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# The outcome of couple therapy for sexual dysfunctions using three different formats

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# The Outcome of Couple Therapy for Sexual Dysfunctions Using Three Different Formats

*Ulrich Clement, Dipl-Psych, and Gunter Schmidt, PhD*

*Couples suffering from sexual dysfunctions were treated using three different formats: 1) two therapists, long-term; 2) one therapist, long-term; and 3) two therapists, intensive. The analysis of outcome data showed no significant differences between one vs. two therapists. There was a slight trend for better results from long-term as compared to the intensive therapy. These differences, however, were no longer evident at one-year follow-up. It is concluded that the success of couple therapy is rather independent of the format. Recommendations are made for a differential indication for the three formats.*

Between 1973 and 1978, 202 couples suffering from sexual dysfunction were treated as part of a research project at the Hamburg Institute for Sex Research.[1-3] One goal of this project was to study the outcome of three different therapeutic formats (see Table 1).

Masters and Johnson[4] employed an intensive quasi-inpatient therapy with two therapists (which resembles our third format). They based their choice of format on certain fundamental considerations, not on empirical data. Their main points in favor of a *team of therapists* are that an interpreter and representative of each patient is essential, that difficulties arising from transference remain minimal, and that the therapists' social and sexual normative standpoints are more evenly weighted. The *intensive treatment* format places the patients in a vacation-like situation, allowing them to concentrate exclusively on therapy without being distracted by professional or domestic duties. These are important therapeutic considerations; however, the Masters and Johnson format involves great expense (two therapists, hotel accommodations for the couples) and, possibly, considerable strain on the patients (arranging care for

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the children, therapy instead of vacation). For these reasons we used the long-term formats (see Table 1) in which the patients can undergo therapy parallel to their everyday activities. One format used a therapist team, the other a single therapist. Comparable formats have been recommended by other clinicians.[5,6]

To our knowledge there has been no systematic comparative analysis of the effectiveness of intensive vs. long-term therapy.[7] On the other hand, there is some empirical evidence that in couple therapy for sexual dysfunctions one therapist has as much success as a team.[8,9] However, only 12 of the couples in one investigation[9] were treated by the Masters and Johnson concept and the other[9] analyzed 36 couples whose therapy was very short (5 to 10 sessions). Therefore, this question requires further empirical examination, too.

## *METHOD*

The method of our investigation has been described and discussed in full elsewhere.[1] We shall therefore confine ourselves to a summary here.

### *Sample*

The sample consists of 202 couples. In 21 couples both partners were suffering from a sexual dysfunction, giving a total of 223 dysfunctions which were distributed over the four diagnostic groups as follows: 108 (48%) female arousal and/or orgasmic dysfunction (hereinafter termed "orgasmic dysfunction" for simplicity's sake); 27 (12%) vaginismus; 57 (25%) erectile dysfunction; 31 (14%) premature ejaculation. In 90% of cases the symptoms had existed for at least three years. The patients were between 18 and 52 years old, the mean was 30 years. Three-quarters of the couples were married, half had children. The marriage or steady relationship had lasted between one and 20 years, the mean was eight years. In comparison with the total population, an above-average number of patients belonged to the middle classes; their school education was above average and in only every forth couple was the husband a skilled or unskilled worker.

TABLE 1

Couple Therapy Formats

1) *Two therapists, long-term*
   Male *and* female therapist, two sessions a week, 35-40 sessions.[a]
2) *One therapist, long-term*
   Male *or* female therapist, two sessions a week, 35-40 sessions.[a]
3) *Two therapists, intensive*
   Male and female therapist, daily sessions for three weeks, 16 sessions.[b]

[a]Number of sessions (drop-outs not included): range 15-60; mean 38. About 60% of all therapies took 25-45 sessions. Duration of sessions: 20-60 minutes, mean 30 minutes.

[b]According to the fixed schedule all therapies had 16 sessions. Duration of sessions: 20-60 minutes, mean 40 minutes.

Eighty-two couples were treated in format 1 (2 therapists, long-term), 53 in format 2 (1 therapist, long-term), and 67 in format 3 (2 therapists, intensive). In format 2, 29 couples were treated by a male and 24 by a female therapist.

