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THE EFFECTIVENESS OF INTENSIVE SHORT-TERM DYNAMIC PSYCHOTHERAPY IN TREATMENT-RESISTANT FEMALE SEXUAL DYSFUNCTIONS

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ABSTRACT

Objectives: This study was conducted to examine the effectiveness of intensive short-term dynamic psychotherapy (ISTDP) in women with sexual dysfunctions resistant to common sex therapy (cognitive-behavioral and bio-medical), and to evaluate their improvement and maintenance required during follow-up.
Method: After subjecting the female clients with sexual dysfunctions in Tehran to several inclusion criteria, and therapeutic screening, five subjects were found to be suitable for the study. The subjects underwent ISTDP. Data was collected using Female Sexual Function Index, Sexual Quality of Life–Female questionnaire, and Subjective Evaluation of Partner's Sexual Function Scale.
Findings: Results showed that a) ISTDP in comparison with common sex therapy improves sexual function of this type of subjects beyond the normal threshold. Therefore, this change leads to significant improvement in the sexual quality of life; b) trend of changes, when the first breakthrough to the unconscious occurred in a subject, showed considerable growth which can be the evidence for psychodynamic etiology of sexual dysfunction; c) promotion of sexual function and sexual quality of life in subjects was remarkable during the follow-up session.
Conclusion: Our findings suggest that in Treatment-Resistant Sexual Dysfunctions, integrative, intensive, and short-term contemporary dynamic psychotherapy can be a suitable alternative for common sex therapy.

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Introduction

According to the fifth edition of Diagnostic and Statistical Manual of Mental Disorders [1], sexual dysfunctions are characterized as a heterogeneous group of disorders which are typically determined by significant clinical disturbance in one's ability to experience sexual pleasure or sexual responsiveness. This diagnostic category is divided into 10 subcategories, three of which concern females (Female Orgasmic Disorder, Female Sexual Interest/Arousal Disorder, and Genito-Pelvic Pain/Penetration Disorder), four of these disorders deal with males (Delayed Ejaculation, Erectile Disorder,

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Male Hypoactive Sexual Desire Disorder, and Premature/Early Ejaculation), and the remaining three involve both sexes (Substance/Medication-Induced Sexual Dysfunction, Other Specified Sexual Dysfunctions, and Unspecified Sexual Dysfunction). According to this manual, people might be affected by more than one dysfunction simultaneously. In such a condition, all of the dysfunctions should be diagnosed. Despite the categorical and anti-theoretical approach of the Diagnostic and Statistical Manual (DSM), psychoanalytic approach to mental disorders is a phenomenological/etiological perspective [2]. All sexual dysfunctions are considered as somatization and functional symptoms in psychoanalytic approach which are manifested dimensionally/continually as the outcome of personality disorders [3, 4, 5, 6].

Some systematic epidemiological data is available in terms of prevalence of different sexual dysfunctions, which show a wide variability. The most comprehensive study which has been conducted on a representative sample of the population in USA indicated that female sexual dysfunctions are more prevalent than what is perceived: 33% Female Hypoactive Sexual desire; 20% Female Sexual Arousal problems; 25% Female Orgasmic problems; 15% Dyspareunia [7, 8].

Some studies in recent years have showed that female sexual problems have been concealed in deep layers of women's family and social lives in Iran. 41-43% of married women in Iran suffered from some kind of sexual problems [9]. The first extensive and systematic study on the prevalence of sexual dysfunctions in Iran, showed remarkable prevalence of sexual dysfunctions compared to other countries [10].

Nowadays, sexual dysfunctions are treated not only by common biomedical treatments (medications, hormone therapy, surgery) and mechanical treatments (Pumps, Prosthetics, …), but also since 1970 until recently the dominant paradigm of psychological methods to treat sexual dysfunctions (such as Masters & Johnson dual-sex therapy) have been generally based on cognitive-behavioral paradigm [11, 12]. Obviously, such therapies have had their own effect as they are short-term and have cognitive-behavioral paradigm which facilitates clinical research. In general, several studies have confirmed the effectiveness of biomedical therapies and psychotherapies based on cognitive-behavioral paradigm (such as training sexual behavioral skills, gradual desensitization, directive marriage counseling, …) [2].

Unfortunately, clinical trials which rely on group-based statistical methods usually ignore a minority of patients [13]. This minority group of patients are those who 1) either resist to accept suggested tasks and guidance of such treatment methods or lack enough motivation to change; 2) leave the course of treatment unfinished; 3) benefit very little or nothing at all despite completing the full course of treatment; 4) experience recurrence of the previous symptoms shortly after termination of treatment and recovery; 5) report alternative symptoms after termination of treatment and recovery of the symptoms [4, 5, 14]. Thus, it is necessary to continue making further efforts to discover new and effective treatment methods to support this certain clinical group.

