THE TRADITIONAL MASTERS AND JOHNSON BEHAVIORAL APPROACH TO SEX THERAPY

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Introduction

William Masters and Virginia Johnson's (1966, 1970) contributions to the field of sexology and the birth of short-term sex therapy are based on the first laboratory research into the physiology of human sexual response (Althof, 2010; Atwood & Klucinec, 2007). Although they were not opposed to the use of additional data sources, they emphasized what became their heralded theoretical foundation, namely, that *sex is a natural physiologic function*, because their contention was that the physiology must be understood and appreciated before attention can be paid to additional layers of social, psychological, relational and other influences on human sexuality.

After laboratory identification of the physiological patterns of sexual arousal and interviews with laboratory subjects suggested the critical factors associated with sexual functionality, Masters and Johnson applied this knowledge to the treatment of sexual dysfunction. Their approach was based "on a combination of 15 years of laboratory experimentation and 11 years of clinical trial and error" (Masters & Johnson, 1970, p. 1). It was qualitatively different from what had been the customary psychoanalytic process of treating sexual concerns through processing deeply rooted conflicts interfering with healthy sexual expression. Masters and Johnson concluded that effective treatment of non-medical sexual dysfunctions might be accomplished using a short-term, intensive psycho-educational approach coupled with behavioral assignments. This was publicized as "a second astonishing triumph…emerging from the Masters and Johnson clinic—a new psychosexual treatment to rival Freud, with far better results.… *Time* placed Masters and Johnson into a gallery of other sexual pioneers, including Sigmund Freud, Alfred Kinsey, and Havelock Ellis" (Maier, 2009,

pp. 184, 212). Their approach not only greatly reduced the length of time required in therapy, but also altered the theoretical approach to these concerns, honoring the psychophysiological underpinnings of sexual responsiveness rather than psychodynamic processes.

Purpose

Despite their innovations, difficulties arose almost immediately upon the publication of *Human Sexual Inadequacy* (1970), especially with regard to the understanding of the initial aspects of Masters and Johnson's concepts and procedures.

> *Human Sexual Inadequacy* lacks a formal presentation of the model and offers no comparisons with other approaches. Much of the presentation is limited to the assignments, but even the rationale for the assignments is given only the most limited coverage and the way the results are actually used in the therapy is entirely left to the reader's imagination. (Apfelbaum, 1984, p. 6)

Interpretive and practical application difficulties were due to a number of factors, most notably the lack of publications clarifying their thinking and the evolution of their model over 25 years of experience. This is particularly the case with the initial therapeutic suggestions, perhaps not surprisingly because, "The actual clinical and conceptual processes of the leaders in the sex therapy field have been available only to the small group of clinicians[1] who interact directly with them on an ongoing basis" (Schnarch, 1991, p. 145). The purpose of this chapter is to disseminate accurate and detailed information about Masters and Johnson's sex therapy concepts and procedures to a much wider audience. Additionally, the intent is to delineate the specific suggestions and phases involved in their approach to sex therapy so that much less is left to speculation.

Masters and Johnson's Conceptualization of Sexual Problems

It is important to remember the U.S. culture of sexual propriety during the mid-1950's and early 1960's when Masters and Johnson undertook their endeavors. They made it

a point to assume a scientific stance in their writings, and a clinical stance during therapy sessions (e.g., wearing of white laboratory coats), in order to finesse any misinterpretation that their research and treatment were of a prurient nature.

The theory underlying Masters and Johnson's perspective has been alluded to previously (Weiner & Avery-Clark, 2014) and rests on the deceptively simple but elegant idea that "Sexual functioning is a natural physiological process…[like] respiratory, bladder, or bowel function" (Masters & Johnson, 1970, p. 9). All natural functions have three characteristics in common: they are processes (1) *with which one is born*; (2) that *cannot be taught*; and (3) that *are not under immediate voluntary control*. However, all natural functions can be influenced by any negative emotional state (such as anxiety), and by distractions (such as spectatoring oneself). While in Western culture we expect that apprehensions and ruminations might keep us from falling asleep, we have difficulty accepting that these similar preoccupations can affect sexual responsiveness. One of the most common distractions affecting sexual functioning is *fears of performance* (Masters & Johnson 1970, p. 10). This expresses itself as trying to make sexual desire, arousal, and/or orgasm happen. This is an example of the more general, paradoxical principle characterizing all natural functions: the more one tries to make them happen directly and at a particular moment in time, the less likely they are to happen. For example, in the case of a man dealing with erectile dysfunction and comments on female fears of performance,

> With each opportunity for sexual connection, the immediate and overpowering concern is whether or not he will be able to achieve an erection…. His fears of sexual performance are of such paramount import that in giving credence to or even directing overt attention to his fears, he is pulling sexual functioning completely out of context…. An exactly parallel situation can be a factor in female sexual inadequacy…. The popular magazines, with their constant consideration of the subject…. have…provided her with real fears of performance by depicting, often with questionable realism, the sexual goals of effectively

> responsive women…. *fear of inadequacy is the greatest known deterrent to effective sexual functioning, simply because it so completely distracts the fearful individual from his or her natural responsivity by blocking reception of sexual stimuli either created by or reflected from the sexual partner*. (Masters & Johnson, 1970, pp. 10-12, italics theirs)

If fear-based distraction interfering with sexual stimulation is a primary contributor to non-medically based sexual concerns, it would seem logical that treatment would center on teaching skills for identifying and managing these concerns and distractions. It is upon this contention that Masters and Johnsons developed their therapeutic approach.

Masters and Johnson's Treatment of Sexual Concerns

Premises

Short-Term Intensive Therapy

While the importance of understanding the full individual and the relational history of the couple was underscored in their work, the focus of Masters and Johnson's signature short-term therapeutic approach was not on the remediation of historical contributors to the sexual difficulties, unless necessary to achieve results. Instead, it was on the alleviation of immediate causes such as anxiety, cognitive distractions that disrupt natural sexual expression, and any relational concerns that impede. Their goal was to do as much but no more than required to resolve the difficulty. Masters and Johnson also believed that the intensive format, seeing couples daily or several times a day for a 14 day period and generally away from the home environment, could foster rapid progress for two reasons. First, social isolation for the couple facilitates focusing on their relationship and minimizing other obligations and distractions. Second, there is the opportunity for a high frequency of sensual interaction. One of the ways to overcome fears of performance is to affect such a build-up of physiologic tension that it is difficult for sexual desire or arousal to be waylaid by

disruptive anxieties. “With the subject [and experience] of sex exposed to daily consideration, sexual stimulation usually elevates rapidly and accrues to the total relationship” (Masters & Johnson, 1970, p. 17).

The Masters and Johnson 14 day intensive model includes laboratory testing, medical exams, and history-taking. Then there is the regular processing of therapeutic suggestions. Two year follow-up telephone contact is offered to assist with re-entry into everyday lives as well as facilitating the integration of couples’ new knowledge and skills into their routines.

Sensate Focus

If sexual functioning is negatively impacted by anxiety provoking distractions, providing clients an alternative focus, like counting sheep when one cannot sleep, is a logical strategy. In order to provide an alternative to the “white elephant in the room” (“Am I going to get aroused?”; “Will my partner be upset?”), Masters and Johnson developed Sensate Focus, a series of structured touching opportunities that focus attention on tactile sensations of skin temperature, texture of hair and skin, and varying pressures of firmness and lightness. Dr. Johnson reportedly developed these exercises as she recalled “facial tracing” by her mother during her childhood (Maier, 2009, p.182). Sensate Focus serves several functions: allowing clients to focus on something over which they have voluntary control (attending to tactile sensations) instead of focusing on that over which they have no voluntary control (generating arousal); and providing an opportunity for the inexplicable magic of intimate connection. “The *Upanishads*, one of the oldest spiritual texts, tell us that the energy that supports all creativity manifests as the warmth that arises when we are touched” (Aanstoos, 2012, p. 51). Sensate Focus provides an attentional alternative that neutralizes attempts to make natural sexual responses occur, or prevent them from occurring, thereby paradoxically

allowing these responses to manifest on their own. The exercises also serve to systematically desensitize the client to anxieties interfering with sexual response. This neutralizing of apprehensions by attending to sensory experience in the moment is referred to today as *mindfulness,* a practice that has been formally used by some sex therapists (Brotto & Heiman, 2007; Weiner & Stiritz, 2014).

Sensate Focus exercises are both therapeutic and diagnostic . They assist in identifying contributing factors to sexual problems such as avoidance, anxiety, and spectatoring as well as problematic couple dynamics.

