True-False Assessment - 2021

1. The major predictor of marital success is love and communication.
2. Sexually, the happiest time is the first 6 months of marriage.
3. The honeymoon is a great way to start a marriage, especially sexually.
4. Having a baby during the first year enhances martial satisfaction and stability.
5. Couples who establish a good premarital sexual relationship find marital sex requires little additional effort.
6. Traditional sex roles are the most satisfying for both the man and woman.
7. Affection is primarily the woman's domain and intercourse the man's domain.
8. There is strong empirical support for John Gray's concept that men are from Mars and women are from Venus.
9. Planning a child reduces sexual fun and spontaneity.
10. Same-sex friends give the most honest, helpful advice about marriage and marital sex.
11. Having a child strengthens a fragile marriage.
12. The male should be the sexual initiator.
13. Seeking couple therapy, sex therapy, or a martial enhancement workshop is an indication of major marital problems.
14. The birth of a planned, wanted child heralds a period of increased couple intimacy.
15. Most affairs occur after 10 years of marriage.
16. Most divorces occur after 10 years of marriage.
17. Intercourse lasts between 10-30 minutes, less than 5 minutes indicates premature ejaculation.
18. Over 90% of women have orgasm during intercourse, e.g. vaginal orgasms.
19. "G" spot orgasms and multiple orgasms are the most satisfying.
20. Pain during intercourse is quite rare, and usually is a symptom of relationship alienation.
21. A couple with a good marriage and good sex are immune from extra-marital affairs.
22. Intimacy-based couple therapy almost always enhances sexual desire, especially erotic feelings.
23. For successfully treated couples, there is no need for a relapse prevention plan.
24. When there is a history of sexual trauma, trauma issues must be addressed before couple sexuality issues.
25. Couples who cohabitate before marriage, especially longer than 2 years, experience better sex and less divorce.

Traditional Learnings about Marriage Therapy and Couple Sexuality - 2021

1. Sexual dysfunction is caused by individual or relational problems. When therapy resolves these underlying issues, sex will spontaneously improve.

2. The more love, communication, and intimacy, the better the sex.

3. Deal with core problems first—anxiety or depression, bi-polar disorder, alcoholism, trauma, family of origin issues. Then address relational issues caused by the core mental health problem. It is usually unnecessary to address sexual problems.

4. The therapeutic strategy is to deal with sex indirectly.

5. With advances in the bio-medical field, a stand-alone medical intervention will resolve the great majority of sexual problems.

6. Once the couple has created a healthy sexual relationship, they can proceed on their own. Except in rare cases, they do not need further help.

Core Concepts - 2021

1. Healthy couple sexuality involves desire, pleasure, eroticism, satisfaction.

2. The challenge is to integrate intimacy, non-demand pleasuring, and erotic scenarios and techniques.

3. Personal responsibility/intimate team model of change.

4. Positive functions of couple sexuality—shared pleasure, reinforce and deepen intimacy, and sex as a tension reducer.

5. Sexuality adds 15-20% to marital vitality and satisfaction. Paradoxically, a non-sexual marriage is a powerful drain, playing a 50-75% role.

6. Goal of a satisfying, secure, and sexual marriage.

OVERVIEW OF INTEGRATIVE COGNITIVE-BEHAVIORAL COUPLE SEX THERAPY - 2021

I. Guidelines for couple sex therapy

A. One-two combination of personal responsibility and being an intimate sexual team.

B. Focus on psychosexual skill exercises, attitude change, cognitive restructuring, utilization of bibliotherapy, and therapist verbal modeling. Adopt a healthy, integrated attitude toward sexuality.

C. Reduce performance anxiety and distraction. Increase comfort, pleasure, and eroticism. Choose a couple sexual style which reinforces sexual desire with awareness of potential "traps."

D. Non-demand pleasuring, desire exercises, arousal/eroticism exercises, and specific function/dysfunction psychosexual skill exercises.

E. Structure of sexual dates; ping-pong pattern of initiation; integrate intimacy and eroticism; and set positive, realistic sexual expectations.

II. Structure of couple sex therapy

A. Initial session as couple—Assess past and present therapy, medical and medication factors, motivation, couple dynamics, and assign psycho-education reading to reduce stigma.

B. Conduct individual psychological/relational/sexual histories.

C. Couple feedback session—Establish understanding of problem and expectation for change, enhance motivation to address problem as an intimate sexual team, and assign first series of psychosexual skill exercises (desire or non-demand pleasuring).

D. Begin with weekly couple sessions—1) Process sexual exercises (ideally couple do 2-4 per week); 2) Assess positive learnings, then sexual anxieties and inhibitions; 3) Discuss relational style and coupe sexual style; 4) Assign or design exercises for next week.

E. Typical course of sex therapy is 10-25 sessions, 3 months to 1 year.

F. Crucial to develop an individualized relapse prevention program, including booster session and 6-month check-in sessions for 2 years.

Individual Psychological/Relational/Sexual History - 2021

1. Done individually, not together.
2. Start by saying, "I want to understand your psychological, relational, and sexual history both before and during this relationship. I want to hear all your strengths as well as vulnerabilities. I appreciate your being as forthcoming and blunt as possible. At the end, I'll ask if there is anything sensitive or secret that you do not want shared with your partner. I will not share it without your permission. However, I want to understand you and your experiences as much as possible so I can be the most help in resolving these problems."
3. Guidelines: Structure chronologically, move from less anxious to more anxiety-provoking questions, be non-judgmental about atypical behavior, ask open-ended questions, probe for dysfunctional attitudes, behaviors, and emotions.
4. Initial open-ended questions—"What did you value about growing up and what caused you problems and regret?"
    a. Formal education, including sex education
    b. Religious background, including religious sex education
    c. Parents as marital and sexual model, including attitudes toward touching and privacy
5. Social and sexual experiences as a child
    a. Experiences with others (siblings or peers). How have your siblings done sexually as adults?
    b. Comfort with body and gender
    c. Did you have a happy or troubled childhood?
6. Puberty and Adolescence
    a. First orgasmic experience—age, situation, feelings
    b. Masturbation—how learned, technique used, first orgasmic experience, use of fantasies and written or online material (has that changed or stayed the same?)
    c. For females—menstruation: age at onset, preparation for, cognitive and emotional response of self and others.
    d. Socially and sexually, what was high school like? How did you feel about your body image? Was dating a positive experience or a source of anxiety or guilt?
    e. How old were you at first orgasm with a partner? How old were you at first intercourse? Was this a positive or negative experience? How long did the relationship last and how did it end?
    f. Same sex question—Many men (women) have sexual thoughts, feelings, fantasies, and experiences with men (women). What were your experiences and feelings about being sexual with other men (women)?
    g. Many people experience unwanted pregnancies or sexually transmitted infections—What were your experiences? How did you feel about it at the time? In retrospect?
    h. As you review your childhood and adolescence, what were your most important positive psychological, relational, and sexual learnings and experiences?
    i. As you review your childhood and adolescence, what was the most negative, confusing, guilt-inducing, or traumatic psychological, relational, and sexual experiences?
7. Adult sexuality
    a. (If attended college) What was college like socially and sexually? (If work or service) What were your young adult relationship and sexual experiences?
    b. (After determining when the couple met) As you review your dating and sexual history, what were the most positive and negative experiences? What was happening in your life 6 months before meeting your spouse (partner)?
8. Present relationship