American Psychological Association defined "treatment-resistance" as "refusal or reluctance on the part of an individual to accept psychological or medical treatment, or unwillingness to comply with the therapist's or physician's instructions.... lack of positive response by a client to the techniques being applied or to what the client feels is a rupture in the therapeutic alliance, which requires the use of other strategies or efforts to repair the alliance by the therapist" [15]. It is also defined as "failure of a disease or disorder to respond positively or significantly to a particular treatment method" [15]. The term "treatment-resistance" and adapted treatment methods concerning this particular clinical group of patients have already drawn the attention of researchers throughout the world in different types of mood disorders [16], anxiety disorders [17], and major psychiatric disorders [18]. In the area of sexual dysfunctions, researchers such as Williams and Orsmond have focused on this particular type of patients [14].

Having referred to the extensive growth of neurological studies in recent years, we are now on the verge of a fundamental paradigm shift in psychology and psychotherapy in which causal dominance is gradually shifting from cognition to emotion [19, 20]. Parallel to this change, a new wave of emotion-focused psychotherapy is going to dominate cognitive-behavioral psychotherapies. After years of recess this new discourse on psychodynamic theories and psychotherapies has drawn the attention of researchers and clinicians [21, 22]. Also, modern theories of psychotherapy are moving more and more towards integration and benefiting of all common factors of change [23, 24, 25].

Intensive short-term dynamic psychotherapy (ISTDP) was developed by Davanloo [26, 27, 28] over the past 45 years. This treatment method focuses on providing patients complete relief from symptom of disturbances and character structure multi-dimensional changes. Davanloo, an Iranian psychotherapist and the inventor of ISTDP is one of the contemporary research pioneers in psychotherapy. After analyzing 632 therapy session videos, he presented his theory of the rise of neurosis as a primitive reaction to damage to the child's attachment. According to this theory, failure to secure attachment (the threat of losing the object of love) leads to a chain of pain, rage (primitive murderous rage), guilt and grief; which finally forms a complex series of defenses that enclose dynamic nuclear emotions which are difficult for the patient to deal with. This complex defense mechanism is reinforced and consolidated by avoiding any type of intimate, authentic, and meaningful human relation [29, 30, 31].

Despite the prevailing notion induced by the domination of cognitive-behavioral paradigm, dynamic psychotherapy is known as an effective treatment method according to the recently published meta-analyses [32]. Although ISTDP is a relatively new treatment method, many research studies have confirmed its effectiveness. Specific controlled studies on ISTDP reveal that this therapeutic method is effective and economical [33, 34, 35], especially for treatment of personality disorders [36, 37],

treatment-resistant depression [38], chronic back pain [39], and chronic headache [40]. Also ISTDP in its modified and gradual form can help treat some psychotic states [30, 41].
Baldoni et al. conducted an ISTDP study on females with urethral syndromes and pain, but with no organic disease. After treatment, urethral pain completely disappeared in 70% of patients, and follow-ups showed a remarkable decrease in syndrome in the remaining patients [42]. Moreover, Coughlin Della Selva explains a successful treatment by ISTDP in one case of primary sexual dysfunction. In his view, encounter with anxiety and defense against aggressive feelings to achieve balance in sexual desire is not sufficient. Thus, all prohibitions against sexual desire should be explored to reach such a balance. She concludes that feeling of being in danger attached with expression and experience of sexual emotions and emotional closeness are rooted in one's past history [43].

Bianchi-Demicheli & Zutter in their case study, "intensive short term dynamic sex therapy" tried to apply ISTDP as a method for intensive intervention in clinical sexology. Having mentioned the positive aspects of this treatment method, they hail it as a new generation sex therapy. Besides providing a dynamic formulation and trend of treatment for each subject, they reported improvement after termination of the therapy [44].

According to this limited research background, it seems that evaluating effectiveness of this treatment method on a particular range of sexual dysfunctions in females would be considered as a step forward. In the present study, ISTDP was employed on Iranian females suffering with a particular range of sexual dysfunctions and did not responded to common sex therapy. Consequently, this research aimed to provide suitable response to the following important questions: 1) what is the effect of ISTDP on females with treatment-resistant sexual dysfunctions? 2) how improvement of females treated by ISTDP could be maintained with follow-up sessions?

2. Material And Method

2-1. Participants

The study conducted in 2015 comprised "females in Tehran with treatment-resistant sexual dysfunctions". The term "females with treatment-resistant sexual dysfunctions" in this study refers to those who met all the following criteria: A) age range of 20-40 years (sexual activity regardless of the potential effects of biological age); B) having received a course of common therapeutic interventions (medical and cognitive-behavioral) based on PLISSIT model [45] by researcher's colleagues, and presence of at least one type of sexual dysfunction based on Female Sexual Function Index (FSFI) and clinical interview (treatment-resistance); C) having sexual dysfunction which is neither induced by her sexual partner's dysfunction nor by anatomic-medical problems, drugs, severe relationship distress between couples, or important stresses in life (equivalent to D criterion in female sexual dysfunctions in DSM-5); D) absence of severe impulse control problems, psychotic disorders, or substance related disorders (ISTDP exclusion criterion for inappropriate patients); E) the patient must have given consent to enter the study, and she must have decide to continue the treatment till the end of the trial session (the first session of ISTDP) (informed consent criterion).
Available subjects who underwent the study had been referred to the team of researchers by gynecologists, psychiatrists, and psychologists, or had directly entered the study via notifications sent to different health clinics in Tehran. Due to various inclusion criteria and scarce number of available subjects, the study was carried out by a sample size of five subjects.

