II

THE SEXUAL EXERCISES

A. An Erotic Technique Used for Many Dysfunctions

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Sensate Focus I – Pleasuring

The term "sensate focus," invented by Masters and Johnson, is a rather clumsy term for a simple and beautiful activity. It means that the couple desists from intercourse and orgasm for several days or weeks during which time they gently caress each other's bodies and genitals. I prefer the term "pleasuring" (which was also introduced into the literature by Masters and Johnson). Many authorities believe that these exercises are among their most significant clinical innovations.

Application of Sensate Focus—Pleasuring

Masters and Johnson state in their book, *Human Sexual Inadequacy* (Little, Brown, and Co., 1970), that all the couples they treated, regardless of the nature of their complaint or of the psychodynamics of their problem, start the experiential aspect of their treatment regimen with the sensate focus exercises. This is usually prescribed on day three of the therapeutic procedure, after the nature of the sexual problem has been discussed with the couple by the cotherapists during the "round-table" meeting. I have also been impressed with the profound therapeutic impact the sensate focus experience has on many persons, and I use

it extensively in sex therapy. However, I do so in a more flexible and individualistic manner. I prescribe pleasuring only when it seems specifically indicated by the nature of the dysfunction and by the requirements of the dynamics of that particular case. Thus for example I do not routinely prescribe pleasuring at all for couples whose chief complaint is vaginismus or premature ejaculation or for totally inorgasmic women.

For these dysfunctions I employ the specific indicated therapeutic tasks which will be described later: dilatation, Semans' maneuver, and self-stimulation respectively. However I may of course also prescribe pleasuring in such cases but only if it is really needed. The timing of the prescription is also flexible and dictated by dynamic considerations. Therefore, I may not use pleasuring as the initial experience, but only after the case has progressed. Thus for example I might prescribe sensate focus for a couple after the man has already attained a good degree of ejaculatory control by means of the Semans' exercises, or if the couple continues to avoid tactile contact, or if they are too orgasm-oriented, or if they need to be confronted with their anxiety about intimacy, and so on. For other dysfunctions sensate focus is employed more often.

I commonly prescribe pleasuring in the initial stages of the treatment of erectile disorders, general nonresponsivity of women, and relative orgastic inhibitions. But I do not do this routinely because often other types of experiences seem to be more rational. For example in treating some particularly defended impotent patients, I might avoid gentle, slow stimulation because in some men this causes excessive anxiety. I might use other forms of stimulation such as erotic films or art literature to promote arousal in such cases.

Rationale

The mechanism of action of sensate focus is not completely clear. Probably there are various dynamics to account for the profound effects which these seemingly simple and gentle exercises frequently evoke. These effects may be understood on several conceptual levels.

The pleasuring prescription often (though by no means always) produces a reduction of tension in the sexual transactions. Each partner is freed of the expectation that he/she must produce an adequate response in himself and in his partner. He doesn't *need* to have an erection, it is *not her duty* to *make* him have one. Neither is *allowed,* much less pressured, to reach orgasm. Failure is practically impossible under these circumstances. Furthermore medical authority has given permission, indeed *prescribed* pleasure. From the perspective of learning theory this creates conditions ideal for the *extinction* of sexual anxiety. Under such relaxed, easy conditions old fears can be extinguished. Anticipatory anxiety related to failure and injury can gradually be reduced. Under these circumstances the emergent pleasurable responses also reinforce more adequate sexual behavior.

Apart from their teaching function, the sensate focus exercises are also intrinsically enjoyable and provide the couple with the opportunity to give and receive pleasure from each other. Gentle stroking and nuzzling and caressing seem to evoke highly pleasurable emotional responses from most persons, providing there is no significant conflict about the pleasuring experience. This is true on the infrahuman as well as on the human level. Petting a dog is highly rewarding and may be used as reinforcement, and "gentling" young laboratory animals is a well-known technique for producing tame and cooperative experimental subjects. Clinical evidence suggests that mutual, gentle, tactile stimulation can enhance the affectionate *bond* between people. Again on an infrahuman level, Harlow found tactile contact to be an important component in the affectionate bonds developed by baby chimps. One tends to respond with love to a person who gently caresses and pleasures one. Tender, tactile contact seems to increase intimacy and mutual involvement. Stringent experimentation is of course needed to support these clinical impressions.