a. How did you meet? What was the initial attraction? What were first sexual experiences like?
b. When was sex best in this relationship? What made it good for you? How do you communicate sexually (verbally and non-verbally)? When was desire/pleasure/eroticism/satisfaction best?
c. Are you attracted to your partner? Do you have loving feelings? When did sexual problems begin? What caused this and how has it played out? Do you view the sexual dysfunction as an individual or couple problem? How much anger, guilt, resentment, blaming is involved?
d. What are your strengths and vulnerabilities as a couple? What three changes would you request of your partner?
e. How is your general health and are there health problems? What medications do you take and what are the sexual side effects? Have you talked to your internist or specialist about sexual concerns?
f. Are financial issues a relational strength or vulnerability? What doesn't your partner understand about how you deal with work and financial issues?
g. (If parents) What are your strengths and vulnerabilities as a parent? Do you enjoy parenting?
h. Many people have thoughts, feelings, fantasies, and experiences regarding sex with others. What have your experiences been? What did you feel during the extra-marital involvement and how did it end? Is it secret? What's your guess about your partner's extra-marital experiences?
i. What is the role of alcohol or drugs in your life and relationship?

9. Wrap-up questions
    a. What else should I know about you psychologically, relationally, or sexually?
    b. What was the most negative, confusing, guilt-inducing, or traumatic sexual experience in your life?
    c. Is there anything you do not want shared with your partner? What is the positive reason for keeping this secret?
    d. What else should I know about you, your relationship, and your life, which would help in treatment planning?
    e. Is there anything you want to ask me?

Resource: Metz, M., Epstein, N. & McCarthy, B. (2018). Cognitive-Behavioral Therapy for Sexual Dysfunction.

Guidelines for Revitalizing and Maintaining Sexual Desire - 2021

1. The keys to sexual desire are positive anticipation and feeling you deserve pleasure in your intimate relationship.
2. Each person is responsible for his/her desire with the couple functioning as an intimate sexual team to nurture and enhance desire. Revitalizing sexual desire is a couple challenge. Guilt, blame, and pressure subvert the change process.
3. Inhibited desire and conflicts over desire discrepancies is the most common sexual dysfunction, effecting almost half of couples. Desire problems drain intimacy and good feelings from your relationship.
4. One in five married couples has a non-sexual marriage (being sexual less than ten times a year). One in three non-married couples who have been together two years or longer have a non-sexual relationship.
5. The initial romantic love/passionate sex/idealized relationship phase (limerence) lasts less than two years and often only six months. Desire in an ongoing relationship is maintained by developing your couple sexual style.
6. The essence of sexuality is giving and receiving pleasure-oriented touching. The prescription to revitalize and maintain sexual desire is intimacy, pleasuring, and eroticism.
7. Touching occurs both inside and outside the bedroom. Touching is valued for itself and does not always lead to intercourse.
8. Couples who maintain a vital sexual relationship can use the metaphor of touching consisting of "five gears" (dimensions). First gear is clothes on, affectionate touch, including hugging, kissing, holding hands. Second gear is sensual touch, which can be clothed, semi-clothed, or nude (non-genital body massage, cuddling on the couch, holding and caressing, touching going to sleep or on awakening). Third gear is playful touch which intermixes genital and non-genital touch, clothed or unclothed, romantic or erotic dancing, touching in the bath or shower, on the couch or in bed, whole body massage, playing strip poker or Twister. Fourth gear is erotic touch (manual, oral, rubbing or vibrator stimulation) to high arousal and orgasm for one or both partners. Fifth gear integrates pleasurable and erotic touch that flows into intercourse. Intercourse is a natural continuation of the pleasuring/eroticism process: not an individual pass-fail sex test.
9. Both the man and woman learn to value affectionate, sensual, playful, erotic, and intercourse experiences.
10. Both partners are comfortable initiating touching and intercourse. Both feel free to say "no" and suggest an alternative way to connect and share pleasure.
11. A key strategy is to develop "her," "his," and "our" bridges to sexual desire. This involves ways of thinking, talking, anticipating, and feeling that invite being sexual.
12. Sexuality has a number of positive functions for your relationship—a shared pleasure, a means to reinforce and deepen intimacy, and a tension reducer to deal with the vicissitudes of life and a relationship.
13. The average frequency of sexual intercourse is from four times a week to once every other week. For couples in their twenties, the average is two-three times a week, for couples in their fifties is once-twice a week, and for couples in their sixties once a week.
14. Personal turn-ons (special celebrations or memories, feeling caring and close, erotic fantasies, anniversaries or birthdays, sex with the goal of pregnancy, initiating a favorite erotic scenario, being playful or spontaneous, sexuality to celebrate a career success or sooth a personal disappointment) facilitate sexual anticipation and desire.
15. External turn-ons (R or X-rated videos, music, candles, sex toys, visual feedback from mirrors, being sexual outside the bedroom, a weekend away without the kids) facilitate anticipation and desire.

16. Non-demand pleasuring is a way to reinforce attachment, to share pleasure, and a bridge to sexual desire.
17. Intimate coercion is not acceptable. Sexuality is neither a reward nor a punishment. Sexuality is voluntary, mutual, and pleasure-oriented.
18. Realistic, mutual expectations are crucial for maintaining a satisfying sexual relationship. It is self-defeating to demand equal desire, arousal, orgasm, and satisfaction each time. Realistically, thirty-five to forty-five percent of experiences are very good (both partners experience desire/pleasure/eroticism/satisfaction). The best sex is mutual and synchronous, but the majority of sexual experiences are positive, but asynchronous (better for one partner than the other). Twenty percent are very good for one (usually the man for couples under 40) and fine for the other. Fifteen to twenty percent are okay for one and the other finds it acceptable. Be aware that five to fifteen percent of sexual experiences are dissatisfying or dysfunctional. Couples who accept occasional mediocre or dysfunctional experiences without guilt or blaming and try again when they are open and responsive have a vital, resilient sexual relationship. Satisfied couples use the guideline of Good Enough Sex (GES) to promote positive, realistic sexual expectations.
19. Contrary to the myth that "horniness" occurs after not being sexual for weeks, desire is facilitated by a regular rhythm of sexual experiences. When sex is less than twice a month, you become self-conscious and are in danger of falling into a cycle of anticipatory anxiety, tense and performance-oriented intercourse, and avoidance.
20. Healthy sexuality plays a positive, integral role in your relationship with the main function to energize your bond and reinforce feelings of desire and desirability. Paradoxically, conflictual or non-existent sex plays a more powerful negative role than the positive role of good sex.

Resources: McCarthy, B. & McCarthy, E. (2020) Rekindling Desire. (3rd edition).

