

# THE ROLE OF THERAPEUTIC FORMAT IN THE TREATMENT OF SEXUAL DYSFUNCTION: A REVIEW

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**ABSTRACT.** *Review of the literature evaluating different formats for the delivery of behavioral sex therapy suggests that group therapy, minimal therapist contact bibliotherapy, and standard couple therapy all have demonstrable effectiveness; such differences as have been found between them have been subtle. Variations within these formats indicate that one therapist is as effective as two, the gender of the therapist does not influence therapeutic outcome, and that massed and spaced sessions, with minimal exceptions, produce equivalent therapeutic effects. The authors argue, however, that it is premature to conclude that all therapeutic contexts are equally effective. Human sexual response is complex, therapy programs are multifaceted, and therapy outcome may be measured in multiple ways, yielding dramatically different results. Judgments regarding therapeutic effectiveness will vary as well depending upon whether cognitive, affective or behavioral therapy outcome criteria are employed. Adequate evaluation of therapy as a function of mode of therapy delivery must take these considerations into account.*

A variety of therapeutic contexts have been explored in an effort to provide low cost and effective sex therapy services. Masters and Johnson (1970) originally ad-

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vocated the use of a male and female co-therapy team, couples seen individually, in an intensive (daily) 2-week program. As this form of treatment is extremely costly, both in therapist and client time and expense, clinicians and researchers have made significant modifications to the original Masters and Johnson format. These modifications include the use of one therapist as opposed to two, weekly rather than daily therapy sessions, and therapy delivery via group sessions or minimal therapist contact and bibliotherapy formats.

The purpose of this review is twofold. One objective is to review the state of the art with respect to the range of sex therapy formats used and their relative effectiveness. The second objective is to sensitize the reader to some of the methodological issues involved in investigations of the effectiveness of different formats of sex therapy delivery. The studies reviewed examine variations in the format in which modified Masters and Johnson sex therapy is delivered (e.g., individual couple therapy, group therapy and self-help or minimal therapist contact treatments.) Within these formats, the effects of variations in number and gender of therapists and in number and spacing of therapy sessions are reviewed.

Studies evaluating the effectiveness of various modes of sex therapy delivery highlight a range of methodological limitations. These include: (a) pre-post therapy comparisons in clinical samples with either no control group or with a no treatment control group only, rather than comparative evaluation of different therapy formats; (b) simplistic data analyses, such as descriptive statistics and multiple *t* tests; (c) poorly specified treatment programs; (d) heterogeneous problem samples and inadequate description of problem and sample characteristics; (e) poorly specified and often questionable measures of treatment outcome (e.g., therapist ratings only, self-report only, or a combination of global sexual and marital satisfaction measures); (f) small sample size and considerable dropout rates, (g) short or non-existent follow-up evaluations; (h) no control for therapist bias; and (i) a variety of treatment confounds which make evaluation of the independent effects of differing therapy format variables impossible.

### **THErapy DELIVERY FORMATS**

The classic recipients of sex therapy are individual couples. In spite of recent criticisms and demonstrations that sex therapy is not the panacea it was heralded to be (Brender, Libman, Burstein, & Takefman, 1983; Everaerd, 1983; Zilbergeld & Evans, 1980), numerous controlled studies have shown that sex therapy with individual couples is effective (see Kilmann & Auerbach, 1979; Marks, 1981; Sotile & Kilmann, 1977; Wilson, 1982 for reviews). Variations of the classic couple format, such as group therapy and minimal therapist contact bibliotherapy are more recent. Evaluation of the effects of these variations has ranged from simple pre-post therapy comparisons to complex designs in which different formats are compared. A listing of studies reviewed, including information such as therapy format employed, sample characteristics and outcome measures used, is provided in Table 1.

