Part III:

Special Issues in Marital Therapy

Chapter 6

Sex Therapy: An Adlerian Approach

by

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Walking into our offices today are individuals, couples and families with sexual questions that are explicit, implied or hidden, yet fundamental to their visible troubles. Many books describe likely therapeutic solutions to these questions from many theoretical perspectives, yet the power of the Adlerian approach to sex therapy is not well known. The major goal of this chapter is to elaborate and apply this power. We assume that the reader is already familiar with Adlerian theory; we have included a bibliography that covers the now-standard sex therapy in sufficient detail to employ. We present here the application of an Adlerian approach to problems of sex therapy, in the form of a working model and illustrations of its use.

Many people already familiar with sex therapy techniques would improve their practice by learning Adlerian principles, and adept Adlerians should be able to apply their theory to the challenges of sex therapy by learning sex therapy principles. We are suggesting a way to create these two bridges.

To accomplish this, we note Adler's stance and present basic Adlerian assumptions that bear, in particular, on sex therapy. While it is impossible in one chapter to provide a comprehensive discussion of the subject, we provide a flowchart mapping a therapeutic sequence that, with examples, supports our theme and builds a substantial foundation.

How does the Adlerian approach, not devoted to sexual issues per se, provide such a good foundation? One may peruse virtually any journal on human sexuality and find evidence of the debate over whether a particular "dysfunction" is "caused by" or "based upon" more physiologically or psychologically defined factors. Adlerians know that sexual functioning cannot be divided into parts existing separately and independently of the rest of human living.

Adler's Stance on Sexuality

First, Adler himself noted the importance of sex. "Adler considered it one of the three great life tasks every human being must meet, the others being work and social relations," the Ansbachers wrote in the preface to their classic compilation of Adler's work, *Cooperation Between the Sexes* (Adler, 1978, p. viii). He recognized sex to be not mere physical activity or drive-regulated behavior, but a foundation of the whole family and thus society. Whereas Freud's emphasis was more on biological functioning, for Adler sex was a very sophisticated social behavior. Shulman agreed, stating:

> The amount of cooperation required in sex is probably greater than that required in most other human relationships. Indeed, in my opinion, the ability of husband and wife to cooperate in bed is a mirror of their ability to cooperate in other aspects of their relationship (Shulman 1967/73, pp. 84-85).

But like behavior in those other aspects, sexual behavior, according to Adler, can be learned and unlearned. It is therefore amenable to therapy and to change.

Second, sex therapy needs to be an option simply because of popular demand. The layman knows that something like sex therapy exists, and is likely to assume that marriage counselors know something about it. Clients today are quite willing to identify marital problems as sexual; they have expectations that their own or (more often!) their spouse's sexual behavior can change; and they are willing or even anxious to discuss sexual issues with the therapist in the context of dealing with other marital issues.

A peculiar fact may increase these expectations even more. What statistical evidence exists suggests that couples report relative sexual happiness. Tavris and Sadd (1975) wrote in the much-cited Redbook report, a large—100,000 respondents—though not representative study, that only about one in twelve wives reports or is believed by her husband not ever to reach

orgasm. More importantly, Tavris and Sadd reported that a third of the respondents reported their sexual happiness as very good and an additional third said it was good. *One might expect people to be more interested in bringing their satisfaction up to nationally advertised expectations levels, rather than identifying their problems as a serious "dysfunction" requiring explicit "sex therapy."*

Third, many Adlerians believe that once the Lifestyle is known, the patterns in the client's life are understood and can be applied perhaps even more effectively (than ordinarily used) to the sexual area—so sex therapy per se is not needed. While this is true some of the time, specific sexual therapy techniques not only are expected by clients but also give the therapist additional openings for effective intervention.

Fourth, Adlerian Psychology (as the first social psychology) considers human behavior in the context of society. Today, sexual behaviors range across a broad spectrum, evolved over the past century from a time of Victorian denial (where physicians could not view a patient's nude body) to the much-argued permissiveness of the "sexual revolution." Overlaid on this situation and contributing to its flux is the "information boom," studded and laced with sexual data, opinions, options, implications and instruction. Sex is broadcast, however, relentlessly by the mass media via books, newspapers, magazines, movies, radio and television, and it is treated academically, popularly, pornographically and every other way.

Four Illustrative Cases. What might be done, for example, for the following couples?

> **Case One.** Adam and Ann were referred by Adam's urologist for sex therapy to solve his "impotency." They had not had intercourse for nearly six months, and Adam asked if something could be done. Ben's NPT (nocturnal penile tumescence) tests showed adequate erectility, suggesting a diagnosis of impotence with psychogenic origins. Ann was in full agreement, having been aware of Adams's degree of arousal some early mornings, yet angry at his rejection of her and fearful of losing him.
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> **Case Two.** Bill and Beth came in as a couple because we insisted that we see them as a couple. Beth had originally called and didn't want her husband to know she was seeking help for "low sex drive" and

for the pain associated with intercourse. She reluctantly agreed to invite him on the basis that we prefer working with both spouses, believing therapy is more effective that way.

Case Three. Charlotte and Charlie came in for a "pair of sexual problems." Embarrassed, she reported not having had orgasms for years, and Charlie called his rapid ejaculation "having a hair trigger." They had argued following a passionate but brief intercourse after a friend's wedding reception. Charlotte had neared orgasm as Charlie climaxed, and her years of resentment tearfully exploded into his years of embarrassment. While she had been getting it over with quickly and he had been accommodating, now he wanted to "learn control" and she wanted to "feel more like a queen than a tramp."

Case Four. Domingo and Dolores fought over Domingo's lack not only of erections but also of sexual interest. They wanted to start a family, and their family wanted them to start a family, but Domingo, driven in his career, was only midway through professional school. Dolores was angry and ready to separate and he was embarrassed and desperate.

How to proceed with these typical cases depends, of course, upon the therapist's theoretical and practical model. Outlining the basic assumptions that particularly apply Adlerian sex therapy will demonstrate the potency of an Adlerian approach.

Basic Assumptions

The following assumptions come from several sources: Adlerian Psychology, the authors' training and clinical practice, and the field of sex therapy. The assumptions are consistent with each other and imply a foundation of some sources and solutions for sexual difficulties.

1. Behavior is interactional.

Behavior is formed in a social setting—the family of origin. There is no "I" without a "we." There is no psychology without sociology. Dreikurs (1955) wrote: "Every action is interaction" (p. 70). Sexual behavior is a social phenomenon. For the sexual relationship to be good, many other aspects of the relationship must also be good. A complicated set of social skills is necessary for good social functioning: How to cooperate, to listen, to talk, to ask, to notice, to savor and appreciate, to care, to focus, to

empathize, to help, to lead and to follow, to overlook, to remember, to forget, to commit, to observe, to attend to, to be vulnerable, to represent oneself, and especially, to risk. Some implications of this position for sex therapy are as follows:

(a) Both people are seen together. Therapy is balanced so that neither partner can be blamed for the problem. One of Masters' and Johnson's most frequently cited observations is, "In a sexual problem, there is no such thing as an uninvolved partner" (1982, p. 383; 1976 notes; paraphase of 1970, p. 9-12).

(b) If only one partner is available for therapy, the work must be done in context and must be interaction-based.

