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A 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 that *sex is a natural physiological function*. Their contention was that the physiology of sexuality must be understood and appreciated before attention can be paid to additional layers of social, psychological, relational, cultural, and other influences on human sexuality.

After laboratory procedures identified the physiological patterns of sexual arousal, and after interviews with laboratory subjects revealed the critical factors associated with sexual response such as arousal and orgasm), Masters and Johnson applied this knowledge to the treatment of sexual dysfunction. Their approach, detailed in *Human Sexual Inadequacy*, 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, at the time, had been the customary psychoanalytical process of treating sexual concerns through long-term psychotherapy in which clients were assumed to have deeply rooted psychic conflicts that interfered 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 an "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). This triumph was so influential that the Masters and Johnson short-term, intensive approach became synonymous with the term "sex therapy" for the majority of sex therapists who followed in the subsequent decades.

Purpose

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

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> *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)

Interpretative and practical application difficulties were due to a number of factors, most notably the lack of publications clarifying the details of Masters and Johnson's treatment approach and the evolution of their treatment model over their more than 25 years of experience. This is perhaps not surprising because "The actual clinical and conceptual processes of [Masters and Johnson] have been available only to the small group of clinicians who interact directly with them on an ongoing basis" (Schnarch, 1991, p. 145). The purpose of this chapter is to provide accurate and detailed information about Masters and Johnson's sex therapy concepts and procedures.

Masters and Johnson's Conceptualization of Sexual Problems

The theory underlying Masters and Johnson's perspective has been described 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 to some degree by any negative emotional state (such as anxiety), and by distractions (such as observing and negatively evaluating oneself). Although in Western culture we expect that apprehensions and ruminations might keep us from falling asleep (which is also a natural physiological function), we have difficulty accepting that these similar preoccupations can affect the natural function of sex. One of the most common distractions affecting sexual functioning is *fear of performance* (Masters & Johnson, 1970, p. 10). This expresses itself as trying to make sexual desire, arousal, and/or orgasm happen. The harder one tries to achieve a sexual response, the more difficult it becomes. 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. A nonsexual version of this would be trying to urinate on command when a doctor asks for a sample. In the case of sexual responsiveness, Masters and Johnson wrote:

> *... fear of [sexual] 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 in original)

If fear-based distraction interfering with sexual function is a primary contributor to non-medically based sexual concerns, it would seem logical that treatment for these concerns would emphasize teaching skills for identifying and managing these fears and distractions. Masters and Johnson developed their therapeutic approach based on this logic.

Masters and Johnson's Treatment Premises

Short-term intensive therapy

Although the importance of understanding the full individual and 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 addressing those was absolutely necessary to achieve results. Instead, the focus was on the alleviation of immediate causes (anxiety, cognitive distractions) that disrupt natural sexual expression, and any relational concerns that impact sexual interest or functioning. Masters and Johnson's goal was to do as much but no more than was required to resolve the difficulty. Masters and Johnson also believed that an intensive format—seeing couples daily or several times a day for a 14-day period—and meeting at a location 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 opportunity for a high frequency of sensory-oriented interactions. One of the ways to overcome fears of performance is to develop such a build-up of physiological tension that it is difficult for sexual desire or arousal to be waylaid by disruptive anxieties. According to Masters and Johnson (1970), "with the subject [and experience] of sex exposed to daily consideration, sexual stimulation usually elevates rapidly and accrues to the total relationship" (p. 17).

The Masters and Johnson 14-day intensive model includes laboratory testing, medical exams, and history-taking. Following this there is a feedback session (*the roundtable session*) and then 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 to facilitate the integration of the couple's new knowledge and skills into their routines.

Sensate Focus

If sexual functioning is negatively impacted by anxiety-provoking distractions, then a logical strategy is providing clients with an alternative neutral focus, similar to counting sheep when one cannot sleep. In order to provide an alternative to distracting thoughts (e.g., "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. Johnson reportedly developed Sensate Focus in response to her memory of "facial tracing" by her mother during her childhood (Maier, 2009, p.182). Sensate Focus is the core feature of Masters and Johnson's sex therapy, and it serves two primary 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 generative intimate connection. Sensate Focus provides an attentional alternative that neutralizes unhelpful attempts to make natural sexual responses occur (or prevent them from occurring). By refocusing away from problematic distractions, Sensate Focus paradoxically allows the natural sexual responses to manifest on their own. The exercises also serve to systematically desensitize the client to anxieties interfering with sexual response. This neutralizing apprehensions by attending to sensory experiences 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; see also Barker, this volume).

Sensate Focus exercises are both therapeutic and diagnostic. In addition to addressing anxiety and distraction, they also assist in identifying contributing factors to sexual problems. These include avoidance, *spectatoring* (watching arousal), and 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. Failure to include both partners is to ignore "half the problem" (Masters & Johnson, 1970, p. 3). As they put it:

> 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 original Masters and Johnson model also includes a dual-sex therapist team. At the beginning, Masters and Johnson emphasized a male/female conjoint approach with 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 their use of dual-sex therapy teams is related to the significance of transference; the dual team serves to enhance transference in one regard and minimize 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 believed that a dual sex therapy team may reduce unproductive and distracting transference by de-emphasizing the 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 a transference in which the therapists are viewed only in the limited roles of medical and psychological authorities. At Masters & Johnson Institute, therapists wore white lab coats, sat behind a desk, and all sessions were audio-recorded. There was no couch in the office and client privacy was 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 clients' needs.

