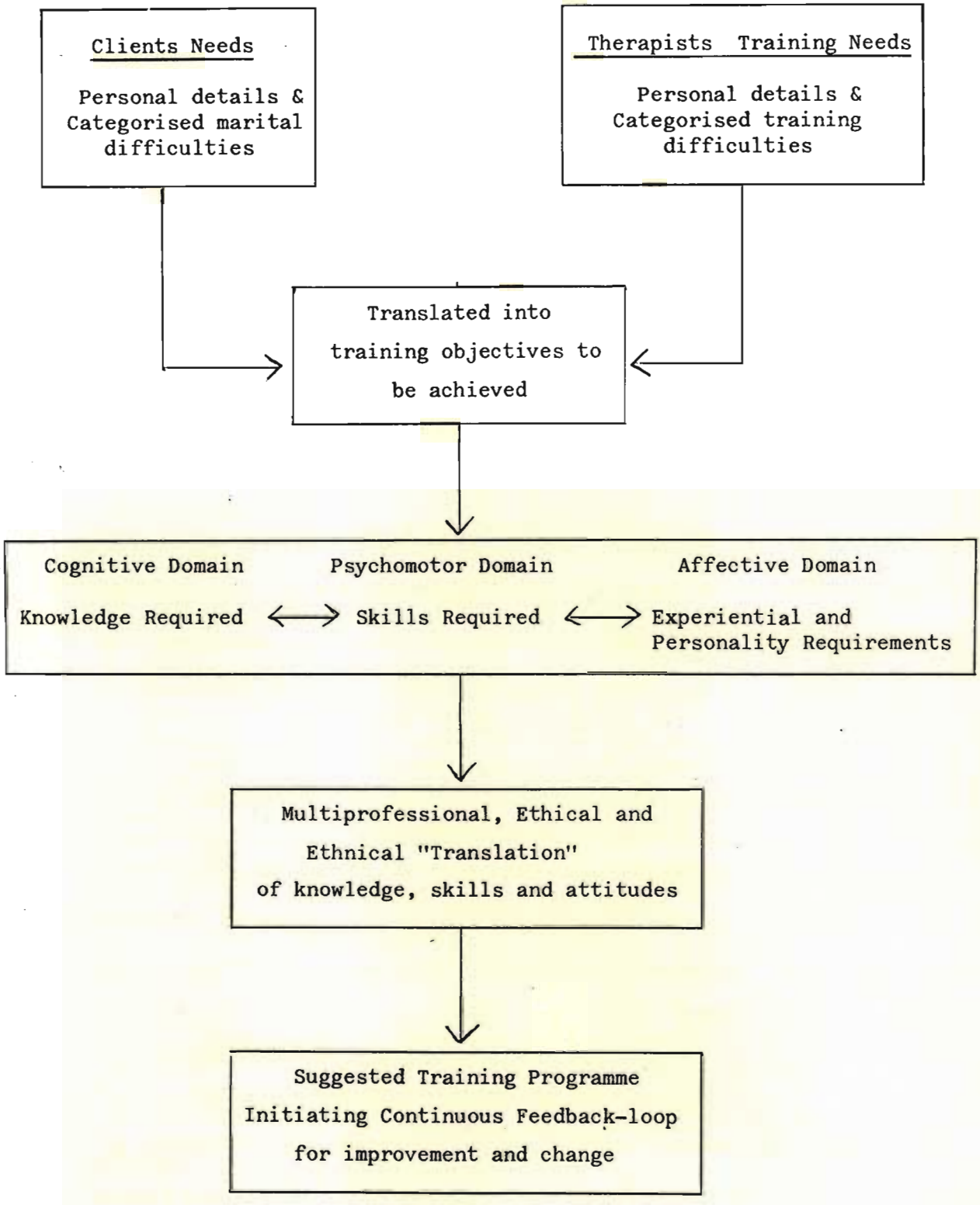
In the final explanatory stage a multi-professional "translation" of knowledge, skills and attitudes will be attempted, enabling the researcher to draw up a suggested training programme. Thus initiating a continuous feedback loop of re-evaluation, improvement and change.

These three stages represented by this model will overlap and interrelate functionally. Therefore the extensive data base will be reduced to concentrate on emerging issues.

In view of the researcher's experience both as practitioner and administrator it was possible to utilise collaborative enquiry, structured interviewing, and documentary and background sources to assemble an adequate information profile.

FIGURE 2

THE RESEARCH MODEL



As indicated, observation occupies a central place in illuminative evaluation and the investigator builds up a continuous record of ongoing events, transactions and informal remarks.[18] This took place during individual and small group discussions, participation in seminars and attendance at workshops and conferences in related areas.

5. DATA COLLECTING PROCEDURES

5.1 Observation

5.1.1. Collaborative Inquiry

In this research where collaborative inquiry was used, the primary interest has not been to generalise but the specific application of knowledge to, hopefully, improve the research area. Analysing data from each members point of view, noting incongruities between espoused values and actual behaviour, spanning four different qualities of reality,[19] formed part of this method.

Awareness of the outside world, one's own and other's thinking and feeling and the dynamics of human attention; gaining, losing or changing focus, was an essential skill utilised throughout this research. Empirical, behavioural, theoretical and attentional skills were fully utilised in the collaborative inquiry and this will be discussed in more detail later.[20]

Suffice it to say that this inquiry included a variety of qualitative research methods such as diffusion, innovation, componential analysis, participant observation and the structured interview as described.

5.2 Interviewing

5.2.1 Structured Enquiry Interviews

As indicated, interviewees were selected by 'theoretical' sampling.[21] People from various professions with special insight, expressed interest and experiential as well as academic knowledge were included in this enquiry

5.3 Content Analysis

The Durban Society for Marriage and Family Life was approached and permission was obtained to conduct a content analyses of 1961 completed case records. The 1983 case records were utilised and personal details of clients were summarised as well as marital difficulties recorded in the case histories.

Content analysis is defined by Berelson as "a research technique for the objective, systematic and quantitative description of the manifest content of communication." [24]

According to Holsti "content analysis is any technique for making inferences by objectively and systematically identifying specified characteristics of messages." [25]

Osgood as quoted by Holsti has defined content analysis as a "procedure whereby one makes inferences about sources and receives from evidence in the messages they exchange, this would include decoding dependency of events in listeners and readers (their meanings, emotions, attitudes and the like) upon the content and structure of messages." [26]

Content analysis has become a basic research tool in various disciplines and was utilised for the purpose of this research.

A list of coded marital difficulties is presented as Figure 3.
These will be discussed in the next chapter.

FIGURE 3

CODED REFERRALS AND MARITAL DIFFICULTIES OF CLIENTS ATTENDING THE DURBAN BRANCH OF FAMSA

Referrals by:	Self
	Lawyers
	Other clients
	Relatives
	Friends
	Churches
	Legal Aid Society
	Medical Doctors
	Psychologists
	Welfare Organisation
	Other FAMSA Societies
	Employers
	Others
Presenting Problems:	Desertion
	Infidelity
	Personality Problems
	Emotional Problems
	Mentally Disturbed
	Sexual Problems
	In-laws
	Non-support
	Budgetting
	Alcohol
	Role Confusion
	Communication
	Wife-battering
	Legal Problems
	Pre-marital Problems
	Family Problems
	Child Rearing Problems
	Divorce
	Other

5.4 Follow up Enquiry

As indicated by the above coded categories there was no clear indication of sexual difficulties as such and some categories were ambigious. This will be discussed further in Chapter 6.

Marriage Guidance Workers were requested to indicate any additional marital difficulties mentioned by their clients apart from those listed. No reason was given to the workers for making this request to prevent an artificial situation or induced awareness which could have affected the objectivity of the worker during the counselling session with the client.

Following an initial enquiry it was apparent that a tendency towards structured categorisation may well prevent the worker and the client from deeper understanding and insight into the client's problem. This will be discussed in the next Chapter. At this stage the researcher agreed with George [27] who maintained that qualitative analysis of a limited number of crucial communications may yield better clues than more standardised techniques.

5.5 Summarised Personal Information

Personal details about clients and consultants were summarised as part of the content analysis and is presented in Chapter 6.

5.6 Structured small group discussions and Follow-up Interviews

Following the content analysis and brain storming sessions, small group discussions and follow-up interviews were organised to discuss the categorised problem areas with the counsellors in more detail. The outcome of these discussions will also be discussed in Chapter 6.

The main objective of these discussions was to compare the research findings with the counsellors' experience and to gain more general information about the specified categories.

Respondents were restricted in these discussions as the writer utilised the research interview method, for this purpose. This method which was well described by Khan and Cannel was used by the writer "for the specific purpose of obtaining research relevant information and focused on content specified by research objectives of systematic description, prediction and explanations...." The writer presented each topic by means of specific questions and decided when the conversation has satisfied the research objectives.[28]

As a result of limited feedback opportunity with marriage guidance counsellors because of the very nature of the counselling processes these observational techniques were applied. Without any formal testing to assess training outcomes, these techniques were also utilised to assess the affective and psycho-motor results of the training. This will be discussed in following chapters as well as data collecting procedures utilised towards a suggested training programme.

5.7 Documentary and Background Information

Prior to planning the data collecting procedures, Committee Meetings and Staff Discussions were attended and interviews arranged with the Directors of Marriage Guidance Societies, Family Planning Organisations and Faculty Heads.

Annual Reports, Case Records and various handouts offered to clients were perused and this was followed by further individual enquiries directed by Family Planning, Marriage Guidance and University staff.

This provided the researcher with essential background knowledge and facilitated follow-up interviews and discussions.

5.8 Small Group Discussions

Small group discussions were attended and some were organised to discuss experiential knowledge of medical practitioners, social workers and some para-medical staff.

In groups organised by the researcher, the research interview method was used to obtain research relevant information and focus was on content specified by research objectives of ..... systematic description, prediction and explanations. [29] Each topic was presented by means of specific questions and the researcher decided when the conversation satisfied the research objective.

6. VALIDITY

> "It would be a mistake to think that the investigator undertaking a description of communication content can merely assume the validity of his findings or that he is free, in designing and executing his research design, from making decisions which may significantly affect their validity. Lack of proper attention to any of several problems may vitiate the findings of an otherwise carefully designed study. These include careful formulation of the question in theoretical terms prior to coding and analysis so that the interpretation process is not reduced to finding some explanation to fit the data; preparation of a sampling design that reduces the universe of relevant data to manageable proportions without introducing biases which preclude valid generalizations from the sample back to the universe; construction of categories which meet both the theoretical requirements of the problem

> at hand and the general canons of category construction; and precise operational definition of categories so that coding can be done with an acceptable level of reliability."[30]

In this research every effort was made to meet both the theoretical and practical requirements within the accepted boundaries of reliability and validity. The writer realised that reliability is a necessary condition of valid enquiry but "paradoxically" the cost of some steps taken to increase reliability may be a reduction in validity as indicated. Compare notes 31 and 35.

When categories were analysed and reclassified, following our pilot study, efforts were made to enhance the likelihood of valid inferences in this research. Validity is usually described as the extent to which an instrument is measuring what it is intended to measure. During our follow-up discussion this was confirmed.

The American Psychological Association has distinguished between content validity, predictive validity, concurrent validity and construct validity. Although clients' statements were taken at face value and content validity was relied upon in the content analysis the researcher was also interested in construct validity involving both the measure and the underlying theory.

Categories as analysed by the researcher were found to be consistent with the problems of marriage guidance clients throughout the world and the same measure was successfully utilised at Marriage Guidance Societies throughout South Africa. Efforts were made to corroborate inferences about latent meanings of messages by additional data collecting procedures in small group situations and individual interviewing as indicated.

Although the manifest level of content was taken into consideration the communication process between client and therapist prior to recording did affect the message and we are not presuming any level of "manifest purity" in these categorised messages.

According to the literature, selective sampling of definitions indicate that along with persisting consent about some characteristics of content analysis there has been a marked tendency to broaden the boundary of content analysis by means of less restrictive definitions. George as indicated refers to the value of qualitative content analysis in applied Social Science, while Holsti has indicated the value of content analysis when data accessibility is a problem and limited to the messages provided by individuals, as in this research.

Throughout this investigation the investigator has been aware of the inter-relatedness in the validity, sampling, design and reliability of this investigation. It has been confirmed that valid inference is a goal of all enquiry but it does not exist independently of other aspects of the research process .

As indicated validity is often a problem in evaluative research, requiring special attention. Efforts were made to enhance validity by utilising unbiased measurements including follow-up checks in an attempt to determine the degree of validity and by re-evaluation of initial categories,[31] combining both qualitative and quantative techniques.

Selective observation was attempted in the investigation of the training programme and, as indicated, efforts were made to provide clear boundaries by utilising objective evaluative techniques. This was taken into consideration not only in the analysis of factual information but especially in the evaluation of feedback information obtained in the affective and psycho-motor areas.

7. LIMITATIONS OF THIS RESEARCH

7.1 The Problem-centred Approach

As a result of the assessment of client's needs and the decision to concentrate on the clients' verbalised statements, this part of the research is problem-centred.