Conjoint Therapy

One of the most significant premises of Masters and Johnson's treatment approach is that regardless of which client presents as the *identified patient*, both partners are affected by the sexual difficulty and each is critical to resolving it. To do otherwise is to ignore "half the problem" (Masters & Johnson, 1970, p. 3).

> There is no such thing as an uninvolved partner in any [relationship] in which there is some form of sexual inadequacy…. Isolating [either of the partners] in therapy from his or her partner not only denies the concept that both partners are involved in the sexual inadequacy with which their…relationship is contending, but also ignores the fundamental fact that sexual response represents (either symbolically or in reality) interaction between people. (Masters & Johnson, 1970, p. 2)

In short, the *relationship is the client*.

Conjoint Therapy Team

The Masters and Johnson model also includes a dual sex therapist team. At the beginning, Masters and Johnson emphasized a male/female conjoint approach with predominately heterosexual couples because "Controlled laboratory experimentation in human sexual physiology has supported unequivocally the initial investigative premise that

no man will ever fully understand woman's sexual function or dysfunction…. The exact converse applies to any woman" (Masters & Johnson, 1970, p. 4).

A second rationale for the dual sex team is the importance of transference, both enhancing it in one regard and minimizing it in another. First, because the primary relationship in sex therapy is between the partners and not so much between the clients and therapists (as is usually the case in individual therapy), Masters and Johnson discovered that a dual-sex therapy team reduced unproductive transference emphasizing therapist/client interaction. Additionally, because sex therapy can present ethical and even legal concerns, the dual-sex therapy team creates a therapeutic environment that provides protection and evokes transference with regard to the therapists only in the limited roles of medical and psychological authorities. Therapists wear white lab coats, sit behind a desk, and all sessions are audio recorded. There is nary a couch in the office, and client privacy is assured with a series of enclosed waiting alcoves.

Education

Masters and Johnson conducted their research and developed their treatment in an era when misconceptions and misinformation about sexuality abounded. Thus, they stressed the importance of disseminating detailed, sex-related, anatomical and physiological information pertinent to the client's needs.

Procedures

Assessment

Sex therapy begins with a thorough assessment of medical, psychological, cultural, and relational as well as lifestyle factors that might impact sexual functioning. "There is never any excuse for treating a physiological dysfunction as a psychological inadequacy"

(Masters & Johnson, 1970, p. 53). Next, the couple is seen conjointly to review past and present therapy, current therapy goals, and to assess the relationship dynamics and motivation of both partners. Individual psychosocial evaluation, referred to as *history-taking*, of one to three sessions follows. The focus is on individual psychological makeup, attachment, family of origin, relationship and sexual history as well as the partner's personal perceptions of one another and the presenting problem(s). The history-taking

> is structured to develop material within a chronologic framework of life-cycle influences, which reflects sexually oriented attitudes and feelings, expectations and experiences, environmental changes and practices. History-taking certainly must provide information sufficient to define the character (etiological background, symptom onset, severity and duration, psychosocial affect) of the presenting sexual dysfunctions. Equally important, history-taking contributes knowledge of the basic personalities of the…partners and develops a professional concept of their interpersonal relationship adequate to determining (1) changes that may be considered desirable, (2) personal resources and the depth and health of the psychosocial potential from which they can be drawn, and (3) [relationship]-unit motivation and goals (what the…partners actual expect from therapy). (Masters & Johnson, 1970, p. 24)

This is designed to rule out other medical as well as psychological issues such as clinically significant depression, psychosis, and substance abuse. These conditions make short-term therapy difficult and might suggest the need for medication or alternative treatment.

However, the most important goal of history-taking is understanding the sexual difficulty in its psychosocial context. It suggests "the individual as a whole person…. when taken out of context of the total being and his environment, a 'sex' history per se would be as relatively meaningless as a 'heart' history or a 'stomach' history" (Masters & Johnson, 1970, p. 23). Out of this emerges each client's *sexual value system*, "derived from sensory experiences individually invested with erotic meaning" and "reinforced by years of psychosocial adaptation" (Masters & Johnson, 1970, pp. 24-25). An understanding of this

sexual value system is critical so that the treatment suggestions are sensitive to each client's core sexual identity.

Techniques and Interventions

Next, couples are invited to a *roundtable* session during which the therapists share their assessment of the sexual and/or relational difficulty, and outline the treatment plan to address these concerns. Several critical attitudes are introduced, the first of which is a neutral, essentially Gestalt-like *here-and-now* approach with regard to the present, and focusing as little as possible on the past ("This never worked before!") or future ("Will this work?"). Second, is an attitude of *radical self-responsibility*, applying the skills while refraining from focusing on how effectively the partner is applying the skills. This diffuses projections of blame and circumvents unproductive interactions. Although not emphasized in this chapter, communication skills are a third critical component. Other self management and relationship skills are offered as needed: identifying, accepting, and managing feelings; negotiating differences; creative problem solving; and using the partner as a resource, among others. These are necessary to create, revive, and/or sustain a secure relational environment conducive to change.

For the purposes of this chapter, however, the most important feature of the roundtable session is the introduction of Sensate Focus. As previously indicated, this is the centerpiece and primary modality through which sexual difficulties are more fully understood and addressed. This appears to be the case not only for therapists trained in Masters and Johnson's approach but also for a large percentage of sex therapists in general. The results of a nine week investigation conducted through Surveymonkey and involving 117 AASECT and SSTAR sexologists indicates that 42% of clinicians surveyed often use Sensate

Focus with a multitude of clients, and an additional 43% use the techniques sometimes. A total of 86% of respondents use Sensate Focus in some fashion and 77% find it effective (Weiner & Stiritz, 2014).

The Magic Formula

When first presented, clients can experience Sensate Focus as alternately daunting and/or immensely awkward. In order to gain agreement and cooperation with engaging in it, it is vital to provide the rationale that "is given only the most limited coverage" in the original publication (Apfelbaum, Spring 1984, p. 6). Much time is spent describing how Masters and Johnson, through their laboratory and interview research, captured what might be considered a *magic formula* with regard to satisfactory and even optimal sexual functioning. Each responsive subject practiced three skills: *touching for him- or herself* rather than focusing on the partner; focusing for his/her own *interest* (defined as physical sensations) rather than for pleasure or arousal; and *redirecting attention* back to sensations when distracted.

The first aspect, touching for oneself, represents an entirely new perspective. Many books are sold describing how to *turn on your partner*. Masters and Johnson were responsible for cultivating the radical notion that people's sexual responsiveness is essentially *self-focused*, and that people are actually aroused by taking in the sensory information either through touching (or looking at or listening to) the partner, or having the partner touch (or look or listen). This amounts to absorbing the sensations provided by each other's bodies in a lend lease agreement. Reflecting on the question, "When you are being orgasmic, of whom are you thinking?" highlights this attentional orientation. It suggests the importance of people's being absorbed in their own experience, centering within themselves,

and ultimately following their own sensations to higher levels of arousal. Clients are educated about the difference between this radical *self-focus* and unproductive *selfishness*: selfishness is being so absorbed in one's own experience that one is *unresponsive* to partner requests, whereas self-focus is being absorbed in one's own sensory experience *until and unless* the partner makes a request, in which case one responds as best one can. This is because an aroused partner provides a critically erotic feedback loop that keeps the person touching continuing to do so for him- or herself.

Another component involves *touching for interest* rather than for arousal or pleasure, focusing on sensations without goals or evaluation. *Interest* is defined as focusing on tactile sensations of temperature (cool or warm), pressure (hard or soft), and texture (smooth or rough). While forcing a natural, emotional experience like arousal or pleasure is not under voluntary control, attending to sensory experience is. This component honors the foundational belief that sex as a natural function that, like all natural functions, it is not under direct influence but is, paradoxically, more likely to happen if the pressure to voluntarily control it (make it happen) is neutralized. Anxieties about touching correctly, having a sexual response, eliciting a sexual response in their partner, looking forward to the opportunity, and enjoying the experience are nullified because these impossible demands are no longer the goals.

It is unfortunate that the importance of touching for self without regard for self or partner responsiveness and pleasure has often been misinterpreted. "Masters and Johnson's (1970) sensate focus assignments have been widely misunderstood as practice in focusing on the sensations that please one's partner…. It actually refers to exactly the opposite: avoiding

any effort to please one's partner" (Apfelbaum, 2012, p. 6) and, we would add, even avoiding effort to please one's self.

