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The Effects of Marital Therapy on Sexual Satisfaction

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Twenty couples with marital distress and for whom sexual functioning was not the primary referral problem received ten weekly sessions of marital therapy. Both partners completed the Golombok Rust Inventory of Sexual Satisfaction, a measure of sexual functioning, before and after therapy. A significant improvement in the reported quality of the couples sexual functioning was found, particularly for the frequency of sexual intercourse, communication, and sexual satisfaction. It was concluded that behavioural marital therapy alone may be effective in the treatment of sexual problems.

Couples presenting with marital or sexual problems have generally been viewed similarly in as much as the difficulty represents an issue within dyadic functioning. The relationship between marital and sexual adjustment has been controversial, with some authors putting forward the view that sexual problems underlie a basic marital problem (Ables & Brandsma, 1977) while others suggest some independence between marital adjustment and sexual adequacy (Hartman, 1980a). The complexity of this interaction has lead therapists to adopt a more holistic approach. However, there still exists the myopic tendency among clinicians to assume that marital and sexual problems are functionally different.

Sex therapy and marital therapy address different features of the same entity, that is, the couple, but most clinics combine marital and sexual dysfunction in

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treatment. The recent tendency is a move away from pure psychosexual clinics. Sager (1976) has noted that there have been some problems in deciding whether to highlight sex, marriage or both in treatment. He divides couples into three descriptive categories: those where sexual problems produce marital discord; those where marital discord impairs sexual functioning; and those where severe marital discord precludes a sexual relationship.

Recent theoretical developments in the study of relationships have led to the idea that dysfunctions fulfill vital roles for the couple. Pallazoli et al (1978) have introduced the concept of "positively cannoting symptoms" suggesting that symptoms function as major factors in the maintenance of the relationship. For example, a couple's continued bickering may provide them with their only verbal interaction and to remove it would render them silent. Therefore, the function of the symptom is the maintenance of some contact between the couple. Similarly, it can be hypothesised that marital/sexual problems function in a particular way by alerting the couple and the therapist to problematic aspects of the relationship.

The influence of marital therapy on the sexual satisfaction of 44 couples has been studied by O'Leary & Arias (1983). They found a significant increase in sexual satisfaction for both husbands and wives after therapy. Hartman (1980a; 1980b) and Hartman & Daly (1983) have also investigated the relationship between marital and sexual therapy. From their work they suggest that sexual problems and marital distress operate independently of one another. Hartman has argued that successfully treating marital discord may be neither neccessary nor sufficient for improving sexual functioning. In the most recent study (Hartman & Daly, 1983), a balanced cross-over design of behavioural marital therapy and directive sex therapy was used to investigate the relationship between the two. It was found that couples who initially received sex therapy showed significant improvements in sexual satisfaction ratings at the mid-treatment assessment compared with those for whom marital therapy preceeded sex therapy, and the later marital therapy showed little additional effect. At the end of both treatments the groups did not differ in sexual satisfaction.

The present study investigates the extent to which marital therapy influences the couple's sexual relationship. The emphasis of the study is not to delineate causal relationships between marital and sexual problems but rather to look at the extent to which behavioural marital therapy affects sexual functioning.

METHOD

Subjects

The sample comprised twenty couples who had requested marital therapy. They were all General Practitioner referrals and were treated in a marital and family therapy unit. The couples had on average been married for 6.5 years, and the marriages had been distressed for an average of 1.5 years. The mean age of the husbands was 30 years, and of their wives, 27 years. The average social class

was 2 (Registrar Generals classification). All consecutive referrals were included in the study provided that the following exclusion criteria did *not* apply:

1. Couples had been married or had lived together as a dyad for less than twelve months.
2. Primary referral problem was of a sexual nature; if the sexual relationship was a secondary problem, then they were included in the study.
3. Presence of organic, psychotic or alcoholic condition.

Treatment

Couples received ten weekly sessions of marital therapy. They were consecutively assigned to one of three treatment conditions: Conjoint marital therapy where both partners were treated together (n=7), group marital therapy which comprised three couples meeting as a group (n=6), or treating one partner alone (n=7). The major components of the treatment included communication training, problem solving and contingency contracting (Jacobson & Margolin, 1979). One male therapist treated all the couples. Bennun (1983, 1984) has shown the three contrasting treatment conditions to be equally effective in relieving marital distress. In view of this, and the small within group sample size, the groups were pooled for the purposes of the present study.

