Applying a Common Factors Perspective to Sex Therapy

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Since the ground-breaking research on human sexual response by Masters and Johnson almost forty years ago, how much more do we know about the effective treatment of sexual complaints? Few outcome studies focus on the treatment process variables in sex therapy, and this, in tandem with the over medicalisation of the field, has led sex therapy down the path of drugs, devices and surgery. A consideration of the history of sex therapy alongside the history of psychotherapy in general reveals no difference in efficacy among the various treatments. In this article DONAHEY and MILLER argue for the application of a common factors approach to all forms of therapeutic work with clients who present with sexual difficulties. Case studies are used to illustrate the application of the four factors that provide the most significant contribution to change: extratherapeutic; relationship; placebo, hope and/ or expectancy; and, structure, model and or technique. In applying a common factors approach Donahey and Miller argue further that successful sex therapy is more about people who are experiencing sexual difficulties than about the application of an approach or technique.

Almost forty years have passed since Masters & Johnson (1966) first proposed their model of human sexual response. Soon after, their landmark Human Sexual Inadequacy (1970), proposed a treatment approach for male and female sexual disorders.

In this new millennium, however, serious questions remain about both the understanding and efficacy of the treatment of sexual complaints. For all the growing complexity in the conceptualization of sexuality and sexual disorders, and in spite of the proliferation of models and techniques, there is, '*a paucity of controlled outcome research or studies of treatment process variables in sex therapy*' (Rosen & Leiblum, 1995, p. 877). Those studies that do exist typically find only moderate levels of success. More troubling, over the last several years, there has actually been a dramatic decrease in the number of outcome studies and a growing medicalization of the field (Ackerman & Carey, 1995; Hawton, 1992). For example, Schover & Leiblum (1994) pointed out that in the years between 1982 and 1992, the number of articles presenting outcome data in the *Journal of Sex and Marital Therapy* steadily declined to zero. At the same time, the field of sex therapy has witnessed a dramatic increase in studies adopting a clinical trials approach based on largely medically oriented procedures such as drugs, mechanical devices and surgeries (Leiblum & Rosen, 1989). An issue of the *Journal of Sex and Marital Therapy*, devoted to medical treatments, was heralded as a '*turning point in the treatment of sexual dysfunction*' (Plaut, 1998, p.183).

Been there, done that

As unique as these observations may seem to the field of sex therapy, they have a familiar quality. Upon reflection, the history of sex therapy seems similar to the field of psychotherapy in general. Following the emergence of various psychological theories and schools, came the rapid proliferation of methods and techniques designed to treat the various psychological disorders. A generation of researchers began putting the various approaches to the test, pitting the warring factions against one another in a grand '*battle of the brands*' (Miller, Duncan & Hubble, 1999). As it turned out, the hope that one (or more) therapeutic approach would prove superior to others received virtually no support (Hubble, Duncan & Miller, 1999a; Norcross & Newman, 1992). Aside from the occasional significant finding for a particular therapy, the critical mass of data revealed no differences in efficacy among the various treatments– from psychodynamic and client-centered approaches, from alcohol and drug to marriage and family therapies (Hubble, Duncan, & Miller, 1999a; Lambert & Bergin, 1994; Project MATCH, 1997; Sprenkle, Blow & Dickey, 1999). As Lambert & Bergin (1994) observed in a review of the literature, '*Research carried out with the intent of contrasting two or more bonafide treatments shows surprisingly small differences between the outcome for patients who undergo a treatment that is fully intended to be therapeutic*' (p. 158). In the field

of sex therapy the same ideological battle has been carried out between the proponents of the psychogenic and organic perspectives, particularly with respect to erectile dysfunction (ED), with largely similar results. Mental health clinicians treated the psychogenic cases and urologists treated organic cases. Subsequent knowledge and clinical practice have shown the dichotomy to be outdated and erroneous, and the classification largely useful in determining whether the client will be treated by a mental health professional or urologist (Althof, 1998).

While studies on psychotherapy in general have provided little evidence of differential effectiveness, significant research findings have shown treatment to be superior to both placebo and no-treatment control groups. Among other findings, literally hundreds of studies conducted over the last thirty years found the average treated person better off than 80% of those in a control group who received no treatment (Lambert & Bergin, 1994; Smith, Glass & Miller, 1980). In spite of the various shortcomings and research problems, Schover & Leiblum (1994) make similar observations about the field of sex therapy, and note that in spite of a dearth of quality research, '*it remains one of the more effective psychotherapies, when practiced appropriately*' (p.24).

