

**Getting “In the Mood” (for a Change):**

Stage Appropriate Clinical Work for Sexual Problems

Scott D. Miller, Ph.D.<sup>1</sup>  
Institute for the Study of Therapeutic Change  
Chicago, Illinois

Karen M. Donahey, Ph.D.  
Northwestern University  
Chicago, Illinois

Mark A. Hubble, Ph.D.  
Institute for the Study of Therapeutic Change  
Chicago, IL

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<sup>1</sup>Requests for reprints and comments regarding this chapter may be directed to the first author at: ISTC, P.O. Box 578264, Chicago, Illinois, 60657-8264. E-mail: [scottdmiller@talkingcure.com](mailto:scottdmiller@talkingcure.com).

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“The readiness is all.”

Shakespeare  
(*Hamlet*, act 5, scene 2)

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In 1966, researchers Masters and Johnson reported that the physiological response to sexual stimulation progressed through a series of stages that were the same for *all* human beings: excitement, plateau, orgasm, and resolution. Prior to their pioneering research of human sexual behavior in a laboratory setting, studies had been limited to what people said rather than what they actually did. While perhaps difficult to imagine now, the identification of the stages of arousal revolutionized the scientific understanding of the human sexual response cycle and opened the door to understanding differences in and developing therapies for sexual difficulties.

A less well-known but equally revolutionary finding in the field of psychotherapy is that people progress through a series of “stages of arousal” while “getting in the mood” to change. While a number of systems for classifying these stages have been proposed (see Berg & Miller, 1992; Miller & Berg, 1991; Fisch, Weakland, & Segal, 1982; de Shazer, 1988), none to date compares to the Stages of Change model developed by Prochaska, DiClemente, and associates. For more than 15-years, these researchers have been piecing together “the puzzle of how people intentionally change their behavior” by studying how people change naturally, spontaneously, and on an everyday basis (Prochaska, DiClemente, & Norcross, 1992, p. 1102; Prochaska, 1995, 1999, Prochaska

& DiClemente, 1982, 1983; DiClemente & Prochaska, 1982). Along the way, these pioneering researchers have not only been able to identify the various stages, but have also found that, “at different stages people apply particular processes to progress to the next stage” (Prochaska, 1999, p. 228).

Throughout most of the history of the psychotherapy, motivation for change has been dichotomized: either the people in treatment were considered motivated or they were not. Those falling in the latter category earned the label, “resistant.” In 1904, Sigmund Freud placed the concept of resistance to change at the center of his evolving theory of therapy. Based on his observation that clients would frequently and often vigorously reject the interpretations he offered, Freud concluded that “patient[s] cling to [their] disease and . . . even fight against their own recovery.”

While the concept has seen many modifications over time, the belief that people sabotage or otherwise subvert the change process survives (Anderson & Stewart, 1983; Singer, 1994). *Secondary gain* (Freud, 1909; Weiner, 1975), *habit strength* (Dollard & Miller, 1950), *homeostasis* (Jackson, 1957; Hoffman, 1981), *self-protection* (Mahoney, 1991), *lack of motivation* (Malan, 1976; Sifneos, 1992), and the recent and popular characterization of people as *being in denial* are just a few of the terms used nowadays that reflect Freud’s original concept. This belief, as Mahoney (1991) noted in his massive and systematic review of psychotherapy process research, has led to “one of the most important points of convergence across contemporary schools of thought in psychotherapy: significant psychological change is rarely rapid or easy” (p. 18).

Research on the “stages of change” indicates, however, that the whole concept of resistance needs to be rethought—perhaps even jettisoned altogether. All people, the

work of Prochaska and colleagues makes clear, have motivation. While people who do not share their therapist's motivations have historically been assigned one of the aforementioned labels, it may be more correct to say that their "stage of arousal for change" is different from that of their therapists. A number of studies have found that therapists improve the chances of success when the treatment they offer fits with their *client's* stage of change (Brogan, Prochaska, & Prochaska, 1999; Reis & Brown, 1999; Miller, Hubble, & Duncan, 1997; Prochaska, 1999). Stage appropriate interventions increase client engagement in the treatment process, a factor which 40 plus years of research has established to be "*the most important* determinant of outcome" (p. 361, Orlinsky & Howard, 1994)

From this vantage point, even the distinction between long and brief forms of therapy can be seen as a muddle. Indeed, the length of treatment is largely irrelevant to successful outcome. Rather, *efficient* and *effective* treatment results from working cooperatively with people to facilitate their movement to the next stage of change. Prochaska et al. (1992) found that people who moved from one stage to the next during the first few sessions of treatment doubled their chances of taking effective action to solve their problem in the next six months. A movement of two stages as much as quadrupled the chances of success (Prochaska, 1999). Other research shows that such movement generally occurs early in the treatment or *not at all*. Nearly all large-scale meta-analytic studies, for example, show that people's response in the first few sessions is highly predictive of eventual outcome (Hubble, Duncan, & Miller, 1999; Duncan & Miller, 2000).