Measures

Both partners in all treatment conditions completed the Golombok Rust Inventory of Sexual Satisfaction (GRISS) (Rust & Golombok, 1983) before and after therapy. The GRISS provides a separate male and female score of the quality of sexual functioning within the relationship. In addition, the following subscale scores are obtained: Impotence, premature ejaculation, anorgasmia, vaginismus, infrequency, non-communication, male dissatisfaction, female dissatisfaction, male non-sensuality, female non-sensuality, male avoidance and female avoidance. For the male and female scores, split-half reliabilities have been found to be high with values of 0.94 for women and 0.87 for men (Rust & Golombok, 1985a). The internal consistencies of the subscales are also high for scales with a small number of items, averaging 0.74 and ranging between 0.61 for non-communication and 0.83 for anorgasmia. Both the overall female scale (point biserial $r = .63$, $p < .001$) and the overall male scale (point biserial $r = .37$, $p < .005$) have been found to discriminate well between the clinical and non-clinical groups (Rust & Golombok, 1985b). Validation of changes in GRISS scores against therapists ratings of improvement provides correlations of $r = .054$ ($N = 30$, $p < .005$) for women and $r = .43$ ($N = 30$, $p < .01$) for men (Rust & Golombok 1985a).

RESULTS

For the GRISS main scales before therapy, the mean male score was 70.21 (s.d. = 14.58), and the mean female score was 73.16 (s.d. = 16.93). After therapy the mean male score was 58.31 (sd = 12.86), and the mean female score was

60.89 (sd = 13.19). A t-test comparing pre and post therapy main scale scores gave $t = 4.76$ ($p < .01$) for men, and $t = 2.96$ ($p < .01$) for women. It thus seems that marital therapy improves levels of sexual functioning in both partners.

The twelve subscales of the GRISS were analysed to investigate the pattern of changes with therapy, using paired t tests. Results appear in table 1.

Table 1

Means and standard deviations of GRISS subscale scores before and after marital therapy, together with the t-test for the significance of the change for each subscale.

Subscale	After		Before		t-test and	
	Mean	s.d.	Mean	s.d.	sig	level
Impotence	3.3	2.5	3.6	2.8	<1	n.s.
Premature Ejaculation	5.5	1.8	5.6	2.3	<1	n.s.
Male Non-sensuality	3.2	2.5	3.5	3.2	<1	n.s.
Male Avoidance	7.8	2.6	8.8	3.8	1.12	n.s.
Male Dissatisfaction	4.6	2.4	7.0	4.0	2.80	p<.05
Infrequency	7.5	4.1	11.0	4.9	3.44	p<.01
Non-communication	6.2	3.0	7.8	3.3	2.56	p<.05
Female Dissatisfaction	5.0	2.8	7.4	4.7	2.44	p<.05
Female Avoidance	7.4	1.7	8.9	3.2	1.59	n.s.
Female Non-sensuality	4.3	3.6	4.7	4.1	<1	n.s.
Vaginismus	3.5	2.4	4.0	3.0	<1	n.s.
Anorgasmia	5.5	3.6	7.7	4.4	2.79	p<.05

It can be seen that several of the subscales showed significant improvement, the largest effect being for infrequency, but with male and female dissatisfaction, non-communication and anorgasmia also being significant. No significant changes were found for non-sesuality or avoidance, but care must be taken here about interpreting a null hypothesis given the sample size and the reliability le-

vel of the subscales. Of the four specific dysfunction subscales, only anorgasmia was signficant, which may relate to the increase in frequency of intercourse. The other specific dysfunction subscales show t values of less than 1.

It is interesting to examine whether or not the subscale scores which did show a significant effect were operating through a common factor, or whether several factors were at work. Changes in subscale scores showed, as expected, a large number of significant correlations with each other (not reported here). A factor analysis of this correlation matrix was carried out. The first two factors, accounting for 37% and 20% of the variance respectively, were interpreted and subjected to a varimax rotation. These appear in table 2.