TABLE 1. Therapy Delivery Formats

Study	Format	Subjects	Dysfunction	Outcome Measures	Number and Gender of Therapists	Number and Spacing of Sessions
<i>Group Therapy—Uncontrolled Studies</i>						
Barbach (1974)	Group	83 women 6/group	Primary nonorgasmic	Self-report of orgasm	2 females	10 sessions 2/week
Barbach & Flaherty (1980)	Group	26 women 5–7/group	Secondary nonorgasmic	Self-report of orgasm and of effects of group	Not reported	10 sessions 1/week
Kaplan, Kohl, Pomeroy, Offit & Hogan (1974)	Group	4 couples	Premature ejaculation	Self-report & partner validation of ejaculatory control	Male/female team	6 sessions 1/week
Lobitz & Baker (1979)	Group	9 men 6/group	Erectile disorder	Self-report, sexual satisfaction questionnaire, 'TAT'	2 males	12 sessions 1 or 2/week
McGovern, Kirkpatrick & LoPiccolo (1978)	Group	4 couples	Primary nonorgasmic, premature ejaculation	sexual & marital questionnaires	Male/female team	15 sessions 1/week, then 2/6 weeks
Price & Heinrich (1977)	Group	14 women 7/group	Secondary nonorgasmic	Self-report of orgasmic experience with partner	1 female	8 sessions 1/week
Schneidman & McGuire (1976)	Group	20 women 10/group	Primary nonorgasmic	Self-report of orgasm, sexual & marital questionnaires	Not reported	15 sessions 1/week
Wallace & Barbach (1974)	Group	17 women 5–6/group	Primary nonorgasmic	Interviews, self-esteem & body acceptance scales, marital adjustment & sexual attitude questionnaires, Attitude Toward Women scale	2 females	10 sessions 2/week
Zeiss, Christensen & Levine (1978)	Group	6 men 3–6	Premature ejaculation	Marital adjustment test, sexual activity forms, timed ejaculatory latency (by partner)	2 males	6 sessions 1/week, then 2/8 weeks
Zilbergeld (1975)	Group	25 men 7/group	6– Mixed male disorders	Self-report	Male/female team or 2 males	12 sessions 1/week, then 1/2–3 weeks
<i>Group Therapy—Controlled/Comparative Studies</i>						
Ersner-Hershfield & Kopel (1979)	Couples group vs. affected individuals group	22 women 4–6 couples/ group 6 women/ group	Primary nonorgasmic	Sexual & marital questionnaires	Male/female team (couples), 2 females (individuals)	10 sessions 2/week vs. 1/week
Golden, Price, Heinrich & Lobitz (1978)	Couples group vs. individual couples	10 couples 3–4/group	Premature ejaculation, secondary nonorgasmic	Sexual & marital questionnaires	Male/female team	12 sessions 1/week

**TABLE 1. Therapy Delivery Formats (Continued)**

Study	Format	Subjects	Dysfunction	Outcome Measures	Number and Gender of Therapists	Number and Spacing of Sessions
<i>Group Therapy—Controlled/Comparative Studies-cont.</i>						
Perelman (1977)	Individual couples vs. affected individuals group vs. couples group	6 men 5 couples	premature ejaculation	Self-report of ejaculatory control and general sexual functioning	1 male	10 sessions 2/week
Trudel & Campbell (1983)	Affected individuals group vs. waiting list controls	43 women	Primary & secondary nonorgasmic	Sexual questionnaires, self-monitoring	Male/female team	10 sessions 1/week
<i>Self-Help &amp; Minimal Contact—Uncontrolled Studies</i>						
Kass & Strauss (1975)	Bibliotherapy	30 couples	Mix male/female disorders	Unknown	N/A	3–4 months
Takefman & Brender (1984)	Minimal contact	16 couples	Erectile disorder	Sexual & marital questionnaires, daily self-monitoring, success/experience ratio	1 female	4 weeks
<i>Self-Help &amp; Minimal Contact—Controlled/Comparative Studies</i>						
Dodge, Glasgow & O'Neil (1982)	Minimal contact vs. delayed treatment information controls	13 women	Secondary & primary nonorgasmic	Sexual questionnaires, self-report of orgasmic experience	1 female	7 weeks
Heinrich (1976)	Bibliotherapy vs. group vs. waiting list controls	44 women	Primary nonorgasmic	Sexual, marital & personality questionnaires	1 female	5 weeks 2/week (group)
Lowe & Mikulas (1978)	Minimal (telephone) contact vs. waiting list controls	10 couples	Premature ejaculation	Estimated ejaculatory latency (by male)	1 male	3 weeks
Mathews, Bancroft Whitehead, et al. (1976)	Minimal (mail) contact vs. individual couples	36 couples	Mixed male/female disorders	Client and therapist ratings of general and sexual relationship	Male/female team vs. 1 male or 1 female	10 weeks
Zeiss (1978)	minimal (telephone) contact vs. individual couples vs. bibliotherapy	18 couples	Premature ejaculation	timed ejaculatory latency, sexual & marital questionnaires	1 male	12–20 weeks