(c) Each person is seen as maintaining the problem in some way, and will therefore need to be included in the process of change. There are no "good guys and bad guys."

2. Reality is unique to each individual.

The individual's subjective, phenomenological view of the world is the key to that individual's view of sexuality and thus one's own sexual functioning. A woman who has never had an orgasm because she places top priority on "pleasing" and is therefore less likely to stand her ground, ask for what she wants, and attend to her own body pleasure, requires a different kind of therapy than a woman who has never experienced an orgasm because she is uncomfortable being out of control and vulnerable.

In this chapter, we assume that the therapist knows how each client's private view of the world affects sexual individuals' phenomenological reality to stimulate better acceptance and therefore therapeutic effectiveness.

3. Behavior is internally and externally holistic.

Sex therapy draws from many fields: biology (physiology, medicine, endocrinology, pharmacology), psychology, sociology, anthropology, health and so on. Just as the presenting (and hidden) problems may be defined in these different vocabularies, so is the research and clinical work carried out and published in disparate settings. We assume the therapist is always alert to new opportunities to learn, find and integrate theory and data from these allied disciplines, which overlap more than is commonly assumed. The concept of holism unites this apparent diversity.

In this chapter we will treat sexuality in the form of a holistic model then, assuming that thoughts, feelings, chemistry, behavior, social interaction and so forth all function together, indivisibly. We will use the principle that sexual functioning cannot be separated from the rest of human functioning to delineate a particular therapeutic process and steps toward its accomplishment.

4. Human behavior is purposeful and follows a pattern.

To achieve significance within the family setting, the individual develops those traits considered by that individual to be the most useful. To that extent, given behaviors have no intrinsic value or measure, but must be interpreted according to their function; this is a "psychology of *use*." The person organizes cognitions, beliefs, feelings and behaviors into a pattern governed by rules derived by that person, and thus unique to that individual—the Lifestyle (See Chapter 3).

5. Every couple develops its own interactive style.

This development could be called "the couple Lifestyle," which is more than the sum of the two partners' separate Lifestyles; it is their dynamic *product*. This product depends, as Dreikurs put it, "on the interaction of their particular goals and purposes. Each somehow senses what he or she can expect from the other, and their agreement implies a certain acknowledgement of cooperation in pursuit of each one's goal" (Dreikurs 1955/1960, p. 72). Further, Adlerian theory holds that even though persons are not cognitively aware of their personal goals, they yet make demands and behave consistently with them and face other people's reactions to them.

6. Each therapy plan is unique.

Because of the above assumptions, the procedures for change suggested in this model will take into consideration and will vary according to: (a) the level of difficulty of the problem observed and interpreted (rather than the problem as presented), and (b) the uniqueness of the couple's and individuals' patterns.

Flow of the Model

The manner in which any therapy progresses can be modelled as a sequence of events from the time of first client-therapist contact through the termination of therapy. The approach proposed here is particularly fitting for Adlerians to use in conduct-

ing sex therapy, even at an elementary level. Referral to other specialists or redirecting one's focus of therapeutic content is feasible at any point. Phases of this process are, at the assessment level, intake, initial interview and then deciding what should be done first: medical treatment, marital therapy or family therapy, individual therapy or sex therapy. This last option, or direct therapy for the sexual problem using an Adlerian approach, will proceed through simple therapy, psychosexual and Lifestyle assessment and specific sex therapy. With the decisions linking these phases, we propose the flowchart in Figure 1. Let us first discuss the process and then elaborate the principles of the flowchart.

Because this chapter only addresses sex therapy, and sexual issues may be the presenting issue by clients or by referral, the main flow pursues the linked objectives of solving the sexual problems identified by clients and the interactive issues defined by the therapist(s). Since sexual issues also may emerge in the midst of counseling or therapy for other concerns, that point will be assumed for present purposes to be the entry point, at which the clients either are referred to us or arrive on their own volition. When clients raise a sexual issue they wish to resolve during ongoing therapy, the same model may be seen to fit with obvious adaptations.

Referral and Intake

When physicians are the referral source, clients have usually been examined for organic sexual dysfunction. To assume that all possible organic factors have been covered, however, may be erroneous. The therapist should directly ask, for example, how often and to what degree nocturnal erections are experienced by the man coming for "impotence," or what cultures has the gynecologist run for the woman complaining of painful intercourse. When these issues are presented by clients without prior medical workup, referral should be made to an appropriate physician, presumably one with whom the therapist is able to discuss the case. Clients can, following medical treatment, return for sex therapy if they still want it. This is the ethical and practical sequence, regardless. Furthermore, when referral is from another therapist, the same early assessment routine should be followed.

Intake forms vary widely, but usually require certain minimal data for clerical use. Carefully designing a form for the clients to write out typical family constellation data, role of prior therapy, educational and occupational situation, health status and reasons for seeking therapy provide more than just the begin-

nings of assessment. They focus nervous, angry, embarrassed or anxious people on data, thus calming them and providing safe areas for beginning the inquiries of the initial interview.

Initial Interview

The four primary goals of the initial interview are:

- To establish rapport indirectly
- To gather data for developing therapeutic hypotheses
- To intervene minimally and powerfully near the end of the session and
- To assign therapeutic homework.

Specifically, these goals may be approached by accomplishing or at least beginning six distinct tasks during this first session.

- **Create rapport while obtaining background information.** In marital and sexual therapy, the task of establishing trust and confidence is much more difficult than in individual therapy. The partners are often at war and polarized on how they see the problem; each one is hoping to gain the therapist as an ally. The success of therapy may well depend on the therapist's ability to establish a balance or neutrality that helps both partners feel they can be represented and understood.
- **Obtain a brief description of the problem from each person.** Implicitly there are separate perceptions, and each is validated.
- **Ask each spouse to list other major complaints.** Thus, all pertinent problems can be stated and put on record, then put aside pending later consideration at the therapist's discretion.
- **Obtain a brief history of the marriage.** ' clude information on who is living in the household, the courtship, cohabitation, reasons for marrying, pregnancies, miscarriages, abortions, children and their domicile, duration of marriage, previous marriages and their terminations (and nature of deciding on all of these).
- **Ask both partners some things they like most about the other, their selves and the relationship.** Partners' likes are indicators of the strengths of the relationship and of the respective individuals. This information is useful later for planning strategies and interventions.

- **Ask both partners what they want to achieve in therapy.** Since this leads directly to the therapeutic contract, specifics and accuracy are important. Demonstrable behavioral objectives are imperative; fuzzy abstractions typically lead to disagreement. (Occasionally, the difficulty one partner has with specifying what one wants evokes a realization of why the other cannot deliver it.)

Other things being equal, the model assumes that the therapist will respect the clients' request; if they come in asking for sex counseling, that is the place to start. With their attention and energy focused on sexual issues, the couple will probably be more motivated to move there. However, when conflict, resentment and bitterness in a relationship are so intense that one or both partners are unable to become aroused or are unable to cooperate in the sexually therapeutic homework, then marriage counseling must be done before the couple can work effectively on their sexual problems. Segal (1983) synopsized this difficulty with simplicity: "Doctor, make him an erection while I tell him what an ass he is."