2-2.Measures

2-2-1. Female Sexual Function Index (FSFI). This questionnaire of 19 items is a scale to measure female sexual function in six areas: desire, arousal, lubrication, orgasm, satisfaction and pain. This scale was developed by Rosen et al., and validated in the normal female group (n=128) versus the peer group with sexual arousal disorder (internal consistency based on Cronbach's alpha 0.97, and test-retest reliability of total score based on the Pearson correlation coefficient 0.88) [46]. This index has been employed in numerous studies, and has always shown high degree of internal consistency and validity, so it is known as "Gold standard measure for assessing therapeutically induced change in female sexual function" [47]. Moreover, conducted studies show significant difference between scores of clients and those of the control group in all six areas. Wiegel et al. performed this test on samples of normal females versus those with multiple sexual dysfunctions with the purpose of cross-validation, and obtained the total score of 26.55 as optimal cutoff to differentiate normal females from those with sexual dysfunctions [48]. This cutoff point, by Young Oh et al., obtained the total score of 20.25 for Korean females [49].
FSFI was first validated in Iran by Mohamadi et al. on a sample of normal females versus those with sexual dysfunctions. In this study, the internal consistency was obtained by Cronbach's alpha 0.92, and the Persian version of this index was introduced as a reliable and valid tool to assess female sexual function; also it was found to be appropriate for screening. Moreover, the optimal cutoff point obtained the score of 28 for the total scale [50]. Fakhri et al. conducted a more accurate and comprehensive study in which FSFI was performed on a large sample size of Iranian women, and internal consistency by Cronbach's alpha 0.86, and test-retest reliability of the total score based on intra-class correlation coefficient 0.77 was

obtained. In addition, the total score of 24.75 was defined as the optimal cutoff point to distinguish normal women from those with sexual dysfunctions [51].

2-2-2. SexualQualityofLife–Female(SQOL-F). SexualQualityofLife–Female (SQOL-F) questionnaire is a self-report tool which was developed by Symonds et al. (2005) to assess destructive effect of sexual dysfunctions on the sexual quality of females' lives. The results of a semi-structured interview with a sample size of 82 subjects from seven countries helped to develop this questionnaire which was then validated on a sample size of 730 cases. SQOL-F questionnaire has 18 items which should be scored by subjects themselves on a 6-point Likert scale (completely agree to completely disagree) [52]. Maasoumi et al. validated this questionnaire in Iran, and reported a high internal consistency and reliability. The internal consistency by Cronbach's alpha 0.73, and test-retest reliability of the total score based on intra-class correlation coefficient of 0.88 was obtained. Also, content validity index (CVI) of 0.91 and content validity ratio (CVR) of 0.84 were obtained which was indicative of high validity of the questionnaire [53].

2-2-3.Subjective evaluation of partner's sexual function (SEOPSF). Subjective evaluation pursues clinical criterion by asking others this question whether intervention has resulted in qualitative changes in the subject or not. Accordingly, people who are in close contact with the subject, and are able to evaluate their behavior are asked to make their overall evaluation of the subject's function. If this evaluation showed that clients had a much more efficient function, this treatment approach would be considered effective [13, 58]. So subjective evaluation was made by asking the subject's sex partner the question "how do you evaluate your partner's sexual function during the last two weeks?" The partner was supposed to respond within the framework of a 7-point Likert scale (very good, good, a little good, not bad, a little bad, bad, very bad) [55].

2-3.Research design and the procedure

This study is based on a single subject research design [13, 56, 57, 58], and the procedure of the clinical-research project consists of screening and therapeutic intervention. The process began with the client referring to the reception of the clinic. Then, she was provided with basic information about the clinical-research project, and was asked to fill out demographic information forms. Having explained about the aim of the study and how to answer the questionnaires, the receptionist handed in FSFI & SQOL-F questionnaires to the client and SEOPSF scale to her partner. Ultimately, an appointment was made for her first interview.

The researcher's colleagues (Psychiatrists and sex therapy professionals) confirmed the presence of a sexual dysfunction based on DSM-5 criteria during first session of the interview after assessing the history of the problem and previously received interventions. According to case formulation of the basic interview, common sex therapy interventions (bio-medical and cognitive-behavioral) were performed by researcher's colleagues based on PLISSIT model during weekly sessions (a maximum of five sessions, and if necessary in presence of her sexual partner). During the final session, having evaluated the accomplished therapeutic objectives, the researcher would provide the client with FSFI & SQOL-F questionnaires and her partner with SEOPSF scale. In the case of criteria, "A", "B", "C", and "D" of the operational definition; and if the client agrees to undergo complementary treatment (ISTDP), trial session (the first session of ISTDP) would be arranged.