The Crucial Couple Sexual Dialogue: Five Dimensions of Touch- 2021

The core psychosexual skill exercise is to increase awareness of each partner's preferences for gears (dimensions) of touch. The majority of couples only use two gears- affection or intercourse. They fall into the trap of believing that sex=intercourse. This results in lower levels of both touch and intercourse.

In contrast, this psychosexual skill exercise focuses on five gears of touch (based on a ten-point scale of pleasure/arousal).

First gear: Affectionate touch—this usually involves clothes-on touching, such as holding hands, hugging, or kissing. Affectionate touch is not sexual, but it provides the foundation for intimate attachment. Subjective arousal is anchored at 1.

Second gear: Sensual touch—this involves non-genital pleasuring which can be clothed, semi-clothed, or nude. Sensual touch includes a head, back, or foot rub; cuddling on the couch while watching a DVD, a trust position where you feel safe and connected, cradling each other as you go to sleep or wake. Sensual touch is an integral part of couple sexuality. It has value in itself as well as a bridge to sexual desire at that time or later. Subjective arousal 1-3.

Third gear: Playful touch—this intermixes genital pleasuring with non-genital touch (usually semi-clothed or nude). Playful touch can include touching in the shower or bath, full body massage, seductive or erotic dancing, games such as strip poker or Twister. What makes playful touch inviting is the enhanced sense of pleasure and unpredictability. Playful touch is valuable in itself and/or can serve as a bridge to sexual desire. Subjective arousal 4-5.

Fourth gear: Erotic touch—this is the most challenging gear. Erotic, non-intercourse touch can include manual, oral, rubbing, or vibrator stimulation. Erotic scenarios and techniques are an integral part of couple sexuality providing a sense of vitality, creativity, and unpredictability. Erotic touch can be mutual or one-way. It can proceed to orgasm or transition to intercourse. Subjective arousal 6-10.

Fifth gear: Intercourse—there are two crucial concepts in integrating intercourse into the gears of connection approach. First, intercourse is a natural continuation of the pleasuring/eroticism process, not a pass-fail sex performance test. Second, transition to intercourse at high levels of erotic flow (7 or 8) and continue multiple stimulation during intercourse. Subjective arousal 7-10.

We suggest each partner fill out this chart separately. Then discuss feelings and preferences.

Touch Type	**Current percentage of all touch**	**Percentage of touch desired**
Affectionate touch		
Sensual touch		
Playful touch		
Erotic touch		
Intercourse touch		

The purpose of this exercise is to facilitate dialogue with a focus on enhancing sexual desire and pleasure. Sexuality is more than intercourse. The essence of couple sexuality is sharing pleasure—

oriented touch. You develop a common language to facilitate communication and embrace a variable, flexible approach to intimacy, touching, sexuality, and intercourse.

Resource: McCarthy, B. & McCarthy, E. (2019). Enhancing Couple Sexuality.

Desire Psychosexual Skill Exercises - 2021

First exercise: Comfort

A first step in healthy couple sexuality is developing a comfortable, non-demand approach to touch and sensuality. How can you enhance sexual comfort? Begin by setting aside at least two occasions for this exercise, one in your bedroom and a second time in the family or living room. Although most of the psychosexual skill exercises involve nudity, this exercise begins with clothes on.

Sensuality involves being receptive to and enjoying non-demand, non-genital touching. Sensuality means touching for its own sake, not as a goal toward arousal, intercourse, or orgasm. Being open to the joys of slow, tender, caring, rhythmic touch is the basis of sexual response and is essential for maintaining desire.

This exercise takes place in your bedroom with clothes on and focuses on nonverbal communication, with the woman as initiator. Traditionally, women have not had permission to initiate sensual or sexual activities. You can initiate in the morning, in the late afternoon on a rainy weekend, or early in the evening. We suggest not doing it right before bed when you are tired and do not have the energy or focus to engage in sensual exploration. Begin by taking a bath or shower and playfully washing each other. Towel dry your partner in a slow, caring fashion, and proceed to the bedroom. Put on clothing you feel comfortable with; it could be pajamas or an informal outfit.

How personalized is your bedroom? Does it have valued mementos? Is it decorated the way you like? Is there sufficient light? Is it a comfortable room to be in? Orchestrate the milieu to increase sensuality. You could burn a fragrant candle or put on music to romanticize the atmosphere. Be sure you are not too warm or cold.

Touch for yourself; do not try to second-guess your partner. Give yourself permission to experiment with a variety of ways to touch, hold, and caress. Use your fingertips, palms, both hands, or only one. Do not limit yourself. Use your legs; rub your body against his; let your lips or tongue explore his body. He can take off as much or as little clothing as you prefer. Some women find they are more comfortable if initially he keeps his eyes closed; others enjoy eye contact throughout. Try it both ways. Which do you find more sensual? Explore and enjoy his body from the hairs on his head to the soles of his feet. Be aware of at least two areas you enjoy touching. Do not be surprised if there are body parts you do not like; this is not Tom Cruise made up to look perfect on a movie screen, but your live partner with a scar on his kneecap, a roll of flab on his midriff, more hair than you like on his back. Switch roles and let him explore your body to redevelop sensuality and comfort.

The bedroom is one thing; being comfortable in the living room or family room can be quite another. Do the second part of the exercise in the next day or two. Since this exercise is done in the nude, ensure that you will have privacy and not be interrupted by neighbors or children. An intimate relationship erodes because of lack of quality couple time. Couples discuss and problem-solve about practical, external problems but take little time for personal, intimate feelings and communication.

Make this your special time. Would you rather talk in the kitchen, living room, or family room? Would you like a cup of tea or glass of wine? Would music in the background enhance or distract from communication? Sit comfortably, facing each other. Nonverbal components of communication—especially eye contact, body posture, facial response, and touch—carry a message as important as words. Is talking enhanced by holding hands, having your arm around your partner's shoulder, playfully touching your partner's hands, or caressing your partner's face and neck?

How do you talk as a sexual couple? Is it comfortable to use proper words or to employ slang? Do you have a private sexual language? Can you share emotional feelings and intimacy as easily as you make sexual requests? Can you discuss what pleasuring and intercourse techniques increase sexual responsivity? To be an intimate couple, you need to be able to discuss both emotional and sexual feelings and preferences.

Share your fondest sexual memory. Take the risk of being vulnerable and discuss how you felt during and after that experience. The only time most couples are nude in the bedroom is while having sex. Being nude, touching, and talking comfortably in the living room, den, or kitchen can be a liberating experience. Enjoy the freedom and openness of non-demand pleasuring and talking while nude outside your bedroom.

Is it helpful to touch while clothed in the bedroom? How do you feel about touch while nude in the living room? Touching both inside and outside the bedroom is an excellent way to nurture sexual desire. Conclude this exercise by making requests and suggestions to make your sexual relationship, especially initiating sexual encounters, comfortable and inviting.

Second Exercise: Couple Sexual Attraction

Sexual attraction is not static. It is not a "magic" quality that you either have or you don't. Sexual attraction is a dynamic process between two people that waxes and wanes. Attraction is affected by myriad factors. Physical attractiveness is but one factor; it is certainly not the only one or even the most important one. Turn-ons vary for each couple, contrary to the media myth that there is a perfect, youthful body type that turns everyone on or a sexual technique that works for everyone. You can increase sexual attraction for each other and for each other.