**TABLE 1. Therapy Delivery Formats (Continued)**

Study	Format	Subjects	Dysfunction	Outcome Measures	Number and Gender of Therapists	Number and Spacing of Sessions
<i>Individual Couple—Controlled/Comparative Studies</i>						
Libman, Fichten, Brender, Burstein, Cohen & Binik (1984)	Individual couples vs. affected individuals group vs. minimal contact	23 couples	Secondary nonorgasmic	Sexual & marital questionnaires, daily self-monitoring	1 male or 1 female (individual couples & minimal contact) 2 females (group)	15 sessions 1/week

### Group Therapy

A number of uncontrolled studies have shown that the group format can be effective in improving sexual functioning and satisfaction. Problem categories have included: primary orgasmic dysfunction in women (e.g., Barbach, 1974; McGovern, Kirkpatrick, & LoPiccolo, 1978; Schneidman & McGuire, 1976; Wallace & Barbach, 1974), secondary orgasmic dysfunction in women (e.g. Barbach & Flaherty, 1980; Price & Heinrich, 1977), mixed sexual dysfunctions (e.g., Zilbergeld, 1975), premature ejaculation (e.g., Kaplan, Kohl, Pomeroy, Offit, & Hogan, 1974; Zeiss, Christensen, & Levine, 1978), and erectile dysfunction (e.g., Lobitz & Baker, 1979).

Comparative study of the effectiveness of group versus individual couple therapy has also shown the group format to be a viable alternative to individual couple therapy. For example, Golden, Price, Heinrich, and Lobitz (1978) compared the effectiveness of sex therapy delivered to individual couples and to groups of three to four couples with the problem of premature ejaculation and secondary orgasmic dysfunction. The same therapy program was used for both conditions. Outcome measures included latency to ejaculation for males and increased orgasmic range and frequency for females, as well as paper and pencil measures of sexual and marital satisfaction. Both treatment delivery formats led to significant post-therapy improvement. There was some suggestion that group therapy was somewhat more effective than couple therapy, but there were no differences apparent at follow-up. No control group was included in the experimental design; this represents a significant weakness in an otherwise careful effort to evaluate systematically these two forms of sex therapy delivery. The importance of control groups is underscored by the findings of Trudel and Campbell (1983). These investigators not only found no differences between women receiving group treatment for orgasmic problems and women in a waiting list control group, but also found that subjects in both treated and untreated groups made highly significant gains on a variety of outcome measures.

Studies of groups composed either of couples or of the affected individuals only have also suggested that the group format is equally effective with either group composition. For example, Ersner-Hershfield and Kopel (1979), working with a sample of 22 pre-orgasmic women, compared a couples group and a women only group. Improvement in both individual and couple sexual functioning was dem-

onstrated in both conditions. A similar design with a sample of males complaining of premature ejaculation was conducted by Perelman (1977). He not only found both conditions equally effective in improving both ejaculatory control and overall level of sexual functioning but also found that treated groups had outcomes superior to an untreated control group.