Thus sensate focus is a learning experience whereby pleasurable responses are reinforced and sexual anxiety is diminished because the fear of failure is removed. An additional feature apart from the intrinsic value of this experience relates to psychodynamics of the couple's psychosexual problems. In gently caressing each other the couple may be confronted with an experience which they have pre-

viously avoided because physical intimacy arouses anxiety in one or both partners. With the arousal of such anxiety and of the defenses this anxiety elicits, both become subject to psychotherapeutic exploration, and this is very important for the therapy of all but the most simple cases of sexual dysfunction.

It is the clarification of such negative emotional responses which is the crux of intervention in the therapy of most cases of sexual dysfunction. This point will be elaborated in a later section of this chapter which deals with some typical patient responses to sensate focus.

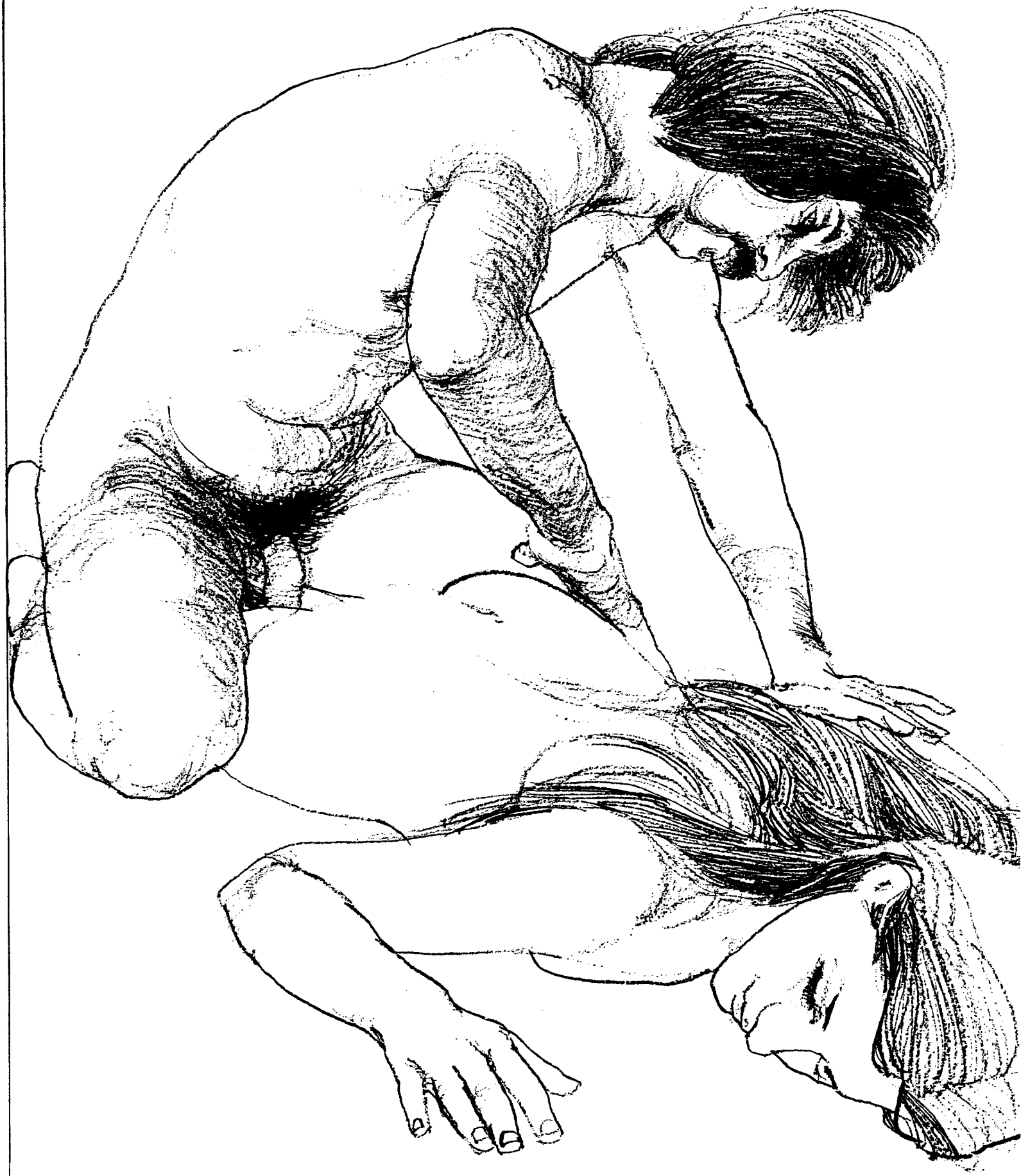
Directions

If a therapist is open and essentially conflict free about sex and pleasure, he is likely to give the pleasuring directions in an effective manner. Conversely, patients are likely to respond negatively to a therapist's lack of ease or to his own anxiety.