The couples were assigned to formats randomly, with two important exceptions: 1) Out-of-town patients (living more than 60 km from Hamburg) were treated only in intensive therapy. As a great many of these patients had erectile dysfunctions or vaginismus, these diagnoses are overrepresented in format 3. 2) Vaginistic women were to be treated only by teams as we expected few patients from this diagnostic group. For technical reasons (no therapy teams available) three such women were treated by one therapist after all. However, this diagnostic group is still underrepresented in format 2. The assignment procedure described led to an uneven distribution of the diagnostic groups over the three formats. Our comparisons were therefore made with samples matched according to diagnosis and education. This resulted in a reduction of the sample to 104 couples for the comparison of one vs. two therapists and 112 couples for the intensive vs. long-term therapy comparison. The matched samples are described in Table 2.

*Treatment*

The treatment applied was couple therapy. The therapeutic concept was modeled on Masters and Johnson's procedure[4] but was modified in three respects:[1] 1) Indication was widened to include couples with (sometimes severe) partner conflicts as well as partners with (sometimes severe) neurotic disturbances. It was merely ensured that there was a distinct and chronic sexual dysfunction and that the partners wanted to continue their relationship. Counterindications were acute psychosis and acute drug or alcohol addiction. 2) Working through psychodynamic and partner conflicts was assigned a relatively large part in the therapy sessions. Our therapy therefore lasts substantially longer than that of Masters and Johnson. 3) The couples were treated in different formats (see Table 1).

*Therapists*

The core group of therapists comprised 16 psychotherapeutically trained clinicians (8 male, 8 female; 5 psychiatrists, 11 psychologists; between 24 and 42 years old). Of all therapies, 85% were performed by these therapists and the other 15% by 7 female and 6 male colleagues from other therapeutic institutions who had all conducted one to four therapies with an experienced therapist in couple therapy training. If one considers therapists experienced when they have conducted at least four couple therapies, about half the long-term and a third of the intensive team therapies were led by one inexperienced and one experienced therapist in each case. One-therapist treatment was not conducted by inexperienced therapists. According to our data there is no evidence that team treatment with two experienced therapists is more effective than with one experienced and one inexperienced therapist; this holds true for both long-term and intensive therapy. Therapist experience as defined above, thus, should not affect our results.

TABLE 2

Therapy Formats: Comparison of Samples[a)]

| | 1 Therapist N = 52 | | 2 Therapists N = 52 | Intensive N = 56 | | Long-Term N = 56 |
|---|---|---|---|---|---|---|
| *Diagnosis* | | | | | | |
| orgasmic dysfunction[b)] | 31 | | 31 | 25 | | 25 |
| vaginismus | 3 | | 3 | 10 | | 10 |
| erectile dysfunction | 12 | | 12 | 15 | | 15 |
| premature ejaculation | 6 | | 6 | 6 | | 6 |
| *Duration of dysfunction* | | | | | | |
| less than 2 years | 5 | | 7 | 7 | | 7 |
| 3-5 years | 13 | | 14 | 16 | | 15 |
| 6 years or more | 34 | ns | 31 | 31 | ns | 34 |
| *Age* mean/years | 31,0 | ns | 29,7 | 29,1 | ns | 29,6 |
| *Age of partner* mean/years | 31,8 | ns | 30,5 | 30,0 | ns | 30,4 |
| *School education* | | | | | | |
| − 9 years | 22 | | 24 | 23 | | 24 |
| 10-12 years | 12 | | 11 | 17 | | 18 |
| 13 + years | 18 | ns | 17 | 16 | ns | 13 |
| *School education of partner* | | | | | | |
| − 9 years | 19 | | 21 | 21 | | 21 |
| 10-12 years | 15 | | 14 | 18 | | 19 |
| 13 + years | 18 | ns | 17 | 17 | ns | 16 |
| *Marital status* | | | | | | |
| single | 13 | | 13 | 16 | | 14 |
| married | 39 | ns | 39 | 40 | ns | 42 |
| *Duration of relationship* mean/years | 8,8 | ns | 8,6 | 7,7 | ns | 8,5 |

[a)]Statistical tests for age and duration of relationship according to t-test; all others according to chi-square.

[b)]Includes "general sexual dysfunction" and "lack of desire" sensu Kaplan.



### *Assessment*

The couples were examined at six different points throughout the study: twice before therapy (3-12 months prior and immediately before the beginning of therapy) and four times after therapy (immediately upon completion and three months, 12 months, and 2½-4 years after completion).