Start this exercise clothed in a comfortable, private setting conducive to communication. Set aside at least 45 minutes that could extend 2 hours if you wish. Present yourself in a manner that you feel is attractive; choose an outfit you particularly like, shave, fix your hair, brush your teeth, dab on your favorite perfume or after-shave. Do the kinds of things people do to get ready for a date but usually don't do in a relationship they unfortunately have taken for granted.

Discussing attraction can be awkward so we suggest a semi-structured communication exercise. Let the woman begin. Tell your partner at least five (and up to 15) things you find attractive about him, being as clear and specific as possible. You might find his slightly balding head attractive or like his new glasses, the way he jogs, his arms and hands, how he looks in a suit and tie, his laugh, the tenderness he displays when putting the children to bed, how he handles a household emergency, the look in his eyes before initiating sex, how responsible he is about paying bills, the sounds he makes when he has an orgasm, his newfound skill at cooking, the muscles of his legs, how caring he was when his aunt died, how enraptured he is with classical music yet can still enjoy country, the way he orally stimulates you, how generous he can be with his time when someone needs help, his penis when he is aroused, how he puts up a tent when you go camping. Be honest in disclosing what you find attractive—physically, sexually, and emotionally. He listens and acknowledges his positive qualities; he does not shrug them off or minimize them.

Now pick one, two, or at the most three things you want him to change that would increase his attractiveness for you. Do not just state the problem. Make a specific request for change. Say, "I'd like you to cut your hair one-and-a-half inches shorter and comb it at night," rather than, "I don't like your hair; do something about it." Say, "When you initiate, kiss me and stroke my arms before you touch my breasts," not, "you come on too strong." Say, "Talk and play with each child individually," rather than, "I get upset because you never pay attention to the kids."

Let us suggest two guidelines about requests. First, request things your partner can actually change. For example, if he is 6 feet tall, you can't say you are attracted to men over 6 feet 5 inches. You can suggest that he carry himself more positively by walking tall and forcefully. Second, frame this as a "request" not a "demand." Your partner can agree, modify, or say no, and there will be no punishment or negative consequences. A healthy relationship is based on acceptance and a positive-influence process, not demands, ultimatums, or threats.

Switch roles and have the man share what he finds attractive about his partner. You may like the way she wakes you with a kiss, that people view her as super-organized, how she purrs when her back is scratched, that she can fix broken items, the shape of her breasts, what a good athlete she is, how wet she

becomes when she is aroused, how she sings to the children before bedtime, how seductive she looks in a see-through nightgown, how she cheers you up after a bad day, how her nipple gets erect after you lick it, the way she pads around the house in bare feet, how attractive she looks when dressed for a night out, the care she takes planning family picnics, the effort she makes in picking clothes for the children, how she moves when she is sexually turned on, how assertive she is with neighbors. What is special about your partner that you value and find attractive?

In addressing the one to three requests for change, feel free to make them either sexual or nonsexual. What will increase your partner's attractiveness for you? Remember, it is a request, not a demand. Say, "I want you to sit with me once a month and plan big purchases," not, "Your don't care anything about money except spending it." Say, "I want you to try orally stimulating me when I'm standing," not, "Stop being so hung up about oral sex." Say, "I wish you would initiate by stroking my chest when you wake up on a weekend morning," rather than, "You never initiate." Remember, these are requests for things your partner can change, not things your partner can't change. In terms of response to requests, she can accept, modify, or say no. A request connotes acceptance without a threat of negative consequences. A demand says I don't accept you and if you don't agree to these changes there will be negative consequences. This is especially important in terms of sexual scenarios and techniques. There is no place for "intimate coercion" in your couple sexuality.

After discussing the process of maintaining and enhancing attraction you can end the exercise or engage in touching, which could lead to intercourse.

Third Exercise: Trust and Intimacy

A major value of your intimate relationship is trusting that your partner is on your side, has your best interest in mind, and would not do anything intentionally to hurt you. Trust is a central ingredient in your intimate relationship. Communicate how you feel about the level of trust in your relationship, both in the past and at present. If it is not as high as you want, what can you do to increase trust? What "trust vulnerabilities" does your partner need to be aware of? What can each of you do to increase trust? Trust is not something that occurs automatically; it takes time to allow feelings of trust to develop and be expressed both verbally and physically.

You can establish a "trust" or "safe" position where you feel cared about and secure. This involves being nude in the privacy of your bedroom. Personalize your bedroom. Have a special light that gives a warm glow, a favorite erotic book or love poem by the bed-stand, thick curtains so there is privacy, a full-length mirror to increase visual stimuli. Do you enjoy hanging out and talking in your bedroom? Caress your partner's face and recall a time when you felt vulnerable and your partner was there for you.

You have experimented with non-demand positions to increase receptivity, sensuality, and responsiveness. Develop a safe or trust position that facilitates feelings of intimacy and attachment. You might lie side by side holding each other, your bodies touching from the tips of your toes to your forehead. Try a position where he is sitting up with his back supported and you are lying with your head on his lap while he strokes your hair. Another trust position is lying next to each other, holding hands and being silent. Some couples use a "spoon" position where you lie with your chest against his back, put your arms around him, and breathe in unison with his rhythm. In another position, he lies on his back and you nestle your head against his shoulder, your faces close so that you can maintain eye contact. A trust position some couples value is sitting facing each other, keeping eye contact, putting one hand on your partner's heart. What adds to your sense of trust? Body contact, eye contact, being comfortable, feeling secure, being enveloped, talking, silence? Find at least one position where you feel intimate and trusting. Develop your unique trust position that establishes a solid base of physical security and connection.

In subsequent sexual experiences, when you become anxious, depressed, frustrated, or angry, utilize this trust position as a "port in the storm." Rather than ending a sexual experience on an anxious

or frustrated note, switch to your trust position as a way of anchoring yourself. You can choose whether to continue the exercise or end the experience from your trust position. This helps you remain connected and realize you can depend on each other. You trust you are an intimate team and your partner "has your back."

Fourth Exercise: Create Your Sexual Scenario

When a relationship is new, there is strong anticipation of being sexual even if the quality of sex is not particularly good. Sex serves as an affirmation of your desirability and desire to be a couple. Romantic love and passionate sex energize a new relationship and make it "magical". It is the thrill of sexual exploration as well as energy that goes into making your relationship exciting and erotic.

After the initial romantic love and passionate sex phase has dissipated, it takes most couples 3-6 months to develop a couple sexual style that is intimate, functional, and satisfying. Part of the process is crafting couple sexual scenarios, the focus of this exercise. As a reminder, you are not a machine, so it is normal in the best of couples to occasionally have mediocre or negative sexual experiences. A sign of a healthy couple is your ability to accept and not overreact to negative experiences and to turn toward each other as intimate and erotic friends.

What do you value most in a sexual experience? Each individual develops their sexual scenario. Let the women introduce her scenario first. At another time the man can develop his.