Here is the usual way I give these directions. They vary of course with the couple, their level of anxiety, the nature of psychopathology, if any, and their socioeconomic and cultural backgrounds. My method should not be imitated unless it seems natural. Each therapist should develop his own individual style of communication.

"First, I do not want you to have intercourse or orgasm for a little while. How do you feel about that?" (The therapist should then deal with any feelings expressed.) "You *will* have physical contact however, of a very special kind. After dinner tonight, when all your responsibilities are done, I want you both to take showers and then go to bed without any clothes on. Then I want you to caress each other. First you caress her." (The choice of who does the pleasuring first is sometimes of little importance and at other times it is crucial, depending on the dynamics of the couple's problem: for example, if one spouse has an inhibition about *asking* the other for pleasure. If she is so afraid of rejection, so insecure, so guilty that she is heavily involved in giving as opposed to taking some share of pleasure for herself, then I will—after I point this out—ask her to pleasure her husband first. That way she is more likely to be able to relax and abandon herself to her pleasure,

Pleasuring—Woman face down



because she has already "paid." On the other hand if a partner is paranoid, and if he feels controlled and demeaned that he must "serve" his wife, that his beautiful erection is not sufficient to stimulate her, then I will—again after *gently* pointing out some of the fallacies of his attitude—suggest that he be the initial receiver. *After* he has been duly caressed, it might be easier for him to give himself to the task of caressing his wife without experiencing anger.)

"You [the man] lie on your stomach. Then I want you [the woman] to caress him as gently and tenderly as you can. Start with the back of his head, his ears, his neck. Go slowly down his back and sides. Down his buttocks, the insides of his thighs. Gently, his legs and his feet. You [the receiver] must try just to concentrate on your feelings. This is very important. Don't worry if she is getting tired or bored. Try to stay with your feeling. And give her feedback. If something feels unpleasant, if she is doing it too fast or too light tell her. If something feels particularly good, tell her or show her.

"When you both have enough of the back turn over. Now do the front the same way. Start with the head and face and neck. Slowly and gently with as much sensitivity as you can find, caress his chest, belly, sides, but not the penis this time. Do the thighs, legs, and feet. Do it till he and you have enough. Then it is your turn. Now you [to the other] do her the same way. Skip the nipples and clitoris and vaginal entrance. Just concentrate on caressing the rest of the body. Any questions? Either of you?"

Reactions to Pleasuring

It is very important to evaluate both partners response to pleasuring in detail and depth. The next therapeutic session usually starts with an inquiry about their experience. Couples are likely to respond briefly: "It was great," "It didn't work," and so on. That is insufficient. A detailed discussion which clarifies the actual experiences of both must be elicited in order for therapy to proceed rationally. In addition, there is a therapeutic value in an open discussion of such feeling as it begins to facilitate authentic communication between the couple.