Data were collected with respect to three areas: sexuality (symptoms, sexual functioning, sexual behavior, sexual attitudes); relationship in general between partners (understanding, affection, openness, communication, joint activities); and personality traits (psychovegetative symptoms, emotional stability, self-acceptance). Data for each of the three areas were assessed by various instruments (rating scales, questionnaires, psychological tests) and by several observers.

*Therapists.* The therapists assessed sexual functioning and the relationship between the partners on the basis of interviews and two rating scales. The first scale (R 1) recorded details of the patients' sexual functioning, sexual desire, erection strength and duration, frequency and timing of ejaculation, lubrication, arousal, orgasm frequency in masturbation, and coitus with steady and other partners. The second contained a general classification of therapy outcome (R 2, cf. footnote to Table 3).

*First Consultants.* The physician or psychologist who indicated therapy in our department rated patients' sexual functioning (R 1) after interviewing them.

*The Two Partners.* The patient and his/her symptom-free partner kept a multiple-choice diary describing their sexual behavior for a week (Q 1) without consulting each other; filled out questionnaires on sexual behavior in the last three months (Q 2), on their attitudes to sexuality (Q 3), on how they assessed changes in sexuality and the relationship after therapy (Q 4); and completed psychological tests—the Freiburg Personality Inventory and the Giessen Test.[3]

For simplicity's sake we confined ourselves to the overall outcome ratings of therapists (R 2) and to couples' self-ratings of changes induced by therapy (Q 4) at *two points of measurement:* upon completion of therapy and one year thereafter.* *All other data analyzed did not produce any fundamentally different results.*

## RESULTS

### *One Therapist vs. Two Therapists*

Table 2 shows that samples of couples are comparable in respect not only of diagnosis and school education, but also of other important background characteristics such as age, marital status, occupation, working hours, duration of the dysfunction and the relationship. We analyzed the data for male and female dysfunctions separately; but since the results did not differ, we shall give here only the results for the total sample.

Therapy with one or two therapists, according to the therapists' assessment at the end of treatment, does not differ between the formats. This applies to all three aspects of therapy assessment (Table 3): sexual functioning, the partners' relationship in general, and sexual satisfaction. One year after completion of therapy we encountered the same result and observed that the long-term effect of therapy with one or two therapists did not differ. Moreover, the self-assessments by couples according to questionnaire do not differ among formats, whether at the end of therapy or during the one-year follow-up (Table 4).

### *Intensive vs. Long-Term Therapy*

The samples are comparable both in regard to diagnosis and education and other background data (see Table 2). Upon completion of therapy the thera-

*70% of couples were present at one-year follow-up; 13% could not be reached by mail or completion of their therapy dated back to less than one year when we finished the study. 17% refused follow-up despite repeated invitation. Couples who came or did not come to the one-year follow-up did not differ in respect of therapy outcome as assessed by therapists on completion of therapy.[1]

TABLE 3

Assessment of Outcome by Therapists:[a] 1 Therapist vs. 2 Therapists

| | Upon Completion | | One-Year Follow-Up[b] | |
|---|---|---|---|---|
| | 1 therapist N = 52 | 2 therapists N = 52 | 1 therapist N = 27 | 2 therapists N = 31 |
| *Sexual functioning*[c] | | | | |
| (1) Separation of couple[d] | 4 | 3 | 0 | 1 |
| (2,3) Breaking off therapy | 6 | 12 | — | — |
| (4,5) Therapy completed, not or slightly improved | 4 | 2 | 4 | 2 |
| (6) Therapy completed, improved | 16 | 11 | 8 | 9 |
| (7) Therapy completed, much improved | 8 | 9 | 5 | 10 |
| (8) Therapy completed, cured | 14 | 15 | 10 | 9 |
| | ns | | ns | |
| *Partners' relationship in general*[c] | | | | |
| (0) Inapplicable[e] | 10 | 15 | 0 | 1 |
| (1) Disturbance unchanged | 4 | 3 | 1 | 0 |
| (2) Disturbed, but clearer perception of problems | 6 | 3 | 3 | 5 |
| (3) Intact as before | 3 | 3 | 2 | 2 |
| (4) Deteriorated | 0 | 1 | 0 | 3 |
| (5) Improved | 20 | 22 | 15 | 14 |
| (6) Intact, previously disturbed | 9 | 5 | 6 | 6 |
| | ns | | ns | |
| *Sexual satisfaction*[c] | | | | |
| (0) Inapplicable[e] | 12 | 18 | 1 | 1 |
| (1) Less satisfying than before therapy | 0 | 0 | 0 | 0 |
| (2) Just as unsatisfying | 3 | 3 | 4 | 2 |
| (3) Slightly more satisfying | 17 | 11 | 8 | 12 |
| (4) Satisfying | 20 | 20 | 14 | 16 |
| | ns | | ns | |

[a] Statistical tests according to chi-square.