Procedures

Assessment

Sex therapy begins with a thorough assessment of medical, psychological, cultural, relational, and lifestyle factors that might impact sexual functioning. Emphasizing that physiological causes should be considered prior to beginning sex therapy, Masters and Johnson (1970) wrote, "there is never any excuse for treating a physiological dysfunction as a psychological inadequacy" (p. 53). First, the couple is seen conjointly to review past and present therapy and current therapy goals, and to assess the relationship dynamics and motivation of both partners. Then follows individual psychosocial evaluations, or *history-taking*, of one to three sessions each. Each partner meets first and individually with one therapist, and subsequently

with the other therapist. The focus is on individual psychological makeup, attachment, family of origin, relationship and sexual history, as well as the partners' 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 actually expect from therapy).
>
> (Masters & Johnson, 1970, p. 24)

The history-taking 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 treating "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 the psychosocial sexual history 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 to ensuring that the treatment suggestions are sensitive to each client's core sexual identity.

Techniques and interventions

Following the history-taking, couples are invited to a *roundtable session* during which the therapists share their assessment of the sexual and/or relational difficulties and outline the treatment plan to address these concerns. Several crucial attitudes are introduced in this meeting, the first of which is a neutral, Gestalt-like, *here-and-now* approach, that focuses as little as possible on the past ("This never worked before!") or future ("Will this work?"). Second is an attitude of *radical self-responsibility*, in which each individual applies the skills while refraining from focusing on how effectively his or her 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 including, among others: identifying, accepting, and managing feelings; negotiating differences; creative problem-solving; and using the partner as a resource. These are necessary to create, revive, and/or sustain a secure relationship 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 in a Masters and Johnson approach. This also appears to be one of the aspects of the Masters and Johnson's approach that has most influenced the entire field of sex therapy. In a questionnaire study involving 80 sex therapists, 42% said that they "often" use Sensate Focus, and an additional 43% said that they use the technique "sometimes." Of those that used Sensate Focus in some fashion, 77% found it effective (Weiner & Stiritz, 2014).

The magic formula

When first presented, clients may experience Sensate Focus as alternately daunting and immensely awkward. In order to gain agreement and cooperation with engaging in it, it is vital to provide the rationale for the activities. Unfortunately, this rationale "is given only the most limited coverage" in the original Masters and Johnson publication (Apfelbaum, 1984, p. 64). Describing the rationale includes discussing 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. This includes each client's practicing three skills: (1) While touching his or her partner, each client practices *touching for him- or herself* rather than focusing on the partner; (2) while touching or being touched, the client practices focusing on his/her own *interest*, which is defined as tactile sensations, rather than on pleasure or arousal; and (3) *redirecting attention* back to the touch sensations when distracted.

The first aspect, *mindfully 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-generated and self-focused* and that people are actually aroused by taking in sensory information either by touching (or looking at or listening to) the partner or by having the partner touch (or look or listen). This amounts to absorbing the sensations provided by each other's bodies. The question, "When you are being orgasmic, of whom are you thinking?" highlights this attentional orientation. Most individuals are thinking of their own physical sensations immediately before and during orgasm. This suggests the importance of people being absorbed in their own experience, centering within themselves, and ultimately following their own sensations to higher levels of arousal. In a Masters and Johnson approach, 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 who is doing the touching continuing to do so for him- or herself.

The second component involves *touching for interest* rather than for arousal or pleasure (i.e., 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). Trying to make a natural, emotional experience happen, like arousal or pleasure, is not under voluntary control, but attending to sensory experience is. This component honors the foundational belief that sex is a natural function that, like all natural functions, is not under direct influence but is, paradoxically, more likely to happen if the pressure to voluntarily control it (make it happen) is neutralized. Once the desire to control the response is neutralized, anxieties about touching correctly, having a sexual response, eliciting a sexual response in one's partner, and ensuring an enjoyable and pleasurable experience are nullified because these 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. As stated by Apfelbaum (2012), "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" (p. 6), and, we would add, even avoiding any effort to please one's self.

The third 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 thoughts such as "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 for the impossibility of making sexual response happen for themselves or their partner. The emphasis is on directing attention to sensory absorption, something they can do voluntarily.

Therapeutic Suggestions

Preliminaries

In the intensive model, clients are asked to schedule one to two touching opportunities daily. In a less intensive outpatient format, this is often modified to include one to three sessions a week. 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 it is not an expectation. Clients are also encouraged to spend unpressured time together beforehand, but they are discouraged from cultivating a *romantic* atmosphere, as intentionally generating romantic feelings represents yet another untenable demand. Couples are asked to conduct the session in a quiet, private setting, with some lighting, a comfortable temperature, as few clothes as possible, and as few external distractions as possible.