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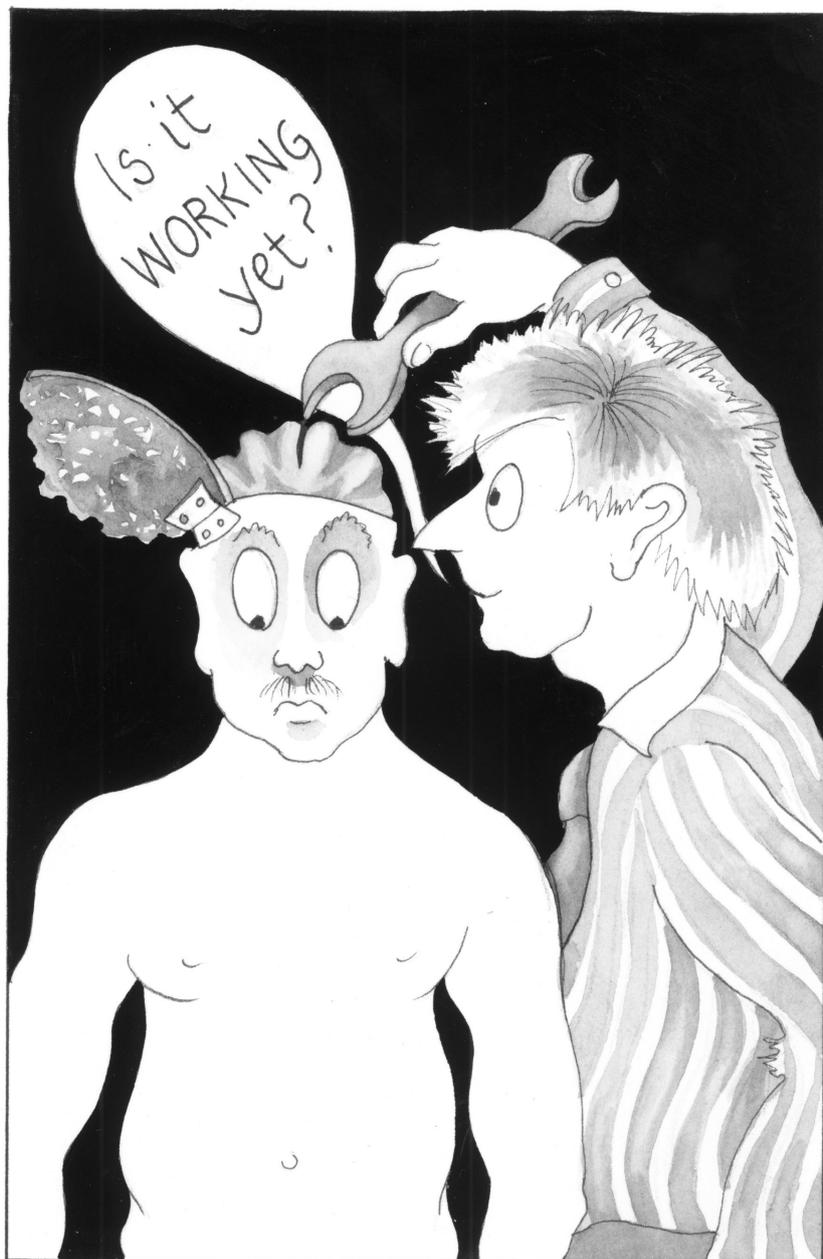
As early as 1936, Saul Rosenzweig suggested that the overall effectiveness of competing psychotherapy approaches had more to do with commonalities than the divergent theoretical or technical factors on which they were based. Frank & Frank (1991) developed this insight further by applying the thesis across various forms of healing (groups, medicine, religious, etc.). However, the work stood virtually alone until the 1980s, when an outpouring of writing began to appear on what came to be known as the common factors – features shared by all effective therapies (Strupp, Hadley, & Gomez-Schwart, 1979; Weinberger, 1995). Lambert (1992) reviewed the empirical literature and proposed four factors as the principal elements accounting for improvement in those undergoing psychotherapy:

- extratherapeutic
- relationship
- expectancy or placebo, and
- model and techniques.