### *Self-Help and Minimal Therapist Contact Bibliotherapy*

There are a considerable number of sexual self-help books on the market. Some of these describe highly credible therapy programs, often based on treatments shown to be effective when delivered via individual couple therapy. But how effective, and perhaps more importantly, how deleterious (Fisher, 1984) are such programs without therapist supervision or with minimal therapist supervision? In keeping with developments in the behavior therapy literature (Rosen, 1982), some investigators have explored the effects of "self-help" and minimal therapist contact bibliotherapy programs in the treatment of sexual dysfunction.

An uncontrolled study of no therapist contact bibliotherapy for mixed sexual dysfunction was conducted by Kass and Strauss (1975). They concluded that a behavioral sex therapy program in written format was effective for those couples who followed the program, at least in the short term. However, data were not systematically collected, outcome criteria were unclear and the drop-out rate was considerable: 19 out of an original 30 couples. In a component analysis study of sex therapy for erectile problems, Takefman and Brender (1984) found, in a sample of 16 couples, that a 4-week minimal therapist contact treatment resulted in significant improvements pre- to post-therapy.

In a comparison of treated and untreated waiting list control subjects, Lowe and Mikulas (1978) assessed the effects of a bibliotherapy program plus twice weekly telephone contact with a therapist in a sample of 10 couples where the presenting problem was premature ejaculation. Their results indicated significant improvement in treated couples compared with waiting list controls. However, their sample size was very small (five per condition), their program lasted an average of only 3 weeks, the measure of improvement was a time estimate by the male only of latency to ejaculation, and no follow-up data were reported. Dodge, Glasgow, and O'Neil (1982), using a sample of 13 predominantly secondary non-orgasmic women, reported significant improvement with a 7-week minimal contact bibliotherapy (3 one-half-hour individual meetings with a therapist) as compared with a delayed treatment information control. Generalizability of these results is limited by the small sample size of the treatment and control groups (which contained both primary and secondary non-orgasmic women), as well as the somewhat questionable method of evaluating differences within and between groups.

The comparative effectiveness of individual couple therapy, minimal therapist contact (6 minutes/week telephone contact), and no therapist contact bibliotherapy was investigated by Zeiss (1978). In a sample of 18 couples presenting with premature ejaculation, 12–20 weeks of bibliotherapy plus minimal therapist contact was almost as effective as individual couple treatment; no therapist contact bibliotherapy, however, was totally ineffective.

Group therapy and minimal therapist contact bibliotherapy have also been compared. For example, in a well-controlled investigation, Mathews et al. (1976) used a sample that included both male and female sexual problems. A comparison was

made between maximal (one or two therapists present at each of 10 therapy sessions) and minimal (weekly exchange of letters) therapist contact. No clearly significant differences in outcome between these two conditions were found. Heinrich (1976) explored the effects of treatment with and without a therapist in a sample of women complaining of primary orgasmic dysfunction. The relative efficacy of therapist-run groups was compared with a self-help bibliotherapy treatment program. The results indicate that improvement occurred in both conditions, but the therapist-led form of treatment was clearly more effective.

The studies reviewed above do not permit the formulation of any firm conclusions concerning the effectiveness of a no therapist contact treatment program. We must concur with Leiblum and Pervin (1980) who stated years later, that "the import of these (self-help) books on reducing the incidence of sexual dysfunction is unknown" (p. 18). As for minimal therapist contact bibliotherapy, the results suggest that this may be an effective treatment alternative. The data do not, however, provide information on the relative efficacy of individual couple, group and minimal therapist contact bibliotherapy formats.

A major difficulty in assessing the comparative effectiveness of these three major therapy formats is partly due to the frequent use of non-homogeneous problem samples and to the absence of studies comparing these three therapy modalities directly. A recent study by Libman, Fichten, Brender, Bustein, Cohen, and Binik (1984) addressed this issue. The sample consisted of 23 couples presenting with secondary orgasmic dysfunction. The same 15 session cognitive-behavioral sex therapy program was administered using either individual couple, group therapy or minimal contact bibliotherapy formats. Therapeutic outcome was evaluated by both subjective satisfaction and reported behavioral frequency measures. Subjects in all three conditions improved on a wide range of subjective satisfaction and behavioral outcome measures, and there were few differences between groups. Such differences as were found tended to favor the individual couple therapy condition; group and minimal contact bibliotherapy appeared to be equally effective. In this study, the duration of the problem was 10 years, which suggests that the observed positive changes were related to the therapy process. Nevertheless, the experimental design would have been strengthened by the inclusion of a no-treatment or a placebo control group.