Analysing problems rather than areas of competence has become an occupational and scientific hazard for psychologists, psychiatrists and some educationists.

As counsellors are trained to be positive in counselling and assist clients to overcome marital difficulties, emphasis on areas of stress only, could therefore result in a negative rather than positive emphasis in counselling.

Efforts to direct both clients and counsellors from the negative to the positive aspects, finally achieving a positive approach in counselling are essential. It should be stated, however, that the criteria to define competence in marriage has as yet not been established and as confirmed by Kieren and Tolman [32] this adds to difficulties in training.

Adopting a "problem-approach" was further necessitated by the fact that it is essential for the counsellors to establish a good working rapport with the client in the interview. Clients verbalise about problems interviews. Trainees are taught that their needs must be acknowledged, if possatisfied, during these interviews. Counsellors must be able to do this and f actual lectures and counselling techniques must be offered during training in accordance with these needs. The result - almost a vicious circle of a problem-centred tendency reinforced by training in view of the clients' verbalised needs.

7.2 Limited Feedback following Counselling Sessions

Clients returning for counselling may be motivated by many factors and the counsellor's efficiency may only be one of peripheral importance. It cannot be presumed that this in itself indicates successful counselling.

In marriage guidance work, as in many areas of the helping professions, "failures" are more prominent than "success". Perusal of the daily divorce columns is often the only feedback.

A further limitation was the fact that interviewees' responses were taken at face value when they were required to evaluate the coded areas of stress during follow-up enquiries. Their own needs, personal experience of similar areas of stress in their own marriage, might have resulted in subjectivity, empathy or withdrawal, thus affecting their responses. Individual enquiries following all these responses were beyond the scope of this investigation. It was merely assumed that experienced counsellors had sufficient self-knowledge and objectivity to respond with accuracy and insight. According to Smith the trait-theory is still the most acceptable in the absence of any alternative, in spite of above limitations which may or may not affect ratings.[33]

7.3 The "Hawthorn" Effect ; Placebo and Self-fulfilling Prophecies

Although successful control was partly obtained, the regular interviews, especially with the Marriage Guidance Counsellors, did result in "improved morale" and self-fulfilling prophecies to a lesser extent.[34]

7.4 Limitations of Illuminative Action Research

Action research is almost completely empirical and local although it could contribute to the integration of facts into theory, provide for testing of theory and concepts and clarify and integrate previously existing theories.

Because of the maximum flexibility which is required in the operation and interaction of multiple variables in the situation, identification of causes may be difficult, even when results are obtained.

Action research starts with a sample taken as it is and therefore it is not always clear to what population conclusions will apply.

However, action research can generate tentative hypotheses and generalisations.

It does appeal to the practitioner and often bridges the gap between rigorous research findings which cannot always be applied, and changing attitudes of practitioners, enabling them to utilise research findings in practice.

7.4.1 In illuminative evaluation foremost concern usually involves the 'subjective' nature of the approach. Can 'personal interpretation' be scientific? Sceptics may also ask whether collection, analysis and data reporting are not entirely at the discretion of the researcher only.

However, these questions are based on the erroneous assumption that forms of research exist which are immune to prejudice, experimenter bias and human error. Any research require skilled human judgements and this is vulnerable. [35]

Even in evaluation studies with automatically processed numerical data judgement is necessary throughout.

However, to prevent gross partiality which is a possibility, interviews were structured, cross checks were made and members of small groups were asked to discuss their own interpretations. With careful control the use of interpretative human insight and skills can be advantageous, especially when the researcher is also a practitioner, and utilisation of these skills on occupational routine.

7.4.2 A further aspect which could be a disadvantage with the inexperienced researcher is the effect his or her presence may have on the conduct and progress of those included in his area of research, as any form of data collection creates disturbance.

This was recognised and specific efforts were made to be unobtrusive, not secretive, supportive not collusive and non-doctrinaire without being unsympathetic. Interpersonal skills, where co-operation is sought but the researcher cannot demand it, is of the essence.

7.4.3 With this specific topic tact and responsibility, when data was collected in areas where personal issues may affect responses, have been of paramount importance. The same ethical requirements pertaining to private practice have to be adhered to by the responsible investigator. In the reporting stage the individual's privacy is of greater importance than richness of data and disciplined presentation is an important requirement.

7.4.4 It could be concluded that the above disadvantages for the inexperienced non-practitioner or unprofessional academic may well prevent them from utilising illuminative evaluation, mainly perhaps because of possible limited practical experience and inadequacy regarding interperson skills and ethical awareness.

However, according to Argyris, researchers who are unable to provide help needed when research evoked responses within individuals require this, will let down their public. Moreover, they may miss the opportunity to conduct research describing existing features of the Social Universe that have been unavailable for study. According to him researchers will be required to exhibit skills of intervention, to help systems

alter their make up and skills to design learning environments to accomplish those requirements. [36]

Until this has taken place Rowan warns against inexperienced illuminative evaluators. Lack of attention to ethics or politeness, according to him, can undoubtedly backfire and create a severe nuisance rather than a sense of benefit. He therefore strongly recommends careful choice of those researchers permitted to utilise this method.[37]

The need to train post graduate researchers especially in the helping professions to be "responsible therapists" seems to be an area that warrants more attention in the writer's opinion and in view of experience gained during this research.

The research findings will be presented and discussed in Chapters 6 and 7.

CHAPTER 5

REFERENCES AND EXPLANATORY NOTES

1. Paris, O.E.C.D — Innovation in Education. Centre for Educational Research and Innovation, Paris, 1971. See the se of reports reviewing developments in other countr

2. Price D Jde S. — Little Science, Big Science. Columbia University Press, 1963.

However, as a new field the evaluation of curriculum projects has encountered a wide range of problems both theoretical and methodological Current concerns include the 'roles' of evaluation (Scriven 1967); the neutrality of the evaluator (Caro 1971); the value of classroom observat (Light & Smith 1970); the function of formative evaluation (Smith 1971); the use of objectives (Popham 1963); and the value of longterm studies (Caro 1971). As a developing field of study evaluation proceeds in the absence of agreed frames of reference.

3. Kuhn, T.S.(1970) — Paradigms and Revolutions. Gary Cutting, Notre Dame Univ. Press, 1980.

4. Parlett, M. — Evaluating innovations in teaching . Quoted by H J Butcher & E Rudd, London, McGraw Hill, 1972.

Many statistical and experimental techniques used in educational researc were originally developed in agricultural experiments. Parlett refers t the "Agricultural-botany Paradign" in this regard.

5. Young, M.F.D. — Knowledge & Control. London Collier-MacMillan, 1971.

6. For instance within this framework Lindvall and Cox (1970) have argued that the 'effectiveness' of an innovation is 'determined' by the answers to four basic questions.

'(1) What goals should the program achieve?

(2) What is the plan for achieving these goals?

(3) Does the operating program represent a true implementation of the plan?

(4) Does the program, when developed and put into operation, achieve the desired goals.

At face value these questions seem reasonable. But they embody problematic assumptions. For example, projects rarely have clearly specified and commonly agreed 'desired goals'. Measurement of 'goal achievement' is never unequivocal. To speak of a 'true implementation' is utopian, even nonsensical in terms of educational practice.

Within this framework, it has been proposed that

'the search for (compensatory) programs which are working well should become a three-step procedure:

(1) First, locate the best recreatable centers, employing techniques which use estimates of average random variation. This will require analysis of variance, followed by multiple comparison procedures.

(2) Estimate, separately, the impact of random factors upon only the best-performiang centres.

(3) Use this selective estimate of random variation to test whether these best centers are out-performing chance, and are worth recreating.'

This evaluation suggested here is based purely on numerical results; no other data would be collected or eligible for consideration. Recently, however, there has been increasing resistance to evaluations of this type. The more notable shortcomings have already been mentioned.

Light, R.J. and Smith P.V. Choosing a future: Strategies for designing and evaluating new programs. Harvard Educational Review, 40 Winter, 1970. pp. 1-28.

Lindwall, G.M. The I.P.I. Evaluation Program , AERA Monograph No. 5, pp. 5-6, 1971.

7. Parlett, M. Seminar:Donforth Foundation Workshop on Liberal Arts Education. Colerado Springs, 1972.

8. Gutentag, M. Models and methods in Evaluation Research . Journal: Theory of Social Behaviour 1, pp 75-95, 1971

In addition to Gutentag, Stake, Mac Donald, Taylor (1971) and Parlett et al all have developed their objections extensively in this regard.

9. Trow, M.A. Methodological Problems in the evaluation of innovation . New York : Holt Rinehart & Winston, 1970.

The term Illuminative Evaluation is drawn from Trow while the evaluation as described grew from research in association with B.R. Snyder & M.J. Kalwi. See Parlett et al.

Snyder, B.R. The Hidden Curriculum, New York, 1971.

10. For studies examining various aspects of this approach and its relationship to intellectual development and social context see

Becker, H.S. Making the Grade, New York : Wiley and Sons, 1968.

11. See note 9. p. 302.

12. Triangulation is a technique of using multiple reference points to pin-point an object's exact position, for example a radio transmitter, or in navigation or military strategy.
In Social Science methodology the term is used metaphorically to indicate the use of multiple methods, combining quantitative and qualitative strategies effectively in the study of a single problem, it is also described as convergent methodology, convergent validation or multi-method/multitrait.

Bouchard, T.J. Unobtrusive Measures: An inventory of uses. Sociological Methods and Research 4, 267-300, 1976.

Jick, T.D. Mixing qualitative and quantitative methods: Triangulation in action. Administrative Science Quarterly, 1979, 24, 602-611.

Strümpfer, D.J.W. One Hundred and One Years after Wundt National Psychology Congress, Johannesburg, 1980.

Webb, E.J. Unobtrusive Measures: An inventory of uses. Sociological Methods and Research 4, 267-300, 197

13. See note 4. p.9.

14. During subsequent discussions with colleagues and supervision consultants the "team-approach - facilitating - an - over awareness - of the - other - man's - discipline" has been considered as a possibile explanation.

15. Olivier, L. Sexual Dysfunction amongst Whites, Indians, Coloureds and Black People in South Africa. H.S.R.C., 1982.

16. In some urban areas psychologists in private practice and gynaecologists are also approached while Family Planning Clinics are not fully utilised for this purpose by others.

17. Olivier, L. See Notes Chapter 2, No. 49.

Robertson, L.I. Panel doctor and general practitioner specialisir in sexual dysfunctions.

18. The writer is a firm supporter of "the emerging group of psychologists who express deep concern over alienating methods of doing research" and is in full agreement with Wolfe (1980) who said:

"How ironic! Those who provide data in the social and behavioral sciences are called subjects, but for the most part are treated as objects - as things to be observed examined, proded and probed, manipulated and controlled. Even when the researcher is interested in the person's subjective reality it is filtered through various instruments and devices intended to make it more objective. In any case, the 'subject's experience and response is generally treated as quite separate from and different than the researchers own subjective reality" (1980, p 1).

In a similar vein, Fineman (1979) commented on the term "subject" as being too distant, too depersonalizing, as if it gives the researcher a licence to manipulate and deceive. Both of these psychologists, speaking from a humanistic vantage point, plead for greater authenticity in the research relationship, for research processes that will affirm the basic humanity of both the "subject" and the researcher, but that would also bring the "subject" into the process as a participant whose quest for self-understanding and personal growth will be supported and enhanced. In the organizational context, Fineman spoke about not just being another leech on the time of one's participants, and not denuding the organization by grabbing their data without returning anything.

Experience during this research also clarified the need of some to remain "objective and distantiated". It is much easier, less time consuming but limiting personal enrichment and perhaps community responsibility.

Wolfe, D.M. On research participant as co-inquirer. Symposium on Alternative Approaches to Research: Proposals and examples. Academy of Management

Fineman, S. A psychological model of stress and its application to managerial employment. Human Relations, 1979, 32, 323-345.

19. Anderson, S.B. & Ball, S. The profession and practice of program evaluating. Jossy Boss Ltd., London, 1978.

20. In Collaborative Enquiry we are spanning four different 'Territories' of human reality: 1) The outside world; 2) One's own behaviour; 3) One's own and other's thinking and feeling and 4) The dynamics of human attention as it gains, loses or changes focus narrowing or widening qualities of which it is aware.
At any given time attention may include all four qualities of human reality and their interaction with awareness,or only one quality.
Its main aim is not generalizing to other 'settings' but applying knowledge to improve effectiveness. For ethical responsibilities in this in depth evaluation compare Andeson, S.B. and Ball, S.:"The profess and practice of program evaluation," Jossy Boss Ltd., London, 1978.

21. Glaser, B.G. & Strauss, A.L. Discovering of Substantive Theory A Basic strategy underlying quantitative researc American Behavioural Scientist, 1964-1965, 8, 5-

22. Kahn R.L. & Cannel, F.F. The Dynamics of Interviewing: Theory, Technique and Cases. New York. John Wiley & Sons, Inc., 1965.