Miller, Duncan & Hubble (1997; Duncan, Hubble & Miller, 1997; Hubble, Duncan & Miller, 1999b) have written extensively since on these factors as the best bridge between the various schools of therapy.

From sex therapy to therapy with people who present with sexual concerns

A common factors perspective would suggest that successful sex therapy is more about people who are experiencing sexual difficulties than about the application of a unique therapeutic modality or treatment technique, such as the squeeze technique or sensate focus. While we would venture to say that most clinicians who practice sex

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therapy are aware of this (Shover & Leiblum, 1994; Levine, 1997), the primary focus of research still seems to be on discovering what technique or treatment is more effective for any one particular sexual disorder. We suggest a focus on how to heighten the contribution of the common factors in our clinical work with clients presenting with sexual problems, rather than a focus on developing new therapies. As noted earlier, researchers point to the existence of four factors common to all forms of therapy despite theoretical orientation, mode, frequency and number of sessions, or specialty (problem type, professional discipline, etc.). In the order of their relative contribution to change, these elements include:

- extratherapeutic (40%),
- relationship (30%),
- placebo, hope &/or expectancy (15%),
- structure, model &/or technique (15%)

(Lambert, 1992; Miller, Duncan & Hubble, 1997; Hubble, Duncan & Miller, 1999c). Applications of these elements in work with clients who present with sexual problems is discussed below.

1. Extratherapeutic Factors: the role of the client and chance change-producing events

Extratherapeutic factors are the single largest contributors to change and refer to any aspects of the client and their environment that facilitate recovery regardless of formal participation in therapy. Research on the extratherapeutic factors makes clear that clients play a significant role. By being mindful of the significant role that client strengths, capabilities, resources, social supports and the fortuitous events that weave in and out of client's lives play in everyday practice, sex therapists can enhance their contribution to treatment outcome. Four useful suggestions are as follows:

Become change-focused

A therapist can listen for and validate change for the better, whenever and for whatever reason it occurs (Miller, Duncan & Hubble, 1997). Consider the studies that show 15-66% of clients experience positive, treatment related gains *prior* to the formal initiation of treatment (Howard, Kopta, Krause & Orlinsky, 1986; Lawson, 1994). Such pre-

treatment change cannot be attributed to either the therapy or therapist. Whatever the cause, the high percentage reported indicates that clinicians can empower the contribution of extratherapeutic factors by listening for, inviting and using the description of such change as a guide to therapeutic activity. For example, it is not unusual for couples if they haven't been sexual for a period of time to announce that prior to the first session they had sex, or that they have had fewer arguments since making the call for treatment.

Therapists can also be change-focused in their work by heeding and amplifying any references the client makes to between-session improvement such as experiences of feeling sexual desire, or report of a spontaneous sexual encounter with his/her partner. In the opening moments of a session, therapists can ask clients directly about what, if any, changes have occurred since their last visit with the simple questions '*What is different?*' or '*What is better?*' A sizeable body of research literature shows that improvement between treatment sessions is the rule rather than the exception, with the majority of clients experiencing significant symptomatic relief earlier rather than later in the treatment process (Howard et al., 1986).

Potentiating change for the future

Regardless of whether change begins before or during treatment, whether it results from the client's own actions or by happenstance, it is crucial that the effect of extratherapeutic factors is enhanced. Clients need to be supported to see that any changes, and the maintenance of these, are a consequence of their own efforts (Miller et al., 1997). If clients come to view the change as resulting, at least in part, from something they did, they feel confident they can repeat this in the future. Therapists support these changes by exploring the role of the client in changes that occur during treatment and asking questions or making direct statements that presuppose client involvement in the resulting change (Berg & Miller, 1992). Even if clients attribute change to luck, fate, the acumen of the therapist, or a medication, they can still be asked to consider in detail how they adopted the change in their lives, what they did to use the changes to their benefit and what they will do in

the future to ensure their gains remain in place.

Case example

John, a 56-year-old male who had been widowed for six years, sought help for intermittent difficulties in sustaining an erection. The problem was most noticeable in the early stages of a relationship. Several weeks into the therapy, John remarked that he had decided to postpone having sexual relations with a woman until he knew her better. When the therapist asked what had influenced this decision, he stated that he realized he 'rushed' into relationships before he felt emotionally comfortable. He believed that he would experience fewer sexual difficulties if he simply waited until he felt a strong emotional connection with his partner. His perception proved to be true. A few months later he became involved with a woman who later became his wife.