Yet another element of the magic formula is management of distractions, especially those associated with demands for sexual and/or emotional responses. Clients are encouraged, whenever distracted by anything other than tactile sensations (including, "I am having such a wonderful time"), to *redirect their attention onto that over which they do have voluntary control, namely, the physical sensations*. One cannot focus on any other thought, feeling, or behavior and simultaneously attend to tactile sensations at any one moment in time.

If clients practice the magic components of mindfully touching for their own interest, managing fears, and dealing with distractions by refocusing on tactile sensations, they cannot fail. The self-focused perspective allows them to let go of responsibility not only for turning their partners on (an impossibility) but also for turning themselves on directly and immediately (another impossibility). The emphasis is on interest in sensory absorption, and the associated redirection of attention onto the sensations, relieves them of responsibility for effecting natural, emotional responses that are impossible to generate directly.

Therapeutic Suggestions

Preliminaries. Clients are asked to schedule one to two touching opportunities daily. They can stop the touching or modify it according to their needs, but they are encouraged to do *no more* than what is suggested. This is critical and utilizes the paradoxical nature of sex as a natural function to their advantage: just as responsiveness is less likely to occur if there is a demand for it, it is also more likely to occur if restricted. Clients are also encouraged to spend unpressured time together beforehand, but they are discouraged from cultivating a

romantic atmosphere, another impossible demand. Couples are asked to conduct the session in a quiet, private setting, with some lighting, a comfortable temperature, as few clothes as possible at first, and as few external distractions as possible.

Sensate Focus Phase 1. Initial, *Sensate Focus Phase 1* begins with an explicit verbal invitation by the partner assigned to touch first (Weiner & Avery-Clark, 2014, p. 11). The person with the purported presenting difficulty is usually the initiator in an attempt to avoid partner pressure. The person touching, the Toucher, touches the partner all over their body, avoiding breasts and genitals, focusing on his/her own experience of variable temperatures, textures, and pressures offered by the partner's skin and hair, bringing attention back to sensations when distracted. Kissing and full body contact are discouraged to minimize performance pressures. Partners can assume any position that is comfortable. The person being touched, the Touchee, has two responsibilities: attending to the sensations wherever he/she is being touched; and moving the Toucher's hand away from any area that is physically uncomfortable and/or ticklish. This is particularly important in cases of low desire and aversion where the Touchee must perceive that he/she has considerable control during the session. If the hand is moved, this is framed not as the failure of the Toucher to touch correctly but as the Touchee's being self responsible and vulnerable by providing the Toucher with critical information. The Toucher is, therefore, able to touch with abandon, trusting that the partner will let them know if anything is physically distressing, and allowing them to self focus. These strategies tend to lower anxiety for both partners.

The Toucher is encouraged to touch long enough to get over any initial discomfort, but not so long as to get tired or bored; the initial sessions usually last between five and 15 minutes, but clients are encouraged not to watch the clock. The partners switch, and the

Toucher becomes the Touchee. The focus is on self experience, practicing mindfulness, bringing attention back to temperature, texture and pressure, and allowing the partner to take responsibility for managing his/her discomfort. When the second Toucher has finished, he/she says "Stop," and the partners complete the session by lying together. They are asked not to engage in any sexual contact until suggested. As continued Sensate Focus suggestions are made and it becomes evident that clients continue to feel aroused even after lying together for awhile, they are invited to indicate this to the partner, and the partner can choose one of three alternatives for providing release: either informing the partner asking for release that he/she prefers the partner do so in private; providing manual release for the partner; or lying next to and holding the partner while the partner provides his/her own release via manual stimulation.

Sensate Focus Phase 2. As previously noted, the initial Sensate Focus instructions are just that, the beginning of Sensate Focus, with the emphasis on psycho-educational and behavioral techniques as well as needed relational and individual suggestions. Subsequent, *Sensate Focus Phase 2* suggestions begin to incorporate more partner sharing of information about what each prefers physically (Weiner & Avery-Clark, 2014, p. 12). This Phase 2 Sensate Focus will be the subject of future publications. It includes practicing the technique of *positive handriding* where the Touchee places his/her hand on top of or beneath the Toucher's hand and moves the Toucher's hand towards areas that the Touchee might find of interest (i.e., vivid in terms of tactile sensations) while continuing to move the Toucher's hand away from anything that is uncomfortable. Additionally, verbal communication about more subtle preferences is encouraged.

Sensate Focus Hierarchy. Sensate Focus was designed as an invariant hierarchy of touching exercises. Usually clients do not engage in subsequent stages prior to earlier ones. This is to desensitize clients to experiencing what is usually the inevitable increase of anxiety-provoking distractions as they move up the hierarchy.

Sensate Focus begins with breasts and genitals off limits as described above. In the first few sessions, the Toucher and Touchee can be in any comfortable position and can modify that position at any time. Couples can begin side to side without full body contact; the Toucher can change to kneeling next to the Touchee, or standing beside the bed. The Touchee can begin on his/her side/stomach or back and rotate as he/she feels inclined. When clients are able to touch for self, focusing on sensations, and bringing themselves back from distractions, they begin Sensate Focus with breasts and genitals on limits. If they are not ready, they may be kept at the breasts and genitals off stage with the addition of lotion to vary the sensations and to signify that progress is being made.

When breasts and genitals are added, the couple begins Sensate Focus as they do all suggestions, touching initially with breasts and genitals off limits until they are centered on tactile sensations. Then breasts and external genital touching mixed with full body touching for self-interest is added. Clients are encouraged to attend to changes in sensory experience, not to stay focused on the breasts or genitals once these are on limits, and to move away and experience a full body touching experience. For men with erectile insecurity, the partner is instructed to move away from the genitals if there is any engorgement to reduce focusing on the erection and eliciting greater anxiety. Moving away from engorgement and back again to the genitals allows for repeated experiences of gaining and losing engorgement, often a teaching opportunity for those with erectile insecurity. The same is true for women

experiencing anxiety with breast or genital touching and/or the peak of arousing stimulation that is quickly integrated into a full body experience before defenses can be fully activated.

The couple is offered two positions when breast and genital touching is added. The Toucher can sit up with back against the headboard, pillows behind. The Touchee lies on his/her back, face toward the ceiling, genitals close but not touching those of the Toucher, knees and calves up and over the partner's thighs, feet on the outside of the partner's hips. If the female Toucher feels too exposed in the first position, she can sit between the Toucher's legs, both facing forward, with her back up against the chest of the Toucher, and her legs draped over the Toucher's. The Toucher can reach around the partner's body to include the breasts and external genitals.

When partners can touch for their own interest, focusing on sensations and bringing themselves back from distractions when breasts and genitals are added, they move to mutual touching. Partners lie next to each other and simultaneously touch for their own interest, mixing this with "my turn" and "your turn" experiences. At first they avoid breasts, chest, and genitals and then including them as any other part of the body. This is not as easy as it sounds because each partner focuses not only on sensations where he/she is touching the partner, but also on sensations where he/she is being touched, all the while managing distractions by returning the focus of attention to either one of these sources of sensations which will eventually merge. Clients are confronted with a dynamic tension among different demands for their attention, and must learn to endure the tension until they become adept at letting their focus move where it will. They are honoring the intersubjective space. Eventually, they practice these skills with other areas of the body, and in other positions as will be described below.

During initial Sensate Focus, clients are encouraged to communicate about their anxieties both before and after the sessions in verbal fashion, and predominately nonverbally during the session using handriding and code words when needed. The therapists decide with client input when to move up the hierarchy. Individual and couple dynamics are addressed in vivo as dynamics such as partner pressure, avoidance, couple conflicts or pressuring for goal oriented achievements presents.

Generally after the first experience of breast and genitals on limits, clients are asked to engage in a *clinical look* with regard to each other's genitals. If one or both partners report being unfamiliar with his/her own genitals, the clinical look is conducted individually first. With some lighting on, clients are asked to alternate exploring their genitals with one another. This not only provides accurate information but also brings about a sense of intimate sharing, breaking down barriers of ignorance and discomfort. It promotes more disclosure in Sensate Focus Phase 1, where partners share what is of interest, and in Sensate Focus Phase 2, where partners share what is pleasing.