Sensate Focus Phase 1

Initially, *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 encouraged to be the initiator in an attempt to avoid partner pressure. The person initiating the touching, the Toucher, touches the partner all over his/her body using hands and fingers only. The Toucher: avoids breasts and genitals; focuses on his/her own experience of variable temperatures, textures, and pressures offered by the partner's skin and hair; and brings attention back to sensations when distracted. Talking, kissing, and full body contact are discouraged to minimize performance pressures. 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 or very psychologically uncomfortable and/or ticklish. This latter responsibility is particularly important in cases of low desire and sexual 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 failure on the part of the Toucher to touch correctly, but as the Touchee's being self-responsible and courageously 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 or very emotionally distressing and allowing the Toucher 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 each, 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" or "Finished" or "Done," and the partners complete the session by lying
They are asked not to engage in any sexual contact at this stage. As the therapists co
increase the complexity of the Sensate Focus suggestions, and if one participant co
feel aroused even after lying with the partner for awhile, this participant is invited to
this to the partner, and the partner can choose one of three alternatives for providing
The partner can: (1) inform the participant asking for release that he/she prefers the
pant provide his/her own release in private; (2) lie next to and hold the participant
release while that participant provides his/her own release; or (3) provide manual
the participant seeking release. In intensive therapy, clients usually do not have difficu
ing intentional release for a period of time. In less intensive out-patient settings, cli
invited to do whatever they wish as long as it is separate from Sensate Focus.

Sensate Focus Phase 2

As previously mentioned, the initial Sensate Focus instructions emphasize psycho-edu
and behavioral techniques as well as needed relational and individual suggestions. Subseq
Sensate Focus Phase 2 suggestions begin to incorporate more between-partner sha
information about what each prefers physically (Weiner & Avery-Clark, 2014, p. 12 . P
Sensate Focus, the details of which will be the subject of future publications, includes pra
the technique of *positive handriding* during which the Touchee places his/her hand o
or beneath the Toucher's hand and moves the Toucher's hand *towards areas that the T
might find of interest* (i.e., vivid in terms of tactile sensations). The Touchee continues to
the Toucher's hand away from anything that is uncomfortable (as described above). Addi
verbal communication about more subtle preferences and experimentation is encour
this second phase.

Sensate Focus Hierarchy Sensate Focus was designed as a hierarchy of touching exercises
the purposes of this chapter, this hierarchical approach will be associated primarily with Se
Focus Phase 1. Usually clients in Phase 1 do not engage in subsequent stages prior to e
ones, and they usually complete the entire Phase 1 hierarchy before initiating Phase 2. T
to desensitize them to experiencing what is usually the inevitable increase of anxiety-prov
distractions as they move up the hierarchy. However, the hierarchy is subject to modifi
based on the goals, progress, values, and sexual practices of the couples.

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

When *breasts and genitals are added*, the couple begins Sensate Focus as always, touching
tially with breasts and genitals off limits until they are centered on tactile sensations. Then br
and external genital touching mixed with full body touching for self-interest is sugge
Clients are encouraged to attend to changes in sensory experience, not to stay focused so
on the breasts or genitals once these are on limits, and to move away from breasts and gen
to experience a full body touching experience. For men with erectile insecurity, the partne
asked to move away from and then back to the genitals if there is engorgement in order to red
spectatoring arousal and the elicitation of greater anxiety. Moving away from engorgem

and later returning to the genitals also 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 about their arousal once breast or genital touching is included. Initially, if they experience arousal, they are encouraged to direct their partner to move away from the breasts and/or genitals so that this does not become the focus. This is because it is very difficult at the beginning for clients to focus on breast and genital sensations associated with arousal without promoting anxiety or a goal orientation. However, as they become more proficient at focusing on sensations, they are encouraged to allow their attention to stay with the breast and genital sensations even when they experience arousal. This provides them with the opportunity to experience the return of arousal without having to try to make it happen.

The couple is offered two positions when breast and genital touching is added. The Toucher can sit up with the back against the headboard, pillows behind. For this position, the Touchee lies on his/her back with his/her face looking up at the ceiling and genitals close but not touching those of the Toucher. The Touchee places his/her knees and calves up and over the partner's thighs with feet on the outside of the partner's hips. Alternatively, if the Touchee feels too exposed in this first position, he/she can sit between the Toucher's legs, both facing forward, with his/her back up against the chest of the Toucher and his/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 they include them as they would 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. Clients are confronted with a dynamic tension among different demands for their attention, and they 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 verbally before and after the sessions, and predominately nonverbally during the session using the techniques of moving the partner's hand away from any area where the touching is experienced as physically or very psychologically uncomfortable or ticklish. The exception to this nonverbal focus is when anxiety peaks in the touching. In such an instance, the use of a code word and a change in action are encouraged to help clients move beyond the anxiety. The code word should be chosen by the couple prior to the session and should be positive or neutral in nature, for example, "change."

The decisions about moving up the hierarchy are made in dialogue between the therapists and clients. Individual and couple dynamics are addressed *in vivo* as partner pressure, avoidance, couple conflicts, or pressuring for goal-oriented achievements arise.

Generally after the first experience of breast and genitals on limits, clients are asked to engage in a *clinical look* at 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 visually 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, in the case of heterosexual couples, the woman *going astride* her partner, sitting up on top, facing the partner, 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 with vulva, clitoral, and *mons* contact with her partner's genitals but without insertion. She maintains the attitude of touching for self-interest and redirects attention back to sensations. In the case of same-sex couples, genital-to-genital contact is modified according to the couple's sexual practices, goals, and values.