23. Rowan, J & Reason, P. Human Inquiry.. A Sourcebook of New Paradigm Research. John Wily & Sons, 1981.

He warns against inexperienced evaluators who are unable to adhere to requirements of clients and students because of limited skills and knowledge.

24. Berelson, B. Content Analysis in Communication Research. New York Free Press, 1952.

25. Holsti, O.R. Content Analysis for the Social Sciences and the Humanities. Reading Massachusets, 1969. p. 9.

26. See note 25.

27. See note 25.

28. See note 22.

29. Lindsay, G. and Arenson, E. The Handbook of Social Psychology. Reading Mass. London. Ontario. Addison Wesley Publ. Co., 1968.

30. See note 25, p. 169.

31. The writer is in full agreement with Platt 1964 who maintained that simple observation methods are often more productive than rigid laboratory or statistical experiments.
"Convergence of findings by two methods with different weaknesses enhances our belief that the results are valid and not a methodological artifact". Bouchard (et al) 1976 p. 268.

Platt, J.R. Strong inference. Science, 1964, 146, 347-353.

32. Kieren, R & Tolman, J. The Social Context of Marriage. New York, J.B. Lippercot & Co., 1966.

33. Smith, H.C. Sensitivity Training New York, McGraw Hill Book Co., 1973.

34. Paul, C. Stern Evaluating Social Science Research, Oxford Press, New York, 1979.

Extraneous variables are discussed and good reference made to the Hawthorne effect, placebo and self-fulfilling prophecies affecting research data. P. 71-89.

35. The writer agrees with Van Maanen p. 18 in this regard:
"Real life is, after all what researchers try to illuminate. By doing this on a qualitative basis the distance is reduced between theory and data between context and action. The raw materials of qualitative study are therefore generated in vivo close to the point of origin".

Van Maanen, J. Reclaiming qualitative methods for organisationa research: A preface. Administrative Science Quarterly, 1979, 24, 520-526.

36. Argyris, C. Inner Contradictions of Rigorous Research. Harvard University, Academic Press Inc. (London) 1980.

37. See note 23.

CHAPTER 6

DESCRIPTION OF THE MAIN RESEARCH FINDINGS

In accordance with the model presented in Chapter 5, the main research findings in this chapter will be presented with specific reference to the clients' needs and the counsellors' and therapists' ability to satisfy these needs.

To achieve the final objectives and initiate a training programme, the main research was designed to reply to some specific questions regarding the clients, the therapists and the existing facilities.

In part one of this chapter the findings following a content analysis will be presented as tables 1.1.1. - 1.1.11.

Details were obtained from 1 961 completed case records of all the clients who attended the Durban Family and Marriage Society in 1982/83.

Thirteen categories of marital difficulties applicable to training were finally selected and will be presented in table 1.2.1 and, detailed information about clients who were all seen personally by the writer will be summarised.

In part two the structured questions given to the selected multi-professional group of 56 consultants are presented as Table 2.2 in addition to a summary of their personal details presented as Table 2.1.

Finally the replies obtained from the respondents following personal structured interviewing are summarised.

1. THE NEEDS OF MARRIAGE GUIDANCE AND SEX THERAPY CLIENTS

1.1 Tabled details about clients following the content analysis

TABLE 1.1.1

INITIAL SOURCES OF REFERRAL OF COUPLES WHO SOUGHT ASSISTANCE

	WHITE	COLOURED	INDIAN	BLACK
Self	253	27	81	22
Legal	126	12	12	-
Other	46	15	29	46
Friend	23	10	53	8
Welfare Office	21	13	34	8
Relative	24	4	20	6
Medical	18	-	10	8
Other Clients	46	15	29	46
Employer	4	-	8	1
Psychologist	6	-	3	-
Church	5	-	-	2
F A M S A	2	1	-	-

The self referrals resulted mainly from press advertisements of the facilities of F A M S A (Family and Marriage Society) in Durban according to a follow-up group enquiry held with senior workers in Durban.

In view of a close liaison between the Durban branch of FAMSA and the Legal Aid Society;as well as the high divorce rate, "legal referrals" are of high frequency.

Friends and relatives who had been to F A M S A often referred clients according to social workers and marital couples. This was confirmed during follow up enquiry interviews.

The relatively limited number of referrals from the medical profession confirm that a possible stigma is still attached to any such assistance that may be required but may also confirm ignorance regarding existing facilities.[1]

Many ministers of religion indicated that they accepted marriage and sex counselling as part of their own responsibility. This seems to be confirmed by the small number of referrals from churches in the above Table.

TABLE 1.1.2

FAMILY STRUCTURE

	WHITE	COLOURED	INDIAN	BLACK
Nuclear	419	75	178	57
Extended	90	12	82	29
One Parent	25	1	8	16

Some Indian Social Workers had a few clients whose movement away from their extended families into nuclear family resulted in marital problems. However, 11 couples from extended families maintained that their in-laws and/or economic and occupational factors contributed to marital problems.

Two couples had severe sexual difficulties as a result of the limited privacy in the home of their extended families.

TABLE 1.1.3

DURATION OF THE MARRIAGE AND MARITAL STATE

	WHITE	COLOURED	INDIAN	BLACK
Pre-Marital	25	-	3	10
Divorced	14	1	2	3
0 - 5	218	34	110	26
6 - 10	122	31	60	30
11 - 15	64	10	54	18

In a total of 992 couples, 388 experienced marital difficulties during the first five years of their marriage. This coincides with findings throughout South Africa and the Western World.[2]

This also correlates with the age group 20–30 in Tables 1.1.6 where 842 couples in a total of 1 938 experienced marital difficulties. Although not indicated on this Table couples whose children have left home often experience marital difficulties.

With six couples the menopausal symptoms of wives coinciding with the "empty nest" syndrome after the children left home were main contributing factors to marital breakdown, one husband had an affair and one wife attempte suicide.

According to the responses in our multiracial group of menopausal females, the extended family system serves a very important purpose during this phase especially for the female in contrast to that of the nuclear family.

Often spouses are unable to adapt new roles and different intermarital demands when the children have left home especially in the nuclear family.

Some G.P's confirmed the necessity of anti-depressants in addition to hormone replacement therapy for their female patients at this stage. Often such interventions were preceded by wives complaining about marital unhappiness.

One affluent couple arranged a world tour in an effort to "share a new experience". However, as a result of the wives inability to respond physic to her husband, marital therapy was required after their return.

Two wives went to visit their married children 3–4 times per year "to get away" from their husbands. One husband spent all his time at work or on the golf course as a result of marital unhappiness.

TABLE 1.1.4

INCOME LEVEL OF MARITAL COUPLES

	WHITE	COLOURED	INDIAN	BLACK
R0 - R499	75	38	143	59
R500 - R999	109	22	78	21
R1 000+	325	15	15	2
Unemployed	25	13	32	20

According to consultants two main factors are applicable to the fact that most couples from middle to upper middle-class socio-economic groups seek assistance.

Their level of sophistication and knowledge about existing facilities result in a readiness to seek assistance.

Secondly, the "basic need-satisfaction hypothesis" does not apply to this group, especially inorgasmic wives who claimed that "sex was not enough".

Three couples came for assistance because the wife felt that she was not needed, of these one husband was a medical doctor, one a University lecture and one an engineer. All of them supported their husbands during the first years of marriage while the husband studied. One wife preferred to be "mother" to her husband and was unable to accept him as an "adult", one wife resented being a housewife "and nothing else", while the third wife had an affair "because my husband is married to his job".

An inability to adapt to seniority or occupational success of husbands and the husband's preference to an occupational environment where he receives respect and has more power than at home resulted in a number of marital breakdowns of couples who sought assistance.

One husband was impotent with his wife but otherwise active sexually while two highly successful businessmen "lost interest in sex altogether" according to their statements. With both, regular heavy drinking was part of this daily routine as "successful men".

TABLE 1.1.5

NUMBER OF PREVIOUS MARRIAGES

	WHITE		COLOURED		INDIAN		BLACK	
	H	W	H	W	H	W	H	W
One	103	120	11	10	10	8	12	7
Two or More	15	12	-	1	-	-	2	1

According to the 1982 Census [3] there is no significant difference between this and the larger population group.

With two of the couples where both spouses had been married once before the wives were very concerned about the prospect of "another divorce". One husband appeared to be unwilling to co-operate in therapy while the other husband compared his present wife unfavourably with his ex-wife.

TABLE 1.1.6

AGE OF CLIENTS REQUIRING ASSISTANCE

	WHITE		COLOURED		INDIAN		BLACK	
	H	W	H	W	H	W	H	W
Under 20	2	25	-	2	2	12	-	1
20 - 30	188	239	36	50	115	157	21	36
31 - 40	190	174	38	28	110	81	50	47
41 - 50	94	64	10	5	33	13	15	14
51 - 60	28	10	3	1	5	4	5	-
60+	14	12	2	1	1	-	-	-

More wives in the White, Indian and Coloured groups seek assitance in the 20 - 30 year age group, while age differences of males in the 20 -40 age group are not highly significant.

In contrast to the American "life begins at fifty syndrome"[4] there is a significant drop in the number of couples who seem to require assistance at this stage. A number of husbands were mainly concerned about their inability to maintain erections, while two husbands were impotent and this affected the marital relationship. One wife was unable to accept this and falsely accused her husband of an affair.

TABLE 1.1.7

RELIGIOUS DENOMINATION

	WHITE		COLOURED		INDIAN		BLACK	
	H	W	H	W	H	W	H	W
Roman Catholic	79	97	43	40	-	-	15	16
Protestant	183	231	25	27	19	24	21	23
Jewish	13	8	-	-	-	-	-	-
Tamil/Hindu	-	-	-	-	193	188	-	-
Moslem/Islam	-	-	-	-	40	41	-	-
Zulu	-	-	-	-	-	-	-	-
other	116	126	17	24	10	14	43	52
No Religion	187		-		4		19	

The total absence of Zulu clients and the small group of Black clients confirm the experience of Black professionals who stated that many of their people are not ready or willing to seek assistance from official bodies when there are marital problems. In view of the large number of Roman Catholic, Protestant and Hindu clients the ethical/cultural aspects of these groups were discussed in Chapter 3 as indicated previously.

TABLE 1.1.8

HOME LANGUAGE OF CLIENTS

	WHITE		COLOURED		INDIAN		BLACK	
	H	W	H	W	H	W	H	W
Erglish	436	450	86	58	244	245	–	1
Afrikaans	64	64	1	2	–	–	–	–
Tamil	–	–	–	–	13	13	–	–
Urdu	–	–	–	–	–	–	–	–
Zulu	–	–	–	–	–	–	90	94
Other	12	14	1	1	9	9	1	3

There seems to be a difference between Afrikaans and English speaking couples who sought assistance. The fact that all the Indians and most of t Coloured couples are English speaking increased this numerical difference.

In addition it may also confirm opinions expressed by some social workers that the Afrikaans speaking population in Natal do not avail themselves easily to these facilities.

TABLE 1.1.9

OCCUPATION OF HUSBANDS AND WIVES
WHO REQUIRED ASSISTANCE

	WHITE		COLOURED		INDIAN		BLACK	
	H	W	H	W	H	W	H	W
Professional	83	62	4	5	8	11	4	18
Commercial	121	62	–	10	56	14	4	1
Secretarial	9	76	1	10	17	12	4	2
Trade	116	10	56	1	66	4	5	–
Other	178	79	25	15	115	60	72	48
Housewife	244		49		170		31	

It has been found that more housewives have marital problems than working wives.[5] This is confirmed by the numbers of Indian, Coloured and White wives who sought assistance in this group. The smaller group of Black housewives may well confirm the fact that many are not ready or able to seek assistance.

TABLE 1.1.10

PRESENTING PROBLEMS OF CLIENTS

	WHITE		COLOURED		INDIAN		BLACK	
	H	W	H	W	H	W	H	W
Emotional Difficulties	105		8		15		2	
Infidelity	47		17		48		8	
Alcohol/Substance Abuse	51		20		39		7	
Communication	65		3		12		3	
Legal Aid	61		4		3		1	
Desertion	13		7		29		16	
Divorce	33		8		13		11	
Family Problems	17		1		20		10	
In-Laws	4		6		31		4	
Incompatability	19		3		8		2	
Role/Conflict	27		2		2		-	
Others	19		2		7		3	
Pre-Marital	18		-		5		5	
Sexual	19		2		6		-	
Financial Problems	13		2		7		2	
Non-Support	2		2		6		12	
Violence	10		-		11		3	
Stepfamilies	10		1		-		1	
Housing	1		-		3		7	
Teenage Problems	1		-		1		2	
Religious/Cultural Differences	-		-		2		1	
Ill-Health	-		-		-		2	

In a total group of 969 couples, 394 couples had emotional and sexual problems or difficulties caused by substance abuse. All these have a direct affect on the heterosexual relationship[6] often resulting in desertion, divorce, legal aid, family and financial problems, poor communication, sometimes violence and or role conflict.