Style of questions. The beginning session sets the stage for therapy. Even more than in other issues of couple counseling, it is important in sex therapy to balance attention paid the two persons. Spending equal time supporting each person and asking for their separate views on each issue identified demonstrates and helps establish the neutrality that assures both partners they will each be represented and understood. (In the first interview, confrontation is typically ill-advised but should also be balanced whenever used.) In discussing how one creates a comfortable climate with clients on what they often react to as delicate matters, at least with outsiders, Pomeroy (1976), learned many methods as part of the Kinsey team, has made these suggestions:

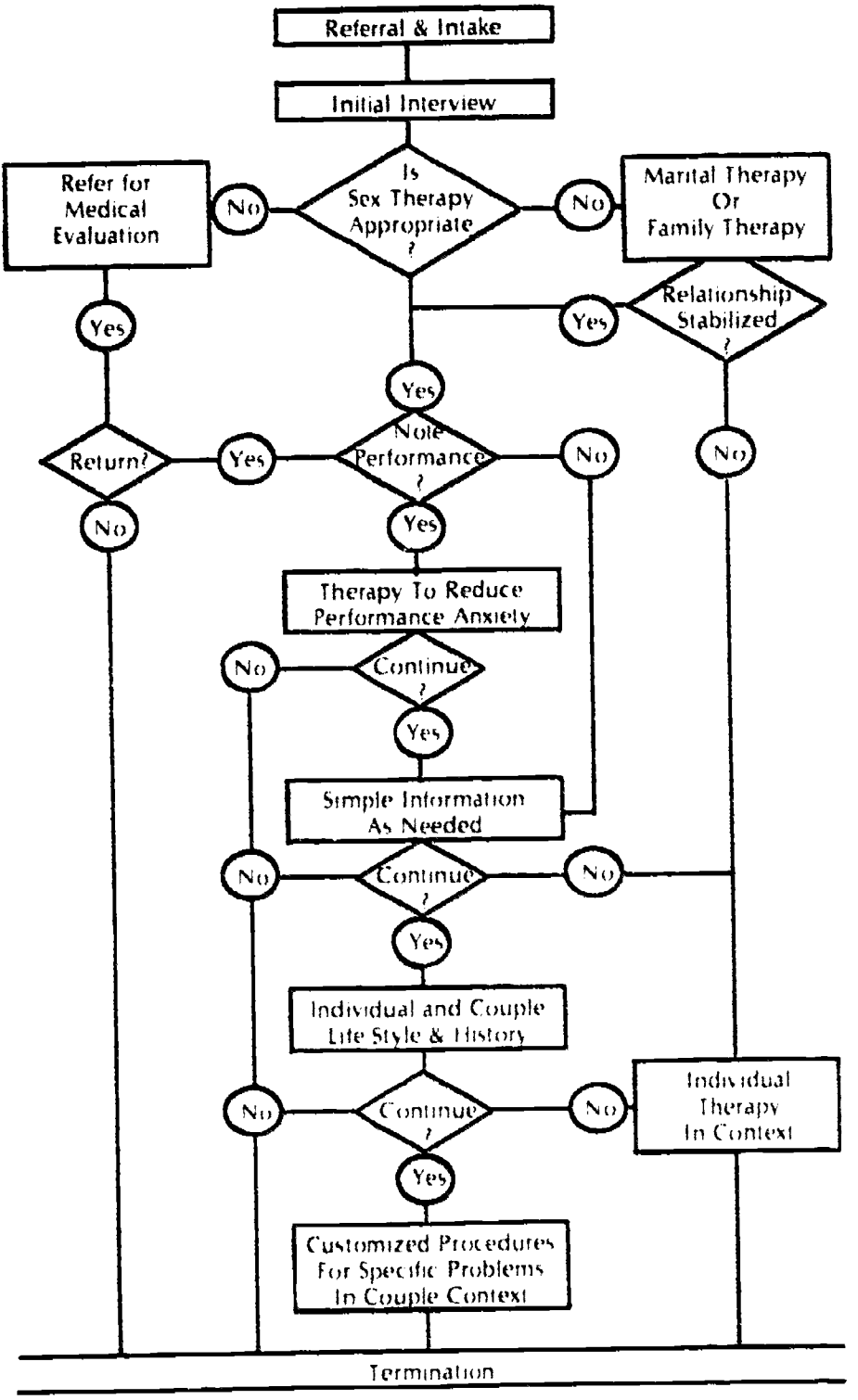
- Communicate a liking for the client; don't be neutral;
- help the client "save face";
- give reassurance continuously;
- do as little writing (note taking) as possible, or none at all, compiling notes after the interview;
- begin with questions about factual, nonsensitive subjects;
- avoid questions that can be answered with a "yes" or "no." We reiterate the advice to balance: Ask each client the same questions.

Content of questions. Certain styles of questions elicit the interactional nature of the difficulty, an aspect that very few couples can notice in the emotional midst of arguing, defending and feeling bad. The following general questions can illuminate the dynamics of the presenting problem. Although the therapist obviously requires this information, the very process of collecting it often proves illuminating for the client(s) as well.

- What is the problem as perceived by each partner?
- What is the history of the problem as perceived by each partner? Explore:
  —its development
  —its duration
  —how it has been intermittent, acute, chronic
- Why are they coming for therapy *now*?
- What have been the concurrent events?
  —births, deaths, affairs, illness, debts, accidents...
  —other crisis, in the minds of the clients
  —sudden or gradual shifts from original expectations for the relationship?
- What has each client done about it?
  —what helped
  —what didn't make any difference
  —what hindered
- What does each client think "caused" the problem?
- How did each client respond to what the other did to solve the problem?
- What does each partner expect of therapy?
- How would your life be different if you did not have this problem?

Routing to therapy tracks. During this first interview everything done should lead to the first hypotheses of therapy, and the strategy depicted in the flow chart (See Figure 1). The first hypothesis answers the implicitly multiple-choice question at this point on the flowchart: "Is sex therapy appropriate?" The answer would be affirmative if there are no apparent medical or other organically questionable conditions present, and if the clients demonstrate: (1) Their ability and willingness to do sexual homework (2) reasonable skills in problem-solving and (3) a stable life situation, free from crises such as illness, grief, dramatic career changes or family conflict.

Figure 1
Flowchart of Therapy Foci and Decisions



This simple flowchart shows a sequence of decision points—shown in diamonds—and treatment emphases—shown in boxes—applicable to most client couples coming for sex therapy.

When a therapist is in doubt about which way to go, the general rule is to pursue a middle path that is least expensive on all counts considering its return, that respects the stated objectives of the clients, and that often yields satisfactory results, making medical evaluation or marital, family or individual therapy unnecessary. Complaints that imply some organic condition that would preempt sex therapy are referred to a gynecologist or urologist: Any reports of pain, discharge, injury or numbness are examples of or factors indicating that the left path on the flowchart is the appropriate one to follow.

