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Title: The state of theory in sex therapy.

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Abstract: Presents a study which examined the state of theory in sex therapy. Historical information on contemporary sex therapy; Discussion on assumptions underlying therapeutic approaches to sex therapy; Critical overview of the general state of research on sex therapy.

THE STATE OF THEORY IN SEX THERAPY

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It has been approximately three decades since the advent of contemporary sex therapy. What is the current state of theory underlying the practice of sex therapy? In attempting to answer that question, I provide a brief overview of the history of contemporary sex therapy and discuss some assumptions underlying common therapeutic approaches. These assumptions are considered with regard to three interrelated dimensions: etiological factors behind sexual dysfunction, the unit of intervention (individual versus couple), and the nature of the actual treatment. Afterward I provide a critical overview of the general state of research on sex therapy, note current, problematic trends in the field, and offer some global suggestions for remediation.

Studies conducted in the U.S. indicate that a substantial proportion of the adult population experiences some sort of sexual dysfunction (Laumann, Gagnon, Michael, & Michaels, 1994;

Rosen, Taylor, Leiblum, & Bachman, 1993; Spector & Carey, 1990). Although many individuals do not seek professional intervention for their sexual difficulties, a great number of people do. Despite criticism from some professionals regarding its legitimacy (e.g., Szasz, 1980, 1983), a specific field, commonly referred to as sex therapy, has evolved to address sexual difficulties presented by clients.

In the past 25 years, numerous articles and books have been published on the practice of sex therapy. Indeed, periodicals such as the Journal of Sex and Marital Therapy have been established explicitly as vehicles for the publication of empirical and theoretical articles in this field. At this point, it is legitimate to reflect on the history of sex therapy. Specifically, what is the current state of theory underlying the clinical enterprise of sex therapy? Attempting to answer this question is the primary focus in the current article.

In attempting to elucidate the current state of theory in sex therapy, I first provide a brief overview of the history of contemporary sex therapy. Subsequently, I discuss some basic assumptions underlying various sextherapy approaches. In other words, the emphasis in the current article is on the implicit and explicit assumptions underlying sex therapy with regard to a few primary dimensions. For example, what assumptions do different sex-therapy approaches entail with regard to etiological factors? What is seen as the appropriate unit of treatment (individual versus couple)? Last, what is the nature of the prescribed therapeutic intervention within each theoretic approach?

As will become apparent, underlying assumptions in these three domains are related yet help define each particular sex-therapy approach. In the current article, the term sex therapy is defined broadly and refers to any systematic attempt by a health professional to alleviate sexual dysfunction or difficulties experienced by a specified client. Also, the references cited in the current article are not meant to be exhaustive, but rather representative, of the reports and treatises published thus far.

Historical Overview

The history of sex therapy as a discipline is relatively brief (Leiblum & Rosen, 1989). From the start of the twentieth century until the late 1960s, sexual dysfunction was typically treated within a psychoanalytic framework (Rosen & Weinstein, 1988), as were most psychological problems (Comer, 1995). From such a psychoanalytic perspective, psychological and sexual problems were viewed as originating from unresolved conflicts dating back to childhood, particularly conflicts over problematic attachments and tension in relation to one's parents (Patterson & Watkins, 1996). Sexual problems were seen as symptoms of greater "core" psychopathology (Rosen & Weinstein, 1988). As such, treatment consisted of longterm, individual psychotherapy to unmask the underlying (and often unconscious) intrapsychic conflicts that manifested themselves as disruption of"healthy" or "mature" sexual functioning. In contrast to this dominant perspective, a few clinicians (e.g., Lazarus, 1971; Obler, 1973; Wolpe, 1958) explicitly applied behavioral principles in the treatment of sexual dysfunction, but such approaches were not the norm prior to the 1970s.

Sex therapy as it is known today was essentially founded by Masters and Johnson (1970), whose published report on a "new" therapeutic approach to sexual problems revolutionized what health professionals saw as the appropriate treatment for such difficulties. In contrast to psychoanalytic approaches, the "new" sex therapy was relatively brief, problem focused, directive, and behavioral with regard to technique. Rather than intrapsychic factors, Masters and Johnson (1970) emphasized social and cognitive causes of sexual dysfunction; ultimately, the large majority of sexual difficulties were seen as arising from a sexually restrictive or religiously orthodox upbringing. Such a personal history appeared to result in decreased communication with sexual partners, a lack of accurate information about "normal" human sexual functioning, and subsequent anxiety and preoccupation over performance during sexual interactions. Accordingly, theirs was a learning model of sexual functioning, and the objectives of treatment consisted of effectively achieving alleviation of performance anxiety and re-educating clients regarding human sexuality.

On the heels of Masters and Johnson, Helen Kaplan (1974, 1979) introduced and elaborated her version of the "new" sex therapy. Potentially viewed as an integration of, or bridge between, the traditional psychoanalytic and more contemporary behavioral approaches, hers included an initial emphasis on immediate symptoms. If the direct approach to symptom treatment worked, the case was closed. If, however, the "new" behavioral techniques met with resistance, the therapist relied on psychodynamic theory, or consideration of "deeper" issues, to understand the possible intrapsychic and interpersonal roles the sexual dysfunction might be serving. In other words, more serious underlying causes of the sexual dysfunction were sought primarily within those cases not responding to direct intervention.