ISTDP in this study implies all techniques of intensive short-term dynamic psychotherapy (challenging with defenses and dealing with resistance, anxiety regulation, and pressure to experience the impulse, and analyzing the conflict triangle on three corners of person triangle) within the standard framework of the central dynamic sequence to unlock the unconscious in 20 weekly sessions of 120minute [28, 29, 30, 31].

The trial therapy session was held according to the standard central dynamic sequence by a researcher. At the end of the session, the therapist provided the client with detailed explanation of the clinical-research project, and obtained her written informed consent to enter the project after making sure of the "E" criterion of the operational definition. Finally, necessary arrangements were made with the client for her weekly therapy sessions.

One hundred twenty-minute therapy sessions were held by the researcher based on the formulation obtained from the trial therapy session. Also, FSFI questionnaire was filled before the fifth, tenth, and fifteenth therapy sessions.

The final therapy session was arranged by the client and therapist for the realization of therapeutic objectives. At the end of this session, the client received FSFI & SQOL-F questionnaires and her partner was provided with SEOPSF scale. Also, the follow-up session was arranged to be held eight weeks later.

The follow-up session consisted of assessing the current situation of the client and evaluating maintenance of changes. The FSFI & SQOL-F questionnaires were handed in to the client, and her partner received SEOPSF scale before starting the session. Figure 1 shows the summary of the clinical-research procedure.