Prochaska's et al. (1992) research shows that stage of change is a better predictor of treatment outcome than the age, socioeconomic status, problem severity, goals, self-efficacy/esteem, and existing social support network--variables which continue to be used in spite of their low predictive power (p. 1106). At the same time, the idea of helping someone "get in the mood" for a change by tailoring treatment to their particular stage has the advantage of shifting the guiding metaphor for clinical practice from one that emphasizes therapist power to one that stresses collaboration and facilitation. From this perspective, therapists assume all the qualities of a good lover; that is, "joining with," "working together," and "cooperating" rather than using "techniques, strategies, and other clever maneuvers . . . for the good of the client" (de Shazer, 1986, p. 73). While rarely stated explicitly, available evidence suggests that experience naturally leads therapists in the direction of attending more to their relationships with clients and less on technical expertise (Duncan & Miller, 2000).

At present, the stages have been successfully applied to the treatment of various compulsive behaviors (e.g., alcohol, food, tobacco, sex, gambling), domestic violence, battered women, the management of chronic health conditions (e.g., chronic pain, arthritis), the prediction and prevention of risky sexual behavior (e.g., condom use to prevent transmission of HIV), the improvement of personal decision making and acquisition of psychological skills, the promotion of health engendering behaviors (e.g., diet, exercise, routine medical screening), and the management of organizational change. A review of the PsychInfo database from 1988 to the present, however, turned up no studies or papers directly applying the concepts to the treatment of sexual problems. This

present chapter illustrates the use of the stages of change model in the treatment of such issues.

### **The Stages of Arousal (For a Change)**

"Not everyone needs or wants the same thing, all the time. . . . In my opinion, a responsible psychotherapist respects those desires, is flexible enough to deal with a wide range of them and to adjust his or her services to each client's current concerns."

Michael Mahoney (1991, p. 280)

Six distinct "stages of arousal" for a change have been identified: (1) precontemplation; (2) contemplation; (3) preparation; (4) action; (5) maintenance; and (6) termination (Prochaska, 1995). Movement through these stages generally happens in two ways. First, change may advance linearly, proceeding gradually and step-wise through the stages from start to finish. Relapse and a recycling through the stages characterize the second, and by far the most common form of progression. This is the process intimated in the popular saying, "Change is three steps forward and two steps back." Sudden transformations in behavior are possible, too, such as the celebrated overnight conversion of Ebenezer Scrooge in Dickens's *A Christmas Carol* (Miller, 1986). In the material that follows, the various stages are defined and illustrated. For each stage, suggestions are offered for the type of clinical work most likely to facilitate progression to the next level.

**Precontemplation.** In this first stage, people "are not intending to change or take action in the near future, usually measured in terms of 'the next six months'" (Prochaska (1999, p. 228). Quite often, these are the people labeled "resistant," "in denial," or "character disordered." In reality, however, they may not "have a clue" that a problem exists. Others may feel there is a problem but they typically have not made a connection between this problem and their contribution to its formation or continuation. People in

this stage may actually have tried to change. Usually, however, their lack of success has caused them to become demoralized and to stop thinking, talking, or reading about ways to solve their problem. As might be expected, people in this stage are often not interested in participating in treatment (Prochaska, 1995). Most often, they come at the behest or mandate of someone else (e.g., parent, partner, probation officer, or court). As such, they may portray themselves as under duress or the victim of "bad luck."

A fitting example of someone in the precontemplative stage is Martin; a 48-year-old Native American man married for twelve years to Donna, a 47-year-old Caucasian woman. Martin and Donna met in AA. In addition to having a past history of alcohol abuse, Donna had experienced several bouts of major depression as an adult while Martin suffered from hypertension and diabetes. They entered treatment at Donna's insistence. For most of the last ten years they have had little to no sexual contact due to Martin's difficulty maintaining erections and absence of sexual desire. While disappointed that they cannot have intercourse, Donna stated she was open to other forms of sexual contact. However, Martin steadfastly refused to consider this; citing his discomfort with oral stimulation and his belief that manually stimulating each other was "just another way of masturbating, which is wrong". He was distressed that Donna was so unhappy about this but felt that she should accept that he was not able to perform sexually anymore due to the medications he was taking to manage both the hypertension and diabetes. He stated he wanted her to focus instead on how well he took care of her with regard to her depression and in her relationship with her mother. In fact, at one point he said, "I think maybe God put me here on Earth to take care of Donna". Donna conceded that he was a "wonderful husband in all other aspects, but I still crave intimacy." She believed that

part of her depression was related to the lack of sexual intimacy in the marriage and stated that she was “hungry for any kind of touch from Martin.” Martin responded by telling Donna that in his culture men and women were not affectionate with one another, and that “white women are too demanding sexually.” He stated that he wanted her to “accept me as I am.”