When is your best time to be sexual? When waking up? After the morning paper? At noon? Before or after a nap? Before dinner (sex as an appetizer) or after dinner (sex as dessert)? In the evening? Most couples have sex late at night; but few people say this is their favorite time.

How do you set your preferred sensual and sexual mood? Do you listen to music, go for a walk, talk, light candles, drink wine, take a bath, have 15 minutes of time alone and then come together, meet your partner at the door and lure him into the bedroom? As a preclude to being sexual some couples enjoy doing together things like shopping, working in the garden, going for a run, or sharing feelings. Many couples start touching and playing in the living room or den and do not move to the bedroom until both are turned on. Others prefer to start in the privacy of your bedroom. What is your favorite way to begin a sexual scenario? Remember, there is no right or wrong; it is your preference.

Once the scenario is under way, what is your favorite script? Do you like to take turns, or do you prefer mutual stimulation? Do you verbally express sexual feelings, or would you rather let your fingers do the talking? Do you prefer a slow build-up or do you begin intercourse as soon as you are aroused? Do you like multiple stimulation or one erotic focus at a time? Do you make use of all your senses—touch, taste, smell, hearing, sight—or does one element (observing your partner's arousal, hearing soft moans, smelling sexy perfume, feeling sexual movement) turn you on? Develop the sexual scenario the way you want. Your partner is open to your guidance.

How do you transition from pleasuring and eroticism to intercourse? Some people prefer to begin intercourse at moderate levels of arousal, but many prefer not transitioning to intercourse until they are highly aroused. Do you want to initiate the transition, or do you want your partner to? Who guides intromission? Do you prefer multiple stimulation during intercourse rather than a sole focus on thrusting? What is your preferred intercourse rhythm and type of thrusting (short, rapid thrusting; slow up-and-down thrusting; circular thrusting; changing intercourse positions)? Do you prefer being orgasmic during intercourse, or do you feel greater pleasure being orgasmic during erotic sex?

How would you like to end the scenario? Afterplay is the most neglected element of the sexual experience. Your needs and desires are important here, too. Do you like to lie and hold, sleep in your partner's arms, engage in playful tickling, have a warm kiss, take a walk, read poetry, nap and start again, talk and come down together?

When it is his turn to create sexual scenarios. She is free to design her own, which could be similar to or totally different from hers. Many men fall into the trap of trying to outdo their partner. Sex

is neither a competition nor a performance. You are not clones of each other. Be yourself-develop an initiation, script, and afterplay scenario that is special and satisfying for you.

Resource: McCarthy, B. & McCarthy, E. (2012). Sexual Awareness (5th edition).

Exercises that Act as Bridges to Desire - 2021

First Exercise: Sexual Dates

You set dates to go to a movie, play bridge, go to dinner. What about sexual dates? Setting times for a sexual date need not be formal or awkward. It can be romantic and fun. A sexual date allows you to anticipate being sexual as you would anticipate a sporting event or a play.

As with other exercises, we suggest taking turns. Divide the week into two parts – for example, Saturday at 5 p.m. until Wednesday at 9 a.m. for the woman to initiate and Wednesday at 10 a.m. until Saturday at 4 p.m. for the man. This is the "ping-pong" system of initiation. After your partner initiates, it is your turn. If your partner did not initiate during this time, it becomes your prerogative to do so. The commitment is for each person to make at least one initiation per week.

When it is your "ping," set the time, place and sexual scenario. Do it your way. Do not try to second-guess your partner or compare your way with theirs. Make the initiation as inviting as possible. Be creative in your invitations. Examples include cooking a special dinner with sex as dessert, cuddling for half an hour in front of the fireplace before starting genital stimulation, calling before you leave work to suggest a sexual date, surprising your spouse by joining him in the shower, putting on your favorite music, bringing lotion to bed and spending 15 minutes giving your partner a sexual massage. Men can and do initiate creative sexual dates, contrary to the myth that romantic, seductive initiation is the woman's domain.

The woman becomes comfortable with her ability to initiate. If sexuality is to remain a vital part of your relationship, learn to be open to creating and crossing bridges to sexual desire. Initiations could include waking your partner in the morning (or from a nap or in the middle of the night) by sucking on his penis and putting him inside you. You can share old pictures or letters to set the mood, rent your favorite R- and X-rated movie and fast-forward to the sexiest parts, ask your partner to put the children to bed and meet him in the bedroom where a scented candle is burning and you are wearing his favorite corduroy shirt, get a babysitter and plan a hotel weekend in the city to roam through art museums, eat Italian food, and have sex without worrying about interruptions.

We cannot stress enough that sex does not just spontaneously happen. It requires thought, planning, and setting aside couple time. Approximately 80% of sexual encounters are planned or semi-planned. Enjoy spontaneous sexual experiences when they do occur, but don't fall into the trap of believing that spontaneous sex is more genuine than intentional sex. Sexual dates are important bridges to desire.

Second Exercise: Overcoming Discrepancies in Sexual Desire

If couples had to wait until both partners were equally desirous, frequency of sex would decrease by at least half. It is the norm, not the exception, for one partner to desire and initiate sex more than the other. What poisons sexual desire is anger about nonsexual issues (which need to be dealt with outside the bedroom) and resentment over feeling

sexually pressured. Under no circumstances is it acceptable to physically force or verbally coerce your partner to engage in sex. “Intimate coercion” has no place in your relationship. Sex is best when it is voluntary and pleasure oriented. Pressure and coercion lead to alienation and anger, and the ensuring resentment poisons sexual desire.

What can you do when one wants to have intercourse and the other does not? This exercise uses the “yes/no” technique to deal with desire discrepancy. Our culture socializes men to always say yes to sex, so the woman is stuck in the role of sexual gatekeeper. In fact, it is perfectly natural, normal, and healthy for men to say no to sex, and on occasion more than 80% have.

In this exercise, each partner has to say at least one “no.” The focus is on expanding your repertoire of what is acceptable when there is a desire discrepancy. The quality of the intimate experience is more important than frequency of intercourse. Sexual intimacy is reinforced by caring about each other’s feelings and sharing pleasure rather than perceiving sex as a goal-oriented power play.

This exercise requires a number of cycles rather than one structured experience. Each person will have several initiations. The initiator speaks from an awareness of what she wants – to feel desirable, attractive, and valued; unpredictability and playfulness; orgasm; time to be alone before erotic contact; multiple stimulation before and during intercourse; affectionate touch. Ask for and initiate activities you enjoy. The woman is aware that her partner will say no at least once and preferably more than once. This allows them to practice negotiating sensual and sexual alternatives. He will not just say no but will offer an alternative that both suits his fancy and addresses her needs. For example, if she wants a whole body massage as a way of meeting her needs for sensuous time before erotic contact and he is lukewarm toward the idea of a body massage, he offers to draw a bubble bath or suggest building a fire and talking and touching in front of the fireplace. If her initiations have been co-opted because he is action oriented, she can offer a number of feeling-oriented, non-intercourse ways to intimately connect.