[b] These data refer only to couples who completed therapy.

[c] See Appendix to Table 3.

[d] For one-year follow-up: separation of couple during the year after therapy.

[e] Couples who did not complete therapy. This category is not included in the statistical tests.

## APPENDIX TO TABLE 3

*Rating of Sexual Dysfunction*
(Categories 3-8 compared to therapy *onset*)

(1) Drop-out, separation of couple during therapy (at follow-ups 3 and 4: separation after completing therapy).
(2) Drop-out, unimproved.
(3) Drop-out, slightly improved.

(4) Therapy completed, unimproved (all steps completed, categories 5-8 invalid).
(5) Therapy completed, slightly improved. (The dysfunction—erectile dysfunction, premature ejaculation, vaginismus, lack of sexual arousal and orgasm—is unchanged; the couple can, however, cope better with these difficulties.)
(6) Therapy completed, improved. (The dysfunction is visibly improved, but still present. ED: intromission or intercourse possible more often than before, but sometimes no erection and/or frequently no full erection. PE: less frequent than before, but still occurs sometimes. VA: intromission possible most of the time, but sometimes impossible and/or mostly unpleasant and painful. OD: intercourse experienced as pleasurable and pleasant, however never orgasm or coitus; orgasm frequency during petting unchanged compared to pretherapy status.)
(7) Therapy completed, distinctly improved. (The dysfunction has been largely removed. ED: intromission (nearly) always possible, sometimes no full erection. PE: never or hardly ever occurs; however, the patient still has to be careful, e.g., pauses, cautious movements. VA: intromission always or nearly always possible, but sometimes still unpleasant or painful. OD: intercourse is pleasurable and pleasant, orgasm still seldom (every fifth intercourse at best) during intercourse or on manual stimulation during intercourse. Or: no orgasm on intercourse but distinctly more frequent during foreplay and petting than was the case previously.)
(8) Therapy completed, cured. (The dysfunction has been removed. ED: always or nearly always complete erection on intercourse until ejaculation. PE: never occurs, even without particular caution. VA: intromission always possible without discomfort. OD: orgasm on intercourse or on additional manual stimulation during intercourse fairly regular, at least once every forth intercourse.)

*Rating of Relationship in General*
(Compared to therapy *onset*)

(0) Inapplicable (therapy not completed).
(1) Disturbed as before (hostile, rejecting, inadequate communication, uncooperative).
(2) Disturbed, but more aware of problems.
(3) Positive state unchanged (acceptant, not hostile, cooperative, satisfying communication).
(4) Deteriorated (more hostile, greater rejection, less satisfying communication, less cooperation).
(5) Improved (less hostile, less rejecting, more satisfying communication, more cooperation).
(6) Distinctly improved (acceptant, not hostile, cooperative, satisfying communication).

*Rating of Sexual Satisfaction*
(Compared to therapy *onset*)

(0) Inapplicable (therapy not completed).
(1) Sexual relations less satisfying than before therapy.
(2) Sexual relations just as unsatisfying as before therapy.
(3) Sexual relations somewhat more satisfying than before therapy.
(4) Sexual relations satisfying (even if dysfunction not removed).