Minding the client's competence

As suggested, therapists can begin to cast their clients in the role as the primary agents of change by listening for and being curious about their competencies (i.e., their part in bringing about and maintaining positive change). This approach requires a balance between empathic listening to their difficulties, and mindfulness to their strengths and resources.

Tapping the client's world outside therapy

Clinicians also mind clients' contribution to change by incorporating resources that the client can draw upon from their world outside therapy. Whether seeking out a trusted friend or family member, purchasing a book or tape, attending church or a self-help group, research indicates that the majority of clients both seek out and find support outside the formal therapy relationship (Garfield, 1994). This natural tendency can be facilitated by the therapist's simply listening for and being curious about what happens in the client's life that is helpful. Several questions are useful to keep in mind:

- what persons, places, or things have the client sought out in the past that were useful?
- what was different about those

times that enabled the client to use those resources?

• what is the client doing now (in addition to therapy) that they consider helpful to understanding or solving the problem?

Case example

A 30 year old female client, who had experienced several childhood incidents of sexual molestation by an uncle, reported difficulty being sexual with her husband. While she reported no problems with her sexual functioning (arousal and often orgasm), she struggled with feelings of guilt when engaged in sexual activity with her husband. Her desire was to feel comfortable and less inhibited with her husband as well as to stop feeling guilty about being sexual. Several weeks into the therapy, the therapist learned that the client and her husband set aside an hour each morning to study the Bible and pray. The therapist inquired if the sexual problem was something the client had talked to God about in her prayers. Somewhat surprised, the client said 'No', but expressed interest in this idea. Three weeks later the client reported a positive sexual experience with her husband. She felt that she was 'choosing to be sexual rather than feeling obligated to do so'. In their prayers each morning, the couple asked God to give the woman the comfort and reassurance she needed in order to be sexual. They also read passages from the Book of Solomon in the Bible. The client explained that she felt that she had God's blessing to relate sexually to her husband. The therapist continued to utilize the client's religious faith as a resource throughout the treatment process.

2. Relationship factors: the client and therapist together

Attributions of success to something as vague and intangible as 'the therapeutic relationship' sounds misplaced and simpleminded within the contemporary context with its emphasis on models and techniques. For the last three decades, professional discourse has basically regarded the therapeutic relationship as a non-specific factor – a means to an end, so to speak (Strupp, Hadley & Gomez-Schwartz, 1979). Clinical expressions such as 'establishing

rapport' and 'fostering an alliance' convey a view of the relationship as a precursor to the real or active ingredients of treatment – namely techniques (confronting dysfunctional thinking, making transference interpretations, teaching sensate focus activities, etc (Bachelor & Horvath, 1999). However, the research is clear; as much as 30% of the variance in psychotherapy outcome is attributable to relationship factors (Lambert, 1992) and the same is true for marital therapy (Estrada & Holmes, 1999).

Research on the power of the therapeutic alliance now reflects more than 1,000 findings (Orlinsky, Grawe & Parks, 1994) and provides concrete

understood as a trait or stable personality characteristic that tags along passively with clients. Instead, it is a dynamic interactive process that is influenced strongly by the therapist.

This view of motivation is reflected in the work of Prochaska and others on what has come to be known as the *transtheoretical* or *stages of change* model (Prochaska, 1999). The underlying premise of this approach is that clients are more likely to engage in change projects when therapists, '*assess the stage of a client's readiness for change and tailor their interventions accordingly*' (Prochaska, DiClemente & Norcross, 1992, p. 1110). Six stages have been identified.

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guidelines to enhance the contribution of relationship factors to treatment outcome. These guidelines include:

• accommodating treatment to the motivational level or readiness of the client for change, and

• accommodating the client's view of the therapeutic alliance.