The right-hand path is the choice if for other than medical considerations, sex therapy cannot feasibly be the focus. For example, if the couple is practically on the way to divorce attorneys; if there is intrusive use of drugs or alcohol; if a child is acting out, compelling inordinate attention; if they are "stuck" in a cycle of who is right or who is in power; if one has not (or both have not) disengaged from family of origin; if either partner is involved with a third party, sexually or not; if either spouse is severely depressed; if one is in therapy because of the other's ultimatum—the relationship must be stabilized through adjunct therapy first. Only rarely can the middle and right-hand paths be taken simultaneously, or alternately, because the subversive power of the distracting dynamics will be greater than the unifying power of sexual risk.

Beginning Therapy: Simple Procedures

In many models of sex therapy, the procedure is to give a very elaborate sexual and life assessment at the beginning, and then to proceed with case planning. The style proposed here instead proceeds immediately with an action-oriented therapy, since elaborate initial assessment is expensive for the client and is often unnecessary. Simple procedures can sometimes solve the sexual problem. Further, whereas in most Adlerian counseling the style is to educate first and then to proceed with therapy, our model starts with simple procedures that educate first and then proceed with the Lifestyle and psychosexual questionnaire when and if that becomes necessary.

Every couple situation is unique, and every case plan is customized. The opposite is also true: All sex therapy cases

have certain things in common and a few simple procedures will be useful with most cases. At the beginning of therapy, therefore, one basic determination is required: Is the couple stuck in a worry cycle (performance anxiety), are they in need of information, or both?

Performance Anxiety

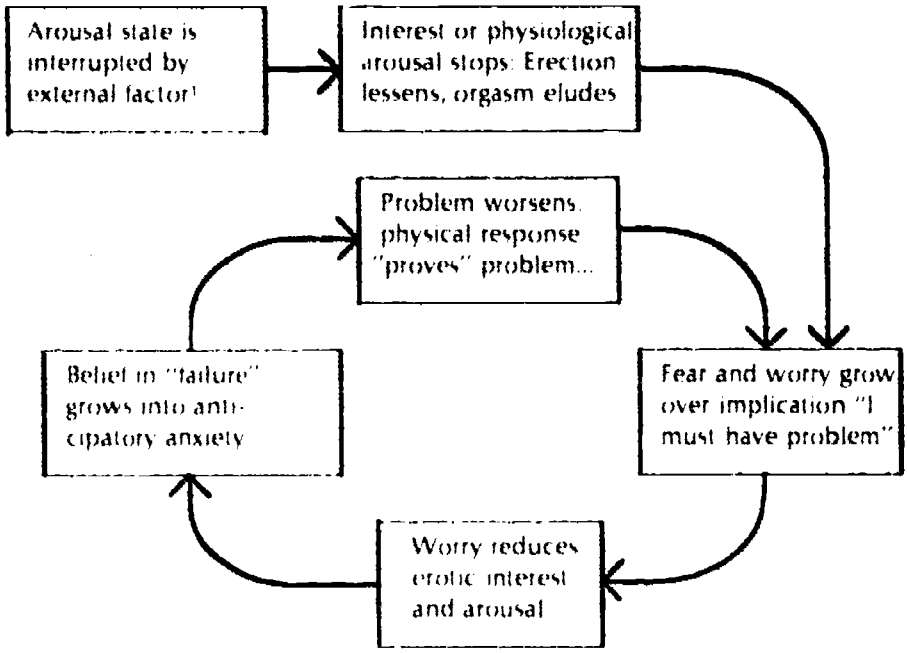
Generally, if a couple defines the most intimate aspect of their lives together as unsatisfactory enough to seek help, their motivation includes anxiety. Combined with this anxiety is a typical pressure to perform—i.e., to have an erection, to control ejaculation, to stimulate the other pleasurably, to have an unmistakable orgasm, to participate with passion and spontaneity. Such pressures create an atmosphere in which the Performance Anxiety Cycle is set in motion: The cycle is usually imperceptible until well established. The paradox of the problem, as Satir (1975) was fond of saying, is that the problem itself is not the problem—the *solutions* are.

The Performance Anxiety Cycle may have no clear beginning. A simple incident such as consuming excessive alcohol, for example, or having a heavy cold may lead to loss of erection. Telling himself, or being then told by his spouse that he is a "failure" or has a "problem," the man is likely to worry and analyze and therefore generate fear. His fear prevents feelings of arousal when with his partner, whose rejection he probably fears more than that of anybody else. Consequently, he avoids her and/or responds less enthusiastically than either deems worthy, thus the cycle is under way.

The goals for working with performance anxiety are simple (see Fail-safe and Sensate Focus in Specific Procedures discussed later in this chapter): Create a situation where failure is impossible (put intercourse off-limits, with no breast or genital touching), and ask the couple to be close and sensual with each other ("Sensate Focus" exercise). This prohibition prevents possible failure and the sensate focus helps create a situation where people can feel aroused. Take for example Case One of Adam and Ann presented earlier, where the forgoing procedure was employed.

After Adam's initial and precipitous erectile loss, both he and Ann each murmured apologetic excuses, rolled over and pretended to go to sleep. At the next attempt at intercourse, Adam was only partially hard, and could not effect penetration. He became less affectionate, lest this affection lead to sex, and even

Figure 2
The Performance Anxiety Cycle



[1] This diversion may be initiated by virtually anything, but most commonly surprise, illness, alcohol, insult ("you are a failure"), guilt, fatigue, drugs (including alleged "aphrodisiacs")

began to avoid responding sexually when Ann seemed interested. She read his first detumescence and the subsequent increasing avoidance as a disinterest in sex, an embarrassing stage in his aging process, and a recognition of her own perceived loss of beauty and appeal. Her way of coping was to share her love for Adam in nonsexual ways and to place no sexual demands on him, thus saving both of them embarrassment.

When they came to our office, they had not had intercourse for six months. They had also not risked confiding in each other about their fears and good efforts. They seemed heartbroken about their affectional rift and somewhat helpless that Adam's *problem* was diagnosed as "in his head," but hopeful that sex therapy might offer some solution.

At the end of the first interview, our prescription for this couple was as follows: Intercourse was to be off-limits, and he was to make love to her "without his penis," (he could bring her to orgasms with manual or oral stimulation, but his penis was not to be involved).

Adam and Ann returned to our office for a second session encouraged by Adam's erection during the exercise. They waited for two weeks and finally broke the rule and had intercourse. We warned them not to be overly encouraged. When Adam had an erection, he was to "make it go down" in order to gain better control. He found this difficult. In five sessions they had broken the performance anxiety cycle. They were both greatly relieved. He was erecting well, and they were enjoying even more sensitive physical love on a par with their lifelong caring and commitment. It was unnecessary to offer much sexual information or to take further time for Lifestyle analysis, and they went happily into retirement.

Informational Impasse

Informational lack or distortion will frustrate the clients' efforts to have a rewarding sexual relationship. Accurate information is needed about oneself, one's partner and the interaction patterns that result from pursuing the goals that these people depend upon. Often people lack accurate information primarily because of precautions well drilled during childhood: Hands slapped while exploring genital feelings, threatening preachments and/or punishments for sexual interests. Family, religious and cultural myths lead not only to inaccuracy, but also to great voids. Such advice as: "Do what comes *naturally*," "Your husband will teach you all you need to know," or "All you need are

the basics, you can learn with a prostitute," deter a person from seeking the best information about self or the other gender. Some clients can be educated easily with information from a book, a handout, anatomical diagrams, puppets, videotapes, therapists' writings or outside sources. Many a husband, for instance, has reacted with surprise and recognition, and subsequently reported improved lovemaking, after seeing a slide that clearly shows the similarity between the clitoris and penis, thus enabling him to realize how much his wife's clitoris rather than vagina is "where the action is."