When genital-to-genital contact is paired with the preceding sensory experiences and the prohibition against doing anything intentional with the associated arousal, there is a harkening back to early, and often exciting, taboo-filled experiences of youthful, playful exploration. It is difficult for most people not to experience significant arousal by this point. However, in the case of arousal difficulties, the natural waxing and waning of responsivity may rekindle clients' fears of performance, especially given that expectations for excitement tend to be amplified when genital-to-genital contact is included in the astride position. These fears are addressed, which allows for the opportunity to discuss the fact that the lower anxiety partner is perfectly capable of being orgasmic even when the anxiety-wrought partner is experiencing little or no arousal. This is particularly important for men suffering from erectile insecurity: It assures them that the partners' absorption, arousal, and even orgasm does not depend on having significant penile engorgement. Therapists can offer a paradoxical injunction suggesting that clients intentionally observe the gaining, losing, and regaining of arousal. This preempts fears of losing arousal. It also facilitates both parties' experimenting with an attentional freedom that they most likely have never experienced before, and this may evoke a previously unbeknownst or forgotten sexual vitality.

Additional suggestions in the astride position may include insertion without movement, absorbing the genital sensations while resisting a goal-oriented agenda. Clients may subsequently explore movement and, slowly progressing into Sensate Focus Phase 2, begin to communicate increasingly about what each finds pleasurable. With clients for whom insertion is not a goal, obviously this step is omitted, 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 client and 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 reported by the couple, the couple's goals, and their unique individual and couple dynamics, will dictate the structure, pacing, and processing of therapy. This is the art of sex therapy. Despite the recommended order of the hierarchy, the pace and process of the progression is not immutable. The therapist and client together adjust the pace and suggest changes in initiation and activity. While not exhaustive, some examples include individuals with low desire being encouraged to develop fantasy. Anorgasmic partners will be encouraged to learn about their responsivity themselves and communicate what they have learned to their partners. Men with rapid ejaculation will be given the coronal and then the basilar squeeze techniques with partner insertion and/or the Semans (1956) stop/start technique to increase their ability to tune into and moderate their arousal. Men with delayed ejaculation will be instructed in successive approximations wherein partner stimulation is mixed with the man's self 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. Trauma survivors will be offered preliminary touching suggestions.

Common Problems Encountered with Behavioral Suggestions

Noncompliance with Sensate Focus touching

One of the most common difficulties with Sensate Focus is the clients' failure to do the touching exercises, or not doing them as suggested. This is processed in the therapeutic session to address confusion, avoidance, anxiety, expectations, discomfort, and problematic relational dynamics that are often the causes of noncompliance during the initial stages, especially when the partners have gone without physical contact for a long time. Specific management strategies are offered, including formally scheduling touching time; changing who initiates and who touches first; identifying, communicating, and managing the anxieties alone and/or with the partner's assistance; clarifying expectations; asking to be held prior to the session; or asking for immediate relief from anticipatory anxiety by proceeding ahead with the touching experience. The couple's anticipation of touching is often more anxiety-provoking than the touching itself which may be experienced as welcomingly non-pressured and emotionally connecting.

Ticklishness

Because ticklishness is a reflexive reaction, it is often experienced as a challenge during initial sessions. Protracted ticklishness across touching opportunities can also suggest myriad anxieties. Sometimes this can be severe and distressing and may be associated with a history of being relentlessly and even sadistically tickled as a child. The most frequent suggestion is to *handride* the partner, that is, to place 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 many aspects of 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 may need to be reiterated, particularly the role that focusing on reliable sensations plays in managing demand expectations. The clients 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 evaluation continues, 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 to sex therapists for direction, the highly structured therapy may chafe at first. 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 may be helpful to review the rationale for these exercises to build the foundation so that spontaneous experiences to later occur. For those who

continue to have difficulty following guidelines, it may be effective to suggest that t temporarily return to touching as they prefer, if only to re-experience the futility of t approach.

Feeling *nothing* during Sensate Focus

Frequently, clients will initially return from Sensate Focus reporting that they *felt nothing* as with feeling bored with or constrained by Sensate Focus, this often means that they are expecting to feel interested, aroused, and responsive despite therapists' statements to the co trary. This becomes diagnostic of a performance-oriented approach and serves as a teach opportunity. Feeling nothing can also be an indication of possible sexual trauma and dissoc tion, or it can point to other concerns such as damaged nerve conduction from illness, me cation, or treatment. Additionally, it can signify a client coming to therapy not actually improve the sexual relationship, but rather with a motivation to prove the sexual relationsh is toxic or irretrievably broken or because there is an ongoing affair or alternative sex interest. Although every effort is made to identify these barriers during initial assessments a roundtable discussions, it is sometimes possible to do so only as problems surface in associat with treatment suggestions.

Doing more than is suggested

It is expected that clients who have experienced the buildup of sexual tension from repea Sensate Focus may be spontaneously orgasmic during the touching as part and parcel natural, sexual functioning. However, there are some couples that repeatedly and intentiona seek orgasmic release as each successive touching opportunity is introduced, and/or wh repeatedly move on to intercourse before this is suggested as part of the hierarchy. The us intervention is to reiterate the concern about returning to goal-orientated expectations, a the importance of keeping Sensate Focus free of this pressure to increase opportunities for suc cess. Sometimes the push for intercourse and orgasm is diagnostic of one partner's pressuri the other, of sexual compulsivity, of a personality disorder, or of a lack of sufficient educatio All this is grist for the processing mill.

Sexual frustration

When Masters and Johnson were developing their sex therapy model from the 1960s to th 1980s, more men and women believed that masturbation should cease once they were in committed relationship. A belief like this often inadvertently pressures the partner into a sexu service role that can have negative consequences for the couple, including resentment, loss o desire, and unwillingness to touch. The Masters and Johnson approach takes into account th value of self-stimulation if clients report they are becoming distractingly or uncomfortabl aroused during the touching sessions. Self-stimulation or, as mentioned, partner choice in aid ing and abetting the partner's release is suggested after breasts and genitals are added.