To help clients in precontemplation take that first step, a light touch is recommended. Having a “light touch” means first and foremost that the therapist is courteous to the client and willing to listen to their point of view (Miller et al., 1997). The goal is not to *make* the client do something. Rather, in accommodating a client in precontemplation, the therapist’s job is to create a climate in which the client can consider, explore, and appreciate the benefits of changing. This could include, for example, providing information or helping the client become aware of the causes, consequences (positive and negative), and cures of their problems or concerns (Prochaska & DiClemente, 1992, p. 304). In all, as the word stage implies, accommodating motivational readiness requires therapists to be “in phase” with the client. In the earliest stage, this means that an important first step has been made if the client expresses an inkling that some action may eventually be necessary.

In the session with Donna and Martin, the therapist explored Martin’s thoughts about just wanting Donna to accept him. Donna listened without interrupting and then said very sadly she would try harder to accept him for who he was with respect to his feelings about sexuality. As the therapist began to summarize what she had heard from each of them, Martin jumped in and stated, “While I’m not promising anything, if you (the therapist) could help me be open to having sexual feelings, I would consider it.” He

then turned to Donna and told her he wasn't sure what he could do, but he hated seeing her so sad, and would come to therapy again to see if he could "feel different." Thus, by the therapist (and Donna) listening and acknowledging Martin's feelings without pushing him to change, he was able to rethink his position and consider making a change. As an aside, the therapist learned at the next session that Martin had held Donna's hand on the way home—something that had not happened for some time.

**Contemplation.** The process of change continues in the second stage, known as *contemplation*. According to Prochaska (1999), people in this stage, "intend to change in the next six months" (p. 229). In traditional treatment approaches, these people are frequently referred to as the, "Yes, but" clients--those who earnestly seek out the therapist's help and advice only to reject it once it is offered. In reality, however, people in the contemplative stage recognize that a change is needed but are unsure whether it is worth the cost in time, effort, and energy. In addition, they are concerned about the losses attendant to any change they might make.

As an example of someone in the contemplative stage, consider the dialogue from a first session with a woman who had been unable to have intercourse with her husband of two months. During their courtship she thought that her difficulty was due to guilt over having attempted to have premarital intercourse. Now that she was married, she saw that the problem was more complex. In addition to the guilt she experienced in having had some premarital sexual contact, this twenty-five year old woman (who reported no history of sexual abuse) had many beliefs and fears about sexual intercourse (e.g., it would be painful, her vagina was not large enough, she would not enjoy it, her husband would not be able to stop if she asked him to because he would be too aroused). At the

same time, however, she did feel badly that she and her husband were not acting “like newlyweds should” and expressed a desire to be “normal.”

While the woman’s husband had been fairly supportive, he expressed growing frustration with what he perceived as her lackadaisical approach to the problem.

Client: I don't like the way things are right now but I'm afraid to have sex. I think it will hurt. I 'm not very big down there.

Therapist: You think your vagina is too small for your husband’s penis.

Cl: Well, I'm not sure, since I've never tried. It just seems like it would be really painful.

Th: Has anyone told you it was painful? A friend perhaps? Or your parents?

Cl: No, my friends don't really talk about it very much. I don't like to hear about it, sex I mean, but when they do say stuff, they seem to act like it's fun. And my mother tried to talk about sex with me when I was a teenager. She told me sex was created by God for married people and it was beautiful. If you were unmarried, it was wrong. I've told her about this problem. She keeps telling me it won't hurt, but I can't get myself to believe her. But I have to, I just have to overcome this! Tom won't be patient forever.

Th: You feel pressure to solve this problem.

Cl: Yes, I don't expect to enjoy it but if I can just do it, it would satisfy Tom. As long as it doesn't hurt, I'll be satisfied.

Th: That's your goal for now.

Cl: Yes, but I don't know how you're going to convince me that it won't hurt either.

Accommodating clients in contemplation takes considerable patience given their tendency to vacillate and be indecisive. An effective approach entails creating a supportive environment in which the client can carefully consider changing without feeling the pressure or need to take action (Duncan, 1989). In certain cases, the therapist might even actively discourage the client from taking action and, instead, simply encourage thinking or observation.