The next Sensate Focus experience is mutual touching with the woman astride her partner, sitting up on top, facing him, her knees on the bed, supporting herself with her knees and arm, in a tripod fashion. She is encouraged to use her partner's genitals much as she would use her own hand, playing around her vulva and clitoris without insertion. She maintains the attitude of touching for self-interest and redirecting attention back to sensations. When this is paired with all the preceding sensual experiences and the prohibition against doing anything intentional with the associated arousal, there is a harkening back to early, and often taboo-filled, experiences of youthful, playful exploration. It is difficult for most people not to experience significant arousal by this point. In the case of arousal

difficulties, the natural waxing and waning of responsivity may rekindle clients' fears of performance, especially since expectations for excitement tend to be amplified when genital to genital contact is included in the female astride position. These fears are addressed, all of which allows for the opportunity to discuss how the partner is perfectly capable of being orgasmic even when the anxiety-wrought client is experiencing little or no arousal. This is particularly important for men suffering from erectile insecurity: it assures them that the partner's absorption, arousal, and even orgasm does not depend on their having significant penile engorgement. Therapists can offer a paradoxical injunction suggesting that clients intentionally observe the gaining, losing, and regaining arousal. This preempts fears of losing engorgement. It also facilitates both parties' experimenting with an attentional freedom they most likely have never experienced before, and this may evoke an unbeknownst or forgotten sexual vitality.

Additional suggestions in the astride position may include insertion without movement, absorbing the sensations while resisting a goal-oriented agenda. Clients may explore movement and, slowly progressing into Sensate Focus Phase 2, begin to communicate increasingly about what each finds pleasurable. Prior to this, clients are informed that, because of the regularity and intensity of physical contact, they may find themselves experiencing orgasm unintentionally in which case they are not to stop the touching. Touching for one's interest merges with what is stimulating for the partner, and the partner's responsiveness contributes to an ongoing dynamic that elicits arousal for both. This becomes a positive sensual feedback loop.

Special considerations. The specific sexual difficulty, and the associated specific individual and couple dynamics, will dictate the structure, pacing, and processing of therapy.

This is the art of sex therapy. Despite the recommended invariant nature of the hierarchy, the progression is not immutable. The therapist and client together adjust the pace and suggest changes in initiation. Individuals with low desire will be encouraged to develop fantasy. Anorgasmic partners will be encouraged to pleasure themselves and communicate this information to partners. Men with rapid ejaculation will be given the coronal and then the basilar squeeze techniques with partner insertion to increase their ability to tune in to and moderate their arousal. Men with delayed ejaculation will be instructed in successive approximations wherein partner stimulation is mixed with the man's own stimulation, and insertion is encouraged at the point of ejaculatory inevitability. Women with vaginismus will be instructed in the progressive use of dilators, choosing partner involvement when they wish. Individuals with pain disorders are encouraged to maintain full control of position and movement if and when insertion is involved.

Common Problems Encountered with the Masters and Johnson's Approach to Treating Sexual Problems

Non-Compliance with Sensate Focus Touching

One of the most common difficulties with Sensate Focus is clients' failure to do the touching exercises, or not doing them as suggested (Hertlin, 2009). This is processed in session to address confusion, avoidance, anxiety, expectations, discomfort, and problematic relational dynamics that are characteristic of the initial stages, especially when the partners have gone without physical contact for a long time and relational dynamics remain problematic. Specific management strategies are offered including: formally scheduling touching time; changing who initiates and who touches first; identifying, communicating, and managing the anxieties by oneself and/or seeking the partner's assistance by asking for partner's acceptance; clarifying expectations; asking to be held prior to the session; or asking

for immediate relief by proceeding ahead with the touching experience. The anticipation of the touching is often more anxiety provoking than the touching itself!

Ticklishness

Since ticklishness is a reflexive reaction, some is to be expected especially during the initial sessions. However, protracted ticklishness across the touching opportunities can also suggest myriad anxieties. Sometimes this can be severe, and may be associated with a history of relentlessly and even sadistically being tickled as a child. The most frequent suggestion is to handride the partner, that is, placing the ticklish person's hand under or over the partner's hand in order to regain a sense of control. In some instances, such as feet ticklishness, the partner is asked to avoid that body area or be quickly responsive to the partner's nonverbal request to move away from the ticklish area for that moment, with the possibility of returning to it at a later time.

Ongoing Evaluation, Performance Goals, and Expectations

Sex therapists should never underestimate the understandable determination of some individuals to resist the paradox that sex is a natural function. Often clients' have succeeded in their lives by pouring conscious effort into whatever they have done. It is difficult for them to embrace the non-goal oriented approach necessary for a natural function to express itself. Discussions of sex as a natural function need to be reiterated, particularly the role that focusing on reliable sensations plays in managing demand expectations. They are reminded that as soon as they remove themselves from immediate absorption in the moment by attending to goal oriented cognitions and negative emotions, they are interfering with natural responsiveness. If their ongoing evaluation is relentless, it may call for a medication consult, as in the case of obsessive-compulsive disorder.

Feeling Bored With, Constrained By, or Not Liking Sensate Focus

It is not uncommon for clients to report feeling bored with or limited by the touching exercises, and to yearn for spontaneity. Although clients come for direction, the highly structured therapy may chafe at first. Clients who present with personality disorders may amplify this complexity. Often when clients report boredom or lack of spontaneity they are still absorbed in demand expectations for enjoying, being excited by, or responding sexually to the touching exercises. It is reiterated that they would not be in sex therapy if they could make sexual responsiveness occur on demand, and they are reassured that Sensate Focus is only one of several building blocks that will be used to address their concerns. For those who continued to have difficulty following guidelines, it may be effective to suggest they do the touching as they prefer if only to re-experience the futility of their approach.

Feeling Nothing During Sensate Focus

Not infrequently, clients will return from Sensate Focus reporting that they *felt nothing*. Just as with feeling bored with or constrained by Sensate Focus, this often means that they are still expecting to feel interested, aroused, and responsive despite therapists' statements to the contrary. This becomes diagnostic as well as a teaching opportunity. Feeling nothing can also be an indication of possible sexual trauma and dissociation; it can point to other concerns such as damaged nerve conduction from illness, medication or treatment. It can also signify a client's coming to therapy to somehow prove the sexual relationship is toxic, irretrievably broken, or that there is an ongoing affair or alternative sexual interest. While every effort is made to identify these difficulties during initial assessments and roundtable discussion, it is sometimes possible to do so only as problems surface in association with treatment suggestions.

Doing More Than Is Suggested

It is not unexpected that clients who have experienced the build up of sexual tension from repeated Sensate Focus may be spontaneously orgasmic during the touching as part and parcel of natural, sexual functioning. Clients are not held responsible if this happens spontaneously. However, there are some couples that repeatedly seek orgasmic release as each successive touching opportunity is introduced, and/or who move on to intercourse repeatedly before this is encouraged. The usual intervention is to reiterate the concern about returning to goal orientated expectations that may result in failure. Sometimes the push for intercourse and orgasm is diagnostic of one partner's pressuring the other; sexual compulsivity; a personality disorder; or a lack of education. All this is grist for the processing mill.

Sexual Frustration

Most men and women no longer operate under the assumption that all arousal must result in orgasm. They also no longer believe that once they are in a committed relationship they should cease masturbating, a practice that often inadvertently pressures their partner into a service organization role that can have negative consequences including resentment, loss of desire, and unwillingness to touch. The Masters and Johnson approach takes into account the value of self-stimulation if clients report they are becoming distractingly or uncomfortably aroused during the touching sessions. As mentioned earlier, self stimulation or partner choice in aiding and abetting the partner's release is encouraged.

Strengths, Weaknesses, and Modifications of the Masters and Johnson's Model

Since the publication of *Human Sexual Inadequacy*, the field has grown richer as many talented clinicians have expanded Masters and Johnson's physiological based, psycho-

educational approach. They have highlighted its strengths and offered modifications to address problems of "theoretical paradigms, diagnostic nomenclature, treatment interventions, research methodology, assessment measures,…effective medications, and leadership" (Althof, 2010, p. 390).

Theoretical Issues

Complexity

Masters and Johnson have been rebuked for over-emphasizing the physiological aspects of sexuality (Foucault, 1990; Gagnon, 1990; Gagnon & Simon, 1973; Tiefer, 1991) and oversimplifying sexual receptivity by suggesting their famous linear model of arousal, plateau, orgasm, and resolution. They have been critiqued for what is regarded by some as prescriptive, "paint-by-numbers sex" (Kleinplatz & Krippner, 2005, p. 304), and even for being "technicians…[whose] work…lacks a philosophy of life and a theory of human behavior" (Abramson, 1994, p. 110). The first sexologists who would agree that sexuality is more than biochemistry and physiology, that sexual responsivity is not a simple, sequential progression, and that the treatment of sexual difficulties requires more than just behavioral interventions, would be Masters and Johnson themselves. Their assertion that sex is a natural function, and their advocating a short-term, operational approach to the initial treatment of sexual problems, *does not exclude* a dynamic model that takes into consideration psychological and social aspects of sexuality, and does not exclude relationship and depth therapeutic perspectives (Weiner & Avery-Clark, 2014).