If this group is presented qualitatively a total number of 442 couples are thus affected. This confirms the spiralling effects of interpersonal and heterosexual marital problems often resulting in divorce.[7]

Apart from the high incidence of emotional difficulties of the Whites there are only a few minor differences between race groups.

During a most useful follow-up enquiry with consultants an Indian Social Worker indicated that the relatively high incidence of desertion and problems with in-laws often occur when the wife returns to her extended family. This may not result in divorce but both in-laws and family members play an important part both regarding problems in young marriages and assisting them to find solutions.

TABLE 1.1.11

STATE OF MARRIAGE OR RELATIONSHIP WHEN ASSISTANCE WAS REQUIRED INITIALLY

	WHITE	COLOURED	INDIAN	BLACK
No conflict	18	1	7	11
Some conflict	87	13	31	20
Severe conflict	122	21	55	23
Separation attempted by one or both	25	1	4	-
Living apart:				
1 month	56	6	54	6
6 months	37	7	29	13
1 year	7	2	13	4
over 1 year	32	2	11	13
over 2 year	15	2	6	3

During follow up enquiries consultants indicated that some wives have a pattern of moving out with regular intermittent periods of "stable marital relationships". With most, however, it constitutes a serious threat to the marriage sometimes resulting in divorce.

Cultural differences as indicated do exist especially where the extended family plays a dominant role in the marriage

1.2 Further Categorization of Coded Marital Difficulties

Following the content analysis of 1961 clients, a brain storming session was organised with a small group of Marriage Guidance Social Workers and Psychologists. The main purpose was to assess the reliability of coded categories by the test re-test method.

As a result of this, thirteen final categories of marital stress were isolated.

In view of the high level of agreement between the writer and the counsellors concerned, and confirmed by follow-up enquiries and group discussions, the thirteen areas of marital stress were finally accepted as a reliable indication of some of the most important areas of training which should be developed so that objectives could be achieved, especially regarding factual knowledge offered to trainees.

Although the sample is relatively small, these findings are in accordance with research findings throughout the world as quoted in Chapter III. These thirteen categories presented in Table 1.2.1 will be discussed briefly with reference to specific problems of 86 individual clients who were contacted personally by the writer.

TABLE 1.2.1. THE 13 CATEGORISED AREAS OF MARITAL STRESS ACCORDING TO THE CLIENTS' STATEMENTS, DURING THE FIRST INTERVIEW (N = 86)

CATEGORY	FREQUENCY	PERCENTAGE
Sexual dissatisfaction	19	23,2
Third Person	17	19,76
In-Laws or Stepchildren	9	10,46
Heavy Drinking or Drugs	7	8,13
Inadequate Personality	7	8,13
Incompatability	6	6,97
Clients requiring guidance	6	6,97
Finances	5	5,81
Mental and Physical Cruelty	3	3,48
Psychotic or Neurotic Tendencies	3	3,48
"Forced Marriages"	2	2,32
Disturbed Childhood	1	1,16
Sterility	1	1,16

According to the findings in the content analysis 23% of the clients stated sexual dissatisfaction was the main problem in their marriage. Three wives blame themselves because of their inability to achieve orgasms; two wives stated that they were too inhibited due to various guilt feelings and their "strict" up-bringing; one wife was forced to marry (and resented physical contact) and one wife was brought up in an orphanage and felt that she was unable to respond physically or emotionally to her husband. Further questioning confirmed initial vaginismus which was not treated.

Four husbands stated that secondary impotence was the main problem, one due to ill-health; one husband, whose marriage was a forced one, had a mistress one failed to respond physically due to heavy drinking and one suffered impotence for many years.

Of the eight other couples both parties stated that sexual dissatisfaction was the main reason for their marital difficulties. Two of these husbands started to drink heavily and it affected their physical relationship;

two husbands resented their in-laws and lost interest in their wives; one wife "changed" after marriage, and due to her inhibited reactions, her husband lost interest; one couple lost interest following financial successes and pre-occupation with their very active social life; while another wife refused intercourse as she never obtained orgasms after marriag The other couple claimed that their loss of interest in the physical relationship was a mutual experience due to resentment and other problems.

Involvement with a Third Person (N = 17)

One wife complained that her husband had relationships with coloured women; one husband had an affair while his wife was in hospital (hysterectom and one husband was impotent with his wife, but not in sexual relationships with other women.

The remaining 14 had various problems in their relationships for many years prior to a third person entering the scene and often reinforcing existing differences. In this group 7 husbands felt that there was a general incompatibility in the marriage while their wives disagreed and blamed the third person entirely. Three wives had affairs; one wife left her husband because he had an affair; three husbands had various relationships with other women. Of the seven husbands five of their "third persons" were either working in the same field or were their personal secretaries.

In-laws or Stepchildren (N = 9)

In this group, four couples stated that the relationship with their stepchildren was the main cause of marital discord. Of these, three husbands complained about their wives' attitudes towards their own children, causing the wife to neglect the husband, while one wife complained about the husband's devotion to their children.

Two wives complained about their in-laws living-in, while one wife felt that her "fighting mother-in-law" was the main cause of marital discord.

One wife had her brother-in-law as a boy-friend, according to her husband, while one husband married a girl whom he did not love because his family forced him to marry her.

Heavy Drinking and Drugs (N = 7)

In this group all the wives informed the counsellors that their husbands' drinking (one drugs) caused marital breakdown. Three of the men agreed that this was the main problem. One was a confirmed alcoholic, while the others were heavy drinkers and two had occasional "lost weekends" (amnesia on a Monday morning).

Inadequate Personality (N = 7)

Three wives claimed that their husbands were unable to cope, neither could keep steady jobs, nor provide for the family and fulfil their roles as husbands and fathers, due to inadequacy. Three husbands had similar complaints (two confirmed by medical reports), and one wife (according to her husband and her own mother) was too immature to take care of her children and her home.

Incompatibility (N = 6)

In this group of six, two couples whose cultural differences caused a complete breakdown in the marital relationship, were included in this section. Three were emotionally incompatible according to the wives (two confirmed by husbands) while one couple stated that their intellectual incompatibility was the main problem. (Both partners agreed).

Clients Requiring Guidance (N = 6)

Three couples required guidance regarding their physical relationship,

one mother came for guidance to assist her teenage daughter, while two young couples received some pre-marital guidance from a counsellor.

Finances (N = 5)

In this group of five, three husbands complained about their wives' inability to adjust to their income, while their wives complained about their husbands' inability to earn a steady income.

Two couples had marital difficulties because of severe financial stresses and an inability to cope generally.

Mental and Physical Cruelty (N = 3)

Three wives complained (two with medical confirmation) about their husbands' physical cruelty, stating this as the main reason for marital breakdown. One husband took drugs occasionally and blamed this on his wife's "mental cruelty".

Psychotic and/or Neurotic Tendencies (N = 3)

Two husbands and one wife were confirmed by medical practitioners as suffering from neuroses. Their behaviour and their poor mental health were the main problems, according to medical information and confirmation by their spouses.

Forced Marriages (N = 2)

Two wives felt that marital problems were caused mainly by the fact that marriage was a forced one.

Disturbed Childhood (N = 1)

One wife indicated that her husband's behaviour as a result of an unhappy childhood was the main reason for their inability to make a success of their marriage. The husband's disturbed childhood was confirmed by a social welfare officer.

Sterility (N = 1)

One wife (confirmed by husband) felt that the sterility of her husband caused marital difficulties and affected the whole relationship.

1.2.2 Summarised Findings

In summary, these findings clearly indicate that problems regarding sexual dissatisfaction contributed to well over 20% of the difficulties of the couples investigated. Individual questioning of both counsellors and clients revealed that the lack of sexual satisfaction was a symptom of a variety of causes but eventually the main reason for dissatisfaction and marital discord.

Involvement with a third person very seldom correlated with physical needs only, but very definitely indicated psycho-social and emotional loneliness and a general need for companionship.

In-laws and alcohol were the next two areas of frequent causes of discontent, according to the clients during their first interviews.

It was noted that in-laws were listed as one of the most frequent problems in Ghana [8], but it was often related to cultural incompatibility.

In this investigation incompatibility was defined in a broad sense and cultural, physical and intellectual variables were all included in this category.

2. THE NEEDS OF COUNSELLORS AND SEX THERAPISTS

Having completed the content analysis and categorisation of areas of marital stress, which will finally indicate the training requirements, an investigation of counsellors, therapists and consultants was conducted to assess their most important needs in offering sex and marital therapy to clients.

In Table 2.1 personal details are summarised about the selected group of consultants, consellors, therapists and lecturers who were approached for this purpose.

The decision regarding the selection of the professional groups for inclusion in this research was made after examining the attendance list of delegates to a workshop on Human Sexuality held at the Natal Medical School in 1983. In addition it correlated, with a few exceptions, with those groups found by Olivier[9] in her research regarding Sexual dysfunctior and facilities in South Africa to have the widest experience of clients with sexual dysfunctions.

In view of the emphasis on training, special efforts were made to obtain information from senior academics in these chosen professions.

The racial proportion is an accordance with the attendance of delegates especially to the National Conference for Gynaecologists held in Durban in October 1983 and the Annual Conference of the Psychologists held in Pietermaritzburg in November 1983. In addition to this the availability and proximity of Whites and Indians in Natal also contributed to the specific ratio in Table 2.1.

TABLE 2.1

PERSONAL DETAILS ABOUT CONSULTANTS, COUNSELLORS, THERAPISTS AND LECTURERS WHO WERE INTERVIEWED TO ASSESS THE AVAILABILITY OF SEX AND MARITAL THERAPY

SEX	AGE	OCCUPATION	MARITAL STATUS	RACE	RELIGION	PROVINCE
F	52	Senior Social Worker/Supervisor	Married	W	Anglican	Natal
F	51	Senior Lecturer/Social Worker	Married	W	Methodist	Natal
F	33	Social Worker/Lecturer	Married	W	Agnostic	Natal
F	58	Psychology Professor & Departmental Head	Married	W	Dutch Reformed	Transvaal
M	53	General Practitioner	Married	C	Anglican	Natal
M	42	Gynaecologist/Private Practice	Married	W	Christian	Cape
M	41	Gynaecologist/Department of Health	Married	W	Dutch Reformed	Transvaal
M	37	Gynaecologist/Private Practice	Married	W	Dutch Reformed	Transvaal
F	40	Clinical Psychologist/Department of Health	Married	W	Dutch Reformed	Cape
M	32	Psychologist/Lecturer	Married	B	Congregational	Cape
M	48	General Practitioner	Married	W	Dutch Reformed	O.F.S.
M	57	Pastoral Psychologist	Married	W	Dutch Reformed	Cape
M	44	Clinical Psychologist	Married	W	Dutch Reformed	Transvaal
M	38	Gynaecologist	Married	W	Christian	Cape
M	49	Pastoral Counsellor/Prof. & Dept. Head	Married	W	Christian	Natal
M	50	Gynaecologist/Prof. & Dept. Head	Married	W	Christian	Natal
F	31	Social Worker	Married	I	Muslim	Natal
F	32	Social Worker	Married	W	Agnostic	Natal
F	38	Social Worker	Married	B	Apostolic Church	Natal

SEX	AGE	OCCUPATION	MARITAL STATUS	RACE	RELIGION	PROVINCE
M	56	Psychiatrist	Divorced	W	Jewish	Transvaal
M	50	Psychiatrist/Prof. & Dept. Head	Married	W	Christian	Natal
M	48	Psychiatrist/Senior Lecturer	Married	W	Christian	O.F.S.
M	38	Minister of Religion	Married	W	Dutch Reformed	Natal
M	42	Clinical Psychologist	Married	W	Jewish	Cape
M	37	Minister of Religion	Married	W	Anglican	Natal
M	56	Minister of Religion/Prof. & Dept. Head	Married	W	Presbyterian	Transvaal
F	32	Occupational Therapist/Dept. Head	Single	W	Christian	Transvaal
F	31	Physiotherapist/Dept. Head	Single	W	Christian	O.F.S.
F	40	Midwife/Dept. of Health	Married	B	Anglican	Transvaal
F	42	Community Nurse/Dept. of Health	Married	B	Apostolic	Transvaal
M	37	Counselling Psychologist	Married	I	Hindu	Natal
M	39	Minister of Religion	Married	C	Christian	Cape
M	48	General Practitioner	Married	B	Agnostic	Transvaal
F	34	Gynaecologist	Single	W	Christian	Cape
F	36	Clinical Psychologist	Married	W	Jewish	Transvaal
F	54	Clinical Psychologist	Divorced	W	Jewish	Transvaal
M	57	Prof. Clinical Psychologist/Head of Dept.	Married	W	Jewish	O.F.S.
M	34	General Practitioner	Married	C	Christian	Cape
M	39	General Practitioner	Married	B	Roman Catholic	Transvaal
F	32	Hospital Matron	Divorced	W	Dutch Reformed	Natal
F	58	Senior Tutor Obstetrics	Married	W	Anglican	Cape
M	39	Clinical Psychologist	Married	W	Christian	O.F.S.