A classic example of accommodating clients who are contemplating change can be found in the "go slow" injunction from the brief strategic therapy tradition (Duncan, 1989; Fisch et al., 1982). The advice to "go slow" (i.e., not change too quickly, postpone, consider how much change is optimal) is not some piece of paradoxical subterfuge. When clients are contemplating change, allying with their ambivalence is perhaps the most empathic stance a therapist can assume. After all, by the time most of these clients see a therapist, they have been exposed to all sorts of exhortations to do something--both from others and their own conscience.

Returning to the case of the woman with vaginismus, the therapist explained to the client that she was not going to try to convince her that intercourse would not be painful (her mother and husband had already attempted this, with no success). Neither was the therapist going to recommend that the client go home and try once again to have intercourse with her husband. Rather, the therapist instructed the woman that "under no circumstances" was she to attempt intercourse with her husband. Instead, if she was willing, she could practice for the next week inserting a Q-tip in her vagina.

The client was both incredulous and relieved. Following is an excerpt from the session:

Cl: You mean that's all you're going to make me do?

Th: Well, I don't want to make you do anything you're not ready to do. Does this seem like it's too big a step? Do you need this first week to just imagine doing it?

Cl: (Thinking for a few seconds). No, I think I could do the Q-tip. I've had Tom's finger inside of me before and it didn't hurt that much. I don't think a Q-tip could hurt.

Th: Well, if it starts to, I want you to immediately stop. Withdraw the Q-tip, do the breathing exercises again, and then try to insert it again. If it hurts, you're done for the day. You can try again the following day.

Cl: That's all I have to do?

Th: Yes, I would rather have you take this slow and increase your chance of being successful.

Cl: Will you talk with Tom about this?

Th: Yes, I think it would be a good idea if the three of us met together next week.

In this case, the therapist responded to the client's ambivalence regarding intercourse by instructing that the client not engage in intercourse and, instead, proceed slowly and cautiously.

A variation of suggesting a client "go slow" is to consider any possible "dangers of improvement" (Fisch et al., 1982). This approach is helpful in accommodating clients who have stayed in contemplation for a protracted period of time--clients whose lengthy inaction, multiple false starts or failures have led them to be labeled "difficult" or "chronic." In raising the "dangers of improvement," it is suggested that change be set aside for some period. The client is then asked to consider carefully any risks that might be associated with their improvement. No danger is too small to contemplate. By taking this very conservative position about progress, the therapist provides an opportunity for the client to explore and express the risks associated with change (Duncan, 1989).

Overall, showing the understanding that change requires time, thoughtfulness, and

sometimes radical accommodation, is respectful, helps to take off pressure, and gives the client the space and support to commit to change.

No matter the particular therapeutic tradition followed or applied in accommodating the client in contemplation, it helps to keep one's finger off the hot button of change. Should therapists attempt to push clients in contemplation to change they will, instead of moving them forward, likely cause them to dig in their heels. As such, it is better to listen, agree, provide a small encouraging nudge when invited, and engage the client in an exploration of what they stand to both gain and lose from changing (Miller et al., 1997).

**Preparation.** In the third stage, a person is preparing to “take action in the immediate future, usually measured in terms of ‘the next month’” (Prochaska, 1999, p. 230). Their main focus is on identifying the criteria and strategies for success as well as finalizing the development of their plan for change. People in this stage also engage in experimentation with the desired change--trying it on for size, noticing how it feels, and then experiencing the effects. For example, a person experiencing premature ejaculation may purposely spend more time in foreplay or otherwise modify the conditions under which they typically have sex (Prochaska & DiClemente, 1992). In contrast to the two previous stages--where the client's relationship with change is more tenuous and delicate--clients in the preparation phase are rarely assigned negative psychological labels. Indeed, these clients are often considered the ideal--their customership is on a surer footing and their intention to take action fits with traditional ideas about the change process (Prochaska et al., 1992).

Clinicians accommodate the client in preparation when they help them sort through and select their treatment goals, as well as explore and map out potential paths that might be taken to reach those goals. At this point, the therapist can assume a more active role in raising possibilities, presenting treatment options or change strategies, and constructively challenging the client's problem-solving abilities. As during all the stages,

however, choice is important (Miller, 1986). Clients in preparation need to be active in choosing and designing their own strategy for change. Therapists are most likely to be helpful when they present alternatives or different methods that clients can use to achieve their goals. Implying there is only one-way leads to resistance and increases the risk of the client terminating treatment prematurely.

Take for example the case of Bill and Sara, a young couple in their early thirties with a three-year-old son. Bill was working full-time and attending graduate school part-time. Sara was finishing her undergraduate degree and taking care of their son. For the past two years the couple had been sexual less than once a month. They admitted having put their energy into school and raising their son. Sex sometimes felt “like too much work.” Yet when they were sexual they enjoyed it and wondered aloud why they “didn’t do it more often.” Both reported wanting to increase their sexual frequency to about three or more times a month.