> The cotherapists are fully aware that their most important role in reversal of sexual dysfunction is that of catalyst to communication. Along with the opportunity to educate concomitantly exists the opportunity to encourage discussion between the…partners wherein they can share and understand each other's needs. (Masters & Johnson, 1970, p. 13)

The fact that Emily Mudd, “pioneering marriage and family counselor… work[ed] closely with the Masters and Johnson clinic in St. Louis, to which she contributed thousands of case histories from her own practice” (Thomas, 1998) is a testament to Masters and Johnson’s appreciation of dyadic dynamics. While this current chapter focuses primarily on the natural underpinnings of Masters and Johnson’s model of sex therapy and on the behavioral aspects of their treatment model, references have been interlaced to critical cognitive, affective, and relational variables in order to suggest Masters and Johnson’s appreciation for the complexity of human sexuality.

Etiology

Related to this appreciation for complexity, the Masters and Johnson model has been characterized as dichotomous and, therefore, overly simplistic when it comes to the etiological factors: either the cause is regarded as medical or psychosocial (Althof, 2010). As the field of sex therapy has become more sophisticated, it is obvious that a modernistic *either/or* perspective is limited and inaccurate. Instead, a post-modernistic *both/and* approach has become increasingly emphasized as necessary attention has been paid to the interaction of physiological sources of sexual distress with psychological, interpersonal, social, and even spiritual contributions (Aanstoos, 2012; Levine, 1992; McCarthy & Fucito, 2005; Perelman, 2009). This all highlights the importance of the *meaning* or *frame* of the sexual concern for each individual (Atwood & Klucinec, 2007). However, once again, *emphasis should not be confused with exclusion*. While the Masters and Johnson approach affirms the previously unappreciated and unresearched medical factors, it does not in any way preclude consideration of, and interaction with, other, critical psychosocial influences. Their emphasis

on the sexual value system of each client is consonant with this concern for the intricacies of sexual responsiveness and etiology.

Sexual Desire

The original Masters and Johnson model does not focus on desire as a primary diagnosis but only as secondary to sexual dysfunction. Sexologists (Lief, 1977; Kaplan, 1977, 1979) have considered this a significant shortcoming, and have added desire as a first, independent, and additional sexual concern in the sequential model of response progression. This has been further refined by researchers who advise that not only is this progression not necessarily linear but also that it may differ for men and women. For example, sexual interest in women may be experienced subsequent to arousal rather than vice versa (Basson, 2001, 2006). This finding is associated with a more general, feminist-inspired critique of sexual norms being "heterosexual male" (Atwood & Klucinec, 2007, p. 65).

Treatment Issues

Efficacy of the Masters & Johnson Model

In *Human Sexual Inadequacy* (1970), Masters and Johnson's claim a success rate of 80% of non-medically related sexual dysfunctions. This became controversial, beginning with an article contending that their research was "flawed by methodological errors and slipshod reporting and fails to meet customary standards" of evidence-based therapies (Zilbergeld & Evans, 1980, p. 29), an assessment shared with other evaluators (Cole, 1985). "Our analysis forces us to conclude that Masters and Johnson have not provided the information necessary for either intelligent interpretation or replication (Zilbergeld & Evans, 1980, p. 32). This challenge was refuted and clarified by Masters and Johnson's colleague and third author on many of their books. He suggests, "genuine attempts at research

replication have been rare" (Kolodny, 1981, p. 316) and have often been conducted by single therapists in weekly sessions and/or by graduate students. This makes it difficult to criticize Masters and Johnson's results, and other researchers concur. "In general there has been relatively little congruence among the actual practice of sex therapy, development and investigation of underlying theory, and empirical research on both" (Wiederman, 1998, p. 95).

Despite the paucity of methodologically sound, comparative research into the efficacy of the Masters and Johnson treatment model, some substantive studies offer clear support. For example, while some have both questioned the depth as opposed to the alleged superficiality of this treatment model, and have also identified omissions in Masters and Johnson's published works, these same investigators confirm their originality and support their methodology (Apfelbaum, 1984; Slowinski, 1984). Studies involving the use of Sensate Focus and a ban on intercourse find a significant increase in the level of satisfaction for subsequent non-coital, sexual caressing as well as intercourse (Fichten, Libman, & Brender, 1983). Binik and Meana (2009) empirically validate the effectiveness of the sexual dysfunction treatment. Randomized, placebo-controlled investigations (Fisher, Rosen, & Eardley, 2005) "demonstrate the negative effect of one partner's sexual dysfunction on the other's sexual dysfunction and the positive effects of treating dysfunction in both the patient and partner" (Althof, 2010).

Population Limitations

While the original research on male and female sexual response that was published in *Human Sexual Response* (1966) was carried out with both identified gay and heterosexual individuals and couples, a complex and sophisticated understanding of sexuality and gender

fluidity had barely been articulated at that time. Therefore, Masters and Johnson's therapeutic model was developed with able bodied heterosexual couples in mind. One of the most fertile areas of expansion has been the investigation of many other populations (Linschoten, Weiner, & Avery-Clark, unpublished manuscript). These include, among many others, people: with disabilities (Bell, Toplis, and Espie, 1999; Melby, 2011; Tepper, 2000); with medical causes of sexual problems (Gallo-Silver, 2000; Jindal & Jindal, 2010; Sanders & Sprenkle, 1980); who have AIDS (George, 1990); who deal with substance abuse problems (Jensen, 1984); who have suffered sexual abuse (Maltz, 2012; Weiner, 1988); who are gay, lesbian, gender queer, or fluid (Hall, 1987; Iasenza, 2010; Leiblum & Rosen, 2007; Nichols, 1982); and from orthodox religious backgrounds (Ribner, 2003). These studies indicate that sex therapy and many of the Masters and Johnson's techniques are utilized for treating sexual concerns across a wide variety of populations.

Dual Sex Team

While sexologists originally heralded the dual therapist team approach as "an extremely exciting research and clinical breakthrough in sexual knowledge," they also pointed out that "there are some evident problems in applying this model to 'typical' therapeutic practice," not the least of which is the "much greater time commitment on the part of two therapists" (McCarthy, 1973, p. 290). Most therapists do not have the luxury of dual sex teams or doing intensive sex therapy, and the clinical model of dual sex teams has been adapted to outpatient setting.

> It would appear that as long as the therapist is aware of both male and female physical and psychological responses, as well as the power and communication aspects of the triadic therapeutic relationship, then he or she can function in a therapeutic way. (McCarthy, 1973, p. 293).

Nonetheless, the effect of a dual therapist team should not be underestimated. The perception of clients' experiencing themselves as "each with a friend in court as well as an interpreter when participating in the [treatment] program" (Masters & Johnson, 1970, p. 4), potentially finesses a number of transference issues.

Intensive Format

If the accrual of sexual tension can be elicited and experienced in contained form as is possible in an intensive therapeutic format, sexual partners can progress expeditiously because they have Mother Nature on their side. For many couples for whom immediate results are critical, this approach continues to be ideal. For those who live in remote locations, and for those who find it impossible to shake off responsibilities while home, sex therapy coupled with social isolation can fan a hot cauldron of change.

However, just as with the dual therapist approach, there are realistic limitations. "The usual practice is for clients to be seen on a once-a- week, 50-minute basis by one therapist—the Masters & Johnson model call for a much more concentrated …commitment" (McCarthy, 1973, p. 290). Some therapists have modified the two-week format to this more common practice, with each session including a review of and concerns with the previous week's assignments, processing the clients' feelings, and offering the next set of suggestions. The advantage of this "elongated therapy period" is that it allows clients "to pace themselves in terms of acceptance of their sexual responses" (McCarthy, 1973, p. 293). It also finesses one difficulty with the intensive format, namely, that couples may have problems with re-entry into their everyday lives. With the protracted format, partners can learn to balance job, family, self care, responsibilities, and other interests while simultaneously maintaining their treatment progress. However, if a rapid, sequestered program is feasible, re-entry problems

can be effectively managed with telephone check-up appointments every other week over a two year course of follow-up. This serves a reminder to partners about setting aside quality time, scheduling touching on a regular basis, and practicing the individual and relationship skills that they have learned.