The new sex therapy, as elaborated by Masters and Johnson (1970), included short-term but intensive work with the couple (conjoint therapy). Detailed information about relevant human anatomy (structure) and physiology (functioning) was provided, as was more general counseling as needed. The therapists conducted their work as a male-female pair of cotherapists; hence, traditional sex therapy involved four individuals (the cotherapists and the client couple). Additionally, the intervention consisted of direct behavioral exercises, including prescription of nondemand pleasuring, or "sensate focus," wherein the objective was to (re)experience sexual pleasure in the absence of anxiety from perceptions of performance demand or excessive selfmonitoring of sexual performance ("spectatoring"). Essentially, clients were aided and encouraged to (re)discover their and their partner's bodies and inherent potential for sexual pleasure. This was accomplished through a series of specific behavioral directives that resulted in pleasurable sensual and sexual experiences in the absence of anxiety. Accordingly, Masters and Johnson's approach was considered behavioral (Hawton, 1982; Rosen & Weinstein, 1988).

As reported by Masters and Johnson (1970), the rates of success with the new sex therapy were remarkably high. Overall, it appeared that their failure rate was only 20% for all sexual dysfunctions combined. The result of Masters and Johnson's work was a set of specific sex-therapy techniques and a general enthusiasm within the clinical community about the promise of sex therapy to alleviate clients' sexual problems. Their approach was quickly embraced by a large proportion of health professionals, a phenomenon probably spurred by sociopolitical factors, such as a greater cultural emphasis on personal fulfillment and openness in discussing sexuality, as

well as the incredible success rates they reported (Schover & Leiblum, 1994).

Regardless of the reasons, Masters and Johnson set in motion a specific, behavioral approach to the treatment of sexual dysfunction that was to have a profound impact on the new field known as sex therapy (Leiblum & Rosen, 1989). This behavioral approach was subsequently summarized and elaborated by others (e.g., Annon, 1974; Hawton, 1982; Jehu, 1979; Wincze & Carey, 1991; Zilbergeld, 1978) and extended to interventions such as directed masturbation training (Barbach, 1975; LoPiccolo & Lobitz, 1972; LoPiccolo & Stock, 1986).

In the 25 years subsequent to Masters and Johnson (1970), several changes have taken place in sex therapy (Leiblum & Rosen, 1995; Rosen & Leiblum, 1995; Schover & Leiblum, 1994). Sex therapy in the 1970s was an outgrowth of an earlier cultural shift toward greater focus on increased sexual gratification and discussion of sexual issues. The typical client seeking sex therapy in the 1970s was relatively young and well educated and had come of age during the 1960s. Accordingly, anorgasmia in women and premature ejaculation in men were the prominent sexual dysfunctions presented to clinicians in the "early days" of contemporary sex therapy (Rosen & Leiblum, 1995). The treatment model Masters and Johnson (1970) provided, including a brief, directive, problem-focused emphasis, was appropriate for many sex-therapy clients during the 1970s, many of whom simply needed to overcome ignorance and negative sexual attitudes (LoPiccolo, 1994). As a result, treatment outcome was generally positive, and a sense of optimism about the efficacy of sex therapy was evident among practitioners (e.g., Leiblum & Pervin, 1980; Zilbergeld & Kilmann, 1984).

At the same time as the birth of contemporary sex therapy, there was a noticeable increase in mass media attention to issues of sexual enhancement (Leiblum & Rosen, 1995). To an unprecedented degree, articles in mainstream magazines broached such topics as orgasm, sexual satisfaction, and ways to achieve them. Similarly, self-help books aimed at improving sexual functioning and enjoyment became widely available. As a result of these cultural changes, many types of cases that early sex therapists saw became scarce during the 1980s (Schover & Leiblum, 1994). That is, adults whose sexual difficulties could be addressed successfully from a direct, educational approach no longer sought sex therapists, as the needed assistance was forthcoming from the mass media (LoPiccolo, 1994). This change resulted in some researchers and clinicians questioning the earlier success rates reported by Masters and Johnson (Zilbergeld & Evans, 1980), and sex therapists collectively bemoaned, "Where have all the good cases gone?"

Over the past decade or so, the types of cases commonly seen in sextherapy clinics have changed dramatically from the earliest days of contemporary sex therapy (Leiblum & Rosen, 1995; Rosen & Leiblum, 1995). As the proportion of clients who simply needed education and direction dwindled, the proportion of clients with more pervasive and chronic sexual problems increased. Accordingly, instances of erectile failure (Rosen & Leiblum, 1992), low sexual desire (Beck, 1995; Kaplan, 1979; Leiblum & Rosen, 1988), and compulsive sexual behavior (Coleman, 1991; Goodman, 1993) have become an increasing part of sex therapists' caseloads (Schover & Leiblum, 1994). These problems present a greater challenge to clinicians and hence do not evidence the high rates of improvement found among the earlier reports on the success of sex therapy (Kilmann, Boland, Norton, Davidson, & Caid, 1986; Rosen & Leiblum, 1995).

