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Measurement of Therapy Outcome and Maintenance of Gains in the Behavioral Treatment of Secondary Orgasmic Dysfunction

Catherine S. Fichten, PhD, Eva Libman, and William Brender

Choice of therapeutic goals and criteria used for evaluation of therapeutic outcome represent fundamental conceptual and methodological issues. The present investigation examined the relationship between how data were obtained (by retrospective questionnaire or ongoing daily self-monitoring), what outcome criteria were used (behavioral or cognitive-affective), whose data were being analyzed (the female or male partner), and when measurements were taken (at posttherapy or follow-up) in a sample of 23 couples with the problem of secondary orgasmic dysfunction in the wife. The results indicate that (a) retrospective measurement was more optimistic than ongoing; (b) cognitive-affective changes were twice as likely to occur as changes in behaviors; (c) females benefited more than males; and (d) there were considerable losses of therapeutic gains at follow-up. These results underscore the need for multiple measurement techniques and highlight the multidimensional quality of the sexual experience.

Since the early 1970s, sex therapy has enjoyed increasing popularity. After a decade of research and practice, early enthusiastic claims of improvement rates have been questioned.[1-3] It has become evident that both the

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treatment of sexual dysfunction and the evaluation of sex therapy outcome are more complex than initially formulated.

The fundamental conceptual and methodological issues concern both choice of therapeutic goals and criteria used for evaluation of therapy outcome. While the goals of sex therapy appear obvious (i.e., improvement in sexual functioning), their operationalization and measurement is a complex matter. Yet, these issues have been addressed infrequently in the literature. What, for example, is the goal of sex therapy for secondary orgasmic dysfunction? Is it to increase the frequency of interpersonal orgasms, a behavioral outcome, or to increase the enjoyment of sexual activities, a cognitive-affective outcome? How should behavioral or cognitive-affective outcomes be measured? Is ongoing assessment through self-monitoring on a daily basis or retrospective evaluation by questionnaires administered at preselected assessment times more accurate? At what point in time will positive outcome be evaluated as more desirable and meaningful, at posttherapy or at follow-up? Whose outcomes should be taken into consideration, those of the female only or should those of the male partner also be considered?

Clinically, these issues rarely pose major difficulties. The range of therapeutic goals stated above are all legitimate and not mutually exclusive. Of course, therapists are interested in achieving improved functioning in both the behavioral and cognitive-affective realms in both the female and her partner at the end of therapy and beyond. Many, therefore, consider measurement and the reporting of outcomes to be in the "research" rather than the "clinical" domain.

It is our contention that the issue of *what* the goals of therapy are (behavioral vs. cognitive-affective), *how* changes are measured (ongoing vs. retrospective evaluation), *when* changes are assessed (posttherapy vs. follow-up) and in *whom* (female vs. male) are of interest from methodological, theoretical and clinical viewpoints.

From the methodological standpoint it is important to recognize that the measurement techniques employed and the outcome criteria selected will determine the type of data which are generated and will, therefore, affect the nature of the conclusions concerning therapeutic effectiveness.[4]

On a theoretical level, the mechanisms mediating therapeutic change need further elaboration. The sex therapy approach has assumed that treatment has its first impact on behavior. Once behavioral improvement has been attained it is expected that cognitive-affective changes in enjoyment and satisfaction will follow. However, a more sophisticated conceptualization of the goals for sex therapy and of the criteria for the evaluation of therapeutic outcomes appears necessary to shed light on both the etiology of sexual dysfunction and on the process of therapeutic change.

On a clinical level, it is important to realize that sex therapy components, such as banning intercourse or sensate focus exercises, may have a different impact on the behavioral and on the cognitive-affective aspects

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of sexual functioning.[5,6] Knowing the differential effectiveness of therapeutic components can lead to stronger and more precisely directed treatment procedures.