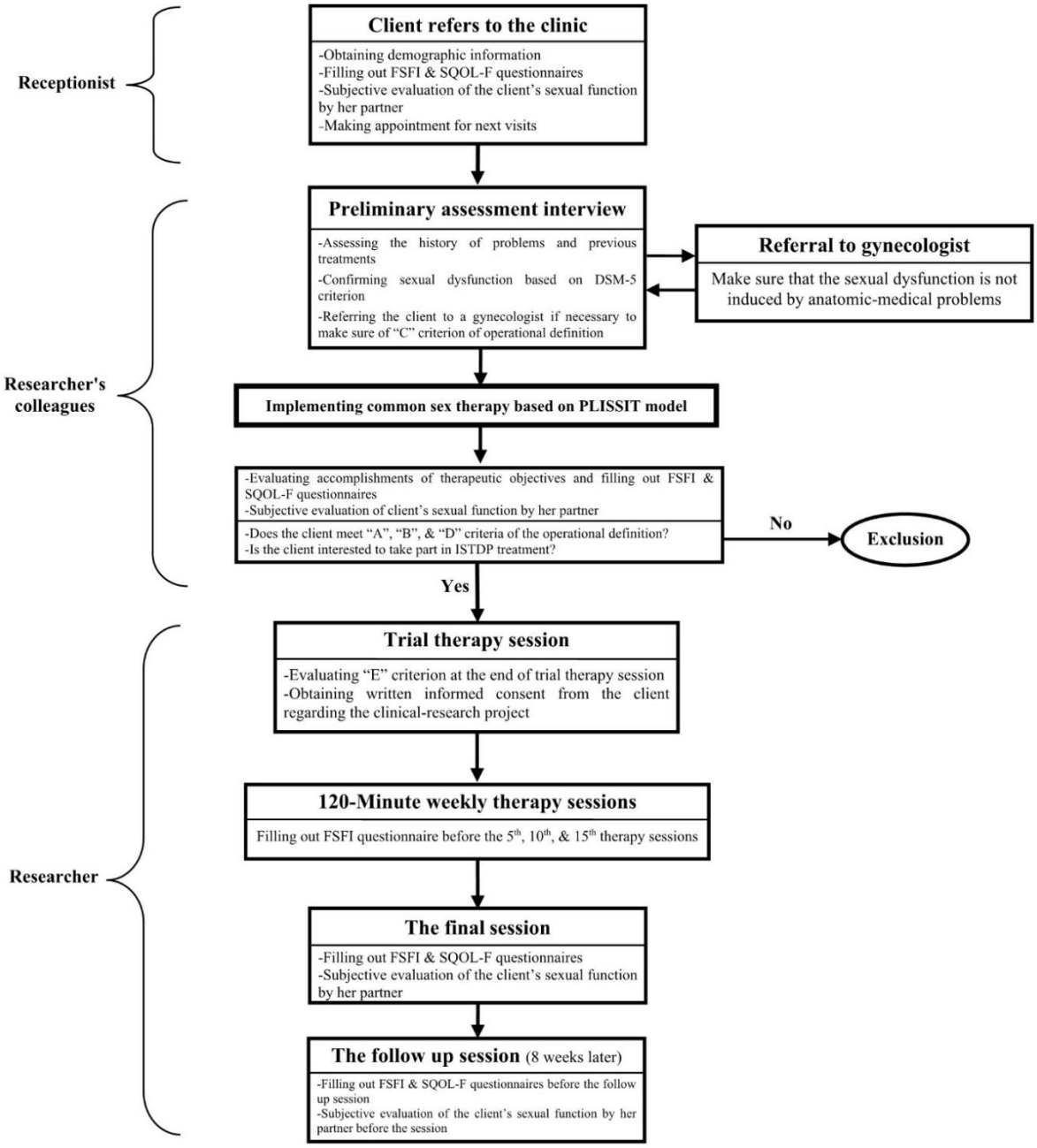


Figure 1. Clinical-research procedure to evaluate the effectiveness of treatment and follow-up

3. Results

In the process of screening (interview & common sex therapy), six of nineteen cases met inclusion criteria "A", "B", "C", and "D"; however, one left the study in the second session due to immigration (table 1).

Table 1. Characteristics of subjects with five inclusion criteria

Subject	Age	Degree of education	Clinical diagnosis*	specifier	subtype	severity	Comorbidities	Physical disease
1	35	Master's	Female Sexual Interest/Arousal Disorder	Acquired	Situational	Moderate	Generalized Anxiety not occurring more days than not	Irritable bowel syndrome
			Female Orgasmic disorder	Lifelong	Generalized	Severe		
2	26	Bachelor's	Genito-Pelvic Pain/Penetration Disorder	Lifelong	Generalized	Severe	-	Fibromyalgia
3	29	Bachelor's	Female Orgasmic disorder	Lifelong	Situational	Moderate	Trichotillomania (hair-pulling disorder)	Functional constipation
4	27	Master's	Female Sexual Interest/Arousal Disorder	Lifelong	Generalized	Moderate	Depressive episode with insufficient symptoms	Peptic Ulcer
			Genito-Pelvic Pain/Penetration Disorder	Lifelong	Generalized	Moderate		
5	32	Associate degree	Female Sexual Interest/Arousal Disorder	Lifelong	Generalized	Severe	-	Migraine headache

* clinical diagnosis, based on DSM-5, was made by clinical interview in the first session of screening. All subjects had problems in other stages of sexual response besides these diagnoses, but they did not meet necessary DSM-5 criteria to receive diagnosis.

In the first session of ISTDP (trial therapy), "E" criterion was confirmed besides psychodynamic diagnosis of the capacity of ego adaptation, common defenses and their degree of syntonicity, the superego pathology, and ultimately place of the client in the spectrum of structural neurosis (table 2).

Table 2. Subjects' characteristics in the first ISTDP session

Subject	Ego adaptation capacity				Common defenses		Superego pathology	Place of the client in the spectrum of structural neurosis
	Differentiate between I/F - A-D	Correct causality between vertices of two triangles	Anxiety manifestations	Projection	Syntonic	Dystonic		
1	Yes	No	-Striated muscle -Smooth muscle -cognitive/perceptual disturbances	Yes	Intellectualization Rationalization Rumination	vagueness Diversification	Severe	Middle right
2	Yes	No	-Striated muscle -Motor conversion	No	Ignoring Dismissiveness Somatization	Helplessness Passivity	Severe	Middle right
3	No	No	-Striated muscle -Smooth muscle	No	Ignoring neglecting Rumination	Galloping	Relatively severe	Middle
4	Yes	No	-Striated muscle -Smooth muscle -Motor conversion	Yes	Intellectualization Denial Somatization Defiance	Externalization	Extremely severe	extreme Right
5	No	No	-Striated muscle -Smooth muscle	No	Helplessness Compliance passivity Dismissiveness	Storytelling vagueness	Relatively severe	Middle

3-1.Group analysis Due to the extremely small sample size [59] for group analysis, repeated measures ANOVA with Greenhouse-Geisser correction was applied after making sure of the assumption of normality of the compared data. Results

are indicative of statistically significant difference between the scores of FSFI in different sessions (entrance to screening, final screening, the last session of ISTDP and follow-up) (F (1.16, 4.65) =205.13, P<0.0005). Bonferronipost hoc test for Pairwise comparisons indicate a significant difference between all paired sessions except for the last session of ISTDP and the follow-up session (table 3). Although group analysis shows a statistically significant difference, it is necessary to analyze each subject individually and evaluate clinical significance of their changes to obtain proper and accurate results.

Table 3. The mean and standard error of the difference of FSFI scores and its statistical significance

Sessions	Entrance to screening	Final screening	Final session of ISTDP	Follow-up
Entrance to screening	-	-4.14* (1.89)	-22.10** (3.66)	-23.14** (3.77)
Final screening		-	-17.96** (2.15)	-19.00** (2.45)
Final session of ISTDP			-	-1.04 (0.55)
Follow-up				-

Note. Figures before parentheses are the mean difference of FSFI scores between the two sessions, and those inside parentheses show standard error. *p<0.05. **p<0.01.