This illustrates the major struggle in desire discrepancy. The woman had a right to request a range of sensual and erotic experiences without her partner contending that only intercourse is real sex. She can suggest manually pleasuring him to orgasm, that they engage in non-genital pleasuring, that he pleasure her and she’ll decide if she wants a mutual sexual experience, that they have oral sex, that they share an activity (going for a walk, playing golf, going shopping) before being sexual, that he stimulate himself while she holds him. He can say no to suggestions he is not comfortable with, but he needs to say yes to at least one of her alternatives. There are many emotional, sensual, playful, and erotic ways to connect that may or may not evolve into intercourse.

A common male trap is using sex to meet nonsexual needs. In extreme cases, men use sex like alcoholics use alcohol – to deal with emotions from anger to boredom, from excitement to emptiness, from celebration to depression. You can learn emotional coping strategies to deal with nonsexual problems. Sharing feelings is a better way to deal with sadness than having intercourse. Celebrating a merit bonus with couple friends can make more sense than using sex as a reward when your partner is not feeling sexual.

The most common issue is inhibited sexual desire. At the other extreme, some men use sex compulsively to avoid dealing with problems and emotions. Hyperactive sexual desire results in an alienated relationship. Sexual bridges are meant to encourage pleasure and intimacy. Couple sexuality is subverted when sexual initiations carry negative emotions and compulsive sex demands.

The man is urged to personalize his sexual invitations. He is less likely to be distracted by nonsexual factors such as fatigue, hunger, anger, alienation, and anxiety about children. This can be a sexual strength, but it can also be a source of misunderstanding and strife. She complains he wants sex, not her. Making your sexual invitations and requests personal and caring will avert this problem. Sex is good, but not when it's at the expense of your partner or relationship.

Will the experience of saying no to intercourse and yes to sensual and erotic alternatives resolve all desire discrepancies? Of course not, but it will allow you to stay intimate friends and provide greater flexibility and degrees of freedom in expressing your needs for intimacy and sexuality.

Arousal and Erection Guidelines - 2021

1. Between the ages of 35-55, 90% of males have experienced at least one erectile failure (not being able to attain or maintain an erection sufficient for intercourse). This is a normal occurrence, not a sign of erectile dysfunction (ED).

2. The majority of erectile problems (especially for men under 50) are caused by psychological or relational factors, not medical or physiological problems. To comprehensively evaluate medical factors, including side effects of medication, consult your internist or a urologist with training in erectile function and dysfunction.

3. ED can be caused by a wide variety of factors including alcohol abuse, anxiety, depression, vascular or neurological deficits, distraction, diabetes, anger, side effects of medications, frustration, hormonal deficiency, fatigue, not feeling sexual at that time or with that partner. As men age, their hormonal, vascular and neurological systems become less efficient, making psychological, relational, and psychosexual skill factors more important. The foundation for erectile response is psychological and physiological relaxation.

4. Medical interventions, especially the oral medications—Viagra and Cialis—can be a valuable resource for facilitating erectile function, but are not a magic pill. You need to integrate the pro-erection medication (or other medical interventions) into your couple style of intimacy, pleasuring, and eroticism.

5. Do not believe the myth of the male machine ready to have intercourse at any time, with any woman, in any situation. You are not a performance machine. You and your penis are human.

6. View the erectile difficulty as a situational problem. Do not overreact and label yourself "impotent" or put yourself down as a failure.

7. A pervasive myth is that loss of an initial erection means you are sexually uninterested or turned off. It is a natural physiological process for erections to wax and wane during prolonged pleasuring. Almost all men prefer to transition to intercourse and orgasm on their first erection, but do not make this a performance demand.

8. In a forty-five-minute pleasuring session, your erection might wax and wane two to five times. Subsequent erections, intercourse, and orgasm are satisfying. A crucial exercise is "wax and wane" of erection.

9. You do not need an erect penis to satisfy a woman. Female orgasm can be achieved through manual, oral, or rubbing stimulation. If you have difficulty getting or maintaining an erection, do not stop the sexual experience. She finds it arousing to have your fingers, tongue, or penis (erect or flaccid) used for stimulation.

10. Actively involve yourself in giving and receiving pleasurable and erotic touch. Erection is a natural result of pleasure and eroticism.

11. You cannot will or force an erection. Do not be a "passive spectator" who is distracted by the state of your penis. Anticipatory anxiety and performance anxiety are major factors in ED. Sex is not a spectator sport; it requires your active involvement.

12. Your partner can initiate intercourse and guide your penis into her vagina. This reduces performance pressure and, since she is the expert on her vagina, is the most sexually inviting procedure.

13. Feel comfortable saying, "I want sex to be pleasurable and playful. When I feel pressure to perform, I get uptight and sex is not good. We can make sexuality special when we take a comfortable pace, enjoy playing and pleasuring, feel erotic and turned-on, and are an intimate sexual team."

14. Erectile problems do not affect the ability to ejaculate. You can ejaculate with a flaccid penis; most men relearn ejaculation to the cue of an erect penis.

15. One way to regain confidence is through masturbation. During masturbation you can practice gaining and losing erections, relearn ejaculation with a firm erection, and focus on stimulation, which is transferable to partner sex.

16. Do not try to use a waking erection for quick intercourse. This erection is associated with Rapid Eye Movement (REM) sleep and results from dreaming and being close to your partner. Men try vainly to have intercourse with their morning erection before losing it. Remember, arousal and erection are regainable. Morning is a good time to be sexual.

17. When sleeping, you have an erection every ninety minutes—three to five erections a night. Sex is a natural physiological function. Do not block it by anticipatory anxiety, performance anxiety, distraction, or putting yourself down. Give yourself (and your partner) permission to enjoy the pleasures of sexuality.

18. Make clear, direct, assertive requests (not demands) for stimulation you find pleasurable and erotic. Verbally and nonverbally guide your partner on how to pleasure and arouse you.

19. Stimulating a flaccid penis is counterproductive. You become distracted and obsess about the state of your penis. Engage in sensuous, playful touching. Enjoy giving and receiving stimulation rather than trying to "will an erection."

20. Attitudes and self-thoughts affect arousal. The focus is "sex and pleasure" not "sex and performance."

21. Realistically, 85% of encounters will flow to intercourse. When that does not happen, you can transition (without panicking or apologizing) to an erotic, non-intercourse scenario or a cuddly, sensual scenario.

22. A sexual experience is best measured by pleasure and satisfaction, not whether you had an erection, how hard it was, or whether she was orgasmic. Some sexual experiences will be great for both, some better for one than the other, some mediocre, and other dissatisfying or dysfunctional. Do not put your sexual self-esteem on the line at each experience. The Good Enough Sex (GES) model of male and couple sexuality is much healthier than the individual perfect intercourse performance criterion.

    Resource: Metz, M & McCarthy, B. (2004) Coping with Erectile Dysfunction.

Guidelines for Ejaculatory Inhibition - 2021

1. Ejaculatory Inhibition (EI) is the least recognized male sexual dysfunction. Primary El occurs in 1-2% of young males and secondary El in 8-15% of men over 50.