In the initial session both Sara and Bill acknowledged having let other things “get in the way of sex” (school assignments, household chores, family outings with their son, time with friends and extended family). They also each pleaded guilty to waiting for the other to initiate sex. Subsequent sessions focused on exploring the conditions under which sex might be possible (e.g., son in bed or at daycare, not late at night, setting aside time for it during the week, spending time thinking about and anticipating it, watching an erotic video to “get in the mood”). Time was also spent exploring how the couple had let the eroticism decline in the past few years. Sara, in particular, spoke of her wish for she and Bill to “become lovers again.” When asked for details, she talked about their earlier days when they were dating and first married. In particular, she recalled fondly their giving each other body massages, cuddling in the mornings before getting up, leaving each other “steamy” notes or voicemails, and “plain, old-fashioned flirting.”

Interestingly, reminiscing about these times in the session rekindled their interest in restoring their sex life. One session, Sara returned to report having bought new

lingerie and massage lotion. During the same visit, Bill reported buying some erotic videos and sending Sara several emails telling her what he'd like to do sexually with her. He also noted having joined Sara in the shower one morning. In a later session, they reported having decided to make Wednesdays a "sexual date" night. Sara would arrange for her parents to have their son over for a few hours in the evening so that she and Bill could have the house to themselves. Bill was able to leave work a little earlier on that day. On the way home he was to stop at a gourmet food shop to pick up some treats for them to eat. Sara would have the wine chilling and music on the stereo. When the day finally came, both acknowledged they had been looking forward to the evening all day long. In fact, talking and planning the date had increased their sense of anticipation as well as their readiness for change. By identifying the criteria that would help Bill and Sara revitalize their sexual relationship, the couple successfully set the wheels in motion and attained their goal.

**Action.** Following preparation, the action stage commences. According to Prochaska (1999), "action is the stage in which people have made specific, overt modifications in their life-styles within the past six months" (p. 230). Because of a tendency to equate the action stage with change in psychotherapy many traditional treatment models erroneously identify this stage as the one in which *the* treatment takes place (Miller, 1986; Prochaska et al., 1992). Research shows, however, that in spite of the field's historical bias toward action, people are *least* likely to be in this stage at the outset of treatment. This mismatch goes a long way toward explaining the persistence of concept of resistance in mental health discourse.

As an illustration of working with someone in the action stage, consider the following dialogue taken from the case of a woman referred for therapy by her gynecologist (Miller et al., 1997). The client had a longstanding history of dyspareunia accompanied by complaints of severe genital irritation and infection. In spite of years of medical testing, no physical cause had ever been identified for the client's complaints,

and the latest in a long list of physicians suspected that the problems were psychogenic.

The client began the session by relating some of the history of her problems:

Cl: I have seen so many doctors over the last, well, several years. I have *had* this problem for thirty years. It's serious because, well, you see, I've been married twice and both times this problem . . .

Th: Uh huh.

Cl: It's a little embarrassing. I've, uh, *had* this redness and infection--well, the doctors have all said that I don't, have never had have any infection--but, on my genitals. I'm always swollen and irritated . . .

Th: Uh huh.

Cl: . . . and, well, it *has* always hurt to have intercourse, you know, because . . .

Th: (*finishing the sentence*) of the redness and irritation.

Cl: (*with relief*) Yeah. The doctor says I'm psycho . . . (*pauses*).

Th: Psycho?

Cl: (*nodding affirmatively*) Psycho . . . psychosomatic.

The client continued for several minutes elaborating on her story and explaining that she had made the appointment for therapy following a recent visit to a new physician. Unable to find anything physically wrong with her, this latest doctor had said that she should consider seeing a mental health professional. The therapist simply listened while the woman related these details. Following a natural break in the process, the therapist seized an opportunity to highlight a statement the client made in the opening moments of the session that indicated she may have recently made specific, overt modifications in her behavior:

Th: You say that you have *had* this redness and irritation?

Cl: (*nodding affirmatively*) Mmm.

Th: Does that mean to say that there have been some changes for the better recently?

Cl: (*surprised*) Well, yes.

Th: What's been different?

Cl: I've tried almost everything. I tried almost every, well, the doctors have tried all the drugs—creams, steroids, antibiotics. Nothing has ever worked, at least not for very long.

Th: And lately?

Cl: Well, I have been applying a mixture of milk of magnesia and Benadryl, just a few drops topically, to the, uh, red, irritated areas.

Th: Hmm.

Cl: And it's much improved over the few weeks that I've been doing it.

Th: Is that right?

Cl: After thirty years, I'd almost given up hope of this ever, well, *changing*.