3-2. Single subject analysis

In this analysis, experimental criterion and therapeutic criterion were employed to evaluate the effects of experimental variable. To assess the therapeutic criterion, social validation criterion was applied by two methods: social comparison and subjective evaluation [13, 54].

3-2-1. Assessment of experimental criterion Graph analysis was done based on four criteria, Change in average level, Immediate change in level, Change in trend, and Latency of change [58]. The analysis indicates that first, ISTDP in comparison to common sex therapy has led to an essential change in sexual function of this range of subjects, and it has been able to move them above the normality cut off. Second, these changes have been maintained after an eight-week follow-up. Moreover, this graph shows that the process of change had a remarkable growth when the first breakthrough to the unconscious (unlocking of the unconscious) occurred in that certain subject (table 2). Also, Graph analysis of changes in total score of SQOL-F reveals that only ISTDP has been able to result in a remarkable change in sexual quality of life of this range of subjects, and raise them above the normality cut off (figure 3).

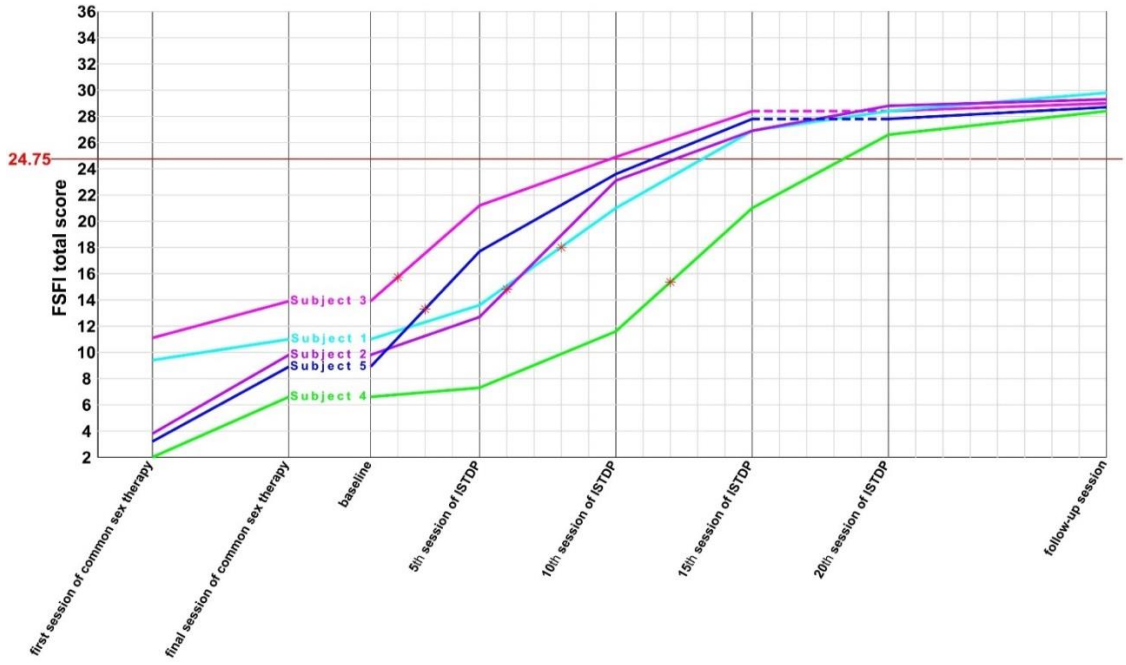


Figure 2. Graph of changes in FSFI total score during the process of research-treatment procedure (The asterisk on the lines of changes show the session during which the first breakthrough to the unconscious occurred. Subjects three and five achieved their expected treatment goals in the 15th session and decided to terminate their therapy with the agreement of the therapist; this period has been shown by a dotted line).