In the present investigation, the effects of sex therapy in the treatment of secondary orgasmic dysfunction are studied. The focus is on an examination of the impact of therapy on the behavioral and cognitive-affective dimensions of sexual functioning (the *what* variable) as measured by both ongoing and retrospective evaluation techniques (the *how* variable). Therapy outcome in both the female and her partner are reported (the *who* variable) for both posttherapy and follow-up testing times (the *when* variable). Data analyses reflect not only comparisons between the two levels of each of these variables, but also an examination of how these variables interact.

One might conceptualize the role and importance of operationalizing the goals and outcome criteria of sex therapy by an analysis of variance (ANOVA) model; this is used as a basis for organizing the presentation of the data and of the conclusions. A 2 × 2 × 2 × 2 factorial design — What (satisfaction/behavior) × How (retrospective/ongoing) × When (posttherapy/follow-up) × Who (client/partner) — would allow one to explore both "main effects" (e.g., How did therapy affect cognitive-affective vs. behavioral outcomes?) and interactions (e.g., How did therapy affect cognitive-affective, relative to behavioral outcomes, in males relative to females?).

The present investigation is part of a larger study in which the major focus was a comparative evaluation of three formats of behavioral sex therapy delivery in the treatment of secondary orgasmic dysfunction.[7] While a "meta-analysis" of therapy outcome criteria was not the major focus, the data lent themselves to such evaluation.

METHOD

Subjects

Subjects were 23 married couples with the problem of secondary orgasmic dysfunction in the wife. McGovern, Stewart-McMullen and LoPiccolo's[8] definition of secondary orgasmic dysfunction was used: women had to have experienced at least one orgasm through some mode of sexual stimulation but have been dissatisfied because of low frequency of orgasmic response or because of the limited range of sexual stimulation required for orgasm (e.g., orgasmic with oral stimulation only or not orgasmic with intercourse). Most of the women reported having experienced orgasms less than 25% of the time with any type of interpersonal stimulation during the last 6 months.

Additional inclusion criteria were: (a) wife aged 20–45; (b) duration of problem at least 6 months; (c) currently married, duration of relationship minimum 1 year; (d) education at least grade 9; and (e) both part-

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ners agreeable to therapy. Exclusion criteria were: (a) current physical illness; (b) current or recent (within 1 year) psychotherapy; (c) pregnancy or menopause; (d) severe marital discord; and (e) severe sexual problem in partner. Couples who did not meet the inclusion criteria were either treated in the Jewish General Hospital Sexual Dysfunction Service or were referred elsewhere, if they so desired.

Couples in the sample had been married 1–20 years, with a mean of 10. Subjects ranged in age from 25 to 44; the mean was 33 for wives and 34 for husbands. Both male and female subjects had an average of 15 years of education. The mean combined income of couples was $36,000.

Measures

Retrospective (Questionnaire) Measures

Subjects completed the questionnaires listed below on three occasions: pretherapy (1 week before), posttherapy (1 week after), and at 3 month follow-up.

Jewish General Hospital (JGH) Sexual Behavior Questionnaire. This extensive self-report instrument consists of questions and rating scales used routinely in the initial evaluation of all couples seeking help at the Sexual Dysfunction Service of the Jewish General Hospital in Montreal. This instrument assesses a wide range of both cognitive-affective and behavioral factors related to sexual functioning. Items are presented in the form of 8-point rating scales. Good test-retest reliability and discriminant validity have been reported and changes in scores from pre- to posttherapy have been found to reflect improved functioning consistent with clinical impression.[9,10]

The following cognitive-affective factors from this measure are included in the results: Sexual Performance Related Variables (e.g., comfort initiating), Communication Variables (e.g., satisfaction with sexual communication), and Enjoyment of Couple Sexual Activities (e.g., enjoyment of manual and oral stimulation).