Table 2

Varimax rotated factor analysis of the GRISS subscale change scores ("Before" minus "after").

Subscale	Factor I	Factor II
Impotence	.58	.59
Premature Ejaculation	.17	-.04
Male Non-sensuality	-.11	.62
Male Avoidance	.38	.73
Male Dissatisfaction	.66	-.22
Infrequency	.75	-.16
Noncommunication	.66	.25
Female Dissatisfaction	.82	-.21
Female Avoidance	.46	-.60
Female Non-sensuality	.70	-.27
Vaginismus	.40	.15
Anorgasmia	.70	.18

It can be seen that those subscales which load heavily on factor 1 are those which have been shown to change significantly with marital therapy. This indicates a common mode of action for these subscales. Factor 2 contrasts some male subscales with some female subscales, and might be interpreted as illustrating a reciprocal relation between subscale score changes. As some male subscale scores improve the female partners' scores deteriorate, and vice versa. This effect is, of course, independent of the overall improvement which occurs within factor 1. In view of the small sample size the results of the factor analysis are merely suggestive. They do, however, conveniently summarize the correlation matrix.

DISCUSSION

The results show that the treatment produced a significant improvement in the reported quality of the couples' sexual functioning. These reported improvements were particularly noticeable for the frequency of sexual intercourse and for communication, as well as for the increase in sexual satisfaction for both men and women. The results need some qualification in view of the absence of a no-treatment control group, it being conceivable perhaps that improvement was the result of repeated testing. However, the most plausible explanation for the results is that behavioural marital therapy did have an effect on the sexual relationship. No significant changes in specific sexual dysfunctions were apparant other than anorgasmia, which may have been an artifact of its correlation with frequency of intercourse. It is interesting to note that as with the O'Leary & Arias (1983) study marital therapy, although having a significant effect on general aspects of sexual functioning, did little to improve specific sexual dysfunctions.

Our results are consistent with those of O'Leary & Arias (1983) but appear to contradict those of Hartman and Daly (1983), who showed that sex therapy had a greater effect on sexual satisfaction than marital therapy. However, a closer look at their findings suggests more similarities than differences between their study and ours. A focusing effect would necessarily lead one to expect larger changes for sex therapy in their design, given the scales used. The items of the sexual satisfaction scale (Lo Piccolo and Steger, 1974) correspond closely to direct instructions given to the couples in the sex therapy treatment programme, thus the large effects found may be to some extent artifactual. This is a common methodological error in the behavioural research literature where outcome measures are not independent of the treatment programme. Furthermore, there were noticeable differences between the variances of the scores for the two groups; in fact a ratio in excess of 5:1. Given the small sample size, particular care needs to be paid to spurious effects that could be caused by extreme scorers in either group. Although not clearly acknowledged by Hartman & Daly, it is evident that there was a positive improvement trend in sexual functioning following marital therapy at the cross-over point in their study. Both the results of the present study, which shows improvement in reported sexual satsifaction after marital therapy alone, and those of Hartman & Daly (1983), indicate an interdependence between marital and sexual functioning. This casts new light on the argument that these two modes of couple functioning are independent.

What are the implications for treatment? While it is accepted that some couples do present primarily with sexual dysfunction, we would concur with Sager (1974) and emphasise a multimodal approach to couples treatment. From our clinical experience it is evident that many couples are unable to delineate between marital and sexual problems, and couples therapists experience difficulty in deciding the focus of treatment. This emphasizes the need for adequate assessment of all aspects of the relationship, with a view to intervening on both fronts. Possibly couples would experience less anxiety if given the opportunity to discuss their marital relationship before approaching the intimate issues of

their sexual interaction. An opportunity to create a more conducive environment for both couple and therapist in this way, may enhance the longer term effects of treatment. For some couples an immediate focus on sexual functioning may provoke hostility, and this could exacerbate the existing distress. Jacobson and Margolin (1979) have described a collaborative set between partners which they feel is essential for successful outcome. This may be strengthened by initially defocussing the sexual relationship and improving the couples social interactions.

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