Corresponding to the changing nature of the cases that sex therapists typically encounter, therapeutic approaches have changed as well. With increasing frequency, systemic approaches have been used to treat the more complex, relationship-bound sexual problems presented to sex therapists (e.g., Leiblum & Rosen, 1991; Rosen, Leiblum, & Spector, 1994). Also, greater attention has been paid to the role of early sexual trauma in subsequent sexual dysfunction (Becker, 1989; Petrak, 1995; Wyatt, 1991). In general, a more complex, integrative, or "postmodern" approach to the conceptualization and treatment of sexual dysfunction has emerged (LoPiccolo, 1992, 1994; Rosen & Leiblum, 1995). Currently, sex therapists appear to employ a broad range of treatment modalities, including bibliotherapy and group therapy (Hawton, 1992; Shah, 1996). At the same time, sex therapists have witnessed a marked "medicalization" of treatment for many sexual problems (Schover & Leiblum, 1994; Tiefer, 1994).

During the 1970s, the majority of cases of sexual dysfunctions were viewed as psychogenic, but with increasing regularity, medical and physical causes of sexual dysfunction are being proposed. Although this shift appears due at least partly to advances in medicine (Schiavi & Seagraves, 1995), the growing popularity of physical/medical interventions in the treatment of sexual dysfunctions seems to be motivated also by professional and sociocultural issues. That is, pharmaceutical companies stand to profit from proliferation of such interventions, insurance companies are more likely to reimburse for interventions by urologists and gynecologists than from behavioral sex therapists, and, because of social stigma over sexual dysfunction, many Americans would prefer to be diagnosed with a "medical" disorder than a "psychological" one (Schover & Leiblum, 1994).

The result of these realities is that physical/medical treatments have been at least tried with virtually all various sexual dysfunctions. (For reviews of the literature, see Beck, 1995; Rosen & Leiblum, 1995; Schover & Leiblum, 1994.) Starting primarily with a medical focus on the treatment of male erectile failure (Rosen & Leiblum, 1992), medical treatments recently have been offered for sexual dysfunctions that traditionally had been seen as psychogenic, such as premature ejaculation (Althof, 1995; Assalian, 1988, 1994; Balon, 1996; Seagraves, Saran, Seagraves, & Maguire, 1993) and low sexual desire (Rosen, 1991; Rosen & Ashton, 1993; Schreiner-Engel, Schiavi, White, & Ghizzani, 1989).

After this brief review of the histow of contemporaw sex therapy, the original question remains "What is the state of theory in sex therapy?" One approach to answering that question is to consider the basic assumptions upon which current sex-therapy approaches rest. Specifically, I considered the underlying assumptions of various sex-therapy approaches with regard to three interrelated domains: etiological factors underlying sexual dysfunction, the unit of treatment (individual versus couple), and the nature of the actual therapeutic intervention.

Basic Assumptions

Etiological factors. All sex-therapy approaches appear to share the underlying assumption that there is a "natural" or "healthy" state of sexual functioning that therapists aim to restore for the client (Haeberle, 1983). Beyond this global belief, a primary distinction among approaches to sex

therapy has to do with the underlying assumptions regarding etiology of sexual dysfunction. A major split among therapists occurs based on whether the sex therapist views sexual dysfunction as having primarily physical/medical (biogenic) or social/psychological (psychogenic) causes. Among those who espouse a psychogenic perspective, another primaw split occurs over whether the sex therapist primarily views sexual dysfunction as resulting from past experiences or present factors. How do the most common theoretical approaches to sex therapy compare on these underlying assumptions regarding etiology of sexual dysfunction?

Prior to Masters and Johnson (1970), psychodynamic or psychoanalytic approaches to the treatment of sexual difficulties predominated (Leiblum & Rosen, 1989; Rosen & Weinstein, 1988). As mentioned previously, such approaches were based on the underlying assumption that current sexual dysfunction was a manifestation of intrapsychic conflicts from unresolved issues in the individual's personal history (Kaplan, 1974, 1979, 1995). Typically, these unresolved conflicts were thought to have dated to childhood. Most notably, unresolved Oedipal conflicts or sexual attractions to parental figures were often considered "at the root" of current sexual difficulties, or the individual may have been traumatized from having witnessed during childhood sexual intercourse between one's parents (the "primal scene"). Importantly, the true etiological factors were seen as unconscious (or at least subconscious), and hence associations had to be reconstructed between current problems in sexual functioning and earlier issues (Rosen & Weinstein, 1988).

In comparison, Masters and Johnson's approach was based on the assumption that clients had the physical and psychological capacity for "normal" or healthy sexual functioning, but that some pathogenic learning experiences, such as a restrictive upbringing, resulted in unrealistic expectations, misinformation, or performance anxiety that was blocking the natural experience of sexuality. At one level, the underlying assumptions regarding etiology from traditional psychodynamic perspectives and the "new" sex therapy shared the basic view that sexual difficulties had a distal cause rooted in the individual's prior development. However, Masters and Johnson took more of a benign, social learning perspective and believed the proximal cause of sexual difficulties was primary, rooted in present experience, and more accessible to conscious awareness.