Behavioral data used in the results are based on Frequency and % Orgasm with Couple Sexual Activities (e.g., frequency of female superior position intercourse, % orgasm receiving manual stimulation). A full presentation of these variables is available in a previous study.[7]

Sexual Interaction Inventory (SII).[11] The SII is a very widely used questionnaire measure of global sexual harmony. The 11 subscales are used to measure cognitive-affective (satisfaction, enjoyment) functioning. This measure has well demonstrated reliability and validity and has been shown to be sensitive to posttherapy changes with a range of sexual dysfunctions and in a variety of clinical and research contexts. There are significant differences on this measure between couples where the female partner suffers from secondary orgasmic dysfunction and sexually satisfied couples.[12]

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Azrin Marital Happiness Scale.[13] The rating scales of this marital adjustment measure were changed to 8-point scales. One item on this scale concerning overall sexual happiness was included as a cognitive-affective measure.

Ongoing (Self-Monitoring) Measures

Daily Self-Monitoring Form. To ascertain the frequency and quality of various sexual behaviors on a daily basis, male and female subjects completed the Sexual Self-Monitoring Form* (See Appendix) throughout the 14-week therapy program. The forms were returned by subjects each week. On a daily basis, subjects: (a) indicated whether they engaged in a variety of sexual behaviors; (b) rated their enjoyment of each sexual experience; and (c) specified whether they reached orgasm, and if so, with which activity. Enjoyment of various couple sexual activities was used to measure cognitive-affective changes, while frequency of couple sexual activities and orgasmic response (%) were used to assess behavioral changes. Pretherapy scores are based on weeks 2, 3, and 4 of the 14-week program and posttherapy scores are based on weeks 11, 12, and 13. (Additional description of this measure may be found in Fichten, Libman & Brender.[5])

Procedure

Couples underwent treatment in one of three therapy conditions: standard couple therapy (husband and wife were seen conjointly by one therapist for 1 hour each week), group therapy (women met once a week and husbands met once every 4 weeks with a therapist) and minimal contact bibliotherapy (couples met with a therapist once at the beginning and once at the end of the program). Treatment lasted 14 weeks; within each treatment condition, the therapy content, the audiovisual presentations, the reading materials and the sequence of therapeutic and outcome evaluation steps were identical. The program included information concerning sexual functioning and training in sexual communication as well as effective pleasuring techniques. Exercises included relaxation, vaginal muscle control, self-stimulation, and sensate focus assignments. (A full description of the program is available in Burstein et al.[14])

During the orientation session, both spouses met with a therapist; couples were provided with a general introduction, an explanation of the merits of the treatment, and all written materials for the 14-week therapy program. Subjects were instructed in the proper use of the program materials and were given instructions to complete and return the Sexual Self-Monitoring Forms each week. At the end of the program, subjects met with a therapist for a final summary meeting. Subjects completed all

*The authors wish to acknowledge the significant contribution of Y. Binik of McGill University in the design of the Sexual Self-Monitoring Form.

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retrospective questionnaire measures 1 week prior to beginning therapy, 1 week after completion of the program, and at the 3-month follow-up. Sexual Self-Monitoring Forms were not completed during the 3-month follow-up period.

RESULTS

Since few differences were found among therapy formats,[7] data from the three treatment conditions were combined for analysis. Although results were analysed using chi-square, the design of the analyses is based on the ANOVA model mentioned earlier and consists of a 4-way comparison: 2 Who (Male/Female) × 2 How (Retrospective/Ongoing) × 2 What (Cognitive-Affective/Behavioral Changes) × 2 When (Posttherapy/Follow-up). In the "meta-analysis" χ^2 tests were used on the ratio of the number of variables on which significant improvement was found (on ANOVA tests described in Libman et al.[7]) to the number of variables assessed. In these tests, *N* refers to variables assessed and not to subjects. Because there was no one-to-one correspondence among items in the various cells, a χ^2 test for independent proportions was used. Thus, the χ^2 test results should be interpreted with caution. For clarity, numbers in tables and figures are reported as percentages.

Table 1 summarizes the percentage of significant improvements from pretherapy to posttherapy and pretherapy to follow-up in the scores of females and males for cognitive-affective and behavioral variables assessed via retrospective (questionnaire) and ongoing (self-monitoring) measures. As no deterioration was found, all changes reflect improvement.