Summary

Despite its limitations, Masters and Johnson's physiologically based, short-term intensive approach to treating sexual difficulties has served as the touchstone for many sexologists for over forty years. We cannot help but be enthusiastic supporters of its vitality and the remarkable and meaningful transformations that can take place through the seemingly simple suggestion of engaging in human touch without regard for result.

A Case Illustration of Masters and Johnson's Model of Sex Therapy

A number of the aforementioned points can best be illustrated through a case study. The Dorns (all identifiers have been eliminated or altered to assure anonymity) present for sex therapy with a pairing of two common complaints, low sexual desire on the part of the wife and erection difficulties on the part of the husband.

Initial Conjoint Consult

The initial conjoint session takes place as soon as it has been determined that there are no medical causes for the presenting sexual complaints. This involves gathering all information necessary to accurately assess the nature of the concern, the resources brought to bear, and the couple's therapeutic goals. The Dorns (not their real names, and all identifiers have been removed or altered to protect their anonymity), a dual career couple in their late 50's, have been married for 30 years. Having raised several children, they are at that time in life when couples re examine and sometimes rededicate themselves to addressing

relationship disengagement. They are steeped in anxiety and hostility as the sexual resentments have built up over the years, affecting their sexual relationship, their ability to be physically affectionate, their communication, and the quality of the time they share. They desire not only to resolve their sexual concerns and to rekindle their original intimate connection but also to cultivate greater meaningfulness than they have previously experienced.

History-Taking

The same-sex individual history-taking sessions are scheduled for the afternoon of the first day, and the opposite sex individual history-taking sessions take place on the second day. The results suggest no clinically significant psychological disorders in terms of depression, psychosis, or substance abuse. In her individual history-taking session, Ms. Dorn reveals that she was sexually active in her 20's prior to getting married, and in his Mr. Dorn reports that he had had few intimate encounters in his adolescence and early adulthood. Both indicate that their sexual relationship had been adequate for a number of years prior to having children. It had tapered off as the dual-career couple balanced professional pursuits and raising children to whom they were devoted. As the frequency of sexual encounters diminished, Mr. Dorn began having difficulties maintaining his erection for intercourse. Ms. Dorn attributes her decreased sexual interest not just to career and children but also to the fact that Mr. Dorn, in her opinion, had become increasingly preoccupied with the activities and paraphernalia associated with intimate encounters (garters, high heels) and was rushing to genital contact and attempts at insertion. Her goal was to feel interested again and she expressed her desire to spend more time savoring the sensory experience of being together in a nonsexual fashion. While Mr. Dorn is not unappreciative of the benefits of sensory

mindfulness, he is more interested in exploring alternative sexual activities. He complains that his wife is unwilling to try variations in their sexual interactions, and he considers this the primary factor contributing to his arousal difficulties. He is a health conscious man and does not want to use a PDE-5 inhibitor, preferring to address his erectile concerns through changes in his wife's willingness to dress for him and tease him.

Roundtable Discussion

The roundtable begins by both mirroring an empathetic understanding of each of the Dorns' concerns and also introducing suggestions for resolving their issues.

Ms. Dorns' Mirroring

It is reflected to Ms. Dorn that her desire for more unhurried, sensually connected time with her husband is not unusual and represents the *erotic* aspect of sexuality in the original sense of the word, having to do with relatedness. It is this giving herself to an overload of sensations that is at the core of Ms. Dorn's sexual value system. The mirroring reflects back to both spouses that Ms. Dorn became enamored of physical contact in her early adolescence the first time she was hugged and kissed by a young man. She vividly recalls the overwhelming sense of comfort she experienced when he pulled her close and wrapped his arms around her. She described in detail the sensations of the moment: the smell of his British Sterling cologne; the sound of his leather jacket rustling around her; the salty taste of his lips; the heat of his skin where his hand caressed her face; and the black, chilly, and cloudless night that surrounded them as they walked to the end of his neighborhood street. The warmth of the skin-to-skin contact left her glowing. She experienced a sense of homecoming, mesmerized by the intense connection that she felt with the young man. When she is able to feel this type of connection with her husband, elicited by unpressured episodes

of sensory absorption, she still feels desire for him, but these episodes have been increasingly infrequent. Ms. Dorn is concerned that every time she acquiesces to one of her husband's scenarios, he will interpret it as meaning she is interested in it to the exclusion of more sensorial and affectionate relating.

While a tear runs down Ms. Dorn's face as she re-experiences the meaningfulness of this first encounter with sensuality, Mr. Dorn is unusually quiet. However, he is in for a surprise because this roundtable reflection is not just to establish rapport with his wife but to educate him as well. He receives information about the importance of greater sensorial absorption for many women prior to being arousable and orgasmic. He is somewhat bewildered to learn that his frequent and self-professed approach of "a kiss on the lips, a touch of the breast, and then a dive for the pelvis" (during which he stimulates his wife's clitoris with the same intensity he stimulates his penis) is often unsuccessful if only for a physiological reason: his wife's clitoris is so sensitive that intense stimulation in the absence of a more give-and-take interchange is overwhelming.

He is also informed that women are not just being *difficult* (to use his word) when they encourage non-demand absorption before and during genital stimulation: they need this to facilitate the clitoris's being available for subsequent stimulation. Sexual desire for women may follow arousal rather than precede it, which is all the more reason for him to attend to what actually arouses his wife. Mr. Dorn is stunned. He takes his wife's hand and demonstrates recognition of the larger issue that burdens: "You mean she's not just being difficult when she says she wants to go slowly?"

Mr. Dorns' Mirroring

Freud suggested, "When inspiration does not come to me, I go halfway to meet it" (cited in Zakia, 2007, p. 16). Mr. Dorn has met inspiration halfway. What he lacks in an appreciation for connecting sensorial immersion he has made up for in years of cultivating an active, masturbatory fantasy life involving specific visual and tactile imagery. These include scripted scenarios such as his partner's dressing up in a red bustiers, wearing black silk stocking with garter belts, sporting the highest stiletto heels imaginable, and then engaging first in oral sex and then in female astride intercourse while speaking to him in a hushed voice.

Mr. Dorn's preoccupations go back to an incident he had in middle school during which he caught a glimpse underneath a female classmate's skirt. This revealed her black stockings and garters. He was able to vividly recall the feel of the soft, black and red skirt as she rose from her chair and brushed by his hand. He became extremely aroused during this encounter. He spent countless hours stimulating to orgasm using this imagery, and encouraged his wife to adorn herself in apparel consistent with his fantasies. He becomes intensely absorbed in the texture of any fabric she is wearing. He is concerned that not only will his wife never appreciate his sexual interests but that if he gives her the affectionate sensory contact she desires she will have all that she wants and will assuredly never want to experiment with what arouses him.

Additional points in Mr. Dorn's mirroring is the negative effect of anger or any negative emotion on sexual arousal, the effects of aging on the vulnerability to erectile insecurity, and the effects of spectatoring his penis which began shortly after he first lost engorgement prior to insertion. The cycle of concern about erection causes him to rush to

insertion, thereby short circuiting the stimulation he needs. This has led to a cycle of failure, resentment and defensive loss of interest on both parts.

Mr. Dorn's roundtable mirroring ends with an educational note for Ms. Dorn: her husband is not necessarily being *insensitive* (to use her word) when he asks her to engage in scripted scenarios. Ms. Dorn is educated as to the differences that appear to exist between patterns of adolescent masturbatory and fantasy activity for men and women (Robbins, Schick, Reece, Herbenick, Sanders, Dodge, and Fortenberry, 2011). As masturbating to specific images is an effective and frequently employed way of conditioning arousal to stimuli, especially during the neurologically impressionable adolescent time period, men have a higher probability of emerging from their teenage years with a more finely honed awareness of the particular cues that assist their becoming sensorally and sexually absorbed.

As Ms. Dorn listens to the information imparted by the male therapist, her countenance visibly softens. She looks over at her husband, down at his hand holding hers, and back to at the therapists. "You mean, he's not kidding? He's not just being an insensitive pig? These scenarios really do mean something to him?" What both are being educated about is the importance of attending to and honoring their own and each other's sexual value matrix. Rather than merely judging the other as difficult or insensitive, they are encouraged to appreciate the objective existence of each other's and their own phenomenological reality. This forges a significant connection between them and reduces power struggles even before therapeutic interventions have commenced.