One case without apparent performance anxiety, but requiring information therapy (the inner right-hand path in Figure 1) was that of Case Two, Beth and Bill. As usual, the presenting problem could not be either understood or addressed when in isolation from the couple's interaction.

Beth and Bill came to be treated for *dyspareunia*, or intercourse that was painful to Beth, and to find out how to increase her "sex drive." She hesitated to bring Bill, who had been hurt by her rejecting him. But he was relieved to know she had initiated the call for help and was impressed that she would open up to a stranger for him. When we put intercourse off limits and prescribed long periods of nongenital, nurturing holding and affection, Beth showed visible delight and Bill was relieved at being spared what he was beginning to believe was his failure as a lover. Since the therapists explicitly barred sex, neither spouse could blame the already typical lack of sex on anger, defense or lessening love, and both could instead focus on pleasure.

At the end of the first interview, we had Beth make an early appointment with her gynecologist to examine for possible low-grade vaginal infection which could be treated concurrently with therapy. One of several common bacterial strains was found and antibiotics were prescribed. Bill's urologist prescribed the same for him to counter possible alternating inflammations or of his being a host.

Anatomy lessons that were never learned by either were now provided via colored slides and standard genital exam homework. Bill had not known the location or even the importance of the clitoris, and Ann could not teach him since she didn't know either. Ann did not know the sensitivities of male genitals, and Bill was unaware of any more subtle gradient than erection and ejaculation. Homework carried out in private helped each learn their own pattern of arousal, which they then

taught to each other. Bill had never learned the fundamentals of female sexual arousal and had assumed pain was typical but temporary; Beth had been deprived of learning her own sexual pleasures. Thus their combined sexual inexperience, focus on orgasm as goal, and stress over Beth's discomfort generated a pattern of confusion and decreased pleasure for him coupled with frustration, pain and lack of orgasmic release for her. Acquiring necessary sexual information encouraged them to develop physical skills, which led to greater confidence and therefore less avoidance, finally yielding the satisfaction they sought.

Homework for Beginning Therapy

Homework is assigned in the first interview for several purposes. Homework reinforces the couple's decision to try new solutions to their problems with outside guidance. It also helps the couple apply their insights from the therapy hour, particularly those affirming that both partners have been working to solve the problem all along, just in defensive and misdirected ways. With homework, new discoveries about each other, learned in the interview, can be examined further in "real life."

Homework is adapted from a set of "tools" or techniques from other approaches to sex therapy, according to the unique nature of the couple and their apparently viable therapeutic issues. Examples, discussed in more detail later are:

- **Fail-safe.** Clients are instructed that breasts and genitals are off-limits, but they are to touch each other affectionately more than usual.
- **Committed playtime.** Time to regain confidence in each other must be scheduled—literally—and protected from intrusion.
- **Sensate focus.** Masters and Johnson's (1982) exercises, starting with their less-known Stage 1, expressing, and continuing with Stage 2, learning, remains paradoxically powerful. (With the degree of erotic contact staged also, this is a major tool.)
- **Kegel exercises.** Muscle-toning exercises for the pelvic web not only tone and strengthen muscles but increase awareness of sensation. Good for men and women, these exercises need to be started early, since physical development requires time.

- **Alone together.** This unstructured date has strong requirements—it is purely and simply a time to recreate and generate new enjoyment of each other's company.
- **Caring behaviors.** The couple learns to negotiate (asking for and granting to the other) unmistakable tokens of caring and commitment.

Lifestyles of Individuals and Couples

If these simple procedures are not enough and the problem continues to exist, it will become necessary to assess the partners' individual Lifestyles, particularly as they pertain to creating and maintaining the sexual problem.

Detailed help in making these individual and joint assessments may be found in Chapter 3. Here, however, we will focus briefly on the sexual issues in the Lifestyle: What additional information needs to be gathered during the Lifestyle assessment to narrow the focus more within the sexual area, and how general assumptions and basic mistakes about life, self and others reflect on the presenting problems and can be emphasized to motivate change as the interpretation is fed back to the clients for re-orientation.

Additional information needed for sexual Lifestyle assessment. For sex therapy, the Lifestyle assessment needs to include an individual and family sociosexual history to determine how and what each individual learned about many specific concepts. The Adlerian therapist must, of course, abstract from these data the process, or "dance," between the partners that results in their visible difficulty. This may be inferred by fitting each client's answers under the rubric, "How did this person fit that to one's own model of life?" The relevant topics for such an assessment of patterns are:

- Information about sex and reproductive functions (what was learned about where babies come from, menstruation, nocturnal emissions, intercourse, petting);
- Attitudes about personal being and interactions (cleanliness, attractiveness, bodily beauty, bodily care, sensual awareness, color-taste-smell-feeling-looks, sharing oneself with others);
- Beliefs of how one loves and nurtures another person (trust, cooperation, willingness to work, kinds of support, expression of positive feelings, response to friends, kindness, nature of illness, sensitivity to others' plights, victories and fortunes);

- Problem-solving and assertiveness (respecting others' boundaries and limits and maintaining one's own, saying "yes" and "no," communicating clearly and effectively);
- Gender roles, being male and female (expectations of males and of females, self and others; reaction or attitude toward these expectations, such as comfort, pride, or resentment).
- Values and morals, right and wrong (relative versus absolute rights or wrongs, degrees and changeability of integrity and loyalty, trust as earned and as assumed, cooperation and competitiveness and conflict, self-respect and respect for others)

These patterns may become most apparent by asking for specific sexual recollections while gathering early recollections with other Lifestyle data. Such specific questions might include: "When was the first time you noticed genital feelings? What happened the first time you felt aroused with another person? Same sex? Opposite sex? How did you learn to masturbate?" This list, rather than being a fixed interview schedule, urges inventive discretion of the individual therapist in posing questions that would reveal the patterns of this particular couple and of these individuals, and the nature of the presenting problems. Knowing these patterns and the beliefs and strengths of the couple, the therapist has most of the necessary information for planning a customized intervention for change.

Assumptions about sexuality. Lifestyle information such as beliefs learned from ordinal position, family and personal values, life experiences and so forth reflect on sexual satisfaction and patterns of sexual interaction. Some examples of how this feedback may be presented to clients follow:

- "From your place in the family as the youngest child, you've learned how to be creatively fun-loving and playful. Your Early Recollections show a great sensual appreciation of smell, sight, touch, taste and rhythms. These sensitivities will be helpful in teaching your more serious partner about this kind of joy, for even though you have not had her experience of having been married before, the delicious delight of learning and savoring can be catching."
- "Both of you learned in your families of origin how to be responsible and to work hard. Sex therapy, or any kind of therapy for that matter, is hard work and will require peo-

ple to be responsible for themselves and for each other. Your early learning will serve you well in this task."