Th: Of course. And the mixture is helping?

Cl: Mmm.

Given her long history of unsuccessful treatment, it might have been easy to view this client as unmotivated or even resistant to change. Careful attention to the woman's language, however, enabled the therapist to highlight a dramatic difference in the client's perception of her sexual functioning indicative of someone in the action stage of change. When clients reach this stage it may seem as though the therapist need not even meet with the client. In contemporary parlance, the client in action is "cookin." However, spending time exploring and reinforcing change, providing measured emotional support, and helping the client monitor, modify, or fine-tune their plan of action is critical for progression to the maintenance stage of change.

Following the excerpt above, the therapist and client continued the conversation by exploring the recent change as well as how she had managed to discover the present solution. The therapist also inquired about how the client knew the “appropriate dose” to use on any given occasion, as well as how she would know when the “medicine” was no longer needed. Thereafter, the therapist inquired about other actions the client may have taken recently that had resulted in improvement:

Th: Anything else that has been different or helpful lately?

Cl: (*surprised*) Well, yes. Right now, I find myself in a situation, well, with a man that I’ve known for most of my life and he’s quite a wonderful person . . .

Th: (*pleased*) Hmm.

Cl: . . . and now we, well, have a sexual relationship.

Th: (*curious*) That is different?

Cl: For the first, last night, it didn’t hurt.

Th: Is that right?!

Cl: (*proudly*) Yeah, for the first time.

Th: How do you think that happened?

Cl: Well, for three weeks . . . well, a lot has to do with Steven. We have, well, there hasn’t been any pressure. We have gone very slowly and the pain just hasn’t been there.

Th: The pain isn’t there?

Cl: I guess it helps that I’m in love with Steven and I don’t really think that I was in love with my husbands.

Th: Sure. What else might be making a difference?

Cl: Well, I'm not as guarded. He is so careful and well, thoughtful of me. Early on, we talked and agreed that if there was any hurt then we'd stop and, oh, I think we spend a lot of time just, well, you know, touching and just, laying there, uh, being together.

The additional steps the client reports taking—including starting a new relationship, communicating with her partner about sexual needs and preferences, and taking the time to become sufficiently aroused prior to attempting intercourse—are clear indications of someone in the action stage of change. For this reason, the remaining time in the session was spent identifying and reinforcing the helpful ways the couple had discovered to communicate with each other about their sexual relationship as well as developing a plan for monitoring and fine-tune her plan of action.

**Maintenance.** In this stage, change continues and stress is placed on what needs to be done in order to maintain or consolidate gains. In contrast to those in the action stage, people in this stage, “are less tempted to relapse and increasingly more confident that they can continue their changes” (Prochaska, 1999, p. 231). This is because they have learned from difficulties and temptations they have encountered while passing through the other stages.

A recent session with a couple that successfully overcame problems with erectile dysfunction demonstrates work with people in the maintenance stage. Jim and Mary, a couple in their late fifties, had sought sex therapy after Jim began to experience frequent problems getting or sustaining an erection. When this occurred, the couple would conclude that sex “wouldn't be happening this time” and refrain from any other sexual

contact. Jim had seen an urologist but no medical problems were detected. Sex therapy was recommended.

During the initial evaluation the therapist learned that Jim and Mary had very similar, and somewhat limiting, views regarding sexuality. For both, sex equaled intercourse. Sexual foreplay consisted of kissing and a few minutes of caressing. Engaging in oral or manual stimulation to orgasm had not been part of their sexual repertoire. However, in exploring this with them, the therapist learned that both Jim and Mary were open to exploring this. Jim was particularly surprised at how receptive Mary was to the idea of oral stimulation. He had assumed she would feel self-conscious or uncomfortable. Mary responded that she had never suggested it because she had assumed he wasn't interested. The couple laughed about their mistaken assumptions. They agreed with the therapist's suggestion that for the next month they would focus on stimulating each other manually and orally and abstain from intercourse.

During the month, the couple learned ways to stimulate each other sexually so that they were not solely dependent on intercourse for sexual pleasure. With the pressure for intercourse eliminated, Jim felt considerably less anxious and responsible for the success or failure of the couple's sexual encounters. Not surprisingly, he had fewer incidents of erectile failure. Together, Jim and Mary discovered that by expanding their definition of sex (e.g. sex is more than intercourse) they were able to enjoy a much more active sex life than they had ever had in their marriage—with or without an erection.

In this stage, providers can accommodate the client's motivational level by helping them anticipate the challenges that might provoke regression or relapse. As they are identified, prevention plans are developed. For instance, if, in the past, a spouse's

work/travel schedule decreased the level of sexual frequency, and eventually, sexual interest, a prevention plan might specify that the couple have a sexual date within two days of his or her return. This way the couple takes active steps to ensure that their sexual relationship remains a vital part of their marriage.