Therapeutic Attitudes

Following the mirroring, the attitude of being focused on or returning the focus back to the present, the concept of self-responsibility rather than partner blaming, the importance

of structuring quality time together and a primer on communication, negotiation and feelings management skills are introduced.

Treatment Suggestions and Interventions

Sensate Focus

Breasts and genitals off limits. Once the Dorns understand and commit to adhering to the attitudes presented in the roundtable, Sensate Focus suggestions are offered. They are encouraged to schedule between two and three touching sessions between the roundtable and next therapy session. Since Ms. Dorn presents with a history of feeling more pressured by her husband, she is selected for initiating the first session, and the third session if the opportunity presents itself, by formally announcing, "I would like to do the touching session." This formality finesses subtleties and indirect ways of approaching the session that can not only be easily misinterpreted but also represent avoidant strategies. Mr. Dorn is told he can always say, "No, I don't want to right now," but then it becomes his responsibility to reinitiate the session and this still counts as Ms. Dorn's initiation. He is responsible for initiating the second Sensate Focus opportunity.

The Sensate Focus instructions are given for the first session with the emphasis on touching for one's interest, focusing on temperature, pressure, and texture, and redirecting attention back to the sensations should focus drift to anything else. While neither has particular difficulty with focusing on sensations, especially once they understand the premise of sex as a natural function, they both have concerns about focusing on these sensations each for his/her own interest. Ms. Dorn resists: "This sounds so selfish!" Much discussion and support is necessary to help her understand that tuning in to her own sensory experience, while it most certainly is self-focused, is different than being selfish as defined by failing to

respond to the partner's input. She is reminded of the freedom Mr. Dorn has to direct her hand away if anything she does is uncomfortable. Even Mr. Dorn bemoans this self-focusing: "But I need her to do things to make me aroused!" He is reminded that sex being a natural function means that his wife cannot make him aroused, and that he will be given more skills for communicating his needs as treatment progresses.

The words of the therapeutic suggestions are chosen carefully to eliminate even subtle implications of demands for particular affective responses; references to relaxation, enjoyment, and pleasure are assiduously avoided. The Dorns are asked to do no more than has been suggested. They are encouraged to focus on their *subjective* sensory experience, The therapists are not interested in either an objective skin measurement, or an evaluation of whether the sensations felt *nice*, *fine*, or *good*. Rather, they are interested in whether the Dorns experienced the sensations descriptively, "taking it precisely as it presents itself" (Aanstoos, 2012, p. 56) in the moment. They are encouraged to make notes of some of the sensations following the sessions so that they can bring in specific experiences.

Ms. Dorn is beside herself with joy. Mr. Dorn is appreciative but none-too-thrilled. He is assured that he will survive and might actually learn something meaningful about himself and his wife much as he has done in the roundtable discussion that very day.

The impact of this shift to honoring sexual responsiveness as natural functioning by redirecting attention to the subjective, momentary tactile experience cannot be overstated. Ms. Dorn returns from the first Sensate Focus exercises sporting a notebook full of specific sensations on which she was able to focus. "I began by touching him on his shoulder, and I noticed that it was hard and smooth and warm." Ms. Dorn also returns to this second therapy session moved by the emotional closeness she has experienced with her husband. She has

never had the opportunity to engage in such sensual exploration, and had become lost in the experience. It was as if she had revisited some long lost force with in her. Her loss of sexual desire already shows signs of abating.

Mr. Dorn is much less enthusiastic about the touching experiences: “ I didn’t feel much.” It is evident that his expectations were to feel sexually aroused mentally and physically. The goals of the touching are reviewed and the couple is asked to repeat touching with breasts and genitals off limits but to add lotion to experience another set of sensations as the lotion first coats, then is absorbed by the partner’s skin. Processing this second set of instructions, Mr. Dorn is agreeable and appreciative of the need for putting aside his goal directedness toward arousal.

Breasts and genitals on limits. After several treatment sessions, Mr. and Ms. Dorn have progressed sufficiently that they are able to focus on sensations for their own involvement more often than not, and they are more frequently recognizing distractions and returning the focus of their attention back to the sensations. Touching with breasts and genitals on limits is introduced, encouraging the application of touching for their own interest on these areas of the body just as they have done on the other areas. Ms. Dorn continues to be assigned the initiation of the first in every set of touching opportunities as this gives her a therapeutic sense of control. She is instructed to touch her husband first as she has done previously, avoiding the chest and genitals, and then assume the position of sitting with her back up against the headboard, her legs spread out in front of her, and her husband’s lying on his back with his genitals close but not touching hers. She is eventually able to incorporate his chest and genitals into the contact, continuing to focus on temperature, pressure, and texture. She is asked to move to the genitals and if there is any engorgement, to move away

quickly, back to his whole body, then back to the genitals, and if engorgement is present, to move away again. Once finished, they are to switch positions with her husband's repeating what she has done with him. A Clinical Look is assigned whereby both partners explore the structure of one another's genitals apart from a touching opportunity.

Mr. Dorn begins to understand that while his aims of having stimulating sex and orgasm with his wife are valid, the manner in which he has been promoting them has been counterproductive not only with regard to his wife's arousal but also with regard to his own. Not only can he not make his wife excited by trying to touch her in a particular way, but also he cannot force himself to experience pleasure. He stops trying to do so much for Ms. Dorn, and he increasingly allows sensorial involvement to happen for himself. Most surprising to him, Mr. Dorn begins having less difficulty experiencing erections. Even more unforeseen to him, he becomes less focused on his erection status altogether. His reports included fewer references to his state of engorgement, and more reports of the meaningfulness of the Sensate Focus sessions to him in general.

Ms. Dorn is also reassured. She is impressed with the didactic component of the therapy sessions if only because she has been able to sit through listening to these details about sex without, in her word, *dying*. She has found it particularly helpful to learn that not only are sexual responses natural functions but that, like all natural functions, they wax and wane. Even if her husband is aroused, his erection will increase and decrease regardless of his level of excitement or what either she or he does in terms of activity. She has been socialized that it is her responsibility to arouse her husband. Her mental set has been to please him, and this has interfered with her own sexual involvement. This understanding helps relieve her of her sense of responsibility for her husband's erection difficulties.

Mutual touching. Next the Dorns are given instructions for mutual touching. This involves their lying next to each other and touching for their own interest at the same time that their spouse touches for his or her own interest, at first avoiding the breasts, chest, and genitals. This reinforces the interpersonal and nonverbally communicative nature of the physical exchange. "We have had you touching essentially with one hand tied behind your back; one of you has been touching while the other one hasn't. Now are going to have you touch simultaneously." The Dorns are introduced to the aim of what phenomenologists refer to as "the fulfillment of a complex intermingling of self and other, with variants of reciprocity or mutuality…. [This is the] primordial intersubjective matrix" (Aanstoos, 2012, p. 63), or "the 'sphere of the between'" (Friedman, 1988, p. 124). Mr. Dorn's interest noticeably picks up: "Now this is more like it!" Whereas only a few sessions before, Ms. Dorn might have fired back with a sarcastic comment suggestive of his aforementioned insensitivity, she appears intrigued. Both the Dorns' burgeoning interest and ability to respond is reflected in their increasingly talking about their own individual experiences rather than the deficiencies of the partner.

Although experiencing regular engorgement during most of the breasts and genital touching and mutual touching, Mr. Dorn had lost engorgement on one occasion when the touching occurred late at night and he was tired. He is paradoxically invited to actually practice gaining and losing his erection in order to develop the skills for redirecting his attention from his penis to something absorbing about his wife and thereby regain his engorgement. This builds confidence and lowers anxiety because increasingly, even when Mr. Dorn loses his erection, he will have an understanding of the reasons this occurred ("I was trying to make myself aroused and I need to refocus on sensations"). Mr. Dorn is further

instructed in the use of a code word, agreed upon with his wife, which signifies his need for her to change the activity so that he is provided with additional, vivid sensations.

Female astride, and eventual intercourse. Having acquired information and confidence about, and management skills for, gaining and losing engorgement, female astride is introduced and Ms. Dorn is encouraged to use her husband's penis for her interest. The first time they try this, Mr. Dorn promptly loses his engorgement. However, Ms. Dorn is orgasmic anyway as she adeptly uses her husband's flaccid penis against her clitoris. This is an astounding revelation for most men suffering from erectile insecurity. Several more sessions of female astride with his gaining and losing engorgement, and using the code word to alter the action, results in Mr. Dorn's experiencing greater security.