Similar to Masters and Johnson's social learning perspective, some sex therapists espouse a cognitive or social scripting perspective. Theorists use the term script to denote a complex cognitive organization of beliefs and values pertaining to a particular referent (Gagnon, 1990; Gagnon & Simon, 1973; Weis & Slosnerick, 1981). An analogy is sometimes made between social scripts and the written scripts professional actors use to guide their performance on stage. In both cases the script provides guidance regarding what is expected of the individual within the particular situation (or scene).

For the professional actor, the written script defines his or her behavior (verbal and otherwise) within the context of the theatrical performance. He or she knows exactly what to do and what to expect from the other performers. If everyone is following the same script, the performance should proceed smoothly without conflict or disruption. For the individual living within a society, the social script, based on cultural norms and past experiences, provides similar direction

regarding how one is expected to perceive and behave. Internalized scripts help the individual make sense out of an otherwise confusing social world. However, if two individuals interact, and each holds a different script regarding appropriate behavior in that situation, conflict is likely to ensue. Although individuals within a defined society share some common components of scripts for particular situations because of shared aspects of culture (such as predominant messages within mass media), individuals also vary in their developmental histories and will exhibit individual differences in their cognitive scripts accordingly.

When it comes to sexuality, those taking a social scripting perspective emphasize the apparently scripted nature of sexual interactions (Laws & Schwartz, 1977; Reiss, 1986). Such scripts are thought to define what constitutes a sexual episode and what is supposed to occur within a sexual interaction. They also are believed to define what is considered normal, appropriate, or adequate sexual functioning; they provide direction regarding what one should "do" sexually and how one can expect a partner to react. The primary etiological assumption underlying cognitive and social scripting perspectives in sex therapy is that sexual functioning is learned and is influenced by the perceptions, beliefs, and attitudes that were accumulated in the process of development. Hence, when there are sexual difficulties, the etiology of such dysfunction ultimately resides in past learning experiences as manifested in current, problematic cognition.

Those theorists taking a more straightforward cognitive approach emphasize current thoughts that apparently interrupt experience of sensual and sexual pleasure (Barlow, 1986; Cranston-Cuebas & Barlow, 1990). From this perspective, interfering cognitions as a result of increased anxiety during sexual performance are believed to underlie various forms of sexual dysfunction. The notion is that, if an individual is too anxious about his or her sexual performance, this increased anxiety may result in cognitions that interrupt focus on sensual experience and pleasure, resulting in decreased sexual functioning.

Researchers in several laboratory studies have investigated the role of performance anxiety and cognitive distraction in sexual dysfunction among men (Abrahamson, Barlow, Beck, Sakheim, & Kelly, 1985; Beck, Barlow, Sakheim, & Abramson, 1987; Cranston-Cuebas & Barlow, 1990) and women (Beggs, Calhoun, & Wolchik, 1987; Palace & Gorzalka, 1990, 1992). Interestingly, anxiety from performance demand appears to result in increased sexual arousal for fimctional men and women, whereas such anxiety is problematic for sexually dysfunctional individuals (Barlow, Sakheim, & Beck, 1983; Cranston-Cuebas & Barlow, 1990; Rosen & Leiblum, 1995). So, whereas distracting cognitions are viewed as the primary etiological factor for sexual dysfunction from this perspective, the ultimate reason such cognitions result in dysfunction for particular individuals and not others is unknown.

With regard to etiological considerations, systems theory exhibits both similarities and differences with traditional sex therapy and subsequent cognitive and social scripting perspectives. The description of systems theory in sexual science has been covered elsewhere in this special issue (see the article by Joan Jurich) but deserves mention here with regard to application of systems principles in sex therapy. A number of authors have elaborated how understanding the couple, or the larger family (Maddock, 1983, 1990), from a systems perspective may explain the role current sexual problems are serving within that system (e.g., Arentewicz & Schmidt, 1983; Heiman,

1986; Leiblum & Rosen, 1991; Verhulst & Heiman, 1979, 1988; Weeks & Hof, 1987; Woody, 1989).

From a systems perspective, it is futile to attempt to understand a sexual problem by focusing on an individual client in isolation. Sexuality entails interpersonal intimacy and interaction with a partner; hence, the belief is that one needs to appreciate the dynamic interplay between the two individuals involved in a sexual relationship (Talmadge & Talmadge, 1986). Each partner brings to the general relationship (or any particular sexual interaction, for that matter) a set of developmental experiences embedded in their family of origin as well as the larger social system, and these experiences within other systems have an impact on the meanings each individual ascribes to the behaviors of the other partner (Hof & Berman, 1986). Additionally, for any couple, the sexual interaction does not occur in a vacuum but rather within the larger context of their ongoing relationship. Hence, relationship conflicts in nonsexual domains (e.g., a relative imbalance of power in the relationship) are believed significantly to affect sexual functioning of one or both partners (Bogarozzi, 1987).

In sex therapy from a systems approach, the sexual problem is seen as indicative of problems elsewhere in the relationship, or the sexual problem is believed to serve some larger function within the relationship. Accordingly, systems theorists avoid labeling one relationship partner as having "the problem" and instead conceptualize the sexual dysfunction as a couple's problem. However, they may question why one particular partner is identified within the couple as the "carrier" of the dysfunction (Golden, 1988).