Another issue pertaining to distracting or uncomfortable arousal has to do with Masters an Johnson's original ban on sexual release outside of the touching sessions. The reason the encouraged this ban was due to the intensive format of their treatment and the greater accru of sexual tension that could be cultivated by deferring release. However, it is difficult to ga client compliance with this suggestion when the treatment format is not intensive. Therefore many therapists in more traditional settings suggest that if clients desire sexual release prior t its being incorporated into Sensate Focus, that they do so separate from the touching sessio themselves.

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

Since the publication of *Human Sexual Inadequacy*, the field has grown richer. Talented clinicians have expanded Masters and Johnson's physiological-based, psycho-educational approach, highlighting 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). However, confusions have arisen and further clarification is needed.

Conceptual issues

Complexity Masters and Johnson have been critiqued for overemphasizing the physiological aspects of sexuality (Foucault, 1990; Gagnon, 1990; Gagnon & Simon, 1973; Tiefer, 1991) and oversimplifying sexual responsivity 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).

Masters and Johnson would be the first to acknowledge 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. Their assertion that sex is a natural function and their advocacy for 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 it does not exclude deeper therapeutic and relational perspectives (Weiner & Avery-Clark, 2014). They stated:

> 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. Although 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, descriptions in this chapter of Masters and Johnson's approaches have been interlaced with references to the cognitive, affective, relational, and cultural variables that Masters and Johnson considered to be critical to the successful outcome of sex therapy.

Etiology Related to the critiques about complexity, the Masters and Johnson model has been characterized as dichotomous and, therefore, overly simplistic when it comes to 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 simple *either/or* perspective is limited and inaccurate. Instead, a more complex *both/and* approach has become increasingly emphasized as necessary attention is 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 highlights the importance of the *meaning* or *frame* of the sexual concern for each individual (Atwood & Klucinec, 2007).

However, emphasis should not be confused with exclusion. Although the Masters and Johnson approach affirms previously unappreciated and unresearched physiological factors, it does not in any way preclude consideration of, and interaction with, other critical influences.

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 (Kaplan, 1977, 1979; Lief, 1977) considered this a significant shortcoming and added desire as a first, independent, and additional sexual concern. This has been further refined by researchers who advise that, not only is this progression not necessarily linear, but it may also 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 forms one of the bases for the change in the recent *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition (DSM-5), which, in contrast to the prior edition, consolidated female interest (desire) and arousal (American Psychiatric Association, 2013).

Treatment issues

Efficacy of the Masters and Johnson model In *Human Sexual Inadequacy*, Masters and Johnson (1970) claimed a success rate of 80% for non-medically related sexual dysfunctions. This claim became controversial for two reasons. Zilbergeld and Evans (1980, p. 29) critiqued the research as "flawed by methodological errors and slipshod reporting and fails to meet customary standards" of evidence-based therapies. Other evaluators arrived at similar conclusions (Cole, 1985). Additionally, Masters and Johnson's published reports were appraised as deficient: "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). Kolodny, Masters and Johnson's colleague and third author on many of their books, has made an effort to address the first critique of methodological limitations by suggesting, "genuine attempts at research replication have been rare" (Kolodny, 1981, p. 316). They have often been conducted by single therapists in weekly sessions and/or by graduate students. The fact that Kolodny does not address the sufficient and necessary information concern suggests he is inferring that there is sufficient and necessary information for replication, but that there have simply been very few attempts at doing so. Nonetheless, there has been a failure to adequately and directly address both the replicability issue and the methodological concerns. Both of these limitations make it difficult to fully assess Masters and Johnson's results. 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, although some have questioned the alleged superficiality of this treatment model and have also identified omissions in Masters and Johnson's published works, these same investigators confirm Masters and Johnson's originality and offer support for their methodology (Apfelbaum, 1984; Slowinski, 1984). Studies involving the use of Sensate Focus and a ban on intercourse have found a significant increase in the level of satisfaction for subsequent nonorgasmital, sexual caressing as well as for intercourse (Fichten, Libman, & Brender, 1983). Randomized, placebo-controlled investigations (Fisher *et al.*, 2005) have "demonstrate[d] 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), thus offering support for Masters and Johnson's couple-based approach to treatment.

Population limitations Although the original research on male and female sexual response published in *Human Sexual Response* (1966) was carried out with both identified gay/lesbian and heterosexual individuals and couples, a complex and sophisticated understanding of sexual orientation 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 of their work has been the investigation of their techniques in many other populations (Linschoten, Weiner, & Avery-Clark, 2016). These include, among many others, people: with disabilities (Bell, Toplis, & Espie, 1999; Melby, 2011; Tepper, 2000); with medical conditions (Gallo-Silver, 2000; Jindal & Jindal, 2010; Sanders & Sprenkle, 1980); who have AIDS (George, 1990); who deal with substance abuse problems (Jensen, 1984); who have a history of sexual trauma (Maltz, 2012; Weiner, 1988); who are gay, lesbian, gender queer, or gender fluid (Hall, 1987; Iasenza, 2010; Leiblum & Rosen, 2007; Nichols, 1982); and who are from orthodox religious backgrounds (Ribner, 2003). These studies indicate that sex therapy and many of the Masters and Johnson techniques can be successfully utilized for treating sexual concerns across a wide variety of populations.