Therapists also accommodate clients in maintenance by helping them design retention plans for the inevitable lapses that accompany any change. Should the client find himself or herself sliding down the slippery slope of relapse, the retention plan provides handholds for the client to grab onto so the slide to the bottom need not continue. For example, if a couple finds themselves slipping back into old patterns (e.g., not having sex for a period of time), then going back to setting up sexual dates may be a way to get back on track.

In the case of Jim and Mary, some time in the latter sessions of therapy was spent discussing any factors that might lead to a set back (e.g., fatigue, illness, anxiety). The couple reported knowing that there were other options for pleasuring each other in addition to intercourse and that sexual activity did not have to come to an abrupt halt as it did prior to entering therapy.

**Termination.** According to Prochaska, in the final stage of *termination*, “there is zero temptation to engage in the problem behavior, and there is a 100 percent confidence (self-efficacy) that one will not engage in the old behavior regardless of the situation” (1993, p. 253). So defined, this stage may actually be more of an ideal than a realistic or achievable state of change. More than likely, most people stay in the maintenance phase. That is, they continue to be mindful of possible threats to their desired change and monitor what they need to do to keep the change in place. For these reasons, when it

comes to ending a successful contact between clients and therapists, the best option is to wish the clients well while leaving the door open for a possible return should challenges, set backs, or a new concern develop.

### **Getting in the Mood (for a change): A Complete Case Example**

In order to gain a sense of how clients progress through the various “stages of arousal” on the way to lasting change, consider the case of Bill and Nancy. Briefly, Bill, a 35-year-old software consultant, and Nancy, a business executive, had been married for two years, but had never had intercourse. Throughout their relationship, Bill had been able to have strong erections with both oral and manual stimulation but always lost them whenever intercourse was attempted.

In the months prior to entering treatment, the couple vacillated between the precontemplative and contemplative stages of change, alternately “fighting about” and “ignoring” the problem. Then, as Nancy described during the first session, “something snapped. We’d go to bed and I’d lay there thinking, ‘We need to talk about this.’ But nothing would happen. I wouldn’t talk. He definitely wouldn’t talk. And I just got madder and madder. I started *thinking*, ‘how are we ever going to have a family if we never have sex?!’ That’s when I *decided* that we needed help.” For his part, Bill reported having been aware of Nancy’s frustration, and alternated between feelings of remorse and anger. “Neither [feeling] changed anything,” he said, “so I just stopped talking about it.” He then added, “I was, in a way, relieved when [Nancy] suggested we see someone about our problem.”

As their statements indicate, both Nancy and Bill were in the contemplative stage of change by the time they made it to treatment. They agreed something was wrong and

needed to change but were uncertain—and even at odds—over what to do about it. Bill believed that the problem was due, in large part, to Nancy “pressuring” him. He suggested, “Things would be better” if she would “just back off.” From Nancy’s standpoint, “his avoidance of the issue” was the reason she’d felt compelled to bring it up on a regular basis. According to her, “backing off was just an excuse to ignore it.”

During the first session, Bill and Nancy described and argued a bit with each other over their contrasting views of the situation. The therapist listened attentively to both and then commented that it seemed important that the couple move steadily (addressing Nancy’s concern) but slowly (Bill’s concern). Bill nodded in agreement, responding that Nancy had a right to be worried as his tendency was to withdraw and avoid situations in which he might fail. Nancy, in turn, indicated her willingness to “go slow” (e.g., “back off”) because Bill seemed willing and interested in addressing the problem. The session ended with the therapist asking the couple to spend the next week thinking about what they would ultimately like their sexual life to look like—a homework task consistent with a contemplative stage of change. In order to give the pair time to think carefully and thoroughly, a session was scheduled two weeks later.

Bill and Nancy each shared their visions of a fulfilling sex life at the next session. “I would like us to make love a couple of times a week,” Nancy said, and then continued, “it would really be stimulating to me if Bill would initiate some of the time, and for sex to become a natural part of our life, together, as a couple. You know, that we don’t have to think, ‘OK, are we going to have sex? And how, and who is going to start.’”

For his part, Bill said, “I would be happy if we had sex three or four times a month, and for there to be, you know, no more problems.” Consistent with the

contemplative stage of change, the therapist encouraged each of them to describe their views in more detail. As the session continued, however, the therapist sensed something was troubling Bill. When asked, he very hesitantly stated that he was worried about “something.”

Therapist: Is this something that we can talk about here, now?

Nancy: (looking from the therapist to Bill).

Bill: (looking from the therapist to Nancy). I think so.

T: OK.