While the studies reviewed above appear to suggest that group therapy and, possibly, minimal contact bibliotherapy are viable alternatives to the more costly individual couple treatment, it should be noted that within each of these therapy delivery formats, a number of additional variations have been explored and need to be considered before generalizations can be made. These within format variations include the number and gender of therapists as well as the number and spacing of therapy sessions.

## **WITHIN FORMAT VARIATIONS**

### *Number and Gender of Therapists*

In the original Masters and Johnson (1970) formulation, a dual sex team was seen as necessary for the implementation of sex therapy with couples. In marital therapy, as well, dual sex teams were frequently advocated (cf. Kaplan-Mehlman, Baucom,

& Anderson, 1983) in order to deal with the complexities of dyadic interaction. Are two therapists really necessary, however? If not, are male and female therapists equally effective? Theoretical assumptions concerning transference and countertransference phenomena would suggest that the gender of the therapist could be an important variable. The question of possible differential effectiveness of male and female therapists with clients of either gender has not yet been resolved in either the counselling or psychotherapy literatures (cf. Jones & Zoppel, 1982). In sex therapy, clients often show a strong preference for a therapist of a particular gender; this appears to be most marked in the case of couples presenting with male dysfunctions, such as erectile problems ("How could a woman possibly know...?") and in the case of single clients. Therefore, the issue of whether the therapist's gender affects sex therapy outcome is an important practical as well as theoretical concern. A variety of studies concerned with these issues are reviewed in this section. These studies, as well as pertinent sampling and format considerations, are listed in Table 2.

Crowe, Gillan, and Golombok (1981) studied therapy outcome in a sample of 48 couples with mixed sexual disorders. Therapy was delivered using the individual couple format. These investigators administered between five and ten therapy sessions twice per week and varied the number and gender of therapists (either a male/female cotherapy team or one male or female therapist only). Both global

**TABLE 2. Within Format Variations: Number and Gender of Therapists, Number and Spacing of Sessions**

Study	Format	Subjects	Dysfunction	Outcome Measures	Number and Gender of Therapists	Number and Spacing of Sessions
Arentewicz & Schmidt (1983) Clement & Schmidt (1983)	Individual couples	202 couples	Mixed male/female disorders	Sexual, marital & personality questionnaires	Male/female team vs. 1 male or 1 female	17 sessions daily vs. 35-40 sessions 2/week
Carney, Bancroft & Mathews (1978)	Individual couples	32 couples	Female lack of responsiveness	Self-monitoring, assessor ratings	1 female	16 sessions 1/week/vs 5 sessions 1/month
Crowe, Gillan & Golombok (1981)	Individual couples	48 couples	Mixed male/female disorders	Sexual, marital, & personality questionnaires, self & assessor ratings on target problem	Male/female team vs. 1 male or 1 female	5-10 sessions 2/week
Ersner-Hershfield & Kopel (1979)	Couples vs. affected individuals groups	22 women 4-6 couples/ 6 women/ group	Primary nonorgasmic	Sexual & marital questionnaires	Male/female team (couples) 2 females (individuals)	10 sessions 2/week vs. 1/week
Heiman & Lo Piccolo (1983)	Individual couples	68 couples	Mixed male/female disorders	sexual & marital questionnaires	Male/female team	15 sessions daily vs. 1/week
Mathews, et al. (1976)	Minimal contact (mail) vs. individual couples	36 couples	Mixed male/female disorders	Client & therapist ratings of general and sexual relationship	Male/female team vs. 1 male or 1 female	10 weeks 1/week

sexual and relationship satisfaction, as well as status of the target problem, were assessed after therapy and at 1-year follow-up. No differences in outcome were found for either number or gender of therapists for either male or female dysfunctions. Similarly, the number of therapists was found to have no effect in a study of 202 couples receiving individual couple therapy (Arentewicz & Schmidt, 1983; Clement & Schmidt, 1983). Only one study found a difference between one and two therapists (Mathews et al., 1976); the effect was only marginally significant.