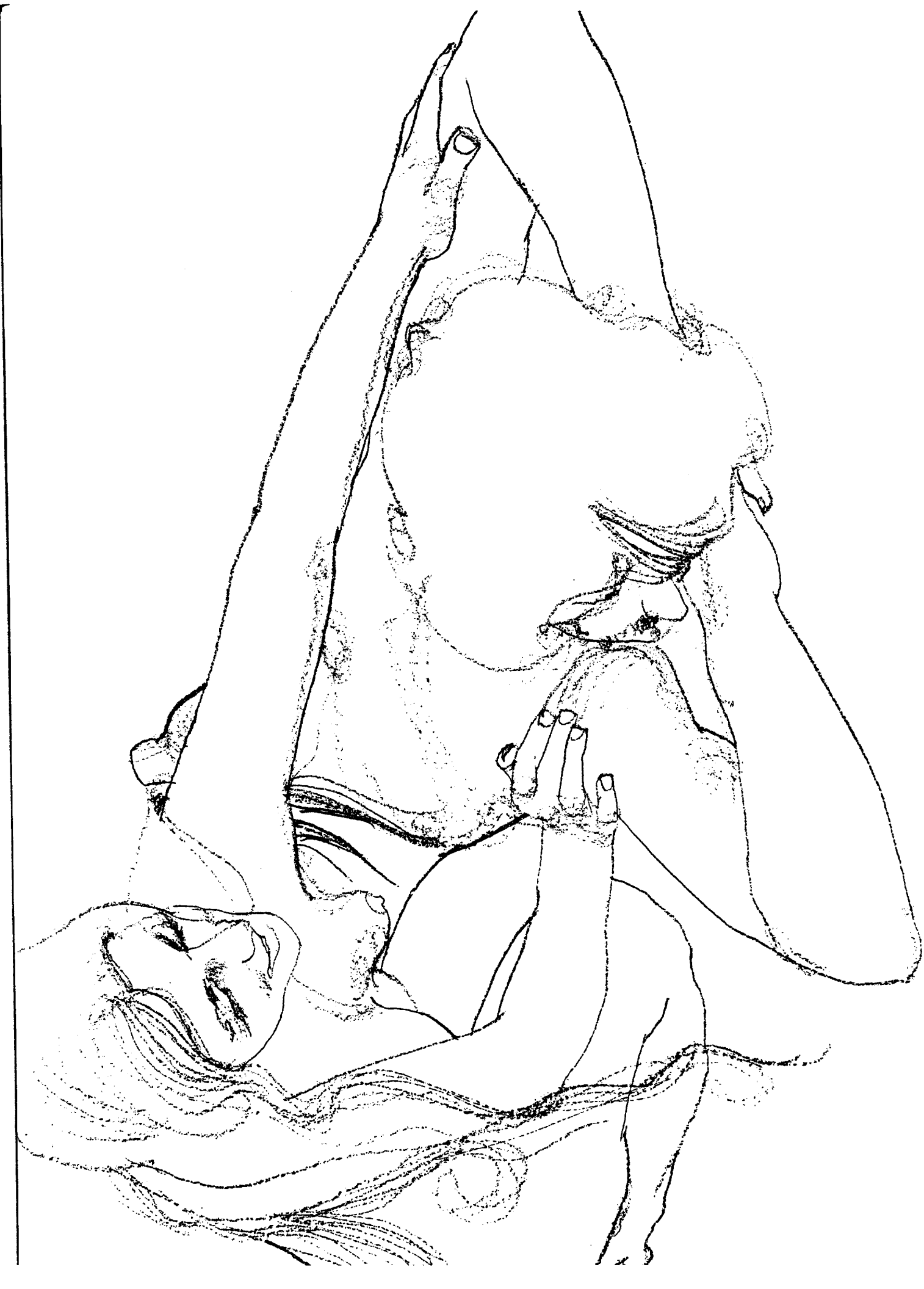
All behavioral prescriptions elicit *emotions* of which the partners may have varying degrees of awareness. These emotions in turn motivate certain patterns of behavior.

An open probing discussion of the experience helps clarify the affective as well as the behavioral aspects of the experience to both the therapist and to each partner. In order to evaluate the unconscious meanings of these experiences in addition to getting the partners to describe their behavioral and emotional reactions in detail, I also ask for any dreams or fantasies which they may have had during this period. Dreams and fantasies are an excellent means of getting insight into the unconscious significances of these experiences. It is a matter of judgment how this material is to be used clinically. In some cases I will make profound interpretations; at other times insights into more superficial and supportive material is all that is indicated. In general one is governed in one's clinical transactions by the need to avoid the mobilization of profound threat and resistances in both partners.

POSITIVE RESPONSES

Many couples respond very positively to sensate focus. The experience is deeply pleasurable. Some persons enjoy receiving more than giving and vice versa. Often the bond between the couple is enhanced and they are more tender and loving towards each other. Often couples who have had a positive response come to the next therapeutic session holding hands. Often the spouses are relieved to learn that they can give pleasure to the other with their hands and lips, that they do not have to "produce" an erection or lubricate or have intercourse to please their partner. Usually the experiences are sensuous rather than erotic. Occasionally however, one or both may experience intensely erotic feelings and the couple may "disobey" and proceed to orgasm and/or intercourse "against orders." Such behavior is sometimes a resistance born of anxiety, but sometimes such sexual enthusiasm is a healthy expression of growing freedom. Again only a detailed, clear, gently but persistently probing discussion of the physical and emotional responses of the couple can help the therapist evaluate patient responses.