- "Your learning to be a good sexual partner requires that you be able to lead sometimes and follow other times. Your experiences as a middle child have already taught you how to do that."
- "Part of the problem with seeing life as a competitive arena is that you must also compete in sex. Since competition involves losing and you're afraid to lose, you avoid sex. When you begin to enjoy being with your spouse, your buddy, sexually and to really focus on your own body pleasure instead of on your performance, you'll find yourself more aroused."

Charlie and Charlotte, Case Three, who presented mutually reinforcing problems of rapid ejaculation and inability to orgasm, had been married for seven years and had a three-year-old daughter and an infant boy. As Charlie felt rejected sexually by Charlotte, he spent less time with her and the family, becoming more involved in his work. Charlotte, feeling abandoned with her children, began to believe that "he only wants my body, not my home, babies or company." She solved her problem by becoming overly involved with home and children and less with Charlie and his demanding work.

Charlotte, the youngest of five children, had three older brothers who made a princess of her. She had "center stage" Early Recollections, with men clamoring to please her, and she showed great dependence on these attentions. In his family, Charlie was the second boy, fifteen months behind the brother whom he eventually overtook, becoming the psychological first. For him, work was a competitive arena where he was determined to succeed and was constantly measuring himself and his progress. Though he was once enamored of his wife's "little girl" goodness and charm, he was now weary of her dependence and excessive demands to be noticed and treasured.

Strengths of their relationship were clear. Charlotte took seriously her feminine roles of being a good mother and the attractive—even showpiece— corporate wife. She started out as a playful sexual companion, but gradually discovered it more fun to attract attention than to enjoy it once found, and for her sex had become a bore.

Charlie provided the kind of Lifestyle that Charlotte loved—a beautiful house, expensive clothes, fancy parties, and admiring

corporate peers. He also was a hard worker and could therefore be motivated in therapy to make some difficult changes if given the right kind of assignments. He was a problem-solver and a "can-do" person.

Such Lifestyle information offers an opportunity to change not only this couple's sexual functioning, but through this rewarding shift to change their relationship in other valuable ways as well.

Charlie's focus on competition had led to his paying little attention to his own sensual pleasure or to Charlotte's. His highs were derived from smashing finishes in racquetball; the subtleties of affectionate touching and foreplay were outside his awareness. He kept score, counting the number of times they had intercourse over a period of time. When Charlotte was not interested in sex, Charlie masturbated and brought himself quickly to relief.

As part of the therapy, we asked them to engage in prolonged, sensuous, mutual touching without going to orgasm. He was uncomfortable at first and felt silly, stopping before ejaculation. The second and third times were easier. Soon he was able to reach a perceptibly higher level of arousal without feeling the need to ejaculate. Eventually he learned that the process of reaching orgasm was more enjoyable than the orgasm itself. In his competitive stance toward life, Charlie had focused so much on "the score" that he had never learned to enjoy his body or Charlotte's. His new success in the sexual area facilitated his using his home more as a place of rest and recreation; he played more with his children and learned to spend relaxed time with his wife.

Therapy for Charlotte required helping her to take responsibility for her own orgasm and for her life generally. For seven years she had waited for Charlie to make sex good for her, and he never quite did. She had never told him how since she had never taken the initiative to learn for herself.

We prescribed long and sensuous genital touching, so that Charlotte could focus on her arousal without distraction. She learned to stimulate herself to orgasm and to teach that process to Charlie. In these weeks she taught herself to fantasize and developed her pelvic muscles to heighten her arousal. (See Kegel Exercises in Specific Procedures, discussed later in this chapter.) She also learned to ask Charlie for what she needed to reach orgasm. We suggested that she ask him, "Please don't go

until I climax." By twelve weeks after they began therapy, Charlie stayed home happily and Charlotte enjoyed making him welcome.

Customized Sex Therapy

A therapeutic strategy can be refined once the therapist understands the individuals' and couple's Lifestyles, sociopsychosexual histories, homework performance patterns and nuances of numerous therapy sessions and can estimate the sexual consequences for this couple. The further down the flowchart (see Figure 1) therapy has proceeded, the richer the profusion of pattern data, but paradoxically, the greater the difficulty in selecting factors to formulate an intervention. By analogy, the grander the array of tools, the more important it is for the user to be a master craftsman.

Techniques are for the therapist what tools are for the craftsman. Techniques have evolved from wide and even disparate sources across time. The product they help fashion depends upon the skillful application of the best tool or technique for the particular raw material, objective and circumstance. While anyone can pick up a particular tool, the apprentice will not get the same result as the journeyman, and the master craftsman or professional may use fewer tools more deftly, adapting to momentary challenges and finish more quickly. Misuse of a power tool, applying a blade that is duller or sharper than expected or misjudging attributes of the raw material may do irreparable damage to product or user. Poor timing may waste time. Cutting corners may cut quality, which will show in the end. People are more concerned that the purpose is met.

The Adlerian concept of use applies to the therapist as well as to the client. Each technique has multiple uses, but operates best as designed, fitting with the usual sequence. And while dumb luck may occasionally be had, it is hardly a technique upon which to rely.

"Customizing" sex therapy is simply applying all available techniques to the emergent situation in accord with working principles. Using again the "tools" metaphor, off-the-shelf parts need careful integration to create a smooth, custom job. In customizing sex therapy, the critical concept is fitting the operating principles of standard techniques to the couple's unique interaction pattern (situation) and to therapeutic objectives. Phrased as a question, knowing this couple and their Lifestyle goals and our therapeutic goals, what procedures and techniques can be used to accomplish the most important of these? The fourth

couple in the case examples introduced early in this chapter, Dolores and Domingo, Case Four, seemed during their first session to be appropriate candidates for sex therapy (central track of Figure 1). They were, indeed, both anxious about performance and needed sexual information. However, working on these was not enough. Their therapy illustrates a very customized procedure utilizing a manageably few additional "standard tools."

Although they had been married for two years at the time they began therapy, Domingo and Dolores had not yet had intercourse. On their wedding night, Domingo was impotent. Prior to their wedding, he had avoided sexual contact of any sort with Dolores, who wanted to be sexually active even before they were married. On their honeymoon trip, Domingo tried unsuccessfully to have intercourse; his tentative erection did not last long. After they returned home, he tried again a few times, again unsuccessfully, and thereafter avoided situations that might lead Dolores to expect sexual excitement.

We began our work with them by teaching such fundamentals as male and female anatomy, arousal and response cycles and by giving safe, sensual homework. We put breasts and genitals off-limits, but asked them to hold and touch affectionately in many other ways.

The emotional impact on both partners was intense. This beginning work was profound as they transcended unspoken fears together. Simultaneously they both experienced relief. She was relieved that they were coming for therapy and by the expectation of an ultimate resolution of their problem; he was relieved by her increased affection and reduced demands that he perform.

Time was an important element for this couple. They needed to do the safe, affectionate exercises many, many times. The atmosphere of safety evolved slowly during the weeks. They carried out their homework with great faith, which gave ample time for us to also take a comprehensive sexual history and general Lifestyle assessment. This process of talking, hearing, understanding and validating also contributed to their experience of safety. Their faith was increased during the second month as they noticed some first stirring of penile tumescence.