B: As I was thinking about our sex life this past couple of weeks, something, I kept thinking about ...

T: Uh huh.

B: (continuing). Well, in my last relationship. Whenever (looking back at the therapist) Stephanie and I...we'd have sex, she'd, uh, it was...she said it always hurt. That it hurt.

Bill went on to say that, because of the pain, he and his former partner had stopped having sex altogether after only a handful of attempts. He then expressed concern that Nancy would experience the same type of pain. Nancy immediately responded that she had never experienced pain during intercourse in previous relationships, and then attempted to reassure Bill by telling him that she would let him know “immediately” if she did so he could stop. He was not easily reassured, however, stating, he “needed some time to think about this.” At the conclusion of the visit, the therapist asked Bill to practice visualizing he and Nancy having intercourse pain-free; specifically, imagining how he would know that Nancy was truly enjoying the

experience. Balancing Bill's desire to "go slow" with Nancy's interest in making "steady progress," the therapist further asked the couple to engage in non-demand pleasuring activities (McCarthy and McCarthy, 1993) that did not include attempts to have intercourse.

At the next session, the couple returned, each reporting having followed through with the two homework tasks. For Nancy, the sexual contact involved in the non-demand pleasuring activities, had made her feel more optimistic. For Bill, the sexual contact and the obvious pleasure Nancy derived from it was very reinforcing and made him feel increasingly more confident as a lover. He'd also been watching her facial expression and physical response and trying to incorporate these into his visualizations of pain-free intercourse. As such, the couple appeared to be moving into the preparation stage of change; that is, identifying the criteria and strategies for success as well as experimenting with the desired change. In spite of this progress, however, Bill continued to feel hesitant about possibly hurting Nancy during intercourse. He reported that the Nancy's obvious pleasure from the non-intercourse sexual activities combined with his visualization of pain free sex had convinced him that his fear was "irrational," nonetheless he "couldn't shake it."

The treatment remained at this stage for several sessions. While Nancy tried to remain optimistic, Bill sensed that she was growing frustrated. He became increasingly fearful that she would not remain patient much longer. The pressure to resolve the problem only intensified when the couple learned that Nancy's younger sister was expecting. At one point, Nancy even suggested they speak to the doctor about artificial insemination since it didn't seem like they would be able to, "make a baby the normal

way.” In response, Bob became quite angry and refused to speak for the remainder of that session.

In the sessions following the angry exchange, the couple gradually stopped doing the exercises together and Bill stopped visualizing. Two appointments were then cancelled. In a message to the therapist, Bill said that he and Nancy each needed time to “think things over”—in short, the couple had slipped from a preparation to a contemplative and then precontemplative stage of arousal for change. The therapist, in turn, left a message for the couple, normalizing the challenging, back-and-forth nature of the change process as well indicating a willingness to continue.

An appointment was scheduled shortly thereafter and the couple returned with the news that they had made some progress. Nancy reported having thought “long and hard” about how to help Bill overcome his fear about hurting her. That’s when she came up with the idea of inserting a vibrator (similar in size to Bill’s penis) to show him that it would fit and not hurt her. When she discussed her idea with Bill, he agreed and they went searching for a vibrator together! After finding one, they practiced, first with her inserting it and then Bill. The couple was once again in the preparation stage of change.

As the couple recounted their progress, Bill indicated that he believed he was ready to attempt intercourse. Consistent with the preparation stage, the therapist assumed a more active role; specifically, instructing the couple on how next to proceed, raising possibilities, and presenting options and strategies. In the next session Bill and Nancy had good news to share: they’d had intercourse twice during the week.

In the two sessions that followed, the couple reported having intercourse two to three times during the week without difficulty. The majority of the time during these

visits was spent reviewing and reinforcing the strategies the clients were using that had led to success. A follow-up call three months later found the couple “doing well and trying hard to get pregnant.”

### **Summary and Conclusion**

“To every thing there is a season, and a time to every purpose under the heaven.”

Ecclesiastes 3:1

The Bible

Recent studies indicate that people progress through a series of “stages of arousal” while “getting in the mood” to change. The important issue in treatment, from the perspective of such research, is neither the amount of time involved (brief versus long term) nor the technique employed (psychodynamic or solution-focused) but rather the timing. Clinical interventions that are congruent with the stage a particular person is in facilitate engagement, thereby maximizing both the effectiveness and efficiency of the treatment process. Though the stages of change have been successfully applied to a variety of clinical issues, this chapter represents the first attempt to make use of the concepts in the treatment of sexual problems. Knowledge of the stages can serve to imbue therapists who are working with clients with sexual difficulties with all the qualities of a good lover, chief among them being a sensitivity to the other’s needs, desires, and level of arousal.

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