Dual sex team Although 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, and this clinical model has been adapted to single therapist, out-patient settings. As McCarthy (1973, p. 293) noted:

> 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.

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 as contained a 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 at 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, as most sex therapy takes place once a week in 50-minute sessions with a single therapist (McCarthy, 1973, p. 290). Some therapists have modified the two-week, intensive format to this more common practice, with each session including (a) a review and discussion of the previous week's assignments, (b) processing the clients' feelings, and (c) 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 ba job, family, self-care, responsibilities, and other interests while simultaneously maint their treatment progress. However, if a rapid, sequestered program is feasible, re-entry p lems can be effectively managed with check-up appointments. This was done at the Ins with twice monthly telephone sessions for two years. This serves as a reminder to par about setting aside quality time, scheduling touching on a regular basis, and practicing individual and relationship skills.

Summary

Despite its limitations, Masters and Johnson's short-term behaviorally- and psychoeduca ally-based approach to treating sexual difficulties has served as the touchstone for many s ogists for over 40 years. We cannot help but be enthusiastic supporters of its vitality and remarkable and meaningful transformations that can take place through the seemingly s suggestion of engaging in human touch without regard for result.

A Case Illustration

A number of the aforementioned points can best be illustrated through a case study. The Do identifiers have been eliminated or altered to assure anonymity) present for sex therap pairing of two common complaints: low sexual desire on the part of the wife and erection culties 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 causes for the presenting sexual complaints. This session involves gathering information ne to assess further the nature of the concern, the resources brought to bear, and the couple's thera goals. The Dorns, a dual-career couple in their late 50s, have been married for 30 years. H raised several children, they are at a time in life when couples often re-examine their relati The Dorns are steeped in anxiety and hostility as the sexual resentments have built up over the This has affected their sexual relationship, their ability to be physically affectionate, their c nication, and the quality of the time they share. They desire not only to resolve their sexual and to rekindle their original intimate connection, but also to cultivate greater meaningfu their sexual and relationship lives than they have previously experienced.

History-taking

This case example is intensive in format and involves a heterosexual couple. The initial with both partners takes place on the first day, and the individual history-taking sessions tak on the second day. The results suggest no depression, psychosis, substance abuse or other cli significant psychological disorders in either partner. In her individual history-taking sessio Dorn reveals that she was sexually active in her 20s prior to getting married. In his, Mr D reports that he had few intimate encounters in his adolescence and early adulthood. Both in that their shared sexual relationship had been adequate for a number of years prior to having dren. The frequency of sex had tapered off as the dual-career couple balanced professional p and raising children to whom they were devoted. As the frequency of sexual encounters dimi Mr Dorn began having difficulties maintaining his engorgement. On her part, Mrs Dorn experiencing decreased sexual interest.

Mrs Dorn attributes her loss of interest in sex not just to career and children but also to the fact that Mr Dorn had become increasingly preoccupied with incorporating what she regarded as objectifying paraphernalia (garters, high heels) into their intimate encounters. Additionally, she experienced him as rushing to genital contact and attempts at insertion. Her goal is to feel interested again, and she expresses her desire to spend more time savoring the sensory experience of being together in a nonsexual fashion.

Although 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 phosphodiesterase type 5 (PDE-5) inhibitor, such as Viagra, 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 with the therapist's mirroring an empathetic understanding of the same-sex partner's relevant history and concerns and, conjointly, introducing suggestions for resolving their identified issues.

Mrs Dorn's mirroring *It is reflected to Mrs 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, and especially relatedness to the immediate, concrete sensory experience. It is this giving herself to an overload of sensations that is at the core of Mrs Dorn's sexual value system. The mirroring reflects back to both spouses that Mrs Dorn became enamored of physical contact in her early adolescence the first time she was hugged and kissed by a boyfriend. 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 musk-scented cologne; the sound of his leather jacket rustling; 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. She recalls having experienced a sense of homecoming, mesmerized by the intense connection. 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. Mrs Dorn is concerned that every time she acquiesces to one of her husband's elaborate sexual scenarios, he will interpret it as meaning she is interested in it to the exclusion of more sensorial and affectionate relating. A tear runs down Mrs Dorn's face as she re-experiences the meaningfulness of this first encounter with sensuality, and Mr Dorn is unusually quiet.*

As part of mirroring Mrs Dorn's sexual values, the therapist also provide education to Mr Dorn about general female responsiveness. 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 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.

It is suggested to Mr. Dorn that his wife is not just being "difficult" (to use his word) when she encourages non-demand absorption before and during genital stimulation. In contrast to many men, women often need this to facilitate the arousal and lubrication necessary for subsequent intercourse and/or orgasm. He also learns that sexual desire for women may follow arousal rather than precede it, which is all the more reason for him to attend to what actually interests his wife. Mr Dorn is stunned. He takes his wife's hand and shows some awareness of one of the larger issues that burdens their sexual relationship: "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 appreciation for emotionally connecting sensual immersion he has made up for in years of cultivating a rich, masturbatory fantasy life involving specific visual and tactile imagery. These include scripted scenarios such as his partner's dressing up in a red bustier, wearing black silk stockings with a garter belt, sporting stiletto heels, and engaging first in oral sex and then in female astride intercourse while speaking to him in a hushed voice.*

Mr Dorn's arousal patterns go back to an incident he had in middle school during which he caught a glimpse of black stockings and garters underneath a female classmate's skirt. He was able to recall vividly 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 and spent countless hours stimulating himself to orgasm using this imagery. This early experience had transferred to his current interest in having his wife engage in his fantasy. Mr Dorn is concerned that not only will his wife never appreciate his sexual interests but also that, if he gives her the affectionate and sensory contact she desires, she will have all that she wants and will never want to experiment with what arouses him.