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TABLE 1

Analysis of Variance Representation of Therapeutic Improvements

When:		Posttherapy		Follow-up	
What[1]	*Who*	*How*[2] Retrospective	Ongoing	Retrospective	Ongoing[3]
Cognitive-Affective Variables	Females	74%	100%	43%	N/A
	Males	52%	50%	43%	N/A
Behavioral Variables	Females	67%	0%	25%	N/A
	Males	33%	0%	8%	N/A

Note: Percentages represent the ratio of number of variables on which significant improvement from pretherapy was found to the total number of variables evaluated.
[1]Cognitive-Affective Variables refer primarily to satisfaction and enjoyment of specific sexual activities and global sexual happiness. Behavioral Variables refer to frequency of couple sexual activities and to % orgasmic response.
[2]Retrospective = questionnaire measures. Ongoing = self-monitoring measures.
[3]Self-monitoring data for follow-up not available.

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Main Effects

The results show important main effects for each of the four variables. For the How variable, results posttherapy indicate that, while on Retrospective measures improvement was found on an average of 57% of variables, on Ongoing measures improvement was found on only an average of 38% variables. Thus, the questionnaire results are more optimistic than self-monitoring results. On the What variable, results show that while there was improvement on an average of 60% of Cognitive-Affective measures, Behavioral changes were found only on 22%. This indicates that improvements in satisfaction and happiness exceeded behavioral changes. On the Who factor, greater benefits were realized by Females (52%) than by Males (31%). Examination of the When variable can only be made on Retrospective measures; this shows that of improvement on an average of 57% of variables Posttherapy, only 30% remain at Follow-up.

Interactions

The Who × What × When × How interaction was broken down into 2-way interactions. Figure 1 shows the interaction of the How × What variables Posttherapy. Results show that How measurement is carried out does not affect Cognitive-Affective changes. Evaluations of Behavior, however, are more optimistic when measured by Retrospective rather than by Ongoing methods, χ^2 (1,82) = 28.84, $p < .01$. When this interaction was broken down by the Who variable, the interactions show that this was true for both Females, χ^2 (1,41) = 15.21, $p < .01$, and Males, χ^2 (1,41) = 31.51, $p < .01$.

The What × When interaction on Retrospective measures, χ^2 (1,140) = 3.65, $p < .06$, presented in Figure 2 suggests that a greater proportion of Cognitive-Affective gains than of Behavioral gains were maintained at Follow-up. When this interaction was broken down by the Who variable, results indicate that this relationship held only for Males, χ^2 (1,70) = 4.41, $p < .05$.

The following interactions were not significant: Who × What at Posttherapy, Who × When on Retrospective measures, Who × How at Posttherapy. Because Ongoing data were not collected during Follow-up, interactions including the How × When variables were not tested.

Covariation between Cognitive-Affective and Behavioral Variables

In order to do a more fine-grained analysis of the relationship between changes in Cognitive-Affective and Behavioral variables, Females' improvement pre- to posttherapy on the Cognitive-Affective variable enjoyment and the Behavioral variable % orgasm were considered separately.