SEX	AGE	OCCUPATION	MARITAL STATUS	RACE	RELIGION	PROVINCE
F	37	Social Worker	Married	C	Christian	Cape
F	34	Senior Nurse (Dept. of Health)	Divorced	C	Christian	Cape
M	38	General Practitioner (Dept. of Health)	Married	B	Christian	Transvaal
M	37	Counselling Psychologist	Married	I	Hindu	Natal
M	43	Gynaecologist/Departmental Head	Married	C	Christian	Natal
M	46	General Practitioner	Married	I	Hindu	Natal
F	28	Social Worker	Married	W	Presbyterian	O.F.S.
F	32	Community Nurse	Married	I	Hindu	Natal
F	33	Psychologist	Married	I	Hindu	Natal
F	42	Social Worker	Married	I	Hindu	Transvaal
M	47	General Practitioner	Divorced	W	Christian	Cape
M	44	Gynaecologist	Married	I	Muslim	Transvaal
M	41	General Practitioner	Married	W	Christian	Natal

During structured research and collaborative interviews the questions presented in Table 2.2 were given to this group of 55 consultants.

TABLE 2.2

Questions asked by the Researcher during a Structured Enquiry Interview with Consultants, Counsellors, Therapists, Tutors, Lecturers, Ministers of Religion and Nurses.

---

1. Are some couples seen by you in need of Sex Therapy?
   1.2. Of what race and religion are they?

2. Are you able to offer this or
   2.1. refer them to people able to assist them adequately?

3. If you offer this service
   3.1. What are your main approach and methods?
   3.2. Is it adequate?

4. If you refer
   4.1. Who are the people you refer them to?
   4.2. Are they able to offer an adequate service?

5. Is there a need for training of Sex Therapists in your opinion?
   5.1. If no, Why?
   5.2. If yes:
      5.2.1. When should this be done?
      5.2.2. Where should it be offered?
      5.2.3. To whom?

6. What is the most frequent sexual difficulty of married couples according to your experience.

7. What do you require to improve your contribution regarding:
   7.1. Knowledge and/or
   7.2. Skills and/or
   7.3. Personal requirements if any

8. Other personal details.

2.2.1 SUMMARY OF RESPONSES OBTAINED FROM THE MULTI-PROFESSIONAL GROUP DURING PERSONAL RESEARCH INTERVIEWS

QUESTION 1 Are some couples seen by you in need of sex therapy?

This question was only given to people in appropriate occupations. Lecturers who did not see private patients were asked to comment only if they were involved in private practice or counselling during their professional careers.

1.2 Regarding race and religion all confirmed that only a very small group of black clients requested assistance. However, heads of medical schools reported a great need for sex therapy and especially sex education to be offered to the black population.

According to 3 black Social Workers they themselves found it difficult to offer such a service while 4 white Psychiatrists and two Indian practitioners indicated a change in attitude especially among some of the female population of the blacks in South Africa. All agreed about the necessity for a well grounded sex educational programme to be offered. There was some difference of opinion whether this should be offered at primary, secondary or tertiary level.

Apart from these Social Workers, two Gynaecologists and one Minister of Religion who indicated that they did not know whether couples seen by them were in need of sex therapy, 51 respondents confirmed their awareness of this need. Most of the respondents saw mainly their own race groups but some Whites, had clients from other ethnical groups.

QUESTION 2 Are you able to offer this or refer them to people able to assist them adequately?

One Psychiatrist, three General Practitioners, four Clinical Psychologists and three Social Workers indicated their ability to offer sex therapy without a need to refer.

Only two General Practitioners in the Cape Province and four Social Workers, two in Natal and two in Transvaal, were satisfied with adequate facilities for referral.

Forty nine respondents indicated their awareness of severe limitations regarding such facilities. These ranged from "no one at all" to "there may be one or two but the service is not fully established". "I have to do it as best I can ..."

The overall response both quantitative and in quality was an emphatic denial of adequate assistance.

Some Social Workers attached to Marriage Guidance Societies mentioned the limited referrals they received especially from the medical profession and indicated their ability to assist as a multi-professional team.

QUESTION 3 If you offer this service

3.1 What are your main approaches and methods?

Clinical Psychologists, Psychiatrists and a small group of Social Workers and General Practitioners were very clear in their responses.

"Sensate-Focus", "Rational Emotive", "Multi-Model" and "Psychodynamic/ Psychoanalytic" were responses obtained from practitioners. The necessity to work as a multi-professional group and the development of inter-dependancies between Medical Practitioners, Social Workers and Psychologists working as a team, was mentioned mainly by respondents in Natal and the Cape, already working together as informal multi-professional teams.

3.2 Is it adequate?

Only five respondents indicated that their methods and approaches were adequate. However, with the rapport established with various professionals during these interviews and in view of experience gained, it was realised by the writer that this question may not be appropriate and responses therefore not highy significant.

4. If you refer 4.1 Who are the people you refer them to.

Seven respondents indicated that they refer to Clinical Psychologists. The fact that the writer is a Clinical Psychologist could have affected some of these responses, however, only some of them were aware of this. These responses also correlated with Olivier[10] who found that Gynaecologists and Clinical Psychologists saw more clients with sexual dysfunctions than the other professional groups.

In addition to Clinical Psychologists - 9 Social Workers referred to General Practitioners while 4 General Practitioners referred to their colleagues and 2 referred to the study groups in Natal and 3 to this group in the Cape. Two referred to Psychiatrists, one in the Transvaal and one in the Cape.

4.2 Are they able to offer an adequate service?

Responses ranged from "yes" to "not at all". The 30 respondents who indicated that they had no one to refer patients to when a need for sex therapy existed were very concerned about the "total absence of facilities".

General Practitioners and Gynaecologists in smaller towns were especially concerned about limited facilities for their patients.

QUESTION 5 Is there a need for training of Sex Therapists in your opinion?

5.1 If "no" why?

Not one respondent replied in the negative. All the respondents indicated the urgency of such training which should commence "Yesterday", "as soon as possible" or "immediately".

If yes 5.2.2 when should it be done?

Regarding question 5.2.2 an interesting observation was made during the collation of these responses. With a few exceptions, academics indicated that it should be offered as an academic Post Graduate Course at Universiti Some thought it would be well placed at the Medical Schools while others preferred Departments of Psychology and Social Work.

Each professional group indicated that training should be offered in their own discipline i.e. Social Workers in the Department of Social Work, Psychologists in the Department of Psychology and Theologians in the Department of Theology. Seven Practitioners indicated their preference for an in-service training course and 5 felt that all the participants should be registered with the Medical Council. A small group of respondents emphasised that inter-professional participation and multi-professional training should be compulsory in training of sex therapists. In this question the close liaison that has developed not only between Psychiatrists Psychologists and General Practitioners was noted but also the inclusion of Social Workers especially with the study group in Natal.

5.2.3 Where should it be offered and to whom?

"To all people in the helping professions who are registered with Medical Council, interested, able and without incapacitating 'hangups". A response from a highly respected senior academic in the Medical Profession in Natal which has proved to be an excellent summary of the responses of 22 respondents.

In accordance with qualitative methodology this question was subsequently used as a topic for a brainstorming session and small group discussions. This will be discussed further in our next section when findings regarding training will be evaluated in more detail.

Another interesting aspect of responses to this question was that 8 Gynaecologists indicated that Gynaecologists should receive such training. Seven Social Workers felt that the training should be offered to Social Workers and similar responses were obtained from 8 Psychologists, 4 General Practitioners, 2 Nurses and 2 Ministers of Religion. 2 Respondents suggeste the training should be restricted to "doctors" and 2 respondents felt that personal selection regardless of occupation would suffice.

QUESTION 6 What is the most frequent sexual difficulty of Marital Couples according to your experience?

Eight Social Workers, 3 Psychologists and 2 Ministers of Religion indicated that any sexual difficulty existed in a dyadic relationship with psychogeni factors. The psychodynamic aspect was regarded by this group as the main area for intervention regardless of the specific nature of the sexual dysfunction.

Seven Gynaecologists indicated that these difficulties were not discussed while 5 General Practitioners and 2 Psychiatrists listed "secondary impotan and "frigidity" as the most frequent sexual difficulties they encountered.

Two Respondents maintained that post-puerperal depression following the birth of a first child was the most frequent cause of sexual distress.

Two General Practitioners, one with extensive experience in sex therapy were emphatic that doctors could not be trained as a homogeneous group-"their training is too narrow, they needed exposure to other disciplines on an experiental level".

The other 24 respondents either felt that they did not have sufficient experience of couples in need of sex therapy to reply to this question or that there were "many difficulties",not one specific area of dysfunction.

QUESTION 7.1 & 7.2 What do you require to improve your contribution regarding 7.1 Knowledge and/or 7.2 Skills.

Nine Respondents gave no indication of individual requirements and 4 of them reiterated the need to have "an adequate place or person" for referral of couples in need of sex therapy. One Minister of Religion wanted to know more about Psychology and another felt that more knowledge regarding human physiology was required. Seven Respondents required "a thorough"

theoretical background"; while 14 did not have "sufficient knowledge or experience"; 18 Respondents expressed a preference for opportunities to work "with other professions": 13 within a multi-professional team and 5 with a co-therapist of the opposite sex

QUESTION 7.3 Are there any Personal Requirements in your opinion?

Only 24 definite responses were obtained from this question. Of these, 6 indicated that sex therapists must be married; 13 felt that a professional qualification was not the only requirement but personal selection was also needed and 5 respondents thought that sex therapists should only offer sex therapy to couples within their own socio-ethnic groups.

8. Other Personal Details

In this group of 55 respondents 12 individuals volunteered some details about their intimate hetero-sexual experiences to the writer.

As indicated previously this left no doubt about the essentiality for the qualitative researcher to have at his disposal interpersonal and often clinical skills applicable to the confidential therapeutic situation.

Although time consuming it was necessary to refer some respondents to appropriate instances and professionals and, in spite of short term disadvantages, accept some for ongoing therapy.

It also resulted in more empathy with many practitioners who had no referral or treatment facilities at their disposal.

3. IMPLICATIONS OF THESE FINDINGS FOR THE TRAINING OF SEX THERAPISTS IN SOUTH AFRICA

The second hypothesis as formulated in Chapter 5 has been confirmed both theoretically and by all the participants in this qualitative research programme. The hypothesis stated that "physical and mental stress often relate to sexual difficulties but as a result of limited knowledge and facilities, treatment cannot be obtained."

During the course of this research it also became clear that obtainable treatment are not always adequate and for some clients and consultants who have the required knowledge to refer or utilise treatment, the need for adequate referral facilities has been confirmed.

Specialist consultants, senior academics, groups of Social Workers and Psychologists all confirmed their concern about the absence of individuals or institutions where sex therapy can be offered adequately.

In addition, the need for education, especially to rural populations, by far exceeds what was initially thought to be required at the onset of this research.

In our society with its wide cultural and educational boundaries a situation exists where community nurses are totally unable to cope with the need for sex education in rural areas on the one hand, yet qualified urbanised black workers have a minimal case load [11] in spite of untold suffering and unhappiness of black marital couples. The readiness to accept that assistance is required and the ability to utilise such a service will only be possible once training at all levels can be offered to the whole population regarding human sexuality in modern society.

Conferences, workshops and seminars about applicability of such service across cultures are irrelevant until training has been made available to all concerned.

This training should be at two levels for all our population groups. On the first level a thorough educational grounding in human sexuality should be offered to a selected group of educaters as counsellors. On the second level only selected people registered with the Medical Council should receive further training in the application of sex therapy and treatment of sexual dysfunctions.

In reply to the questions where training should be offered and by whom, it has been indicated that a high level of subjectivity existed. Most practitioners suggested an in-service training programme offered to practitioners only, while academics preferred a University course at post-graduate level to selected candidates.

It is beyond the scope of this research to accept or reject any one of these suggestions. However, in view of Olivier's unpublished research[12] regarding the establishment of sex clinics in South Africa and various requests from senior academics as indicated, a tentative training programme will be presented in Chapter 7.

Ideally it seems that the training as outlined should be offered by a multi-professional team, attached to a University and initially registration with the Medical Council should be required for all those who will have to work without supervision on completion of training.

An interesting observation made during interviews with some medically qualified consultants was their conviction that training should not take place within Medical Schools. The main reason was the fact that these doctors involved in multi-professional sex therapy have become

far more aware of the need for wider knowledge about interpersonal and psycho-social aspects. In training groups and joint therapy sessions they realised the essential contribution from Psychologists and Social Workers especially in view of their skills in interviewing and group management. It was felt that an all-student-doctors-group would fail to provide the required multi-professional input.

There may be merit in attaching such a training course to a Faculty of Health Sciences, an Institute of Human Sexuality or Education Department facilitating a multi-professional training and wider application of skills.

Initially study groups, welfare agencies or institutes may undertake training. This could lead to actual university courses to be offered at post graduate levels.
Another alternative as suggested by some practitioners may be multi-professional in-service training courses under the auspices of a University Institute or Faculty with final recognition by the Medical Council.