In the female astride sessions, the Dorns are initially restricted from any insertion, and are encouraged to think of their genitals just as they did their hands in the early Sensate Focus sessions. They use them to attend to the touch sensations taken in by their own genital skin, and then focus on the tactile sensations they are experiencing when making contact with their partner's genital using their own. They have never done this in a non-demand, touching-for-their-own-interest fashion.

When they are able to apply the Sensate Focus skills to the genital to genital contact, they are encouraged to explore intercourse in the same way, proceeding slowly, focusing on particularly the warmth and the firmness of pressure, and not pressing for full insertion immediately. When they arrive at complete insertion they are instructed to remain motionless for a period of time, resisting any physiological or conditioned compulsion to engage in thrusting motions. They are urged to withdraw from intercourse, resume other activities and positions associated with Sensate Focus, and then to return to insertion at different times in

the session, all in an effort to cultivate an exploratory mindset from which they could nonverbally communicate.

As the sessions involving female astride progress, Ms. Dorn in particular reports experiencing an energy surge. She becomes increasingly willing to explore sexual options to ascertain her reactions to them. Although she has self-stimulated to a limited degree since she was a late adolescent, she is now willing to try this in the presence of her husband, paying particularly close attention to whether she can become absorbed in the arousal independent of her husband's (very positive) response to her doing so. She also reports that she is now willing to go shopping with Mr. Dorn to purchase the high heels her husband so covets her wearing, and is even considering trying on some cleavage-revealing dresses and lingerie. However, she reports that she is willing to engage in these extra-bedroom activities primarily as exercises in her ability to maintaining exquisite awareness of her own feelings about these activities regardless of her husband's (very positive) reception. Much to everyone's surprise, Mr. Dorn offers no objections!

Following the tenth session of female astride, and the second involving insertion, Ms. Dorn returns to therapy sporting a pair of high heels and a provocative dress. She can hardly contain her giggles. She describes how amazed she is that, contrary to the opinions of most of her feminist friends and the negative beliefs instilled in her about high heels during her days as a hippie teenager, she has moments where she experiences the sexiness of wearing the heels that her husband has assured her she will experience. "I cannot physically wear these shoes very often because they hurt my feet. But that doesn't mean I can't wear them on occasion with my husband." Ms. Dorn reports being most pleased with the spill over effect that her sexual explorations is having on her emotional experience during the fulfillment of

her daily responsibilities. She is more animated at work, when interacting with her children, and even when paying her bills!

Kissing. Perhaps an even more powerful activity is kissing. Kissing is one of the last behaviors attended to in sex therapy. It is discouraged prior to this point in Masters and Johnson's approach because it often represents such a complex and intimate integration of sensory absorption, limit setting, and the ebb and flow of yes and no in communication between partners that it is difficult to engage in without evoking pressure to feel romantic and aroused. All of the physical contact up to this point in therapy is enacted through touching with the hands. However, as Sensate Focus progresses, couples are able to tolerate and incorporate more intersubjectively responsive interactions while maintaining an exploratory mindset. Non-demand kissing-for-one's-own-interest becomes possible.

The power of the non-demand, sensorial, and self-focused attitude on the Dorns intimate interactions, even while engaging in intercourse and kissing is, significant. Ms. Dorns is able to surrender to the tactile immersion for which she so yearns. Her complaints of lack of sexual interest diminished significantly and she confesses she has deviated from the suggestions to such a degree that she is not only more easily aroused during some of the Sensate Focus sessions but is even initiating physical contact beyond that which has been suggested by the therapists. The therapists feign shock! Mr. Dorn professes increasing confidence in his ability to be present to the sensory experience. He also feels he is effectively expressing his interests, and receiving willing attention and responsiveness from his wife. He finds remarkable the sense of calmness, pleasure, and meaningful connection he feels to his wife even when orgasm or dramatic scenarios were not part of their activity. He also finds remarkable the fact that he has not perished. The therapists feign shock yet again!

Mr. Dorn is extremely pleased that he experiences less frequent difficulties arriving at full engorgement; however, he is most pleased by the fact that when he is having arousal concerns, he knows how to manage them. They both report that, despite a quarter century of wedded bliss, they are having genuinely imaginative intimacy for the first time.

Ms. Dorn reports that on several occasions she has lost complete awareness of time, location, and activity when in the throws of embracing absorption. During one encounter when she is astride her husband, she feels compelled to reach up into the air and pull down on what she experiences as the beams of light emanating from, and the arms of the compass being held in the hands of, Urizen, the representation of divine reason in Blake's watercolor, *The Ancient of Days* (Blake, 2000, p. 174). It is for her as if passionate instinctuality were merged with celestial rationality in a moment of sublime transcendence or, as she put it in the vernacular, pardoning herself all the while, "I never felt so fucked in all my life."

Mr. Dorn reports that he often feels transported to another dimension of reality.

> In this phase of sexual experiencing, such a transcendence of self can occur that the descriptor ecstasy can be taken, quite literally, as a "going beyond". This self-transcendence is the fulfillment of a complex intermingling of self and other, with variants of reciprocity or mutuality…. In the mutuality variant, this dialectic is intensified through the reversibility of the flesh. (Aanstoos, 2012, p. 63).

In one session Mr. Dorn is simultaneously aware that it is his wife who is enticingly draped over his bed and wearing the cleavage-revealing, silky red baby doll lingerie and black stockings at that moment while also becoming lost in the fantasy of his first sight of stockings and the feel of feminine texture in his seventh grade classroom. The elements of time matter not in his immersion. The visual images and tactile sensations cascade into a stream of resplendent reverie. He summarizes the experience in so many words: "I could have died and it would have been just fine!"

Conclusion: What Sex Sensate Focus Is and What It Is Not

Masters and Johnson's approach to sex therapy is not exclusively physiologically or behaviorally oriented. Nonetheless, this article has focused on the concept of sex as a natural function that underlies their therapeutic model, and the behavioral and attentional techniques of Sensate Focus that represent the core of their treatment program. Sensate Focus in its initial phase is a set of clinical exercises intended to cultivate an attitude of non-demand touching for one's own interest. It serves as invaluable diagnostic and therapeutic tools, and as procedures for learning about sexual responsiveness by tuning into sensations and refocusing away from evaluative expectations about this responsiveness that represent disruptive interferences to their natural responsiveness. The most important point emphasized by Sensate Focus is that no one has conscious control over making sexual desire, arousal, and orgasm happen, let alone emotional and intimate connection, even though these are clients long-term goals. What clients do have short-term control over is returning the focus of their attention onto omnipresent tactile sensations while engaging in touching activities. This facilitates the conscious mind's getting out of the way of natural responsiveness that is the primary goal of Sensate Focus Phase 1.

Sensate Focus in its initial phases is *not* an attitude of demand pleasuring for the partner or for one's self (Weiner & Avery-Clark, 2013). Sensate Focus is not touching for the other person. Sensate Focus is not touching to sexually arouse one's self or one's partner. It is not intended to foster relaxation, enjoyment, or pleasure. It is not, as it is so often portrayed, "caressing, and sensual massage during noncoital loveplay" (Albaugh & Kellogg-Spadt, 2002, p. 402). It is not aimed at erotic encounter. It is "is intended to be an experience in itself, not a prelude to 'sex' or a form of foreplay" (De Villers & Turgeon, 2005, p. i). "It

is the paradox of pleasure and sexual responsiveness that being present to conscious sensory experience, rather than trying to make these natural emotions happen, is what promotes them" (Weiner & Avery-Clark, 2014, p. 12).

If the behavioral involvement and attentional redirection that are the components of initial Sensate Focus are practiced regularly, they may serve as powerful portals into the subsequent, Phase 2, components associated with the very experiences that patients are longing to experience but cannot make happen, just as the practice of mindfulness can serve as an impressive inroad into cultivating calmness. These include not just desire, arousal, and orgasm, but also the deep connection to one's partner to which Kleinplatz refers as "optimal sexual experience" (Kleinplatz & Ménard, 2007, p. 74). During such experiences, "sexual energy mixes with the sacred, one having the potential for activating the other. The effect can be numinous." (Avery-Clark, 2012). If couples engage in Sensate Focus in the non-demand touching manner that Masters and Johnson suggest, they increase the probability of experiencing the way in which intimate relationship and transformation can arise meaningfully and naturally so as to increase the likelihood of the closeness for which they yearn.

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Footnotes

[1] The authors are among the handful of professionals who were in the unique position of work with Masters and Johnson on a regular basis, being employed as Clinical and Research Associates at Masters & Johnson Institute between 1983 and 1988; the second author was also Director of Workshops and Training during that same period.