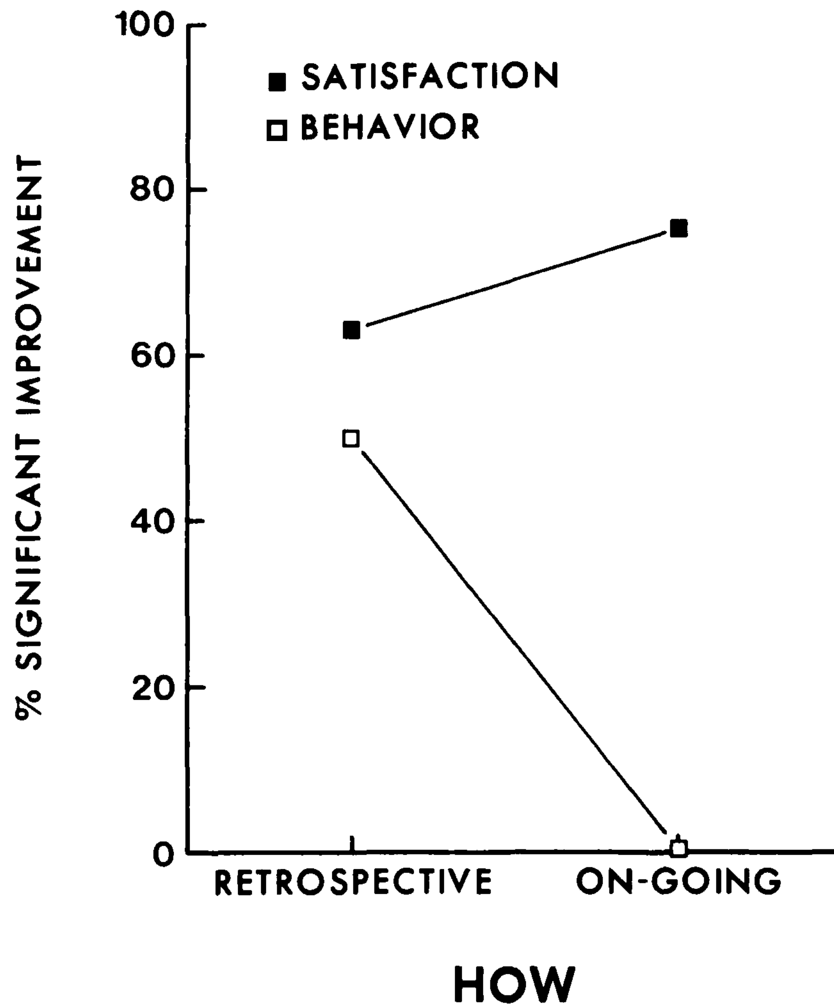

FIGURE 1. How × What interaction at Posttherapy.

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This was done for each couple sexual activity on both Retrospective and Ongoing measures.

On the Ongoing measure, significant (on ANOVA tests presented in Libman et al.[7]) improvement in enjoyment was found on two couple sexual activities; however, there were no corresponding improvements in % orgasm with either of these activities. The same examination on the Retrospective measure yielded a different result: for four of six couple activities both enjoyment and % orgasm improved significantly; for one activity enjoyment improved but % orgasm did not; and for another the reverse happened. These results demonstrate that while the Retrospective measure showed good covariation between Cognitive-Affective and Behavioral improvements, the Ongoing measure did not.