In the Lifestyle assessment, several noteworthy patterns became apparent. Dolores liked to judge. She watched and waited with implied rulership, as one who did everything right and who expected others to do everything right, too. Her early memories

were full of such evidence. Domingo wanted to do everything right in order to achieve and to please. Their joint Hispanic cultural background further complicated the problem: They both perceived the role of the male as pursuer and the female as the one to parry his advances many times before surrendering. Each was angry with the other for being forced into a role that was inconsistent with "the way life should be."

From their sociosexual history, we found that Domingo had never learned to masturbate. His strong desires to please his parents plus their warning against genital touching had prevented such bodily pleasures from early childhood. Dolores described demanding romantic fantasies and dreams of being pursued by men of great wealth and sexual prowess. In her family of origin, she was the oldest of seven children and was placed in charge of their care, brightening the drudgery of her parental day with these sexual mirages, but lacking the skill to elicit such romance from a live human being. Dolores and Domingo met in college. He came from a well-to-do family, was good looking and was pursuing an exacting profession, which, understandably to her, kept him from being available for his unlearned and her imagined sexual exploits. Dolores, he expected, by virtue of her surrogate motherhood, would be competent as a homemaker and skilled as a mother so that he could leave the domestic part of their lives to her and get on with his pursuit of more important goals.

Domingo first began to have erections and feel aroused after their exercise sessions—in which the pressure was off by prescription. We told him to continue doing the affectionate, non-demand exercises, and planned our major intervention, which was to identify her as the problem bearer. We labeled her as having the "sexual dysfunction of virginal vaginismus," (an obvious reading of primary evidence) and asked him to begin preparing her for intercourse, nurturing her with tenderness and understanding. We asked him to begin to dilate her progressively with lubricated pinky, finger, two fingers and three, warning them this must proceed slowly over about three weeks, and that even should he be firmly erect he should not dare penetrate her until she was adequately prepared.

As any therapist should be anticipating, since it was no longer he, but she, with the problem, she could no longer judge him, but instead focused on herself, and he was now the pursuer, caretaker and helper. With no possibility of his having intercourse with her, he had already learned to become aroused and

was erecting daily. Finally they gave up waiting for her slow dilation and had intercourse. She was delighted to be pursued and enjoyed the surrender.

General Principles from Standard Techniques

A few powerful procedures, previously mentioned as basic homework assignments, will be discussed as they apply to common symptoms with attention paid to the interaction patterns. It may be noted that only procedures 5 and 6 are homework assignments that an individual carries out alone. The others impose, stimulate and assume cooperation, and are organized in the therapy session and carried out at home. The procedures are: (1) Fail-safe, (2) Sensate Focus, (3) Committed Playtime, (4) Bibliotherapy, (5) Kegel Exercises and (6) Stop-start. More general working principles will follow.

Specific Procedures

- **Fail-safe. Prohibiting the feared sexual activity defines failure out of existence.** Unsatisfying intercourse is the most commonly addressed sexual problem. The means of failure is unimportant to the proscription; the process itself is powerful. As people develop sexual dysfunctions (e.g., erectile difficulties, untimely ejaculation, elusive orgasm, pain, difficult penetration), they tend to get into the Performance Anxiety Cycle. When the focus is on the organs that are not responding as demanded, whether one's own or the partner's, emotions such as rejection, anger, frustration, disappointment and jealousy grow. Both partners feel like failures—the one as the active lover and the other as the unsuccessful recipient. Prohibiting intercourse and other activity that may result in orgasm breaks this cycle of failure.

  Fail-safe is mandatory in performance anxiety cases and when the symptom-producing cycle is one of the demand/refuse. This technique is also recommended in many other instances thus understanding the principles leads the reader to the most plausible application. Assigning Fail-safe to a couple in the demand/refuse cycle can be tricky. It may be necessary to explain to the demanding partner that there are advantages to be gained by not making the other feel like a demandee. Excess theorizing or educating, however, can reduce the impact of this technique.

- **Sensate Focus.** With Fail-safe prescribed, the couple arranges the most comfortable private setting for expressing their cares nonverbally and through body touching, and they learn and teach what is comforting and erotic. Masters and Johnson's (1976) now classic exercises, starting with their less-known Stage 1, expressing[1], and continuing with Stage 2, learning, remains paradoxically powerful. With the degree of erotic contact staged also, this technique is a fundamental tool of sex therapy.

  Privacy is the first priority. Regardless of the couple's comfort with sexual intimacy, some malaise is to be expected. They should isolate themselves against distraction from telephone, work, family and friends for about two hours of prime time. First they should set up a quiet, relaxed atmosphere, in a room warm enough for nudity without covers and freshen themselves, bathing together if possible. One partner (the therapist may specify or help them establish which goes first) takes the active role, the other remains passive except for letting the active one know of any uncomfortable, painful or alarming intrusions.

  Stage 1 is expressive. The active mate touches and caresses the other (but does not massage or examine) to express love, caring and nurturing without words. "Talk with your hands and body" is an apt instruction. Any expressive kind of touch is permitted (e.g., kissing, squeezing, caressing), provided it is not sent or received as erotic, at least the first time. Partners should express their appreciation for the privilege of this intimacy, but nonverbally. The activity is for the enjoyment of the active partner (contrary, as noted, to the original Masters and Johnson description), not to please or arouse the passive one. After about a half hour, the partners switch places. Any comfortable positions may work.

  Stage 2 is for learning via feedback. The passive partner lets the active one know what is pleasurable, as nonverbally as possible. While sighs and movements do communicate, the "hand-riding" technique that Masters and Johnson

[1] As described here, the exercises are not the same as originally published; Masters and Johnson altered them soon after publishing them (1976) as they described their revised procedures to trainees. The reader familiar with other versions should consider these differences. The essential difference is that Stage 1 is expressive, not manipulative, regardless of how lovingly done. See also Masters, Johnson and Kolodny, 1988.

recommend adds a direction-giving dimension: The passive partner's hand "rides" the back of the active one's hand to suggest preferred pressure, direction, stroke length and so on.[2] Stage 2 offers the often long-fantasized moment to create and explore while learning how the partner may be gratified. Again, after perhaps a half hour, the partners switch.

If the clients do not report this to have been a profound experience, it may be a sign that real blocks to intimacy exist, possibly implying the need for nonsexual therapy.

Stages 3 and 4 apply the same dynamics as Stages 1 and 2, but breasts and genitals are included, with intercourse usually still off-limits. This exercise becomes a most important means for the partners to provide each other with explicit sexual preferences, active and passive, in the trusting and emotionally moving structure that the term Sensate Focus implies. It is a healthy procedure for every couple to enjoy periodically, as they grow and change, and may be recommended with confidence.

Goals of the Sensate Focus exercises are safety from failure; development of broader, more varied, tender and erotic sensation; learning of more intimate and trusting communication; and new confidence and commitment in the couple's intimate future. Sensate Focus is most often indicated for treatment of performance anxiety, freeing the relationship by taking the stress off sexual outcome. This freedom provides an opportunity for each partner to learn to feel cared for without demand being placed on them. Sensate Focus two through four may be prescribed, in addition, for couples who need erotic information, skill in arousing the partner and enjoyment with being aroused (practice and permission), and renewal of intimate interest.