Pleasuring—Man face down



NEGATIVE RESPONSES

When the responses are clearly positive, therapy proceeds to the next behavioral prescription which is indicated for that individual case. Often, however, especially if a significant degree of psychopathology or marital pathology exists, persons have negative responses to sensate focus. Adverse emotional reactions vary in intensity from mild and transient to extremely intense and potentially disorganizing. All of these negative responses must either be resolved or bypassed before treatment can proceed.

Some degree of anxiety or discomfort is frequently elicited by engaging in intimate touching and feeling. This is especially true if such contact has been previously avoided for years, and sex had been primarily orgasm-and-performance-oriented.

Negative emotion may be experienced per se, or it may be expressed by avoidance and rationalizing or obsessive behavior:

We didn't have time to do it more than once.
It is too mechanical.
We did it but found it boring, ticklish, silly, and so forth.
I liked doing it to him, but I felt anxiety when he pleasured me.
I thought her arm was getting tired. I couldn't relax. I thought she would get bored.
When he got an erection I felt I had to bring him to orgasm or he would be frustrated.
I just couldn't keep my mind on it. I kept thinking about the kids and dinner.
I felt awful. I am so fat. I thought he would find me repulsive. I just couldn't let him touch me.
I kept wondering if this should give me an erection.
He is so goddamn clumsy. He tickled me, I didn't like it. He is just a lousy lover.
Do I have to go through all that to get laid? Other women just have orgasms without all that fuss.

Causes of Negative Reactions

The causes of the anxiety and anger which may be elicited by mutual pleasuring are many.

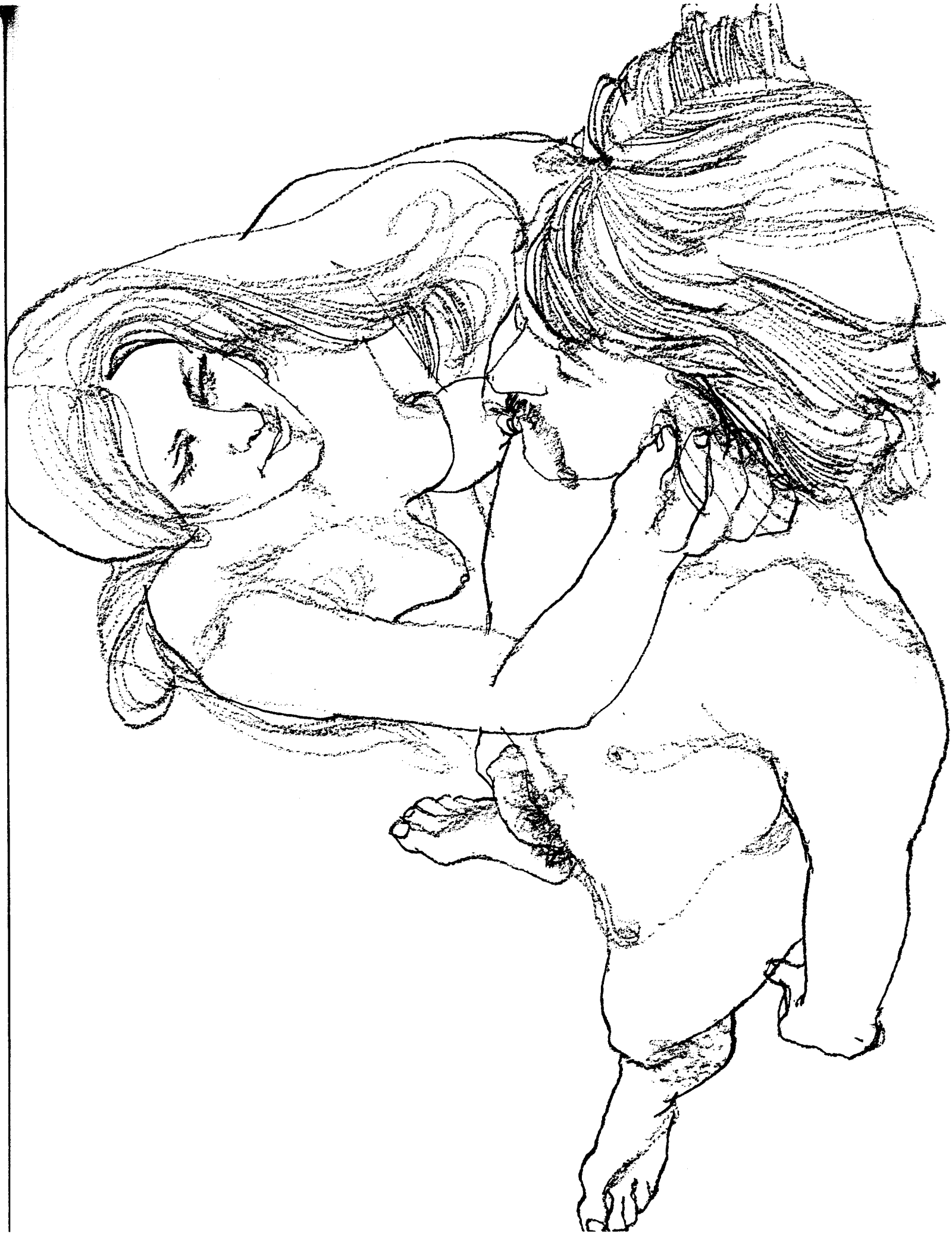
If a person has been deeply injured during his formative years, he may protect himself against further injury with alienating defenses. He becomes detached and *avoids intimacy*. Such a patient may experience profound anxiety and anger if his defenses are threatened by the pleasuring experience which compellingly promotes involvement, intimacy, and love.