As is evident, the primary psychogenic perspectives in sex therapy share some common assumptions about the etiology of sexual dysfunction. Psychodynamic, behavioral, cognitive, social scripting, and systems approaches are all based on at least a vague notion that the individual's past plays an important role in his or her current sexual difficulties. However, psychodynamic and psychoanalytic perspectives place strong emphasis on unconscious processes and unresolved psychosexual conflicts from childhood, whereas the other psychogenic perspectives discussed here seem to share a strong social learning perspective as their foundation. That is, in these latter approaches, sexual difficulties are seen as arising from current problematic thoughts and beliefs that, in some way, are a result of past learning experiences. Next we will see that these assumptions have important implications for treatment.

What about biogenic perspectives on sexual dysfunction? As implied, the etiological assumption is that some medical or physical factor is at the root of current sexual dysfunction. Such factors include illnesses involving the genourinary tract, such as an untreated sexually transmitted disease or interstitial cystitis (Webster, 1996); physical impairment affecting genital functioning, such as decreased arterial flow (Krane, Goldstein, & Saenz de Tejada, 1989; Weinhardt & Carey, 1996); neurological damage; or a constitutional predisposition, such as an inherent oversensitivity to penile stimulation (Faniullaci, Colpi, Beretta, & Zanollo, 1988; Godpodinoff, 1989). This general etiological assumption has obvious implications for the unit of treatment and the nature of the intervention, and these will be considered next. At the least, biogenic perspectives on etiology imply that individuals have the capacity for "healthy" sexual functioning, but some disease entity or physiological problem has disrupted such functioning. Obviously, these etiological factors

have nothing to do with the individual's upbringing, earlier sexual experiences (beyond possible contraction of a sexually transmitted disease), or prior thoughts and emotions.

Unit of treatment. What do proponents of the various theoretical perspectives in sex therapy hold as the appropriate unit for treatment, the individual or the couple? Traditional psychodynamic perspectives held that sexual dysfunction results from an individual's psychosexual conflicts. Accordingly, from this view, the treatment of sexual dysfunction is addressed with the individual client, as the problems reside with him or her; the partner is involved only as the object upon which the sexual difficulty is projected. Hence, Masters and Johnson (1970) were seen as breaking with tradition by explicitly working with the couple to resolve sexual difficulties. Does this mean that Masters and Johnson viewed the couple as the optimal unit of treatment? Masters and Johnson did work with the couple to effect improvement in the sexual functioning of the identified patient. However, their approach was based on individual etiological factors underlying the sexual dysfunction. So, whereas one might view traditional, behavioral sex therapy as developed by Masters and Johnson to be based on the assumption that the couple is the unit of treatment, in reality the individual was the primary focus within the context of meeting with the couple.

Therapists taking a cognitive or social scripting perspective may include both members of the couple, but ultimately the modification in problematic cognitions or scripts must occur within each individual. From a systems approach, the couple is the unit of treatment. However, to effect a change in the couple, one or both members must initiate change. Change in one member will, given the nature of relationship systems, result in a change in the couple. Medical interventions, by their nature, involve primary focus on the individual as the identified client and unit of treatment.

Ultimately, the individual is viewed as the focus of most sex-therapy approaches, although such work might be carried out in the context of the sexual couple or a therapy group. That is, although many sex therapists work with couples, ultimately the interventions are focused on the individuals within that couple.

Nature of intervention. As mentioned previously, psychodynamic or psychoanalytic approaches were based on the underlying assumption that current sexual dysfunction was a manifestation of intrapsychic conflicts from unresolved issues in the individual's personal history. Typically, these unresolved conflicts were thought to date to childhood and exist beyond the individual's awareness. The client was viewed as using such defense mechanisms as denial, repression, or projective identification to cope with the intrapsychic conflicts. Only through the long, indirect, and frequently arduous process of personal psychoanalysis could the individual patient "work through" the conflicts and bring them to conscious awareness (gain insight). Ultimately, insight gained through such analysis would result in dissipation of the power the previously unresolved conflicts had over sexual functioning.

The basic assumptions upon which psychodynamic approaches to sex therapy are based include the notion of symptom substitution. That is, because sexual dysfunction is seen as a symbolic symptom of deeper problems, directly addressing the sexual dysfunction is believed likely to

result in resistance in the short run and, ultimately, therapeutic failure. If the core problematic issues are not resolved, according to psychodynamic theorists, these core problems will inevitably manifest themselves as other, related dysfunctions. The primary goal of treatment, then, is intrapsychic reorganization rather than simple symptom relief. True to this assumption, many psychodynamic and psychoanalytic clinicians who treated individuals with sexual problems undoubtedly were not influenced by Masters and Johnson's work. Interestingly, however, others integrated the short-term, behavioral approach of the "new" sex therapy with more traditional psychodynamic principles, depending on the individual case (e.g., Kaplan, 1974, 1979).