Accommodating the client's motivational readiness or stage of change

Recent reviews of the research show that accommodating the client's readiness for change facilitates the formation of a strong therapeutic relationship (Bachelor & Horvath, 1999; Prochaska, 1999). For decades, the motivation of clients has been dichotomized: either they were motivated or they were not. Yet it may have been more correct to say that 'unmotivated' clients did not match the therapist's goals and expectations for treatment (Duncan et al., 1997). Further, motivation for change is no longer

In the first stage, *precontemplation*, clients typically have not made a connection between a problem in their lives, and their own contribution to its formation or continuation. As a result, they are not available to participate in or establish an alliance with a helping professional (Prochaska, 1995). Helping clients in precontemplation requires a light touch on the part of the therapist (Miller et al., 1997). The goal is not to make the client do something; rather, the therapist's job is to create a climate in which the client can consider, explore, and appreciate the benefits of changing. An example of this would be the client, referred by his urologist or primary physician, who has difficulty seeing the connection between distress in his relationship and his erectile problem.

The second stage of change is *contemplation*. Clients in contemplation are known for their use of two words: 'yes, but'. Frequently, these clients recognize that a change is needed. They may also have a sense of a goal and even

know what they need to do to reach it. Even so, they are unsure whether the change is worth the cost in time, effort, and energy. In addition, they are frequently unsure or ambivalent about the losses attendant to any change they might make (Miller et al., 1997). This is often seen in cases of low sexual desire. Accommodating clients in this phase requires 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.

The third stage is *preparation*. In this stage, the client is actively considering the criteria and strategies for success. For the first time, 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. This phase is also characterized by the client's experimenting with the desired change – trying it on for size, noticing how it feels, and then experiencing the effects. Therapists accommodate such clients when they encourage rather than downplay the significance of such early problem-solving efforts.

Following preparation, the action stage commences. Clients in this phase present with both a firm commitment and plan for the future. In essence, therapists can stand by, offer measured emotional support, and help the client monitor, modify, or fine-tune their plan of action. Curiously, and unfortunately, a strong argument can be made that most traditional therapeutic approaches are based on clients being in the action stage. Anything short of this – and the majority of those seeking treatment are not likely to be in this stage – and clients are labeled, 'resistant' and/or 'in denial'.

Next clients move into the maintenance stage. As the name implies, the challenge of this particular phase is consolidating the changes that have been made and learning what needs to happen in order to maintain gains. Therapists accommodate the client's motivational level by helping them anticipate the challenges that might provoke regression or relapse and develop prevention plans (e.g., keeping date nights, scheduling time for sex).

Finally, clients move into the termination stage. Now, 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'* (Prochaska, 1993, p. 253). So defined, termination may be more of an ideal than an achievable stage. For many, maintenance is where they will stay. 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.

Treatment should accommodate the client's view of the alliance.

Closely related to accommodating the clients' readiness for change is tailoring treatment to fit with their view of the therapeutic alliance or relationship. This means making the client's goals the focus of treatment without reformulation along doctrinal or diagnostic lines.

Consider, for example, research from several fields which indicates that goals specified in small, concrete, specific, and behavioral terms and which clients perceive as both desirable and attainable, are more likely to influence their behavior in the desired direction (Bandura & Schunk, 1981; Miller, 1987). Indeed, in one study, Beyebach, Morejon, Palenzuela & Roriguez-Arias (1996) found that the presence of treatment goals with such qualities increased the likelihood of a successful therapeutic outcome by a factor of two.

Therapists can help their clients describe their goals in terms that match these considerations by asking, 'How did you hope that I might be of help? What is your goal for treatment? What did you hope/wish/think would be different as a result of coming for treatment? What would have to be minimally different in your life to consider our work together a success? How will you know when the problem has been solved? What will be happening?'

However, orienting treatment toward to the client's goals is only one part of a positive therapeutic alliance. Equally important is attending to the client's perceptions of the therapist and the relationship being offered. Estrada & Holmes (1999) found that couples in therapy expected their therapists to be active, directive, and focused while simultaneously providing an empathic and safe environment. However, in their comprehensive review of the research on this topic, Bachelor & Horvath (1999) report that clients have been found to vary widely in their experience of the core conditions that distinguish good therapeutic relationships. They suggest, too, that successful therapeutic relationships are those in which the definition of the therapist-provided variables are extended to fit with the client's own unique experience of those variables. In practice, therefore, clinicians stand the greatest chance of enabling the contribution of relationship factors to outcome when they purposefully tailor their provision of the core conditions to the client's definition. Some clients prefer a formal or professional manner to a casual or warmer one. Others prefer more self-disclosure from their therapist, greater directiveness, a focus on their symptoms or a focus on the possible meanings beneath them, and a faster (or more laid-back) pace for therapeutic work (Bachelor & Horvath, 1999).