These results suggest that one therapist is as effective as two and that in spite of theoretical postulates (e.g., transference phenomena) and client preferences (e.g., for a male or female therapist), the gender of the therapist is irrelevant to therapeutic outcome, at least when treatment is delivered via individual couple therapy. In marital therapy as well, a recent investigation has shown that the number and gender of therapists does not influence the outcome of therapy delivered to couples (Kaplan-Mehlman et al., 1983). Therefore, the presence or absence of marital conflict does not appear to be a relevant variable. Nevertheless, the findings in the area of sex therapy must be considered preliminary rather than conclusive since further investigation of such issues as the nature and characteristics of the sexual dysfunction, the experience and age of the therapist and whether the client is a single individual or a couple remain to be considered. Furthermore, while various investigators have suggested that dual-sex teams are useful in the group therapy format (cf. Mills & Kilmann, 1982), there is no empirical evidence bearing on this issue. In studies of minimal contact bibliotherapy, the issue does not even seem to have been raised.

### *Number and Spacing of Therapy Sessions*

How many sessions are optimal? How should therapy sessions be spaced? Within the context of individual couple therapy, a number of investigations have raised these issues (see Table 2).

The largest study, on 202 couples with mixed sexual dysfunction, was conducted in Germany (Arentewicz & Schmidt, 1983; Clement & Schmidt, 1983). Results on a variety of measures indicate no difference in therapeutic effectiveness in couple therapy delivered by dual-sex teams on an intensive (17 sessions over a 3-week period) and long-term (35–40 sessions twice per week over 18 weeks) basis. In this study, however, the number as well as the spacing of therapy sessions differed; therefore, the independent effect of either variable cannot be evaluated. Carney, Bancroft, and Mathews (1978) showed that five monthly sessions were as effective as 16 weekly therapy sessions in treating lack of sexual responsiveness in the female. This study, however, varied not only the number and the spacing of sessions, but also included concurrent administration of testosterone or diazepam along with sex therapy. Evaluation of the effects of each of these variables separately, therefore, is not possible. A recent investigation of sex therapy outcome in a heterogeneous clinical sample of 68 couples compared daily versus weekly treatment sessions (Heiman & LoPiccolo, 1983). Fifteen hours of treatment were administered by dual-sex teams to couples either on 15 consecutive days or during 15 consecutive weeks. When data were analyzed according to problem category the results suggested somewhat better therapeutic outcome for erectile disorder and secondary orgasmic dysfunction when treatment sessions were held weekly. For other sexual disorders, both treatment schedules appeared to be equally effective.

In the context of group therapy, a comparison in a sample of 22 couples presenting with primary orgasmic dysfunction showed that "massed" (two sessions per week for 5 weeks) and "spaced" sessions (one per week for 10 weeks) were equally effective (Ersner-Hersfield & Kopel, 1979).

The results seem to indicate that the number and the spacing of therapy sessions, at least in the couple therapy format, do not seem to affect therapeutic outcome for "mixed sexual dysfunctions." Heiman and LoPiccolo's (1983) results, however, suggest that different dysfunctions may respond differentially to different treatment parameters. While differences were not substantial (and the methodological limitations of the study did not permit more conclusive statements), nevertheless, carrying out the analysis of treatment outcome by problem category reflects an emerging recognition that the specific characteristics of the dysfunction must be considered in relation to a particular treatment tactic. The issue of time limited versus time unlimited therapy, in the context of individual couple treatment, has not yet been empirically investigated.

In the group therapy format, the one study which has investigated the effects of spacing of therapy sessions found no differences. Since reported group therapy studies show enormous variation in the timing, spacing and even duration of therapy sessions [e.g., Mills & Kilmann (1982) report treatment hours between 4.5 and 45 hours, length of sessions between 45 minutes and 8 hours, and spacing of sessions between daily and weekly], it is impossible to form any conclusions concerning the effects of number and spacing of sessions in group therapy.