Hypothesis 2

In Chapter 5 it was also hypothesised that trainee sex therapists have a tendency to project their own limitations regarding required areas of skills, experience and knowledge by emphasising that specific area during their initial enquiry session with their clients.

It is not within the scope of this research to confirm or reject this hypothesis altogether. However, as a result of information obtained from selected groups and various professionals especially academics involved in training, this has been confirmed by a significant number of experienced educators. For this reason the training programme

presented in Chapter 7 has also been planned to utilise these "projections" fully. With video equipment and the required skills this could form the essence of experiental training in the affective and psychomotor domains simultaneously effecting interdisciplinary sharing of skills and knowledge.

The utilisation of Bloom's Taxonomy of Educational Objectives for this purpose will be clarified in Chapter 7 prior to the presentation of a suggested training programme and a final conclusion.[13]

EXPLANATORY NOTES AND REFERENCES TO CHAPTER 6

1. During personal discussions with Social Workers and Psychologists ignorance amongst Coloured, Whites and Indians were confirmed. Regarding the Black population Senior Staff of Medical Schools and Family Planning Clinics confirmed the total ignorance about facilities in addition to existing taboos regarding sexual matters preventing couples to seek assistance. Community Nurses and General Practitioners quoted intense and prolonged suffering of couples often resulting in aggression or total family disintegration.

2. Mace, D. See note 53 Chapter 2.

3. S.A. Census & Statistics, 1982.

4. Lazarus, A. and Gerdes, Prof. L. — Personal discussion, Pietermaritzburg, 1983. U.N.I.S.A. Group discussion, Pretoria, 1970.

5. Fourie, M.C. — Unpublished M.Phil Thesis, 1980.

6. Uken, J.M. — The Orgasmic Woman. Johannesburg, 1983.

7. Patterson, C.R. and Hops, H. — Coesion, a game for two : Intervention techniques for Marital Conflict. New York: Appleton Century Crofts, 1978.

8. Sewell Reth and West, E. — Counselling Courses in Ghana. Marriage Guidance, Vol. 15, No. 8, 1975.

9. Olivier, L. — See Note 15, Chapter 5.

10. Olivier, L. — As above

11. Personal discussion with black Social Workers and Community Nurses confirmed the dichotomy that exists at present where facilities are not utilised because education has not kept pace with provision made by some organisations. This has been subsequently confirmed by senior staff members of Medical Schools and Family Planning Clinics.

12. Olivier is completing a Ph.D. investigating the desirability of Sex Clinics in South Africa.
Following discussions with Senior Academics and Practitioners, requests for a tentative programme for evaluation were made in view of their perceived need for more knowledge and skills.

13. Burns provided a simplified Taxonomy of Blooms Educational Objectives which was found to be more applicable to this research.

Burns, R.W. New Approaches to Behavioural Objectives, 1977.

CHAPTER 7

A SUGGESTED TRAINING PROGRAMME FOR SEX THERAPISTS AND COUNSELLORS IN SOUTH AFRICA

1. PREFACE

Research into the historical facts of the pre-and post-war period regarding development of Sexology and training of sex therapists seems to indicate that we are now "splitting" provision of essential facilities to a greater extent than previously. Not only Marriage Guidance Societies and the Family Planning organisations as we know them today, with the one operating within the family, favouring a holistic approach, the other, looking at viable family sizes and physiological well being; but also splintering the provision of medical facilities available to the individual, by the mere nature of present day medical specialisation and the narrowing effects of this.

During the research enquiry it became evident that either an "organic" or "psychological" approach was favoured by consultants and, unfortunately, expertise often existed in one area excluding the other.

Hopefully this gap has been bridged by many individuals but unfortunately not as yet leading to the provision of any form of specialised training in Human Sexuality or Sexology. Seventy years after the first Sexology Society was found in Germany we in South Africa still find ourselves without any such facilities.

2. THE ASSESSMENT OF TRAINING NEEDS

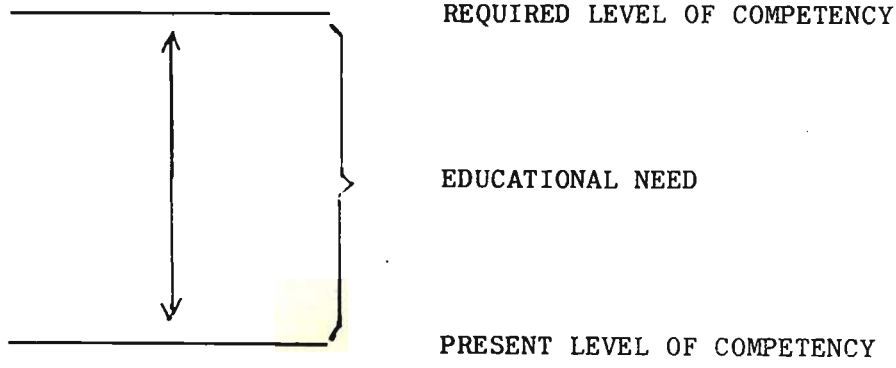
In completion of our analysis of the needs of the clients, the consultants and therapists, we have an indication of existing knowledge and skills in the specific areas.

Subtracting from this, the knowledge and skills that will eventually be required from the trainee sex therapists, we are able to state what the required training needs are.

According to Knowles[1] an education or training need is something a person ought to learn for his own good, the good of the organisation and for the good of the Society. He describes it as the "gap" between his present level of competence and a higher level required for effective performance as defined by himself, his organisation or his society. This definition is portrayed graphically by Kowles and we are presenting this in Figure 4.

FIGURE 4

DEFINITION OF EDUCATION NEED



Model taken from Knowles (1972)

According to Knowles (1972:86)

> The more concretely an individual can identify his aspirations and assess his present level of competencies in relation to them - the more exactly he can define his educational needs - the more intensely will he be motivated to learn. And the more congruent the needs of individuals are with the aspirations their organisations and society have for them (or the other way around - the more congruent the aspirations, organisations and society are with the educational needs of individuals) the more likely will effective learning take place.

Verner and Booth[2] emphasised the difference in the nature of the learning process in adult education in contrast to pre-adult learning. According to them the learning process itself imposes certain requirements on the instructional situation that should be considered. The following principles of learning, particularly relevant to educating adults were summarised by Brunner.[3]

a. Learning is an active process and adults prefer to participate actively; therefore, those techniques which made provisions for active participation will achieve more learning faster than those that do not.

b. Group learning is more effective than individual learning; therefore, those techniques based on group participation are more effective than those which handle individuals as isolated units.

c. Learning that is applied immediately is retained longer and is more subject to immediate use than that which is not; therefore, techniques must be employed that encourage the immediate application of new material in a practical way.

d. Learning must be reinforced; therefore, techniques must be used that insure reinforcement.

e. Learning new material is facilitated when it is related to what is already known; therefore, the techniques used should help the adult establish this relationship and integration of material.

f. The existence of periodic plateaus in the rate of learning necessitates frequent changes in the nature of the learning task to insure continuous progress; therefore, techniques should be changed frequently in any given session.

g. Learning is facilitated when the learner is aware of his progress; therefore techniques should be used that provide opportunities for self-appraisal.

In our suggested training programme these requirements were taken into consideration and active participation of all counsellors has been emphasised throughout this programme.

3. THE FUNCTIONS OF THE SEX THERAPISTS AND SEX GUIDANCE COUNSELLORS

Prior to the presentation of the learning programme an analysis of the particular techniques appropriate to each task of the sex therapist and sex guidance counsellor was completed. The following four main areas of duties and responsibilities of this group were taken into consideration.

3.1 Identification of the most important needs of the clients.

3.2 Assisting clients in accordance with their specific needs.

3.3 Obtaining required knowledge and experience during presentation of cases, case discussions and systematic recording of all cases.

3.4 Active group participation and T-group membership. In Table 3. these specific tasks required from the trainees are presented and the knowledge and skills required to enable the therapists to perform adequately are indicated.

TABLE 3

Main Functions	Task Analysis	Knowledge Required	Skills Required
Identification and integration with the aims and objectives of Sex Therapists and Sex Guidance Counsellors	To function as a therapist by providing assistance to married couples and offer pre-marital guidance to young people in accordance with their needs and the requirements of the Institute/University.	The content of the syllabus of the Institute/University with specific reference to the aims and objectives.	Integration and identification with the whole framework of the Sex Therapist.
	To attend all lectures, group discussions and follow-up in-service training sessions regularly.	Ethical requirements of therapists.	To assess whether the Therapist/Institute is able to assist the client adequately or whether a referral to another agency is indicated.
		To know how to apply correct referral procedures when required.	

Main Functions	Task Analysis	Knowledge Required	Skills Required
Counselling of clients.	To establish meaningful rapport in the first interview and acquire sufficient knowledge about the client's background. To provide an opportunity for the clients to discuss their problems freely and openly in a confidential atmosphere of acceptance and support. To develop a working relationship and a two-way communication with the client and whenever possible to arrange joint interviews with both husband and wife. To peruse detailed notes made during counselling sessions and to plan specific objectives for each counselling session. To finalise counselling at the appropriate time.	Practical knowledge about communication strategies. Factual information regarding counselling and interviewing techniques. Specific knowledge about areas of marital stress of each client. Sufficient knowledge to apply sensate focus, multi-model behaviour, the non-directive approaches or behaviour modification techniques as applicable in marriage guidance and sex therapy in accordance with the needs of individual clients and couples. To assess each counselling session and plan the future course of action.	Utilisation of the personality as the most important "tool" in the application of communication strategies and counselling techniques. To provide an atmosphere of acceptance and reassurance especially in the initial interview. To transfer this knowledg and apply it in counselling in accordance with client's specific need and level of understanding. To be able to do an objective appraisal of the value of the counselling process and to accept this without prejudice or subjective personal involvement.

Main Functions	Task Analysis	Knowledge Required	Skills Required
Systematic case recording and case presentations.	To record all factual information about clients systematically and correctly and to follow the suggested guide. To improve therapeutic techniques by self appraisals and to discuss progress in counselling with senior consultants and therapists. To present cases clearly and objectively indicating areas of marital stress, progress in counselling with senior consultants and therapists, and the final outcome when applicable.	To have a clear concept of the clients personality strengths and weaknesses, physical dysfunctions its effects on the marital relationship and to make tentative diagnoses regarding the clients ability to overcome these difficulties. Sufficient knowledge to select specific therapeutic techniques and procedures applicable to each client. A clear appraisal regarding the affects of client's and the therapist's specific personality traits on the counselling process and on the efficiency of the communication process.	Objective appraisal of main problems, clear documentation and presentation of facts. Ability to seperate factual information offered by the clients from the process that takes place in counselling. Ability to benefit from the evaluation of fellow therapists, consultants and practitioners following case presentations.

Main Functions	Task Analysis	Knowledge Required	Skills Required
Active group and T-group participation.	To be able to verbalise freely about the "self". To have an objective but sympathetic understanding and acceptance of the other group members. To expand in self-awareness and personal growth utilising personality traits and the whole personality adequately as the most important "tool" in counselling and living.	Self-knowledge regarding appreciation, interests, preferences, prejudices, attitudes and aptitudes. Inter-personal understanding of fellow group-members with specific knowledge regarding their psycho-social and sexual needs. Practical insight into non-verbal communication and body-language.	Sensitivity regarding the needs of fellow human beings. The ability to develop an awareness of own subjectivity and personal projections affecting insight and understanding in counselling and communication. Ability to utilise close cohesion in the confidential atmosphere of the T-group. Initial dependency on the leader to eventually develop into the ability to be an active observer and finally perhaps to act as a group leader.

4. DEVELOPMENT OF APPROPRIATE TRAINING METHODS

At the moment marriage guidance counsellors and the small group of sex therapists are experienced adults who were specifically selected and/or trained for this work, some of them with professional background knowledge closely related to marriage and sex guidance work. Future training requirements will therefore vary in accordance with the background and experience of individual trainees and specific needs of each group. In developing appropriate training methods, specifications in Table 3 regarding relevance to performance should be referred to for continuous review of training objectives to be achieved.

In conclusion, training of sex therapists should always take place at the level of action roles and value relationships. It requires continuous development of the individual within his own professional group or organisation. Efficient performance as a result of adequate and applicable training procedures are closely related with inter and intrasocial processes affecting each therapist and client and eventually Society as a whole.

5. THE SUGGESTED TRAINING PROGRAMME

The training programme as presented is seen as the mere initiation of what should become a continuous feedback loop for review, evaluation, up-dating and improvement of training in accordance with the needs of our ever changing society.