## TABLE 4

### Self-Assessment of Couples upon Completion of Therapy[a)]

| | Patient | | Partner | |
|---|---|---|---|---|
| | 1 Therapist N = 31 | 2 Therapists N = 32 | 1 Therapist N = 31 | 2 Therapists N = 31 |
| Our sexual problems are now _____ than before therapy | | | | |
| worse/unchanged | 1 | 1 | 0 | 2 |
| slightly better | 6 | 4 | 11 | 6 |
| much better | 22 | 27 | 19 | 21 |
| completely removed | 2 | 0 | 1 | 2 |
| | ns | | ns | |
| Our relationship is now _____ than before therapy | | | | |
| worse/unchanged | 4 | 6 | 5 | 8 |
| slightly better | 10 | 12 | 8 | 8 |
| much better | 16 | 14 | 19 | 15 |
| | ns | | ns | |
| It is _____ to show my partner tenderness now than before therapy | | | | |
| more difficult/unchanged | 7 | 7 | 6 | 10 |
| easier | 18 | 18 | 18 | 14 |
| much easier | 7 | 7 | 6 | 7 |
| | ns | | ns | |
| We can now find _____ solutions to nonsexual problems than before therapy | | | | |
| much better | 6 | 5 | 5 | 6 |
| better | 13 | 14 | 14 | 12 |
| unchanged/less good | 13 | 13 | 13 | 13 |
| | ns | | ns | |
| My sexual desire is now _____ than before therapy | | | | |
| much stronger | 0 | 4 | 2 | 6 |
| stronger | 16 | 16 | 13 | 11 |
| unchanged/less strong | 15 | 11 | 17 | 14 |
| My sexual satisfaction after intercourse is now _____ than before therapy | | | | |
| much greater | 6 | 7 | 8 | 5 |
| greater | 18 | 17 | 13 | 12 |
| unchanged/less | 8 | 7 | 11 | 11 |
| | ns | | ns | |

[a)]The data refer only to couples who completed therapy. Statistical tests according to chi-square.

pists' assessments of the overall results varied significantly. Long-term therapy produced more drop-outs and intensive therapy was more often completed, with minor or moderate success as regards sexual functioning (see Table 5). One can ssume that those who complete intensive therapy with almost no success are likely to break off long-term therapy.

Self-assessments of sexual functioning by the patients show a tendency for slightly better results in long-term treated couples (see Table 6). However, the therapists' and the patients' assessments are not directly comparable because

TABLE 5

Assessment of Outcome by Therapists:[a] Intensive vs. Long-term

| | Upon Completion | | One-Year Follow-Up[b] | |
|---|---|---|---|---|
| | Intensive N = 56 | Long-Term N = 56 | Intensive N = 35 | Long-Term N = 36 |
| *Sexual functioning*[c] | | | | |
| (1) Separation of couple[d] | 0 | 3 | 3 | 2 |
| (2,3) Breaking off therapy | 6 | 11 | — | — |
| (4,5) Therapy completed, not/slightly improved | 7 | 2 | 3 | 2 |
| (6) Therapy completed, improved | 15 | 8 | 6 | 10 |
| (7) Therapy completed, much improved | 11 | 11 | 7 | 11 |
| (8) Therapy completed, cured | 17 | 21 | 16 | 11 |
| | .05 | | ns | |
| *Partners' relationship in general*[c] | | | | |
| (0) Inapplicable[e] | 6 | 15 | 4 | 2 |
| (1) Disturbance unchanged | 2 | 4 | 0 | 0 |
| (2) Disturbed, but clearer perception of problems | 9 | 2 | 4 | 5 |
| (3) Intact as before | 11 | 6 | 6 | 5 |
| (4) Deteriorated | 0 | 1 | 2 | 4 |
| (5) Improved | 21 | 24 | 14 | 12 |
| (6) Intact, previously disturbed | 7 | 4 | 5 | 8 |
| | ns | | ns | |
| *Sexual satisfaction*[c] | | | | |
| (0) Inapplicable[e] | 7 | 16 | 5 | 3 |
| (1) Less satisfying than before therapy | 1 | 0 | 0 | 1 |
| (2) Just as unsatisfying | 2 | 2 | 2 | 1 |
| (3) Slightly more satisfying | 21 | 10 | 9 | 10 |
| (4) Satisfying | 25 | 28 | 19 | 21 |
| | .10 | | ns | |

[a] Statistical tests according to chi-square.

[b] These data refer only to couples who completed therapy.

[c] See Appendix to Table 3.

[d] For one-year follow-up: separation of couple during the year after therapy.

[e] Couples who did not complete therapy. This category is not included in the statistical tests.

## TABLE 6

Self-Assessment of Couples upon Completion of Therapy:[a] Intensive vs. Long-Term