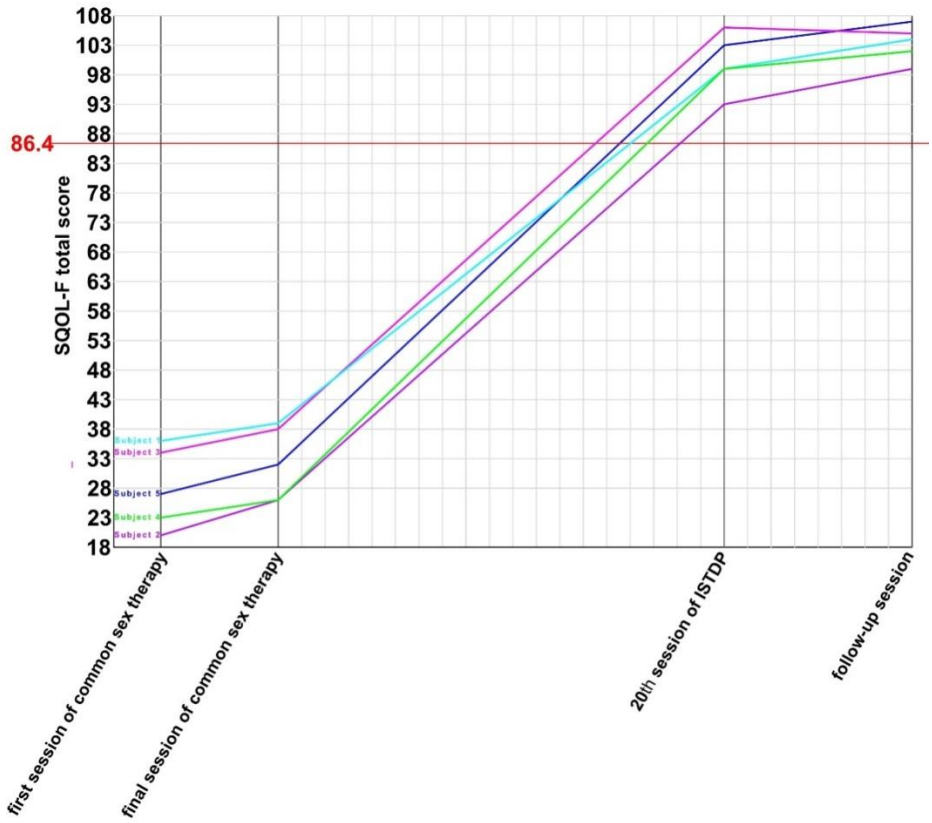


Figure 3. Graph of changes in SQOL-F total score during the process of research-treatment procedure

3-2-2. Assessment of therapeutic criterion via social comparison method. Besides graph analysis which is common in single subject research studies, percent improvement (PI) or symptom reduction score (SRS) [60], Jacobson Reliable Change Index (RCI) [61], and normative comparison (NC) [62] were employed to evaluate the clinical significance of these changes. Evaluation of three clinical significance indices in the process of screening based on common sex therapy clearly shows that despite positive changes in FSFI & SQOL-F scores throughout this intervention, none of those changes were therapeutically significant, and they were not able to promote subjects above the normality level (table 4).

Table 4. Changes in FSFI & SQOL-F total scores in the process of screening based on common sex therapy and three clinical significance indices

Subjects	Test	The first session	The final session	PI (%)	RCI	NC
1	FSFI	9.4	11.0	6.0	0.65	Not improved
	SQOL-F	36	39	4.2	0.59	Not improved
2	FSFI	3.8	9.8	18.6	2.44*	Reliably improved
	SQOL-F	20	26	6.8	1.19	Not improved
3	FSFI	11.1	13.9	11.2	1.14	Not improved
	SQOL-F	34	38	5.4	0.79	Not improved
4	FSFI	2.0	6.6	13.5	1.87	Not improved
	SQOL-F	23	26	3.5	0.59	Not improved
5	FSFI	3.2	8.9	17.4	2.32*	Reliably improved
	SQOL-F	27	32	6.2	0.99	Not improved

Note. PI= percent improvement; RCI= reliability criterion index; NC= normative comparison (not improved/Reliably improved/improved). *p<0.05. **p<0.01.

Evaluation of the three clinical significance indices in ISTDP is clearly indicative of significantly clinical changes in FSFI scores. What is of paramount importance is that changes were maintained in the follow-up session, which was held eight weeks later. Percentage of improvement in all subjects was above 50%, Jacobson Reliable Change Index for all subjects was

significant, and normative comparison indicated that all subjects were shifted above the normality level (table 5). Moreover, evaluation of the three clinical significance indices of changes in SQOL-F score clearly indicated that the elimination of sexual dysfunction considerably promoted sexual quality of life which was still prominent in the follow-up session (table 6).

Table 5. Changes in FSFI total score in ISTDP and its follow-up, and three clinical significance indices

Subjects	Baseline	5th session	10th session	15th session	20th session	PI (%)	RCI	NC	Follow-up session	PI (%)	RCI	NC
1	11.0	13.6	21.0	26.9	28.4	69.6	7.09**	Improved	29.8	75.2	7.66**	Improved
2	9.8	12.7	23.1	26.9	28.8	72.5	7.74**	Improved	29.3	74.4	7.94**	Improved
3	13.9	21.2	24.9	28.4	-	65.6	5.91*	Improved	29.0	68.3	6.15*	Improved
4	6.6	7.3	11.6	21.0	26.6	68.0	8.15**	Improved	28.4	74.1	8.88**	Improved
5	8.9	17.7	23.6	27.8	-	69.7	7.70**	Improved	28.7	73.1	8.06**	Improved

Note: PI= percent improvement; RCI=reliability criterion index; NC= normative comparison (not improved/Reliably improved/improved). Subjects three and five achieved their expected treatment goals in the 15th session and decided to terminate their therapy with the agreement of the therapist. *p<0.05. **p<0.01.