A review of the findings on extratherapeutic and relationship factors leads to the conclusion that therapeutic success depends on enabling and confirming the client's resources, within the context of a partnership that is informed by the client's goals and perceptions.

Case Example

Consider the case of Robyn, a 42-year-old artist who presented for treatment for loss of sexual desire following problems with dysparuenia. While the cause of the dyspareunia had been identified and resolved, Robyn continued to avoid sexual intercourse and participated only minimally in other forms of sexual intimacy. She reported that she and her husband had not had intercourse for the last two years of their four-year marriage. At intake, she expressed a desire to be able to have 'a healthy spontaneous sexual relationship and enjoy sexual intercourse again'. While her husband was very supportive, she also worried about the

potential impact of the problem on their relationship. Clear about her goals and recognizing that the benefits of change outweighed the costs, Robyn was in the preparation stage of change. (Recall that clients in this stage are actively considering the criteria and strategies for success.) The question, of course, was which strategy would be most successful.

Near the end of the interview, the therapist asked Robyn to consider the criteria for assessing the qualities of a helpful intervention. In the ensuing discussion, it became clear that any approach had to 'make sex fun' as sex had, over time, become 'work' to Robyn. At the conclusion of the visit, the therapist agreed with Robyn's idea and scheduled another appointment. When Robyn returned two weeks later, she reported having experimented with the changes she desired. Specifically, she had taken a sex board game she had purchased a year earlier, but never played, out of the closet and invited her husband to play. Much to her delight, she found herself getting into the spirit of the game, feeling sexually aroused, and having fun. Consistent with treatment strategies appropriate for this stage, the therapist supported, even applauded, her idea and efforts to make sex more fun. The result was an immediate increase in Robyn's hope and expectation for a successful resolution to the concerns that brought her into treatment (Donahey & Miller, 2001).

3. Placebo Factors: the role of hope and expectancy

In early 1998, sildenafil citrate (Viagra) was approved for the treatment of ED. Studies reported success rates of 75% to 80% in men taking the drug – even in populations with established organic pathology (e.g., spinal cord injury) (Clinician Reviews Supplement, 1998). Generally lost in the media frenzy accompanying the event, however, was the finding that between 10% and 30% or more (mean = 24%) of those studied experienced significant improvement in their ability to achieve and maintain an erection while taking a placebo (Clinician Reviews Supplement, 1998)! The figure is impressive even when concerns about flaws in the studies known to inflate effect sizes (e.g., use of an inactive placebo, highly select

sample) are not factored into the results (c.f., Greenberg, 1999). While this does not mean that the drug should be withheld, it reconfirms the strong role that hope and expectation play in treatment (Garfield, 1994). Moreover, it suggests that the actual or 'real' effects of any given treatment can be augmented by attending to factors that influence placebo effects (Rodger, 1982).

The suggestions which follow should not be considered comprehensive or exhaustive. Neither do they possess any special curative powers on their own. Instead, their entire value resides in the extent to which they facilitate hope and a positive expectation for change.

Having a healing ritual

Rituals are a shared characteristic of healing procedures in most cultures and date back to the earliest origins of human society (Frank & Frank, 1991; Van Gennep, 1960). Whether giving clients Viagra, or teaching the squeeze or stop-start techniques, therapists are basically engaging in healing rituals. Their use inspires hope and a positive expectation for change by conveying that the user - shaman, astrologer, or therapist - possesses a special set of skills for healing. That the procedures are not in and of themselves the causal agents of change matters little (Kottler, 1991). What does matter is that the participants have a structured, concrete method for mobilizing the placebo factors.

With myriad techniques from which to choose, the perennial question facing therapists is what particular ritual to use when working with an individual client. In this regard, therapists enhance the placebo component of the procedures they employ when they believe in and are confident that the procedures will be therapeutic. Benson & Epstein noted that treatment professionals *'who have faith in the efficacy of their treatments . . . are the most successful in producing positive placebo effects'* (O'Regan, 1985, p. 17). As Sir William Osler once observed, *'One should treat as many patients as possible with a new drug while it still has the power to heal'* (Greenberg, 1999).