Additional educational points in Mr Dorn's mirroring include providing accurate information about: the negative effect of anger on sexual arousal; the effects of aging on erections; and the impact of his spectatoring, which began the first time he had erectile difficulties. Mr Dorn acknowledges that his concern about maintaining his engorgement causes him to resist to insertion, thereby increasing his anxiety and short-circuiting the stimulation he needs. This has led to a cycle of failure, resentment, and defensive loss of interest on the part of both partners.

Mr Dorn's roundtable mirroring ends with an educational note for Mrs Dorn: Her husband is not necessarily being "insensitive" (to use her word) when he asks her to engage in scripted scenarios; rather, he is trying to achieve sufficient arousal to overcome the anxiety that interferes with his erections, and he has also cultivated these arousal patterns because he experiences them as genuinely pleasurable. Mrs Dorn is informed about the differences that appear to exist, on average, between patterns of adolescent masturbatory and fantasy activity for men and women (Robbins et al., 2011). Masturbating to specific images is an effective and frequently employed way of conditioning arousal to stimuli, especially during the neurologically impressionable adolescent years. Thus, men have a higher probability than women of emerging from their teenage years with a finely honed awareness of the particular cues that assist their becoming sensorally and sexually absorbed.

As Mrs Dorn listens to the information offered by the therapist, her countenance visibly softens. She looks at her husband, down at his hand holding hers, and back to the therapist. "You mean, he's not kidding? He's not just being insensitive? These scenarios really do mean something to him?"

In the mirroring sessions, both partners have the opportunity to learn about the importance of attending to and honoring their own and each other's sexual values. This forges a significant connection between them and reduces power struggles even before therapeutic interventions have commenced.

Therapeutic attitudes and skills *Following the roundtable mirroring, the therapist introduces the attitude of being focused on the present; the concept of self-responsibility rather than partner blaming; the importance of structuring quality time together; and communication, negotiation, and feelings management skills.*

Sensate Focus

Breasts and genitals off limits *Once the Dorns understand and commit to practicing 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 the next two*

session. In an intensive format, this would be two Sensate Focus sessions prior to the next day's therapy session; if treatment is in a less intensive, once-a-week format, this would entail one touching session no less often than an average of every 48–72 hours prior to the next week's therapy meeting. Because Mrs Dorn presents with a history of feeling more pressured by her husband, she is encouraged to initiate 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 easily be misinterpreted and that also may 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 Mrs Dorn's initiation. He is asked to be 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. 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 and, in fact, to do less if major problems arise. The therapists are not interested in either an objective skin measurement (e.g., what the BTUs are), or an evaluation of whether the sensations felt nice, fine, or good. Rather, they are interested in whether the Dorns experience the sensations descriptively, "taking it precisely as it presents itself" (Aanstoos, 2012, p. 56) in the moment. They are encouraged to make notes following Sensate Focus exercises of their experiences of the sensations, distractions, and ability to refocus for detailed discussion during subsequent therapy sessions.

Although 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 and without the goal of arousal. Mrs Dorn resists: "This sounds so selfish!" Much discussion and support is necessary to help her understand that tuning in to her own sensory experience, although most certainly self-focused, is different than being selfish (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 and loss of goal orientation: "But I need her to do things to make me aroused!" He is reminded that since sex is a natural function, his wife cannot make him aroused, that arousal is not the goal of Sensate Focus, and that he will be given more skills for communicating his needs as therapy progresses.

Mr Dorn is much less enthusiastic about the touching experiences: "I didn't feel much." It is evident that his expectations are 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 and then is absorbed by the partner's skin. Processing this second set of instructions, Mr Dorn is agreeable and appreciates the need for putting aside his goal-directedness toward arousal.

The impact of the shift to honoring sexual responsiveness as natural functioning by redirecting attention to the subjective, momentary tactile experience cannot be overstated. Mrs 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." Mrs Dorn also reports being moved by the emotional closeness she has experienced with her husband. She has never had the opportunity to engage in such sensory exploration, and she easily becomes lost in the experience. It was as if she had revisited some long-lost force within her. Her loss of sexual desire already shows signs of abating.

Breasts and genitals on limits *After several sessions, Mr and Mrs Dorn have progressed sufficiently such 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 before. Mrs 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, once focused, to assume the position of sitting with her back up against the headboard, her legs spread out in front of her in a "V" shape, and her husband 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 touching 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. This is designed to foster a whole body experience, to minimize spectatoring of the penis, and to reduce anxiety regarding the natural waxing and waning of engorgement. Once finished, they are to switch positions with her husband 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, although 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. He stops trying to do so much for Mrs Dorn, and he increasingly allows himself to become more sensorally involved. 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 verbal reports in the therapy sessions include fewer references to his state of engorgement, and more reports of the meaningfulness of the Sensate Focus sessions to him in general.