### **SUMMARY AND IMPLICATIONS**

Review of the literature evaluating different formats for the delivery of behavioral sex therapy suggests that group treatment of couples and of affected individuals only appear to be equally effective. Group therapy, minimal therapist contact bibliotherapy, and standard couple therapy have all demonstrated some value, and such differences in effectiveness as have been found between them have been subtle. In addition, variations within these formats indicate that one therapist is as effective as two, the gender of the therapist does not influence therapeutic outcome, and that in individual couple therapy, massed and spaced sessions with minimal exceptions produce equivalent therapeutic effects. On the basis of this evidence one would be tempted to concur with Luborsky, Singer, and Luborsky's (1975) verdict that "everyone has won and all must have prizes." We believe, however, that the conclusion that all therapeutic contexts are equally effective and that there is little difference between them is premature and must be tempered by a number of major conceptual and methodological concerns.

Adequate evaluation of therapeutic effectiveness as a function of mode of therapy delivery must take into account a number of variables. First of all, the goals of sex therapy need to be clarified, the techniques for measuring changes induced by therapy must be better understood, and the durability of improvements must be evaluated. Dynamically oriented investigators would consider change in a process variable such as "therapeutic alliance" an important indicator of therapeutic efficacy (e.g., Jones & Zoppel, 1982). Behavioral psychologists, on the other hand, would be unlikely to measure such a variable and less likely to consider it an important aspect of successful therapy outcome. Even within the cognitive-behavioral theoretical framework the choice of therapy goals and the criteria used for evaluation

of therapeutic outcome represent fundamental conceptual and methodological issues. Beyond Garfield's (1981) important reminder that evaluating therapeutic change must extend further than the demonstration of a statistically significant difference between treated and untreated groups, there remain two fundamental questions: what constitutes success and, equally important, how are changes best measured?

Recently, we examined the complex matter of operationalizing therapeutic goals and their measurement in the context of cognitive-behavioral sex therapy for secondary orgasmic dysfunction (Fichten, Libman, & Brender, in press). The questions addressed in this study follow. Is the goal of therapy to increase the frequency of interpersonal orgasms, a behavioral outcome, or to increase satisfaction with and enjoyment of sexual activities, a cognitive-affective outcome? If it is important to make improvements in both of these dimensions, then outcome measures should take both criteria into account. Are outcomes such as these best measured by ongoing assessment through daily self-monitoring or through retrospective evaluation by questionnaires? When is the most meaningful time to collect outcome data, at post-therapy or at follow-up? Whose outcome data should be considered in the determination of therapeutic success or failure, those of the female only or of the male partner as well? That these are fundamental issues is suggested by the results of this study; these showed that cognitive-affective changes were twice as likely to occur as changes in behaviors, that retrospective measurement yielded a more optimistic estimate of therapy outcomes than did on-going evaluation through self-monitoring, that the females benefited more than the males, and that therapeutic gains were more evident immediately post-treatment than at follow-up.

Sex therapy is a multidimensional treatment (Fichten, Libman, & Brender, 1983). The various therapy formats may well interact with specific components of the treatment package, thereby causing differential effects. Therapeutic objectives include correcting deficits in knowledge, improving sexual skills, reducing performance anxiety, and enhancing the communication process. In addition to multiple objectives, the diversity of techniques used to accomplish these (e.g., masturbation, sensate focus, banning intercourse, Kegel and relaxation exercises) make it difficult to determine why a treatment is effective or, indeed, why different investigators report differential treatment success with similar problem populations. It is necessary to isolate and evaluate the effective components in multifaceted treatment packages in order to better understand the mechanisms underlying therapeutic change, to better appreciate etiological factors, and to develop more efficient and economic ways of providing treatment.