- **Committed Playtime.** Every couple, assuming they have a relationship based upon shared intimacy, emotional bonds and a lasting commitment such as marriage, requires "down time" to relax, recreate, reconstitute and reground those criteria. Some couples manage this nearly

2 For many clients a preferred method is to reverse "hand riding," with the passive partner riding and guiding the active one's hand in the preferred manner.

* This is the same as described in text, is not reversed

daily in a comfortable mix of unstressed time together in the midst of other activity that is not of a bond-reinforcing nature. By far the majority, however, live not so much highly stressed lives as lives that simply prevent them from giving attention to this preventive maintenance. The Committed Playtime contract is not so much an exercise as a program designed by the couple to reconnect with each other.

With the help of the therapist, the couple begins to schedule protected time for themselves. A few hours weekly can suffice, provided that they firmly withdraw from routine or spontaneous distractions: friends, family, shopping, making repairs or adding errands ("while on that side of town") that cut into the committed time. The couple contracts for any leisure activity that is pleasurable to both, nonsexual or erotic, for the key principle is scheduling-and-doing. If the partners get together as often as they can in their spare time, after the honeymoon phase of this new experience, they will find less and less of it as obligation and more spontaneous activities will increase.

Couples with any marital strain can benefit from Committed Playtime. It is recommended particularly when either spouse complains of being ignored, "never coming first" or losing interest. Note that some couples will report "doing that already," but somehow keep up their guard against intimacy—most commonly by doing things with other couples, thus precluding intimacy. Even in marriages that are highly businesslike and reserved, Committed Playtime rejuvenates and extends the original contract. The bonds are clarified in intimate time, and reinforcing that true intimacy is a two-person phenomenon.

- **Bibliotherapy.** Some clients find the printed word more helpful than talk, and so like to receive or be directed to written materials such as books and pamphlets. Most people learn better through visual means, so charts, diagrams, slides and chalkboard information are helpful during therapy sessions. They can share what they buy at the bookstore with one another at home, at their own pace, order and selection. Many books are available in regular and used book stores. There are dozens of college human sexuality texts which can be lent for general information or found in libraries; some of the best are Masters, Johnson and Kolodry (1988); Rathus (1983), and Haas and Haas (1987). A rather encyclopedic text is Francoeur

(1982). The best manuals remain, for women, Barbach (1978) and for men, Zilbergeld (1978). Permission for erotic contact can be enhanced by suggesting study of Comfort's first volume (1972). (The above and other recommended books are listed in the Bibliography for Clients at the end of this chapter.) Assigned homework is outlined on handouts so that clients can read, reread and discuss them as they choose. Some word processor-stored materials can be customized to the specific Lifestyle and situational needs of specific clients.

- **Kegel Exercises.** Pelvic muscle exercises may be prescribed in many ways, but however done they should be introduced with several caveats. First, they are of benefit to the person performing them, male or female. Specifically prescribed to reduce urinary incontinence (by Arnold Kegel, a gynecologist), they simultaneously strengthen, tone and increase sensitivity of the vagina and web of muscles that support it and comprise the pelvic floor. In the male (these muscles tie to the penis base—the only large musculature involved in this organ—and Kegel Exercises enhance ejaculatory awareness and control.

  Although all clients can benefit from practicing pelvic muscle exercises since they enhance pelvic arousal, these are prescribed primarily for developing orgasmic response in women and for attaining better erectile capacity and ejaculatory control in men. Specific assignments can be found in Barbach (1982), Heiman, LoPiccolo and Lo Piccolo (1976), McCarthy (1977) and Zilbergeld (1978).

- **Stop-start.** This exercise was designed for men who ejaculate too rapidly, a very common problem that is also very ill-defined. Still most often called "premature ejaculation," it is a highly relative problem, defined by both partner's feelings of disappointment. Stop-start works best if the man is ejaculating a few seconds after penetration of the vagina. If, however, the couple is upset that the man only lasts five or ten minutes with rhythmic movement, the more reasonable therapeutic focus is education for both partners about anatomy or intercourse and, foremost, increasing the partners' sensuality. "Much of the obsession with lasting longer is due to the exaggerated importance most of us have given to intercourse," argued Zilbergeld (1978, p. 258). But caution is wise; both clients' private logic should be learned to prevent resistance and loss of confidence in the therapist.

"Stop-start" is a variation of a design by Semans (1956) that has become a classic in this field. It is an exercise of three main stages, in each of which the penis is stimulated until before the point of "ejaculatory inevitability," as it was labelled by Masters and Johnson (1975, p. 102). (This is the point when prostatic contractions begin, the ejaculation reflex takes over, and the man is unable to prevent ejaculation from occurring in a few seconds.) Stimulation is not to resume until excitement declines, as may also the erection. This Stop-start process is repeated three times, with ejaculation the outcome, but considerably later than usual and implicitly under some control.

The process requires that the man *learn to tolerate increased levels and durations of pleasurable genital sensation*—not to "think about the football game instead." In Stage 1, the man stimulates himself. In Stage 2, his wife stimulates him, with the same objectives and rules. In Stage 3, the wife sits astride her husband's thighs as he lies on his back and moves his penis in her pubic hair and vulva, eventually rising and sitting to contain it in her vagina momentarily, then moving off. This "quiet vagina" phase is followed by movement, increasing each time the man signals the approach of inevitability, until the duration of intromission and the tolerance of vaginal stimulation is satisfactory.

Usually Stop-start is practiced concomitantly with both partners' Kegels Exercises and some regimen to increase orgasmic potential in the wife. The more she is involved with efforts of her own, the less is the pressure and self-consciousness for the husband.

Final remarks on exercises. These are but a few common procedures; others are to be found in sex therapy texts. The therapist should peruse these works and create many other fitting exercises.

Concluding Do's and Don'ts for Clients

Below is a final list of suggestions for clients with sexual concerns. They are so general that they can be used with most couples in most situations.

- Know the conditions for your own sexual arousal. What specifically do you need in order to have a satisfying sexual response? Pay attention to and write down specific

situations that are exciting and arousing for you, and that are indicative of a good sexual experience.

- Learn to relax. Practice relaxation exercises until you are able at will to put your body into a calm state. Give yourself time to feel, to breathe and to enjoy.
- When you are not feeling aroused and your conditions for a good sexual experience are not being met, make love to your partner in ways other than through sexual activity. Expand your horizons. Know several alternative ways for getting close; intercourse isn't the only option.
- Tell your partner what you like. Learn to do this both in sincere verbal ways and nonverbally via touch.
- Keep yourself involved by focusing on your own sensitivity and arousal. Avoid becoming an observer of yourself, since this is counter to arousal.
- Increase touching in your relationship. Know that touching works. Trust and desire sometimes build slowly.
- Become an excellent lover without using your genitals. Be affectionate and loving without expecting intercourse.
- Don't get your identity from your partner's sexual response. Don't try to force a response from the other person.
- Let arousal be something that grows between you. Don't always approach with a goal.
- Make your partner the focus of your loving. "Who" is more important than "how."
- Especially after you've been together more than a few years, don't expect your partner to be aroused on every occasion. Expect to take turns seducing.
- Experiment. The more the above steps have been taken, the easier to try new approaches, positions and moods.
- Most important: Share your sexual "game plan" with your partner, don't require guessing. Anyone would feel complimented—and might even reciprocate.

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