Mrs Dorn is also reassured. She has found it particularly helpful to learn that not only are sexual responses natural functions but also, like all natural functions, they wax and wane regardless of 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 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, and it multiplies the experience of sensations. The therapist explains, "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 we are going to have you touch simultaneously." Mr Dorn's interest noticeably picks up: "Now this is more like it!" Whereas only a few sessions before, Mrs Dorn might have fired back with a sarcastic comment suggestive of her husband's 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 breast 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 engorgement, he will have an understanding of the reasons why this occurred ("I was trying to make myself aroused"). Additionally, he will have a new skill set for dealing with this ("I need to refocus on sensations"). Encouraged to manage anxiety outside of the bedroom, if anxiety occurs during the touching session, the couple is instructed in the use of a positive code word. This signifies their need to change the activity and refocus on different sensations. Both feel empowered to move through the anxiety by changing positions and focus, and continuing on, usually with positive results.

Female astride, and optional insertion *Having acquired information and confidence about, and management skills for, gaining and losing engorgement, the female-astride position is introduced. Mrs Dorn is encouraged to straddle her husband and use her husband's penis against her vulva, focusing on her own tactile sensations in her genitals. The first time they try this, Mr Dorn promptly loses his engorgement, which is common with erectile insecurity at this stage. However, Mrs Dorn is orgasmic anyway as she adeptly uses her husband's flaccid penis against her clitoris. The fact that female orgasm is possible in the absence of an erection is a 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 advised to avoid any insertion and are encouraged to think of their genitals as they did their hands in the early Sensate Focus sessions. Their focus is 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 genitals using their own. They have never done this before in a non-demand, touching-for-their-own-interest fashion.

When they are able to apply Sensate Focus skills to genital-to-genital contact, they are encouraged to explore insertion in the same way if this is of value for both of them. When Mrs Dorn feels ready, she inserts her husband's penis and is asked to remain motionless, resisting any physiological impulse to engage in thrusting motion. This insertion without motion allows both to focus on the sensations of warmth and pressure and allows Mr Dorn to experience his worst fear, namely, the loss of his engorgement, this time in a purposeful way. In subsequent Sensate Focus exercises, insertion with movement is included. Even later, in Sensate Focus Phase 2, the Dorns are further encouraged to play with insertion and move from a variety of other sexual activities back to insertion with movement. This is all in an effort to cultivate an exploratory mindset and increase their nonverbal communication.

As the sessions involving female-astride progress, Mrs 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 he so desires her wearing, and she 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 to explore her own feelings about these activities regardless of her husband's (very positive) reception.

Following the tenth session of female-astride, and the second involving insertion, Mrs Dorn returns to therapy sporting a pair of high heels and a provocative dress. She can hardly contain her excitement. She describes how amazed she is that, contrary to the opinions of most of her 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 for herself. Mrs Dorn reports being most pleased with the spillover effect that her sexual exploration is having on her overall mood.

Kissing *Often, one of the most emotionally charged activity for clients is kissing. For many couples, kissing is one of the first ways the sensorially explore one another. However, it may be one of the last activities attended to in sex therapy. It is discouraged prior to this point in the 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. It is often difficult for partners to kiss without evoking pressure to feel romantic and aroused. All of the physical contact up to this point in therapy is through touching with the hands. However, as Sensate Focus progresses, couples are able to experience 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. Mrs Dorn is able to surrender to the tactile immersion for which she so yearns. Her complaints of lack of sexual interest diminished significantly. 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. 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 are not part of their activity. 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. Both Mr and Mrs Dorn report that, despite a quarter century of marriage, they are having genuinely imaginative intimacy for the first time. They are very pleased with their progress but know that they must work hard to maintain it.

Conclusions

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. These techniques are used by many sex therapists. Sensate Focus in its initial phase is a set of touching exercises intended to cultivate a non-demand attitude of touching for one's own interest, and teach what clinicians would now call mindfulness practice. Sensate Focus serves as a valuable diagnostic and therapeutic tool, and it functions as an educational tool in that it teaches clients to experience sexual responsiveness by tuning into sensations and refocusing away from evaluative expectations that disrupt their natural responsiveness. This facilitates the conscious mind's getting out of the way of this natural responsiveness.

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 or to sexually arouse one's self or one's partner. It is *not* intended to foster relaxation, enjoyment, pleasure, or eroticism. It is *not*, as it is so often portrayed, "caressing and sensual massage during noncoital loveplay" (Albaugh & Kellogg-Spadt, 2002, p. 402). It *is* "intended to be an experience in itself, not a prelude to 'sex' or a form of foreplay" (De Villers & Turgeon, 2005, p. i). As Weiner and Avery-Clark (2014) noted, "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" (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. These are associated with the very emotions clients are long to experience when they first come into therapy but cannot make happen, just as the practice of mindfulness can serve as an impressive inroad into cultivating calmness. The experience of Phase 2 includes 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) and which Avery-Clark (2012) described as "numinous." If couples engage in Sensate Focus in the non-demand touching approach that Masters and Johnson suggest, they increase the probability of experiencing the way in which intimate connection and sexual enjoyment can arise meaningfully and naturally so as to increase the likelihood of the emotional closeness for which they yearn.

In summary, the Masters and Johnson approach involves not only behavioral intervention through Sensate Focus exercises but also educational, attitudinal, cognitive, and affective components inside and outside the bedroom. Its focus is on appropriate assessment of the sexual problem, with individual, family of origin, cultural, relationship, and lifestyle factors influencing the pace and approach taken with the couple. The emphasis on doing no more than is required to address the sexual difficulty offers the opportunity for short-term treatment in consideration of the clients' values and interests.

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