Differing therapy formats can interact with the type of treatment component administered. For example, it has been shown that whether therapy was administered via individual couple therapy, group therapy or minimal contact bibliotherapy clearly affected compliance with therapeutic instructions: couples in minimal therapist contact and group therapy conditions demonstrated more compliance with the program than those receiving individual couple therapy (Libman, Fichten, & Brender, 1984). Therefore, before forming firm conclusions concerning the equivalence of all therapy delivery systems, interactions between format and component variables must be carefully evaluated.

In addition, we may find that response to different therapy formats will vary with the nature of the sexual problem or with specific characteristics of the dysfunctional individual. Individual difference dimensions (e.g., Beutler, 1979) or

different etiological bases for similar problem manifestations (Libman, Fichten, & Brender, 1983) may interact differentially with varying therapy formats. That homogeneity of problem sample is particularly important is underscored by the finding that the few indications that therapy format can affect outcome were elicited only in those studies employing homogeneous samples. This suggests that heterogeneity of problems in most of the studies reviewed may have obscured differences between problem categories. This suggestion is corroborated by Heiman and LoPiccolo's (1983) results, which demonstrated the differential effectiveness of weekly versus daily sessions only when problem categories were analyzed separately.

Even within homogeneous problem categories there are individual differences in sexual response patterns which must be recognized when the relation between treatment procedures and outcome is being investigated. For example, the results of a recent study which explored the effects of differences in pre-treatment sexual repertoire and orgasmic frequency in a sample of women with secondary non-orgasmic problems suggested that the secondary non-orgasmic classification itself is composed of at least two subcategories: women who have never effectively learned the orgasmic response and those who have not transferred the response from the solitary to the interpersonal setting (Libman et al., 1983). Findings from this study also indicated that a standard cognitive-behavioral sex therapy program was differentially effective with these etiologically different manifestations of secondary orgasmic disorder. In the same study it was also found that variables which predicted successful outcome differed depending on the nature of the outcome criteria selected. Improved global sexual harmony, a cognitive-affective measure of therapy success, was predicted by higher pre-treatment orgasmic responsiveness with a partner as well as (rather surprisingly) by lower masturbation frequency and less awareness of the partner's tastes and preferences. On the other hand, the behavioral outcome of increased frequency of interpersonal orgasmic response was predicted by higher pre-treatment orgasmic responsiveness and prior enjoyment of nongenital caressing. Such findings not only underline the importance of carefully selecting the outcome criteria but also suggest that different formats, depending on the nature of the client's presenting problem, may have different effects on the various aspects of the outcome of sex therapy.

Human sexual response is complex, consisting of at least three distinguishable phases: interest, arousal and orgasm. Within each phase, three basic components may be identified: sensory, cognitive, and affective (Schover, Friedman, Weiler, Heiman, & LoPiccolo, 1982). Sexual problems may occur in one or more of these phases and in one or more of these components. Thus, client, problem, and etiological factors may differ even in a homogeneous dysfunction category. In addition, therapy programs are multifaceted, and therapy outcome may be measured in multiple ways which can yield dramatically different results and, consequently, different conclusions, concerning therapeutic efficacy.

In order to identify the effectiveness of different modes of therapy delivery, more methodologically rigorous comparative studies must be carried out in which homogeneous problem categories are used, the therapy content is held constant, and precise, multidimensional assessment and outcome criteria are employed. In addition, we strongly believe that in spite of numerous demonstrations that behavioral sex therapy is effective, investigators still need to incorporate control groups in their studies. While most of the research reviewed found few differences

among various formats of sex therapy delivery, it is difficult to evaluate the meaning of the results since neither untreated control nor placebo treatment groups were used in the vast majority of these studies. Because such results are equally consistent with a “non-specific factors” explanation (i.e., beneficial changes caused by an intervention are not necessarily due to the reasons postulated, Kazdin & Wilcoxon, 1976), it is impossible to determine whether all formats are equally effective or equally ineffective. Therefore, researchers interested in demonstrating the effectiveness of various formats of therapy delivery must return to the fundamental practice of employing both untreated and placebo control groups.

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