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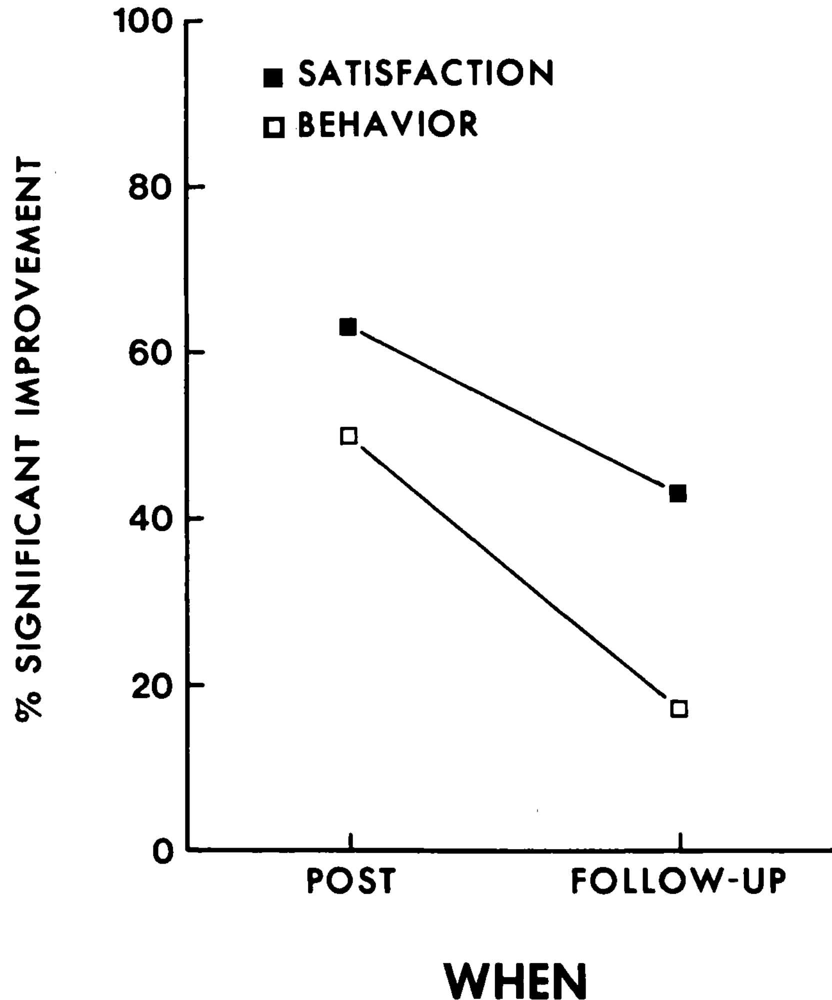

FIGURE 2. What × When interaction on Retrospective measures.

DISCUSSION

The results of this investigation show that the choice of criteria used to assess the outcome of sex therapy can dramatically affect one's conclusions about the efficacy of therapy. Results for the four variables examined (i.e., how, what, who, and when), show that (a) retrospective measurement by questionnaires, including the often used SII, administered at predetermined testing times was more optimistic than ongoing evaluation through self-monitoring; (b) cognitive-affective (enjoyment, satisfaction) improvements were twice as likely to be found as changes in behaviors (reported frequency, orgasmic response); (c) the females realized greater benefits than the males; and (d) there were considerable losses of therapeutic gains from posttherapy to follow-up.

The interactions among these four variables indicate that both retrospective and ongoing measurement yield similar results for cognitive-affective outcomes. For behavioral changes, however, the retrospective technique is more optimistic than the ongoing one. Since the ongoing method relied on daily self-monitoring (i.e., occurrence of sexual activities and of orgasmic responding were recorded daily), one cannot help but believe that the measurement error is one of overestimation on retrospective questionnaires rather than of underestimation by the ongoing self-monitoring.

This has important implications for the evaluation of the outcome of sex therapy for secondary orgasmic dysfunction. Most therapy outcome studies use retrospective questionnaires rather than self-monitoring data to evaluate behavioral change. When one considers that most studies of the efficacy of sex therapy also show that gains in secondary orgasmic dysfunction are more modest than gains in other types of dysfunctions,[15] one wonders whether sex therapy for secondary orgasmic dysfunction makes any significant improvements in the presenting complaint of difficulty achieving orgasm with a partner. Females benefited more from the program than did their partners, which is understandable in light of the specific therapeutic focus. It is noteworthy, however, that measures reflected improvement in both partners for variables related to sexual functioning, such as sexual communication and affectional contact. Specific sexual response tended not to change for the males, perhaps because this was a nonproblematic area from the outset. Deterioration in the follow-up period is a frequent finding in the behavior therapy literature[16] and clearly needs to be addressed directly.

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Mechanism and Mediation of Therapeutic Change

Sex therapy traditionally has assumed isomorphism between mediational process and therapeutic technique, i.e., behavior change is a result of behavior based techniques, cognitions are changed through the use of cognitive techniques.[17] Bandura[18] proposed that the direction of mediation may follow a different path. In a series of studies, he showed that not only can behavior change techniques effect significant cognitive improvements but these changes may take place before behavioral improvements can be demonstrated. Furthermore, he showed that cognitive gains realized prior to behavioral improvements can predict successful maintenance of behavioral changes.