Subsequently, some authors attempted to show how a short-term, behavioral approach to sex therapy can be complimented by a psychodynamic perspective, especially with regard to understanding client resistance to carrying out the relatively structured steps involved in a traditional, behavioral sex-therapy program (Kaplan, 1974, 1979, 1995; Sollod, 1975; Weissberg & Levay, 1981). Others attempted to integrate psychodynamic principles into a behavioral sex-therapy approach by positing that perhaps the client behaviors induced by a structured treatment program have intrapsychic sequelae (Seagraves, 1986). Interestingly, this notion was also extended to the partner of the identified client involved in behavioral sex therapy by positing that changes in the identified client may have intrapsychic ramifications in the partner (Seagraves, 1986). Even more recently, Ravart and Cote (1992) described a psychodynamic approach to sex therapy in which dreams and fantasies are used to gain indirect access to unconscious material pertinent to sexual problems. Sexual imagery is then directly modified in therapy as a way to resolve sexual conflicts.

Masters and Johnson's approach contrasted with earlier psychodynamic perspectives because of its level of directness. As mentioned previously, the underlying assumption was that the individual experiencing sexual dysfunction had the capacity for healthy sexual functioning, but some impediment, such as ignorance or anxiety, had disrupted the natural course. The sex therapist's primary goal was removal of the block, a goal that could be achieved through directly addressing the sexual dysfunction within the context of educative and behavioral work with the couple.

This assumption about the appropriateness of directly intervening to remedy sexual dysfunction is also part of cognitive and social scripting perspectives in sex therapy. Within sex therapy from a cognitive or social scripts perspective, the sexual scripts, cognitive interpretations, and irrational and unrealistic beliefs of the individual or both sexual partners are fully explored, particularly with regard to discrepancies between actual performance and cognitive ideal (Gagnon, Rosen, & Leiblum, 1982; Nowinski, 1980). From this approach, each partner's sexual scripts are evaluated along such dimensions as complexity, rigidity, conventionality, and satisfaction (Gagnon et al., 1982). These theorists note that, frequently, couples presenting for sex therapy experience significant discrepancies in at least some aspects of their respective sexual scripts. From this perspective, interventions in sex therapy involve direct modification of the client's sexual scripts, irrational beliefs, or unrealistic expectations so as to reduce discrepancy between performance and ideal as well as discrepancy between sexual scripts held by each member of the couple.

Although not all sex therapists who work from a cognitive perspective utilize script theory,

interventions among cognitive therapists are similar. The goal of cognitive work in sex therapy primarily is the reduction of distracting anxiety (e.g., from performance pressure or negative evaluation of self or partner) through helping the client modify his or her problematic cognition regarding sexual functioning (Apfelbaum, 1989; Ellis, 1975; LoPiccolo, 1992; McCarthy, 1989; Walen, 1980). Often this work includes dispelling myths about male and female sexuality (Baker & DeSilva, 1988; Golden, 1988; Zilbergeld, 1978) and helping the client focus his or her attention on sexual sensations and pleasure rather than on performance (Barlow, 1986; Cranston-Cuebas & Barlow, 1990). From this approach, the amelioration of sexual difficulties results from actively challenging and modifying the troublesome beliefs, attitudes, and expectations underlying the dysfunction in sexual behavior.

From a systems perspective, the relationship problem for one couple may manifest itself in the sexual realm, whereas another couple may experience problems in other areas. In this regard, the underlying assumptions upon which systems approaches are based share some similarities with those underlying psychodynamic perspectives. For example, the implicit belief is that a direct, behavioral focus on the sexual dysfunction per se is liable to fail because one is not addressing the underlying relationship dynamic that happens to be manifesting itself as the apparent sexual problem. Theorists from this perspective seem to believe that improvement of sexual functioning in the absence of changing problematic relationship dynamics may result in the creation of other psychological symptoms in one or both partners (to maintain system "homeostasis").

The assumptions underlying biomedical approaches to sex therapy are often the opposite of those underlying psychogenic perspectives. That is, a biogenic etiology for sexual dysfunction implies that there is nothing the individual client (or his or her partner) can do to overcome sexual difficulties, and it is unlikely that psychological intervention alone will be of benefit. After all, all of the psychotherapy in the world would not be expected to overcome substantial arterial damage to a man's penis. Some who espouse a medical approach to sex therapy go as far as to assert that, even if a particular case of sexual dysfunction is psychogenic, a physical or medical treatment may result in decreased anxiety and improved functioning as a result (see Schover & Leiblum, 1994). The extent to which such a strategy works, as well as the extent to which practicing clinicians actually integrate medical and psychological interventions, remains a topic in need of empirical research.

Research Outcomes

Given the variety of theoretical perspectives outlined, it is fair to ask "What does the research literature indicate about the effectiveness of each approach?" Since Masters and Johnson's (1970) reports of impressive treatment success, others have reported results of various sex-therapy approaches and interventions. The outcome literature in sex therapy, including biomedical interventions, has been reviewed before (e.g., Hawton, 1992; Kilmann & Mills, 1983; Kinder & Curtiss, 1988; Rosen & Leiblum, 1995; Zilbergeld & Kilmann, 1984), and interested readers are directed to those sources. However, the conclusion one reaches is similar to that reached after reviewing the outcome literature on the efficacy of general couples therapy (Boddington & Lavender, 1995): Some positive outcome has been documented for virtually all published sex-therapy approaches. That is, if one accepts case studies as evidence of therapeutic effectiveness of

a particular approach, all sex-therapy approaches have been found to be helpful to at least some clients.