2. EI refers to the inability (or great difficulty) being orgasmic even though physically aroused. The most common type is the inability to reach orgasm during intercourse, although some men are unable to be orgasmic with partner manual or oral stimulation. The great majority of men with ejaculatory inhibition are orgasmic during masturbation.

3. The traditional derogatory terms were "retarded ejaculation" or "ejaculatory incompetence." Ejaculatory inhibition (another term is "delayed ejaculation") is a non-pejorative term that describes the reality—the man's erotic flow leading to orgasm is inhibited.

4. Many men try to minimize or hide the problem from his partner, feeling he can satisfy himself later. The woman can have a positive, integral role in helping him overcome EI and increase pleasure, eroticism, and satisfaction.

5. Young males with primary EI are mistakenly viewed as "studs" who service and satisfy women. They are admired by male peers who suffer from premature ejaculation. In truth, sex is less enjoyable for the man, as he is performing for the woman rather than sharing sexual pleasure and eroticism with her.

6. A key in changing EI is to enhance subjective arousal. You may look fully aroused, with a firm erection and vigorous thrusting, but your body is "telling a lie." If "0"=neutral, "5"=beginning levels of arousal, "8"=erotic flow, and "10"=orgasm, your subjective arousal is "3-5," even though your objective arousal appears to be "9."

7. Emphasize giving and receiving pleasure. Involve the woman as your intimate and erotic friend. Delay the transition to intercourse until subjective arousal is at least "7" and preferably "8."

8. Two key techniques in changing EI are to use multiple stimulation during intercourse and to identify and utilize your "orgasm triggers."

9. Cognitively, you learn to associate sexuality with comfort, intimacy, pleasure, and eroticism with the woman as your intimate and erotic friend. Behaviorally, you learn to integrate subjective and objective arousal, enjoy interactive sexuality, request erotic and multiple stimulation, and feel comfortable using orgasm triggers. Emotionally, you enjoy the touching process, feel you have a right to sexual pleasure, enjoy erotic flow which naturally culminates in orgasm, and value the Good Enough Sex (GES) model rather than feeling pressure to achieve perfect intercourse/orgasm performance.

10. As men age, especially after 50, rates of intermittent EI increase significantly (8-15%). Men often mislabel the problem as ED because you lose your erection during intercourse. If intercourse lasts more than 2 minutes, the real issue is EI—you lose your erection because you run out of sexual energy.

11. A number of factors can cause intermittent EI including side effects of medication, not feeling sexually receptive or responsive, alcohol or drug abuse, lack of partner involvement, and fatigue.

The most common cause is that you experience sex as routine and mechanical. As a young man, you only needed intercourse thrusting, but now your subjective arousal is muted so you need to be involved in giving and receiving multiple stimulation during intercourse, including erotic fantasies.

12. Ejaculatory inhibition can lead to low desire, avoidance of sexual touch, and a non-sexual relationship.

13. To overcome ejaculatory problems, turn to your partner for emotional encouragement and sexual stimulation. Your partner is your intimate and erotic ally. Make requests for multiple stimulation during intercourse. Orgasm/ejaculation is a natural continuation of the comfort/pleasure/arousal/erotic flow process, not a pass-fail test.

14. Ejaculatory inhibition is different than the normal physiological transition of men over 60 who do not have a need to orgasm at each sexual opportunity. You want to let go and ejaculate, but can't because your subjective arousal is low.

15. You and your partner can experiment with a range of multiple stimulation scenarios and techniques to learn what is erotic for you. These can include rubbing your penis between her breasts and manually stimulating her clitoral area; standing while she orally stimulates you; moving rapidly and rhythmically during intercourse. Erotic fantasies can accompany any of these scenarios. You can change intercourse positions two or three times; ask for testicle or buttock stimulation; change intercourse movement from in/out to circular thrusting; transition from intercourse to manual stimulation and back to intercourse at high levels of erotic flow.

16. Orgasm triggers are very individualistic. They allow you to move from "9" to "10" (orgasm/ejaculation). Use orgasm triggers when you are in an erotic flow (not when your subjective arousal is "5"). Examples of orgasm triggers include tensing pelvic muscles and moving in fast, rhythmic thrusts; focusing on an erotic fantasy and reaching orgasm both in fantasy and in reality; verbalizing "it feels so good I'm going to come," feeling highly aroused by your partner's arousal.

17. It is natural and healthy to use self-stimulation during partner sex to enhance arousal, including to orgasm.

18. Men and couples have different preferences for pleasuring and eroticism—manual, oral, rubbing, and/or intercourse. Some prefer taking turns (self-entrancement arousal) while others enjoy mutual stimulation (partner interaction arousal). Most prefer multiple stimulation; others focus on a single erotic stimuli. Discover and enjoy your couple sexual style of pleasure, arousal, erotic flow, and orgasm.

19. Remember, the essence of healthy couple sexuality is sharing desire/pleasure/eroticism/satisfaction. Enjoy your sexuality; do not view orgasm as the pass-fail test. In Good Enough Sex (GES) 85% of experiences involve erotic flow which naturally culminates in orgasm.

Resource: McCarthy, B. & McCarthy, E. (2012). Sexual Awareness (5th edition).

Dimensions of Good Enough Sex (GES) Model - 2021

1. Sex is a positive dimension in life, an invaluable part of individual and couple desire/pleasure/eroticism/satisfaction.

2. Relationship and sexual satisfaction are the ultimate focus and are essentially intertwined. You are an "intimate sexual team."

3. Realistic psychological, biomedical, and relational expectations are essential for sexual satisfaction.

4. Good physical health and healthy behavioral habits are vital for sexual health. Value your sexual body and your partner's sexual body.

5. Relaxation (psychological and physical) is the foundation for sexual pleasure and response.

6. Desire and satisfaction are more important than arousal and orgasm.

7. Valuing variable, flexible couple sexual experiences (the "85 percent approach") and abandoning the "need" for perfect individual sex performance inoculates you against sexual dysfunction by reducing performance pressure, fear of failure, and partner rejection.

8. The five purposes for sex (pleasure, intimacy, tension reduction, self-esteem, reproduction) are integrated into your sexual relationship.

9. Integrate and flexibly use the three sexual arousal styles (partner interaction, self-entrancement, role enactment).

10. Gender differences are respectfully valued and similarities mutually accepted.

11. Sex is integrated into real life and real life is integrated into sex. Sexuality is developing, growing and evolving throughout your life. You can be sexual in your 60's, 70's, and 80's.

12. Sexuality is personalized: Sex can be playful, energizing, spiritual, and special.

Resource: Metz, M., Epstein, N., & McCarthy, B. (2018). Cognitive-Behavioral Therapy for Sexual Dysfunction.

Guidelines for Female Pleasure, Eroticism, and Orgasm - 2021

There is more written about orgasm than any other area of female sexuality. The good news is that awareness of your "sexual voice" which includes desire/pleasure/eroticism/satisfaction is in the best interest of the woman, the couple, and the culture. The bad news is that sexual performance demands, specifically viewing orgasm as a pass-fail test, increases self-consciousness and reduces sexual desire and satisfaction. Secondary non-orgasmic response is a common problem.