The placebo effects of a given procedure are heightened when therapists show interest in the results of whatever technique or orientation they employ. It has long been known,

for example, that people participating in research studies are more likely to respond in the predicted direction when they know the purpose of the experiment (Matheson, Bruce & Beauchamp, 1987). Clinicians can put the same phenomenon to work by engaging in activities that convey a positive expectation of and hope for client change in the desired direction. Asay & Lambert (1999) suggest that therapists make it a practice to ask about the beneficial effects of the therapy at some point during each session. A more proactive approach is to ask clients to notice and record any changes for the better that occur between sessions (Kral and Kowalski, 1989). Such a homework assignment conveys the therapist's hope for and expectation of improvement, which may in turn create an observational bias on the part of the client favoring therapeutic change.

Finally, procedures or techniques are more likely to elicit a placebo response when they are based on, connected with, or elicit a previously successful experience of the client. As just one example of this, consider research in which people who suffer from rheumatoid and osteoarthritis were given placebo pain medication. Like many others conducting studies in this area, the researchers found that the people receiving placebos experienced significant relief from the pain often associated with these two debilitating conditions (O'Regan, 1985). More interesting, however, was their finding that people who had previously been treated successfully for pain with an active analgesic agent experienced more relief when given a placebo than those people who had not been treated successfully for their pain prior to receiving the placebo.

Anecdotal reports about Viagra shared on the member list serve SSTARGAZE for Society for Sex, Therapy and Research (SSTAR) have noted that some men report *'spontaneous arousal in anticipation of the Viagra taking effect. They even report being spontaneously 'turned on' the next day due to the erotic memory of the previous sexual episode'* (J. Slowinski, personal communication, October 16, 1998). A few years later, in a multicenter clinical trial of 577 premenopausal and perimenopausal women diagnosed with female sexual

arousal, Viagra was found not to improve sexual response, however, at every dose studied (10, 50, and 100 mg), placebo was better than Viagra (Basson, 2000).

Have a possibility-focus

Clients are best served by helping them believe in possibilities – of change, of accomplishing or getting what they want, of starting over, of succeeding or controlling their life. It should be noted that having a possibility focus is not the same as adopting a Pollyanna-type, 'every cloud has a silver lining' attitude toward client difficulties. Rather, hopefulness results from acknowledging both the client's difficulties and limitations and the possibilities for a better future.

There are a variety of ways for therapists to be more possibility-focused in their clinical work. For example, treatment can be oriented toward the future. Assisting clients in describing the future they want tends to make that future more salient to the present (Kessler & Miller, 1995). Therapists can also work to enhance or highlight the client's felt sense of personal control. Research suggests that people who believe they can influence or modify the course of life events cope better and adjust more successfully when meeting adversity. Research has also established a link between a successful treatment outcome and clients' general belief in their ability to influence the course of life events (e.g., Beyebach et al., 1996).

Case Example

As an example of putting the placebo factors to work in sex therapy, consider the case of Bill, a 34-year-old software executive who sought treatment for erection difficulties (Donahey & Miller, 2001). Though married nearly a year, Bill had been unable to have intercourse with his wife. While able to achieve and maintain an erection through oral or manual stimulation, he would become flaccid when attempting penetration. In spite of repeated reassurance from his wife, Bill reported finding it 'hard to imagine' that penetration would not hurt her. When several months of education, homework assignments, and cognitive-behaviorally-oriented treatment resulted in no improvement, the therapist recommended an alternate

approach – specifically, the use of a future orientation.

Therapist: *It seems like you're already anticipating that you're going to fail before you do it. For example, when Michael Jordan goes up for a lay up, it would be disastrous if he were thinking that the ball wasn't going to go in. Instead, he is thinking, 'the ball is going to go in..' What we need to do is to begin to have you imagine yourself successfully having intercourse – to start thinking of yourself as a success rather than a failure at this. So, for the next couple of weeks, I want you two to refrain from trying to have intercourse. Then, I want you Bill to spend 5 to 10 minutes each morning and evening imagining that you are successfully penetrating and having intercourse with your wife. As you imagine this, I want you notice the smile on her face, and how happy she is.*

Bill agreed and for the next 2 weeks he dutifully completed the assignment each

morning and evening. When he returned the next session, he reported having had an idea he thought would enhance the exercise as well as move the process to the next stage: buying a dildo similar in size to his own penis that could be inserted in his wife by her to test for pain prior to attempting intercourse. After a few weeks of watching her and practicing inserting the dildo inside his wife himself, Bill successfully managed to have intercourse. The couple terminated treatment soon thereafter.