The results of the present study suggest that sex therapy for secondary orgasmic dysfunction can produce important and significant cognitive-affective gains in the absence of behavioral improvement. The overall pattern of findings demonstrates that the type of measure used dramatically affects the nature of the results and of the conclusions and suggests that therapeutic effectiveness should be reported in terms of both important dimensions of sexual experience: behavioral as well as cognitive-affective.

The present results also underscore the need for multiple measurement techniques, including both retrospective and ongoing measurement of cognitive-affective as well as behavioral changes in both males and females posttherapy and during follow-up.

Our findings indicate that sex therapy for secondary orgasmic dysfunction may have its greatest impact on cognitive-affective factors rather than on the behaviors which supposedly mediate cognitive-affective changes. We believe that enjoyment of sexual activities is an important dimension of the sexual experience and a valid therapeutic goal. In order for the behavioral change dimension to be addressed, treatment for secondary orgasmic dysfunction must be made more effective. This may be accomplished by careful study of: (a) the specific characteristics of the problem manifestation;[19] (b) the most effective therapy delivery format for the particular dysfunction; [7,20] and (c) the impact of therapeutic components emphasized in the sex therapy program for a given client.[5] The exploration of cognitive mediation of behavioral gains as well as of maintenance issues can best be addressed by ongoing evaluation of both behavioral and specific types of cognitive gains. A promising direction is the assessment of changes in expectations of personal effectiveness. Investigation of the role of "self-efficacy"[18] in sex therapy is presently proceeding in our laboratory.[21]

We also need to know more about normal sexual functioning in order to establish realistic therapeutic goals. The available data is generally based on retrospective questionnaire ratings. Since this study has demonstrated a clear difference between data derived from retrospective and ongoing measurement (with distortion most likely on the retrospective measures), self-monitoring data would be the most accurate technique for establishing normative patterns of sexual behavior.

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APPENDIX

SEXUAL SELF-MONITORING FORM
(Please fill out alone)

NAME ____________________

DATE ____________________

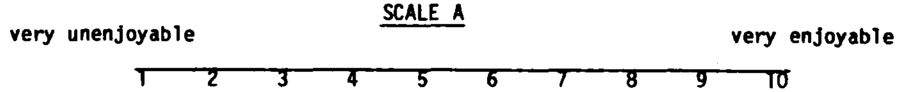
(1) Sexual activities (please check (✓) in column 1 if the activity occurred)

	1 Check if activity occurred	2 Rate according to Scale A
Individual Activities		
a) fantasies (daydreams)	____	____
b) dreams	____	____
c) masturbation	____	____
d) reading erotica	____	____
e) seeing erotica	____	____
f) other (specify below)	____	____
Interpersonal Activities		
g) kissing	____	____
h) caressing-non genital (giving)	____	____
i) caressing--non genital (receiving)	____	____
j) breast caressing	____	____
k) genital touching (giving)	____	____
l) genital touching (receiving)	____	____
m) oral stimulation (giving)	____	____
n) oral stimulation (receiving)	____	____
o) anal stimulation (giving)	____	____
p) anal stimulation (receiving)	____	____
q) mutual masturbation	____	____
r) intercourse	____	____
s) other (specify below)	____	____

(2) Please look at Scale A on the right and then rate each activity checked (✓) above. Write the rating in column 2 above.

SCALE A

very unenjoyable — very enjoyable



(3) How did you feel about your sexual experience today? (put X in box)

very negative — very positive

1	2	3	4	5

(4) Did you experience any orgasms ____________

(5) If yes, during which activity ____________

(6) How satisfied are you with the amount of affection you received today?

very dissatisfied — very satisfied

1	2	3	4	5

(7) In general how did you feel about your partner today?

very negative — very positive

1	2	3	4	5

(8) Please add, in your own words, any important information or feelings concerning yourself, your marriage, your sex life, or any other issues you'd like to bring up in your session with your therapist.

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