Guilt about pleasure in general and sex in particular is ubiquitous in our society. When some persons are caressed and stroked the resulting pleasure evokes guilt, and defenses against such guilt must be resolved in the therapy sessions before such a person can be free to enjoy sex.

Hostility toward a spouse may interfere with giving him/her pleasure. If a person is deeply ambivalent about a relationship; if he/she feels exploited, gypped, trapped; there may be a deep resistance to giving the spouse pleasure so that the *giving* part is abortive, clumsy, or sabotaged in some manner. Other hostile and ambivalent persons do not allow themselves to be aroused by the partner. Arousal to such persons is tantamount to involvement, to which they are essentially resistant.

Fear of rejection is often evoked by sensate focus. Some persons feel unless they are giving they will be rejected. They can't ask for themselves. Such persons are likely to experience obsessive thoughts: they are unattractive, the spouse doesn't like doing this, grocery lists or tax obligations and the like nag while they are being caressed. The therapeutic handling of such obsessive defenses includes confrontation with the anxiety which was experienced, as well as interpretations of its unconscious meaning. Specific behavioral prescriptions may also be helpful. For example, one might instruct the couple that the anxious partner must *ask* for what she desires and that the partner must only do what is specifically asked for. The couple is also instructed to share their feelings and reactions to these transactions. In this manner she learns that she will not be rejected if she "dares" to ask him for something. She learns to take responsibility for her own satisfaction. Again, anxiety and defenses evoked by asking are then dealt with in the therapy sessions.

Although this exercise is specifically structured to insure against failure, the *fear of failure* may nevertheless be evoked by sensate focus. An insecure partner will be afraid that he is clumsy and insensitive and feel hopeless about ever being able to please his partner. Reassurance



and corrective experiences can usually diminish this obstacle to sexual abandonment.

Finally deeply neurotic fears and defenses against sexuality are occasionally elicited by sensate focus. For the male these include unconscious fears of injury if one touches and enjoys a woman's body. Such castration fears have a deep long history in the patient's childhood. Fears of homosexuality and of sadistic and masochistic impulses are also occasionally evoked by the open touching and fondling entailed in the process of sensate focus.

Therapy

A negative response to sensate focus on the part of either partner is an obstacle to further therapy which must be resolved or bypassed.

If the negative response is relatively mild, simple *repetition* of the experience along with an interpretive but essentially supportive and reassuring discussion is very often enough to improve the emotional response.

> Do you think you might have been feeling a bit of anxiety when you had those thoughts about your coronary? It is natural to feel a little ill at ease at first. You never allowed yourself to experience such physical intimacy before.

Deeper anxieties such as fear of injury and terror at intimacy often require interpretive kinds of psychotherapeutic intervention, because a certain degree of *resolution* is necessary in order to permit the sexual response to emerge. Resistance to pleasuring often has its roots in a neurotic fear of sexual functioning. If such is the case, resistances must be worked through for a successful outcome. Sometimes, however, when the *process* of sensate focus, and not the *outcome* (i.e., relief of the sexual symptom) evokes anxiety, it is possible to *bypass* this aspect of the process and proceed with other aspects of the treatment. Thus when a person is anxious about touching and intimacy but does not have severe conflict about sexuality per se, the therapist may choose to skip sensate focus and go on to a more genital-oriented task and still obtain a good result in terms of sexual functioning.