Table 6. Changes in SQOL-F total scores in ISTDP and its follow-up and three indices of clinical significance

Subject	Baseline	Final session	PI (%)	RCI	NC.	Follow-up session	PI (%)	RCI	NC
1	39	99	87.0	12.64**	Improved	104	94.2	12.84**	Improved
2	26	93	81.7	11.46**	Improved	99	89.0	14.42**	Improved
3	38	106	97.1	14.02**	Improved	105	95.7	13.23**	Improved
4	26	99	89.0	12.64**	Improved	102	92.7	15.01**	Improved
5	32	103	93.4	13.43**	Improved	107	98.7	14.81**	Improved

Note: PI= percent improvement; RCI=reliability criterion index; NC=normative comparison (not improved/Reliably improved/improved). *p<0.05. **p<0.01.

3-2-3. Assessment of therapeutic criterion by subjective evaluation method. Paired comparison of the ratings obtained from "subjective evaluation of partner's sexual function" (SEOPSF) in different sessions revealed that, from the partner's point of view, only ISTDP could have a significant effect on sexual quality of life of this range of subjects which remained stable until the follow-up. Wilcoxon signed-ranks test showed a significant increase (p<0/05) in SEOPSF in the final session of ISTDP and follow-up. For example, comparison of the rating of subjective evaluation in the final session of screening and that of ISTDP showed the score of Z= -2.07 (p<0/05) which has a large effect size (r=0.66) based on Cohen criterion (1988). The mean score of SEOPSF rose from 2 in the final session of screening to 6 in the final session of ISTDP.

Table 3. comparison of the subjective evaluation of partner's sexual function (SEOPSF)

Sessions	Entrance to screening	Final screening	Final ISTDP	Follow-up
Entrance to screening	-	-1.41	-2.04*	-2.06*
Final screening		-	-2.07*	-2.06*
Final ISTDP			-	-0.58
Follow-up				-

*p<0.05.

4. Discussion And Conclusion

Close examination of studies on sexuality and its analysis helps us to know that sex, sexuality, gender and sexual relationship play a crucial role in at least six main areas of human life (identity, reproduction, tension reduction and gaining pleasure, interpersonal relationship, intrapersonal relationship, libido, aesthetics, and the transcendental). Therefore, it can be concluded that presence of any kind of pathology in human's sexual life sooner or later can destroy these six areas. That is why sexual health has become an essential concern for specialists and health researchers. Moreover, given the remarkable expansion of the media and worldwide changes in socio-cultural approaches and attitudes, nowadays people are more sensitive and have higher expectations of their sexual lives. Therefore, the number of couples who tend to solve their sexual problems or even promote the quality of their sexual life has been significantly increasing [64]. As a result, therapists are supposed to make further efforts in order to develop more effective techniques and strategies to help this wide range of clients seeking remedies to tackle their sexual problems.

Moradian showed that the acceptable effectiveness level of integrated transtheoretical model to treat female sexual dysfunctions. However, he noted that this holistic therapeutic approach has little effect on minority of clients and certain types of severe sexual dysfunctions. Also, he showed that there is an ambiguous and conventional diagnostic border between sexual dysfunctions which considerably overlap each other and cause a number of challenges in interpretation of the results [55].

This study aims to examine a small range of clients who are usually ignored in "group- based research methods". Since statistical data analysis in such studies does not attend to the performance of each individual, and emphasize is given only to the average score of the whole group. There is a small group of subjects whose treatment fails or has little effect are usually hidden in the shadow of those who have improved, and they are not covered or mentioned in study reports [58, 65]. This study not only targeted such minority through therapeutic intervention, but also developed an individualistic strategy as its methodology.

Our findings showed that although common sex therapy, based on cognitive-behavioral framework has confirmed its effectiveness in majority of clients and in a wide range of sexual dysfunctions, but has failed in addressing the minority of those, who have not been able to experience a clinically significant outcome in their cases. According to the findings of this study, in such a condition, contemporary psychodynamic psychotherapies which have an integrative, intensive, and short-term nature can be considered an appropriate competitor for common sex therapy. This finding is compatible with a large number of recent researches which have revealed the effectiveness of the contemporary psychodynamic psychotherapy in the case of treatment-resistant clients [30, 33, 34, 35, 36, 37, 38, 39].

Although the present study had several limitations, it could be considered as a step forward to more extensive studies to be conducted in the future in order to develop new approaches towards sex therapy and evaluate its effectiveness. We recommend that this new approach implement all psychoeducational and common cognitive-behavioral interventions in a psychodynamic context and framework while facing sexual dysfunctions in order to achieve maximal effectiveness. We believe that ISTDP is the best alternative in this regard. Perhaps, it is the time for a paradigm shift, which is currently taking place in the area of psychotherapy, to take sex therapy into consideration too.

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