THE TRAINING PROGRAMME

5.1 Orientation

	Content	Aids and Methods	Number of Training Sessions	Number of Hours
5.1.1	General background regarding existing facilities in sex and marital therapy	Factual lectures by selected lecturers followed by questions and discussions.	2	2

	Content	Aids and Methods	Number of Training Sessions	Number of Hours
5.1.2	Ethical considerations in sex counselling.	Introductory lecture to Cross-cultural case presentations - video or live - followed by discussions regarding ethics involved in accordance with the cultural norms of each client.	4	10

5.2 Administrative Procedures

	Content	Aids and Methods	Number of Training Sessions	Number of Hours
5.2.1	Recording of data, filing and report writing.	Provide trainees with completed case records, application forms and explain methods of recording.	2	3
5.2.2	Handling of telephone enquiries and multi-professional liaison.	Allocate each trainee to a joint therapist and supervisor. Arrange individual discussions and supervision of counselling, report writing and telephone responses.	2	4

5.3 Training in Special Skills

5.3.1	Experiential learning in self awareness and interpersonal skills, personal growth and behaviour modification. Clarification in a "People Laboratory".	Utilisation of various T-group techniques, evaluation and discussion of responses followed by supportive summaries by group leader. One way screen observation and playback of "live" video recordings for evaluation.	4	6
5.3.2	Interviewing techniques.	Client interviews, followed by evaluation - group leader. Handouts on interviewing techniques.	4	8

	Content	Aids and Methods	Number of Training Sessions	Number of Hours
5.3.3	Communication skills and the Client - Counsellor relationship.	Utilise existing video tapes. Interpret video records: Projective responses from voluntary group members to illustrate personal "defects" and "psychological noises".	4	8
5.3.4	The personality as the most important "tool" in the counselling process. Who am I?	Presentations by appointed group members. Handouts and reading reference on counselling techniques.	2	4
5.3.5	The first interview.	Video records illustrating techniques to be evaluated by trainees. Joint and individual interviews.	2	4
5.3.6	Approaches to counselling. Rogers, Gestalt. Rational-emotive therapy, behaviouristic and ecclectic approaches. Joint counselling and family counselling.	Explanation by group leader and group members, where applicable, with short case illustrations. Group members to summarise reading references.	4	8
5.3.7	Counselling techniques continued.	Tape and video recordings followed by client-interviews and group evaluation.	2	4
5.4	Factual Lectures			
5.4.1	Legal Aspects			
5.4.1.1	Marriage; old and new legislation. Marriage and kinship in Africa. The Jewish, Christian Muslem and Hindu Marriage and others	Factual lectures with handouts and reading references, followed by questions and discussion.	4	6
5.4.1.2	Divorce, Seperation and Desertion; grounds, procedures and the role of the counsellor.	As above	2	4

	Content	Aids and Methods	Number of Training Sessions	Number of Hours
5.4.2	Human Sexuality			
5.4.2.1	Human Physiology.	Appointed Lecturers to present Visual aids, i.e. charts, diagrams and films.	4	8
	Endocrinology		4	8
	Reproductive Processes.		3	6
5.4.2.2	Sexual development and sexual dysfunction.		4	8
5.4.2.3	The Psychology of sex.	Observation of couples with follow-up evaluation.	3	6
5.4.2.4	Sexual dissatisfaction and marital unhappiness.	Case presentation and lectures.	3	6
5.4.3	The Family Budget			
5.4.3.1	How to budget	Practical examples. and lectures by appointed lecturers.	1	2
5.4.3.2	Insurance in marriage. Investments in marriage.		1	2
5.4.4	Inter-family Conflict			
5.4.4.1	Stepchildren and in-laws.	Factual lectures, with handouts and reading references, followed by questions and discussion.	1	2
5.4.4.2	Cultural and religious incompatibility. Work, extra mural and other activities affecting sexual satisfaction and husband/wife relationships.	Couple interviews observed by trainees with follow-up training sessions during replay of videos or tapes.	3	6
5.4.5	Psycho-social Pathology			
5.4.5.1	Drugs, alcohol and its affects on marriage and sexual functioning.	Factual lectures, with handouts and reading references, followed by questions and discussion.	3	6
5.4.5.2	Homosexuality	Where possible observation of therapeutic sessions.	2	4

	Content	Aids and Methods	Number of Training Sessions	Number of Hours
5.4.5.3	Sterility and adoption.	Lectures and case presentations.	1	2
5.4.5.4	Infidelity in marriage. Crisis situations and marital conflict.		2	4
5.4.6	The Family System			
5.4.6.1	Husband/wife and parent/child roles. Role confusion.	Factual lectures with handouts and reading references, followed by questions and discussion.	3	6
5.4.6.2	Sibling rivalry and family relationships. Social and cultural change.	Live family assessments with follow up evaluation and cross-cultural comparisons.	2	4
5.4.6.3	The value system within the family, coping mechanisms.	Sociograms to be drawn up by counsellors following examples given by group leader.	2	4
5.4.6.4	Ethics and religion regarding abortion, contraception and sexual practices.	Panel discussions by selected lectures of multi-religious denominations.	2	4
5.4.7	School Guidance			
5.4.7.1	Pre-marital counselling in school groups.	Trainees to accompany seniors to schools for observation and participation in informal group discussions with pupils.	4	10
5.4.7.2	Group dynamics and group principles.	Follow up group discussions and training in group leadership techniques utilising tapes, groups and video equipment.	2	3
5.4.8	Community Resources -	(referral techniques)		
5.4.8.1	Social Welfare, A.A. Samaritans, FAMSA Family Planning, etc.	Representatives to clarify aims, functions and referral systems.	4	8
5.4.8.2	Legal assistance. Other voluntary agencies. Medical practitioners and specialists.		2	4

	Content	Aids and Methods	Number of Training Sessions	Number of Hours
5.4.9	Psycho and Socio-Metrics:			
5.4.9.1	Utilisation of paper and pencil tests. Marriage Rating Scales, Love Development Questionnaire, Biographical details.	Administration of tests, scoring and evaluation. Responses of clients and trainee volunteers for discussion.	3	6
5.5	Integration and Socialisation of Trainees with Senior Consultants			
5.5.1	The role of the sex therapist and the sex guidance counsellor.	Combined group meetings with all senior counsellors and therapist trainees. Structured group discussions summarised by senior consultants.	1	2
5.5.2	Case presentation by senior and junior therapists.	Group evaluation, diagnoses and recommendations for further action.	4	8
5.5.3	Review of course. Advantages, disadvantages and recommendation.	Appointed trainees to summarise and evaluate course content and experiential value, with specific requests and recommendations.	1	2
5.5.4	Programme for in-service course for the following year to be finalised.	Senior and junior therapists and counselors to make specific recommendations. Final programme to be drawn up and handed out with suggested annual changes.	1	2

6. DISCUSSION OF THE TENTATIVE TRAINING PROGRAMME WITH SPECIFIC REFERENCE TO BLOOM'S SIMPLIFIED TAXONOMY OF BEHAVIOUR OBJECTIVES

In accordance with our model presented in Chapter 5 the investigation of the training programme was completed by utilising Bloom's Taxonomy of educational objectives as simplified by Burns[4]. Behavioural objectives were found to be especially applicable to the evaluation of the therapists' ability to understand and respond.

The cognitive domain, dealing with the subject matter and "thinking" of the therapists; the affective domain, indicating behavioural objectives related to emotions or feelings; and finally the psycho-motor variables encompassing any objectives requiring motor and other specific skills. These were utilised to clearly separate specific skills in counselling to be developed by the sex therapists and sex guidance counsellors.

These domains are all inter-related and cannot be separated in any one process but are presented separately to facilitate ongoing analyses of the training programmes, as they clearly indicate different variables for consideration. This simplified taxonomy is illustrated for clarification in Figure 5.

Processes and strategies as indicated in the cognitive domain are also required for application in the psycho-motor and affective domains. The division merely facilitates presentation. It cannot be separated in practice and therefore should not be viewed as separate components. However, when training programmes are analysed factual information; (cognitive domain), development in growth and self awareness; (affective domain) and training in specific skills; (psycho-motor domain) should be separated to clarify aims and objectives.

FIGURE 5

SIMPLIFIED TAXONOMY

Cognitive Domain	
Class One	- Knowledges
Class Two	- Understandings
Class Three	- Processes
Class Four	- Strategies

Affective Domain	
Class Five	- Attitudes
Class Six	- Appreciations
Class Seven	- Interests

Psycho-motor Domain	
Class Eight	- Movements without objects or tools
Class Nine	- Movements with objects or tools

6.1 Planning of the Programme

A suggested programme is presented here but it must be emphasised that the adequate planning of any programme will only be possible if it is done with a thorough knowledge of the specific needs of the group for which it is planned.

Furthermore, the counsellors and therapists who will be required to assist in training must be fully aware of the needs of the trainees and should be an integrated multi-disciplinary team of tutors whose skills and knowledge are transferred in training in accordance with a specific and well planned training programme.

Efforts should always be made to arrange formal lectures according to verbalised needs of both junior and senior therapists. T-group training

It has been observed during the pilot study that the more successful trainee therapists and senior counsellors were those who usually attend group discussions and lectures regularly and continue to attend these long after their own formal training has been completed. Ideally continuous training should never end and senior counsultants should be available to assist with pooling of knowledge and skills through long term group attendance.

6.1.1 Factual Information (Cognitive Domain)

By obtaining knowledge about the therapists' ability to satisfy the clients' needs as indicated in this research, educational objectives were determined in relation to content, and the required behavioral changes were reviewed. In view of the specific requirements for sex therapists the main emphasis in training should be on the affective and psychomotor domain:

Informal discussions and T-group training indicated affective learning outcomes. Role-play, counselling techniques, and recording of data were classified as psycho-motor areas in the learning experience, with an obvious overlap between the affective, cognitive and psycho-motor domains. The term therapist or counsellor were applied interchangebly.

Only trainees should be required to attend the initial course and attendance of group discussions, once training is completed. This should be on a voluntary basis, however, ideally as many therapists possible should attend, in view of continuous changes and development.

Individual lecturers invited to attend to specialised areas should be well integrated into the course as a whole, its main priorities and requirements.

Following a content analysis, clients' most important needs as summarised in Table 1.2.1 were compared with the actual lecture topics required in training programmes.

In a total of 104 Training Sessions 65 Sessions were allocated to "formal" lectures (cognitive domain).

However, it may be advisable to select two groups of trainees and offer lectures on a selective basis in accordance with their needs and the needs of their clients.

For counsellors requiring a broad based training, concentration on educational guidance regarding human sexuality and sufficient knowledge to do a thorough initial assessment may be the most important requirement. A smaller group of Sex Therapists who will be registered with the Medical Council in view of their specific professional backgrounds may then require the total of 65 lectures to enable them to offer specialised sex therapy eventually specialising in such areas as sexology for the disabled; sexual dysfunctions, sexual deviance and the application of remedial techniques.

6.1.2 Training Counsellors in Self-Awareness and Personal Growth (Affective Domain)

For the purpose of this investigation, the above areas which are within the affective domain were analysed with specific reference to therapists' attitudes, appreciations and interests obtained during structured interviews and follow-up small group discussions. Following initial screening trainees should be required to attend a selection conference during which time their group performance, individual responses in an interviewing situation and projections in a group situation and on personality tests, are all taken into consideration.

In addition to factual lectures a T-group should be formed and depending on the approach of the available consultants, these groups may develop into training or therapeutic groups. The main objective throughout training, should be the development of self-awareness and personal growth within individual therapists. Four to eight T-group sessions should be arranged during training and occasionally additional T-groups may be required. Initially, however trainees may well be required to cope on their own

During live case presentations care should be taken that trainees are not so involved in personal details about the clients, that specific processes applicable in counselling cannot be clarified, thereby limiting the value of the actual learning experience. Follow-up enquiries confirmed that the main objective of case-presentations should always be improvement of counselling skills and only those who actually present cases may achieve this objective. In addition it will also improve their recording techniques. Systematic outline of objectives to be achieved must be completed not only for the purpose of these presentations but also prior to counselling.

Knowledge and skills acquired through training are utilised during individual counselling sessions. Unless tape records are used or verbatum records are kept following interviews, feedback is limited and counsellors are left to evaluate training from a subjective premise and often in retrospect.

Behavioural changes, including therapists' attitudes, appreciations and interests affecting counselling, are therefore difficult to assess.

In T-group training affective learning outcomes can be assessed but this assessment depends on the trainees' ability and willingness to verbalise freely in a group. Although free verbalisation in itself could be described as one of the short term objectives of T-group training, it may, in fact, often be a contra-indication of sensitivity and awareness. Too much emphasis on intellectual insight only may affect empathy.[5]
Some therapists may seem to be withdrawn in T-groups and small group situations, yet have more clients returning for continuous counselling. Although this does not necessarily indicate success, it confirms the counsellor's ability to establish a working relationship and communicate successfully.

6.1.3 Training in Specific Skills (Psycho-motor domain)

6.1.3.1 Counselling Process

As indicated by Hamilton[6] Fennlason[7] and Feldberg[8] adequate communication in establishing a working rapport is one of the most essential ethical considerations and the most useful tool in counselling.

According to Burns[9] the psycho-motor domain indicates specific skills with or without objects and it was therefore thought to be appropriate to seperate the counselling process from the affective domain in view of very specific skills required in counselling and sex therapy.