More than a decade after Masters and Johnson (1970), LoPiccolo (1983) noted that sound empirical evidence about the relative efficacy of sex therapy compared to other types of interventions was lacking. Unfortunately, however, outcome research in sex therapy appears to have been less prevalent in the second decade since Masters and Johnson (1970) than it was in the first (Hawton, 1992; Schover & Leiblum, 1994). Even for apparently popular sextherapy approaches, such as a systems perspective (Zimmerman & Darden, 1991), few empirical writings exist. What is conspicuously missing from the sex-therapy literature are large, well-done studies involving adequate comparisons among specified treatment and control groups (Rosen & Leiblum, 1995; Schover & Leiblum, 1994). This deficit is widely recognized among those who conduct sexuality research (Apt, Hurlbert, & Clark, 1994), but it is difficult to find outcome studies in sex therapy that utilize a waiting-list control group, let alone an attention-placebo control group (Hawton, 1992; Rosen & Leiblum, 1995).

In general, conducting outcome research in psychotherapy is a daunting enterprise (Bergin & Garfield, 1994), and conducting outcome research in sex therapy may be even more difficult, given the variety of physical and psychological etiological factors that may be relevant to a group of individuals, all of whom evidence the same manifest sexual dysfunction. This issue may partially explain the apparent decrease in outcome studies in sex therapy (see Schover & Leiblum, 1994, for discussion of other factors). As the clinical presentation of sexual difficulties has become more complex, the idea of applying the same therapeutic approach to all cases may seem increasingly absurd (LoPiccolo, 1992, 1994; Rosen & Leiblum, 1995). Still, in an era of increasingly complex clinical presentations, it is even more important to determine empirically the active ingredients in sex therapy, especially as matched with particular types of clients, dysfunctions, and etiological factors. In other words, we are lacking the necessary data to answer the question, "What type of sex-therapy approaches, with what type of sexual problems, what type of clients, and what type of sex therapist is most likely to result in a positive outcome?" (McCarthy, 1995).

Additionally, other important aspects of sex therapy have not been studied sufficiently. For instance, sexual dysfunction may frequently coexist with marked psychopathology (e.g., Schreiner-Engel & Schiavi, 1986), or at least relevant personality characteristics. As examples, among women, increased rates of sexual dysfunction have been found to coexist with low sexual assertiveness (Hurlbert, 1991), borderline personality disorder (Hurlbert, Apt, & White, 1992), and disordered eating (Wiederman, 1996), to name just a few. The issue of how these and other personality and psychopathology factors have an impact on sex therapy remains unexplored. In contrast, the role of particular relationship factors in sexual dysfunction and sex therapy has received more attention and appears promising. For example, in one study of treatment for male erectile dysfunction, the single best predictor of treatment success was the degree of communication between the relationship partners (Hawton, Catalan, & Fagg, 1992). Still, much additional research is needed regarding the interrelationships among interpersonal relationship issues, personality, psychopathology, and sexual dysfunction.

Given the major shortcomings in the research literature on sex therapy, it is probably not surprising that insufficient research attention has been paid to such important issues as the effect of combining biomedical and psychotherapeutic interventions (Rosen & Leiblum, 1995), client resistance in sex therapy (Lassen, 1995), long-term success of sex therapy (DeAmicis, Goldberg, LoPiccolo, Friedman, & Davies, 1985; Hawton, Catalin, Martin, & Fagg, 1986), relapse-prevention strategies (McCarthy, 1993), or information gained from cases of treatment failure (McCarthy, 1995). Still, what about research on the assumptions and principles underlying standard sextherapy approaches? It appears that research is often lacking here as well, and when relevent research exists, its impact on the practice of sex therapy may be surprisingly minimal.

As one example, consider a primary assumption underlying much of what is done in traditional approaches to sex therapy: Increased anxiety during sexual performance underlies various sexual dysfunctions. As mentioned earlier, the notion is that if an individual is too anxious about sexual performance, this increased anxiety interrupts focus on sensual experience and pleasure, resulting in problems in sexual functioning among men (Beck et al., 1987; Cranston-Cuebas & Barlow, 1990) and women (Beggs et al., 1987; Palace & Gorzalka, 1990, 1992). However, anxiety from performance demand appears to result in increased sexual arousal for functional men and women, whereas such anxiety is problematic for sexually dysfunctional individuals (Barlow et al., 1983; Cranston-Cuebas & Barlow, 1990; Rosen & Leiblum, 1995). Accordingly, it seems that it is not performance anxiety per se that results in sexual dysfunction (Morin, 1995), but rather whatever factors cause this differential response to performance anxiety (Apfelbaum, 1977). One might be surprised to learn that these research findings have had little direct impact on the actual performance of sex therapy (Rosen & Leiblum, 1995).