| | Patient | | Partner | |
|---|---|---|---|---|
| | Intensive N = 35 | Long-Term N = 34 | Intensive N = 35 | Long-Term N = 32 |
| Our sexual problems are now _____ than before therapy | | | | |
| worse/unchanged | 2 | 0 | 2 | 1 |
| slightly better | 13 | 4 | 11 | 7 |
| much better | 15 | 25 | 16 | 19 |
| completely removed | 3 | 5 | 6 | 5 |
| | .01 | | ns | |
| Our relationship is now _____ than before therapy | | | | |
| worse/unchanged | 7 | 7 | 5 | 6 |
| slightly better | 10 | 10 | 14 | 8 |
| much better | 16 | 17 | 14 | 18 |
| | ns | | ns | |
| It is _____ to show my partner tenderness now than before therapy | | | | |
| more difficult/unchanged | 9 | 7 | 8 | 9 |
| easier | 16 | 18 | 17 | 14 |
| much easier | 9 | 9 | 10 | 9 |
| | ns | | ns | |
| We can now find _____ solutions to nonsexual problems than before therapy | | | | |
| much better | 6 | 4 | 5 | 6 |
| better | 15 | 16 | 18 | 12 |
| unchanged/less good | 12 | 14 | 11 | 14 |
| | ns | | ns | |
| My sexual desire is now _____ than before therapy | | | | |
| much stronger | 3 | 5 | 3 | 5 |
| stronger | 15 | 16 | 13 | 14 |
| unchanged/less strong | 16 | 12 | 19 | 13 |
| | ns | | ns | |
| My sexual satisfaction after intercourse is now _____ than before therapy | | | | |
| much greater | 9 | 9 | 7 | 6 |
| greater | 15 | 16 | 17 | 12 |
| unchanged/less | 8 | 6 | 9 | 11 |
| | ns | | ns | |

[a]The data refer only to couples who completed therapy. Statistical tests according to chi-square.

patients who dropped out, but who are included in the ratings of therapists', did not receive questionnaires. The difference in the self-assessments therefore can be explained only by the relatively large number of moderate successes for intensive therapy but not by the varying number of patients dropping out. All the other criteria, whether relating to the partners' relationship or sexual satisfaction, show the same outcome for both formats, whether they are assessed by therapists or couples. The observed differences levelled out one year after therapy (Table 5). No significant differences between the two therapy formats were established for any of the characteristics investigated.

## *DISCUSSION AND CONCLUSIONS*

Apparently the success of therapy is relatively independent of the format used. One therapist can have just as much success as two therapists as long as he or she is experienced in couple therapy for sexual dysfunctions. Therapy on a long-term basis is only superior to intensive therapy for a short time after therapy, but not in the long run.

We began our investigation with the practical question of which format produces optimal treatment. Our results lead us to make the following recommendations:

1) *Long-term therapy with one therapist* is the most suitable format from an economic point of view and is more easily practicable—as long as the therapist is experienced and can maintain ongoing supervision.
2) *Therapy with two therapists* is not more efficient and therefore only preferable in cases where one therapist is inexperienced in therapy for sexual dysfunctions. This format is particularly suited for therapist training.
3) *Intensive therapy* is not more efficient than long-term therapy and should therefore be indicated only for practical reasons; for example, for nonresident couples who have no therapy facilities near their home town or with whom months-long therapy cannot be conducted for reasons such as shift work.

We would like to point out once again that, apart from economic considerations, the therapist's experience with couple therapy and the couples' outward situation alone are relevant to indication for the formats. This does not mean, however, that the psychological situation does not differ from one format to the other. As we discovered in team discussions, therapists consistently found that *team therapy* was more satisfying for them and subjectively more productive than one-person therapy. Feedback and mutual supervision with the cotherapist before or after every session was felt to be more diversified and compact than supervision by a different clinician. The interaction and discussion with the cotherapist lent the sessions added animation.

According to our experience, the dynamics of *intensive therapy* were undoubtedly enhanced by the fact that the couples were particularly open due to the daily meetings and isolation from everyday duties. The therapists had the general impression of coming closer to the patients and of the patients' greater willingness to subject themselves to therapy. Furthermore the time restriction has a two-fold effect: 1) The couples are more likely to take the offensive, as

they want to make progress with their problems. For example, couples very seldom fail to do their homework exercises. 2) The couples relate to each other and care for each other with an intensity scarcely possible in everyday life. It could be that the strong experience of intense mutuality under quasi-holiday conditions triggers off the couples' self-help energies, which then gain their full effect in the period after therapy.

In the case of *long-term therapy,* implantation of the newly learned sexuality in everyday life already takes place during therapy, which explains the stability at follow-up. The therapists find out more about chronic partner conflicts, which are more often put to debate, and the worries about work and family. They are thus able to form a more realistic impression of the bearing sexuality has on all aspects of the couple's life. This can still be interpreted as an advantage of long-term therapy although it is not evident in the therapeutic results.

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