4. Models/Techniques: structure and novelty

Though the research conducted over the last 40 years suggests a much more modest appraisal of the differential effects of theory-driven models and methods, they still have value. Specifically, models and techniques help provide therapists with replicable and structured ways for developing and practicing the values, attitudes, and behaviors consistent with the core

ingredients of effective therapy. In other words, the principle contribution of models and techniques comes about by enhancing the potency of the other common factors – extratherapeutic, relationship, placebo, hope and expectancy. Possibilities for how that occurs are now discussed.

Structure and focus

Not surprisingly, the research literature indicates that focus and structure are essential elements of effective psychotherapy. In fact, one of the best predictors of negative outcome in psychotherapy is a lack of focus and structure. Failure to provide these crucial elements can have a greater impact on treatment outcome than the personal qualities of either the therapist or client (Mohl, 1995). Here again, given the large number of choices available, the challenging question is which structure or focus the therapist should adopt

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when working with a particular client. In this regard, the data indicate that the particular orientation or technique is less important than the degree to which it helps the therapist develop and practice attitudes and behaviors consistent with the common curative factors extratherapeutic, relationship, and placebo, hope and expectancy).

Therapists can evaluate the degree to which a particular treatment approach will empower the common therapeutic factors by considering these questions:

• does the theory or intervention fit with, or can it be tailored to complement, the client's expectations and goals for treatment?

• does the particular strategy capitalize on client strengths, resources, and existing social network?

• does the method identify or build on spontaneous changes that clients experience while in therapy and if so, how?

• would the client describe the therapeutic interaction resulting from

the adoption of the particular strategy or orientation as empathic, respectful, and genuine?

• how does the orientation or intervention increase the client's sense of hope, expectancy, or personal control? Can it be modified to do so?

Models and techniques as novelty

Another way models and techniques can be useful is through giving clinicians different options for case conceptualization and intervention, especially when little progress is occurring. Historically, treatment failures have been attributed to the client or the therapist. Clients were labeled either resistant to change or inappropriate for psychotherapy, therapists were considered inadequately trained or countertransferentially impaired. Once the fault was found, the integrity of the model or technique could be maintained.

Nowadays, with over 400 therapy models and techniques to choose from, little reason exists for continued allegiance to a particular theoretical orientation when that way of thinking about or conducting treatment falters or fails. Instead, another model or technique can be considered. In this light, the different schools of therapy may be most helpful when they provide therapists with novel ways of looking at old situations, when they empower therapists to change rather than make up their minds about clients. This is not to say that therapists should switch orientations willy-nilly every time progress is not immediate. On the other hand, theoretical or technical orthodoxy should be considered secondary to whether progress is being made.

One way for therapists to determine whether a change of mind is called for is to be, as presented earlier, more change focused in their clinical work; that is, to be mindful of – to listen for or inquire about – any changes that the client experiences before, during, or between treatment sessions. As far as timing is concerned, therapists should consider doing something different when they fail to hear or elicit reports of progress from clients within a few weeks rather than months of therapy. Whether switching from passive to active, intrapsychic to interpersonal, individual to interactional,

psychological to medical, clinicians can use the common factors as a guide in choosing alternative approaches. In this regard, orientations that help the therapist adopt a different way to identify or approach the client's goals, establish a better match with the client's stage of change, foster hope, capitalize on chance events and clients' strengths, and utilize or become aware of environmental supports are likely to prove the most beneficial in promoting progress.

Summary

The development of the field of sex therapy has mirrored that of psychotherapy in general. Specifically, a rapid proliferation of models and techniques claiming high success followed by research documenting modest results with little evidence of differential effectiveness and a growing medicalization of the field. While prompting concerns by some that the field of sex therapy is '*withering on the vine*' (Hawton, 1992), an alternate view is that factors common to all therapeutic approaches are more important to treatment outcome than strategies or techniques specific to sex therapy. Four common factors derived from 40 years of psychotherapy outcome research are presented and suggestions given for their application to people who present with sexual concerns.

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