The inter-relatedness of all the aspects of this taxonomy and all the varied aspects of the trainee-counsellors, the client and the counselling process should, however, always be kept in mind. At the same time, it is necessary to indicate clearly specific skills, strategies and attitudes that are requi to develop the relevant therapeutic and counselling skills.

6.1.3.2 Recording Techniques

As indicated in the content analysis and pilot study, situational determinar affect recording techniques to such an extent that data about clients affected reliable categorisation, often because of inferences made by Therapists and Counsellors.

Personal information given by clients to trainee therapists should not be sketchy and inadequate thus failing to provide the therapists and counsellors with an adequate frame of reference to assist in the first and vital client interview.

This overview clearly indicate the necessity for continuous growth in self-awareness and the trainee therapist's ability to be a participant observer throughout the counselling process in order to achieve meaningful rapport and positive results in marriage guidance counselling and sex therap

Once the message-sending-process has been clarified to counsellors, a thorough knowledge about the verbal behaviour of clients will be required.

Some areas that should receive special attention in training were indicated during brain-storming sessions and follow-up enquiries. These will be mentioned briefly.

6.2 Training in Verbal Skills

6.2.1 Dual Functions of Verbal Behaviour in Communication

Communication difficulties often reinforce marital stress and once the therapist has formed a working relationship with one spouse it is often much easier for the counsellor to understand some of these communication difficulties affecting the inter-marital relationship of that particular couple.

6.2.2 Joint Interviews

The desirability of joint interviewing has been indicated. In training therapists to interview a couple jointly a thorough understanding of verbal behaviour in marital communication will be required.

According to Thomas[10] the two functions of verbal behaviour in communication are message sending and behavioural guidance. Behavioural guidance involves holding the attention of the listener, having him track what the speaker says, sustaining speech when the listener talks and maintaining continuity of themes of content, which are covered in the inter-changes. If the verbal behaviour of the speaker creates the wrong impression in the listener, communication will be affected. In the marital relationship wrong impressions created by verbal behaviour often reinforce conflict, estrangement and even a breakdown in the relationship.

6.2.3 Content

As indicated in our content analysis and confirmed by Patterson and Hopps[11] and Thomas[12] the most common areas of discontent in marital communication are the following:- Money, sex, affection, work, in-laws, children, social activities outside the home, handling of alcohol, drugs, religion, politics and family decision making. The frequency with which these matters are referred to during counselling and the clients' verbal and non-verbal behaviour when these matters are discussed, will yield rich areas of information to the observant counsellor, also indicating strengths and limitations in the marital relationship.

6.2.4 Inter-dependencies

As a result of certain patterns of verbal behaviour, inter-dependencies are formed between marital couples. Raush, et al[13] indicated the "Tit-for-tat syndrome" confirming that corrosive acts lead to further corrosion and positive behaviour tends to be reciprocated in kind.

The results of a study by Wills, Weiss and Patterson[14] are particularly relevant here because these researchers studied the relationships of pleasurable and displeasurable behaviours between spouses and across couples. The study involved seven non-distressed married couples from whom detailed data were collected for fourteen consecutive days with focus on the pleasurable and displeasurable behaviour of spouses in relationship to marital satisfaction. One finding was that displeasurable behaviours taken together accounted for 65% of the explained variants of marital dissatisfaction ratings, where as pleasurable behaviours accounted for only 25% of this variance.

Another finding was that in a within-couple analysis in contrast to the across-couple results reported earlier, there was a much greater tendency for spouses to reciprocate displeasurable than pleasurable behaviour. The study also indicated that the pleasurable and displeasurable dimensions of marital satisfaction were independent, thus implying that changing the partners behaviour on one dimension may have no affect on their behaviour in the other dimensions. Because of this independence and the disproportionate influence of displeasurable behaviours in marital satisfaction, these authors concluded that modification programmes should be developed to decrease the rate of displeasurable behaviour rather than to focus only on increasing the rate of pleasurable behaviour in interventio as stressed in some approaches.

6.2.5 The Therapist and the Social Structure of Family Behaviour

In contrast to communication in the world of work or during counselling sessions, where times and areas for discussion are specified, communication families can be said to be "free". Most topics can be discussed at almost any time, although this may be advantageous, the lack of structure also provide an opportunity for communication difficulties to germinate and grow into patterns. Almost all family communication is concurrent with other behaviours, such as eating, driving, watching television or having sex. Mealtime can often become the occasion for airing family difficulties, quarrelling and fighting; the time for sexual activities can be associated with the talk about the day's events, with the result that amorous inclinations diminish, television viewing may be a time during which parents endeavour to plan and administer family matters.

Decision making issues tend to spill over into general family communication and many families completely lack a regular pattern of problem solving. Some problems rarely re-occur and general discussions are often burdened wit a variety of minor decisions, affecting successful and pleasurable

6.2.6 Verbal Behaviour and Vulnerability of the Family

Because of the small number of people and limited audience in families, deficiencies in verbal behaviour have a severe affect on inter-family relationships. A non-responsive listener can diminish the amount of verbal behaviour of his partner or members of the family, an avert listener will positively reinforce the partner; he may greatly accelerate the partners speech, even producing "over talk". This is why deviant family members often have an exaggerated impact on family communications and relationships. With limited reinforcement outside the family, this may be further exaggerated. Individuals whose job satisfaction are limited and who may have few outside interests are often distantiated from society. Rapid changes in urbanised society also bring about a sense of rootlessness and result in reinforced interdependency of couples whose "internal sources of reinforcement" render them more vulnerable to communication problems.

Local psychiatrists and social workers agree that the reinforced inter-dependency within the family caused by external pressures, often results in dissatisfaction, unhappiness, emotional stress and heavy drinking.

In times of stress the family is often isolated from external corrective influences. There is no external control of the internal workings of a family. Members therefore abuse one another verbally, may totally dominate one spouse to the extent of virtually extinguishing speaking behaviour without anyone else knowing about this unless external help is sought.

Therapists are therefore in a unique position where they could assist the family to control this negative external input such as role confusion, anxiety and unacceptable behaviour of children. These often cause continuou vicious circles and may result in a complete breakdown in inter-family communication and sexual activities.

6.3 Notes and Recommendations

The emphasis on training should be on the experiential aspects throughout this course. As much involvement of trainees as possible including actual assessment, interviewing of couples, experiencing co-therapy with members of the opposite sex and of different cultural backgrounds provided it suit the needs of the clients should be ongoing processes throughout training.

Observation of an actual couple in therapy is preferable to case presentations but not always possible. Video recordings are preferable for training to tape recordings but technical equipment may not be available in which case verbatim interview feedback must be attempted.

It has been experienced throughout this research and stated by many researchers as indicated that actual experience of an assessment interview as well as ongoing therapeutic interventions observed by fellow trainees and consultants and partaking in follow-up evaluations of applied methods afterwards cannot be replaced by any other method of training in these required skills. It is time consuming and most demanding but it is also an excellent final selection of suitability as a sex and marriage therapist.

7. FINAL SUMMARY AND IMPLICATIONS OF THIS RESEARCH

7.1 Training in Special Skills - The Psychomotor Domain

The programme as outlined should be seen as a mere tentative suggestion of possible methods and aids, some of these found to be most useful in our pilot scheme of training of sex therapists.

Direct observation of individuals, couples and families while initial assessment interviews and ongoing therapy takes place is ideal, especially if simultaneous video recordings can be made for follow-up training purposes

This is not always possible in view of ethical requirements, the fact that this can only be done with the clients' permission which may well affect the therapeutic relationship and specific demands made on the consultant/ lecturer.

However, it has been experienced that it can be done without harmful effects to the clients provided selection of clients and their preparation for this is done with skill and total honesty by experienced consultants/ lecturers. Written permission must always be obtained and should clients request to view these tapes afterwards this must be arranged inspite of technical and personal complications. Eventually,special training for this purpose should be offered to consultants/lecturers.

Apart from client requests as indicated deliberate playback of video interviews to families for planned treatment such as behaviour modification of husband/wife communication, parent effectiveness training, etc it may not be advisable to play back some of these where negative reinforcement may occur. All this should be made clear to the clients concerned and carefully explained to trainees. Therapeutic value of these methods often outweigh initial hesitant behaviour (with its variables) of some clients and therapists. It does require special skills from the consultant whose dual role as therapist to the clients and educator to trainees can cause various personal and interpersonal complications.

Trainees who have utilised direct observation of their therapeutic interventions with couples, all confirmed the value of this at all levels of learning.

The value of such experiental training and unique opportunity to re-evaluate the cognitive,affective and psychomotor behaviour of clients and trainees during follow up viewing and evaluations by the lecturer/consultant and the training group, can hardly be matched by any other method of skills-training.

7.2 The relevance of Sex Therapy in South Africa

An important aspect to note is the wider application of therapy encompassing marital and family therapy as outlined in the suggested program in contrast to the more specific application of sex therapy outlined in Chapters 2 and 4.

As a result of this qualitative research the writer has come to the conclusion that specialised sex therapy is applicable, especially where couples have been referred by medical and other consultants who have already diagnosed sexual dysfunction. With these couples sex therapy can be offered most successfully, with approaches as outlined initially by Masters and Johnson,[16] with changes and additional methods as outlined by Kaplan.[17]

However, in view of the needs of our multifaceted South African population where attitudes about marriage and sex are so varied and sexual education so badly needed, training in this country will not be adequate and in accordance with the most important needs of the whole population if it is offered as outlined by consultants of the more developed countries.

A wider basic knowledge including family systems, individual and group behaviour, inter and intra ethnic and personal relationships is required. Following this the same level of specialisation should be offered to trainees, but finally selection will be required in accordance with the ability, requirements and professional status of trainees and the most important needs of their clients.

Cross cultural training in this field succeeds in overcoming many interpersonal barriers because of the very nature of such a universal yet basic human aspect of life itself. It has enriched the members of this pilot training scheme far beyond the boundaries of knowledge about human sexuality and contributed to a new growth in self and human awareness of its most experienced members.

7.3 The "Psycho-Sexual ingredients" of the Marital Relationship

Finally it should be made clear that the "wider approach" is not merely necessitated by the needs of our varied population but also by the very nature of sexual problems within marriage.

According to the literature as quoted in previous Chapters and confirmed during our research interviews, most couples with sexual problems are unable to accept these difficulties as an isolated area in their marriage. Which, indeed, it is not.[18]

The fact that the success of sex therapy in itself cannot be measured at all because it results in a total behavioural change of the couple can not be denied. To what extent this change brings about the remedy of an unhappy marriage, only returns us to the battle-field of the behaviourist and the psychoanalyst which fortunately has found a truce in Lazarus[19] and others applying the Multi-Model therapy and other approaches.

In this work it can be concluded that simultaneous training in sex and marriage therapy, within a multidisciplinary and multi-cultural group in South Africa is preferable. It needs a wide foundation and at the advanced training level specific requirements determined by the ability of therapists and the needs of their clients for further specialisation.

A pyramidial training model is envisaged with a knowledge about human sexuality in all its aspect as the broad base from which sex education counsellors move into the community, to the management of sexual dysfunction and deviations by the senior consultants at the tip of the pyramid. Provided the contact is nothing less than a continuous feed back loop of all those concerned with treatment and training in an ongoing review of client requirements constantly reviewing training needs and improving relevant training facilities.

7.4 The Psychomotor domain encompassing the cognitive and affective domains as applied in this research.

The full utilisation of therapist and client's Psychomotor behaviour with continuous cognitive and affective input finds its ultimate opportunity in the process of sex and marital therapy.[20]

In view of the very specific individual requirements necessitating selection of sex therapists with its main criteria in the affective domain, cognitive success in human sexuality training may well depend on this domain. It is also true that the latter may well have a positive effect on the affective domain if it is more dominant in the individual trainee. The so-called "intellectualiser".

However, as indicated in Figure 2, the continuous feedback loop of the behavioural changes required and, as observed to have taken place within trainees, is of a very basic and thorough nature, specifically in sex therapy. It requires continuous self appraisal, re-adjustment and openess to variables affecting both therapist and client regardless of the level of counselling or treatment. In addition there is no personal immunity for both consultant and client, effects of those interventions spill over into marital and family relationships. Finally one of the most rewarding positive side effects noted in training was the close group cohesion and meaningful rapport between joint counsellors, consultants and trainees this brought about, regardless of culture, sex, race or age.[21]

As a result of this experience and the findings in this research it can be finally concluded that training of Sex Therapists in South Africa should take place within a multiprofessional framework.

Inservice training at a Clinic or Institute attached to a recognised University under supervision of a team of registered Psychological, Medical and Para-medical personnel assisted by other consultants in the helping professions will be in accordance with the present needs of both clients and consultants in our multi-facetted South African society, according to the findings in this research.

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21. During a group discussion Florence Kaslow confirmed that this meaningful rapport that develops between co-therapists may even become threatening to spouses of therapists. Knowledge about the private lives of some Family Therapists have confirmed this as well as the greater understanding it brings about across cultures and sexes.

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