In general, it appears that there has been relatively little congruence among the actual practice of sex therapy, development and investigation of underlying theory, and empirical research on both. Part of this problem could be resolved with increased frequency and complexity of empirical research on the process of sex therapy and its outcomes. However, there is the larger issue of tying the practice of sex therapy to more comprehensive theories in an effort to understand human sexuality in general and, hence, sexual dysfunction in particular. Let us now turn our attention to this more general theoretical issue.

Critique and Conclusion

The field of sex therapy can only be as solid as the theories and research methods used in general sex research. Unfortunately for the field of sex therapy, there is a relative dearth of theory and data on even basic aspects of sexual functioning such as sexual desire or motivation (Hill & Preston, 1996; Levine, 1984; Lobitz & Lobitz, 1996). Accordingly, if we are unsure about factors underlying healthy sexual functioning, how can we say much about the causes of sexual dysfunction? These theoretical deficits regarding the nature of human sexuality appear to be what is most hindering further progress in research on the treatment of such dysfunctions as low sexual desire, as even basic issues, such as the measurement of sexual desire and the reliability of diagnosis, remain problematic (Beck, 1995; Levine, 1987; O'Carroll, 1991).

As the purpose of this special issue of The Journal of Sex Research illustrates, sexual science too

frequently is performed in a theoretical vacuum. Additionally, others have noted the need for improved research methods in sexuality research (e.g., Abramson, 1990; Tiefer, 1991, 1994) as well as the need to take a multivariate perspective. How has sexual science responded to the need for more complex theoretical and research models? The venerable sexual scientist and clinician John Money had the following to say:

Sex research today lives in a conceptual ghetto, theoretically poverty stricken, and lacking in consensus. It is still mired in the organic versus psychogenic dilemma, its own version of the long-obsolete nature/nurture dichotomy. For the most part, it still follows the experimental design of classical physics and celestial mechanics, and searches for univariate cause and effect, whereas the phenomena of sex research are, virtually without exception, multivariately determined. (1988, p. 14)

As Money pointed out, human sexuality is surely a multidetermined phenomenon. Attempting to answer what is the nature of sexual desire, or what is the effect of a particular developmental experience on subsequent sexual functioning, is futile. We currently discover general trends in data and attempt to capture or understand the relationships between such variables for a subset of the population. However, there will be many more individuals for whom the simple relationships we seek and occasionally find do not exist. These individuals currently comprise the "error variance" in our studies. To understand and explain sexual functioning adequately, more comprehensive models and theory testing are necessary.

The need to take a multivariate approach to our theorizing and model building is especially pertinent to sex therapy. With the multiple biogenic and psychogenic factors that may underlie sexual dysfunction, the need to consider the complex interplay of multiple factors is especially important in clinical sexuality (Levine, 1995). Of course, such interactive models are, by their very nature, more complex and difficult to investigate empirically. However, the future of sex therapy rests on remediation of the relative deficits in theory and the attendant empirical research.

To be fair to the field, I need to note that the leading sex therapists have taken integrative steps in their practice. Although some inexperienced therapists may apply sex-therapy techniques in a "cookbook" fashion (McCarthy, 1985), current sex therapy frequently consists of an integrative synthesis of the primary perspectives outlined previously. This "post-modern" approach to sex therapy has evolved in response to the increasing complexity of the cases sex therapists encounter (LoPiccolo, 1992, 1994; Rosen & Leiblum, 1995). However, although the process of conducting sex therapy may be increasingly complex, the output of theoretical and research advances beyond medical interventions have virtually ceased (Hawton, 1992; Schover & Leiblum, 1994), as has formal theory building. The increasing medicalization of sex therapy coupled with the stagnation of advances in psychogenic perspectives has led some scholars to question the future viability of traditional sex therapy as a field (e.g., Schover & Leiblum, 1994). What can be done?

Rather than attempting to maintain sex therapy as a distinct discipline, perhaps greater attention should be applied to integrating sextherapy information, approaches, and research into the more general clinical domains of psychology, psychiatry, nursing, and social work. For example, it is evident that graduate programs in clinical psychology generally ignore issues of sexuality and sex

therapy in their training curricula (Campos, Brasfield, & Kelley, 1989; Nathan, 1986). By working to integrate sexuality issues within the traditional mental health professions, sex therapy may gain greater legitimacy and research support.

To the extent that research on sex-therapy process and outcome is a difficult enterprise, increased involvement from a greater number of individuals and disciplines may prove fruitful. Specifically, perhaps professional organizations whose members are currently invested in the promulgation of sex therapy would be wise in lobbying training programs in psychology, psychiatry, nursing, and clinical social work to include greater coverage of sexuality and sextherapy issues. At the individual level, established sex therapists and sexuality scientists should be encouraged to offer themselves as potential resources to faculty members in such training programs who may have some interest in providing sexuality training to students, but who need encouragement and information to do so adequately.

In a broad sense, the future of sex therapy is dependent on the future of sexual science. Advances in theory and research on the components of, and factors related to, human sexual experience allow for further growth regarding interventions to alleviate sexual dysfunction. However, it is also incumbent on those who actually perform sex therapy to elaborate their theoretical assumptions and test the relative efficacy of their interventions through empirical study. The current nature of the complex cases with which the sex therapist is faced makes such research both more difficult and more needed than was true two decades ago.

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