These guidelines empower the woman (and her partner) to value desire/pleasure/eroticism/satisfaction. Female sexuality is first class - variable, flexible, complex, and individualistic, but not inferior to male sexuality. Orgasm is integral to the pleasuring/eroticism process. This approach confronts the performance pressure of having the "right" or "perfect" orgasm as an individual pass-fail sex test.

1. You are responsible for your desire and orgasm. Developing your unique sexual voice is a positive personal challenge. It is not the man's responsibility to "give her an orgasm."

2. You and your partner develop a couple sexual style that promotes desire/pleasure/eroticism/satisfaction.

3. Receptivity and responsivity emphasizes you being active. Sharing pleasure and eroticism facilitates arousal and orgasm.

4. Arousal involves both subjective components (feeling sexually receptive and turned-on) and objective components (vaginal lubrication and physical receptivity to intercourse).

5. "Foreplay"—where the man stimulates the woman to get her ready for intercourse—increases self-consciousness and performance anxiety by invalidating your sexual voice and turning a mutually enjoyable erotic encounter into a command performance. The experience of "pleasuring," which emphasizes mutuality and sharing, facilitates desire and orgasm.

6. Pleasuring and eroticism often lead to intercourse, but intercourse is not a sex test nor is intercourse necessary for a satisfying sexual experience. A key concept is to transition to intercourse at high levels of erotic flow (7-8 subjective arousal).

7. Develop your unique "sexual voice"—being aware of what facilitates and what subverts your sexuality. Be active in verbally and non-verbally making requests and guiding your partner.

8. The prescription for satisfying sexuality is intimacy, pleasuring, and eroticism. Traditionally, female sexual socialization has underplayed eroticism. Eroticism is integral to female desire, orgasm, and satisfaction.

9. Be aware of your preferences—pleasurer-receiver vs. mutual stimulation; focused vs. multiple stimulation; when and how to transition from sensual to erotic stimulation; emotional and physical conditions for vital and satisfying couple sexuality.

10. You cannot say "yes" to sexuality unless you have the right to say "no" to sex. You are free to initiate the transition from pleasuring to intercourse and to guide intromission.

11. Women who prefer multiple stimulation during pleasuring/eroticism usually prefer multiple stimulation during intercourse. You can utilize clitoral stimulation with his or your fingers, request breast or buttock stimulation, enjoy erotic fantasies, and/or switch intercourse positions.

12. Many women want to use pro-sexual medications to enhance desire and orgasm. Medication can be a valuable resource, but is not a stand-alone "magic pill." The pro-sex medication or physical aide needs to be integrated into your couple sexual style of intimacy, pleasuring, and eroticism.

13. Many women, especially after 40, use additional lubrication (hypoallergenic or water-based). This facilitates intercourse, but is not a substitute for subjective arousal.

14. One 1 in 6 women experience the male pattern of one orgasm during intercourse without using additional stimulation. Female sexual response and orgasm is more flexible, variable, complex, and individualistic than male sexual response. You may be non-orgasmic, singly orgasmic, or multi-orgasmic which might occur during pleasuring, intercourse, or afterplay, depending on your unique pattern and preferences.

15. Develop comfort with your desire/pleasure/eroticism/satisfaction pattern. Accept your "orgasmic voice." Sexuality is about experiencing and sharing pleasure; it is not a performance to have a "G" spot orgasm, multiple orgasms, a "vaginal" orgasm, extended orgasm, or whatever is the new performance fad.

16. Orgasm is a three to ten second experience. Orgasm is a natural result of subjective arousal, erotic flow, and giving yourself permission to let go and enjoy the orgasmic experience.

17. The distinction between "clitoral" and "vaginal" orgasm is not scientifically valid. Whether orgasm occurs with manual, oral, rubbing, intercourse, self, or vibrator stimulation, the physiological response is similar although the subjective experience varies depending on your expectations, preferences, and feelings.

18. It is unrealistic to expect orgasm during each sexual experience; you are not a sexual machine. Female sexuality is variable and flexible. On average, women are orgasmic during 70% of sexual encounters. Satisfaction involves orgasm, but is much more than orgasm.

19. Orgasm is integral to female sexuality. Desire and satisfaction are more important than orgasm. You are free to make requests of your partner (prolonged pleasuring, your pace of stimulation, multiple stimulation, preferred erotic scenarios, vibrator stimulation, cunnilingus to orgasm, clitoral stimulation during intercourse) to enhance pleasure, eroticism, and orgasm.

20. Remember, sexuality is not about proving anything to yourself, your partner, or anyone else. Sexuality is about experiencing and sharing desire/pleasure/eroticism/satisfaction.

    Resource: McCarthy, B. & McCarthy, E. (2019). Finding Your Sexual Voice.

Guidelines for Enhancing Sexual Comfort and Reducing Painful Intercourse - 2021

1. Occasional discomfort or pain during sex is a common experience for most women. However, chronic pain is neither normal nor acceptable. Approximately 15% of women experience sexual pain problems.

2. Traditionally, when a gynecologist did a pelvic examination and found no specific medical cause for pain, it was diagnosed as a psychosomatic problem—"it's in your head." In truth, sexual pain is in your vulva or vagina. Sexual pain is a psychobiosocial phenomenon with multiple causes, dimensions, and solutions.

3. Consultation with a competent, caring gynecologist, internist, or nurse practitioner with a specialty in sexual pain can help you understand the pain problem and learn if there is a medical intervention or change in health habits that could facilitate your efforts at pain management.

4. In cases of chronic and severe pain, an interdisciplinary treatment team includes a couple sex therapist, a physician or nurse practitioner specializing in pain, and a female physical therapist with a specialty in pelvic floor musculature.

5. It is important to understand the issue as a pain problem, not a sex dysfunction. You can learn to manage sexual pain and build sexual comfort. You deserve to feel desire/pleasure/eroticism/ satisfaction, including during intercourse.

6. Use of a sexual lubricant (water-based and hypoallergenic), which feels and smells good, is helpful. Use the lubricant preventatively, as part of pleasuring. Waiting until you feel pain creates distress and reduces your enjoyment of the sexual experience.

7. Learn and utilize relaxation and mindfulness techniques, both cognitive and physical. These exercises help you relax your whole body, especially your pelvic muscles.

8. Use of graduated sized vaginal dilators is a valuable technique for many women who practice under the supervision of a female physical therapist.

9. It's important that you feel comfortable and into erotic flow before transitioning to intercourse. Many women find when you guide his penis into your vagina this minimizes discomfort and increases your sense of control.

10. During intercourse, identify and make use of the positions and types of thrusting that increase comfort and pleasure.

11. When you are not aroused or experience pain, suggest engaging in an alternative sensual or sexual scenario. This can involve erotic sex (manual, oral, rubbing, vibrator stimulation); a cuddly, sensual encounter; or asynchronous sex where you pleasure your partner to orgasm and/or he pleasures you to orgasm.

12. You have a right to veto sexual activity that is painful, but don't avoid sexual touching. Let your partner know that you value him and sexual touching, but that you feel anxiety about sexual pain.

Pain is best approached as a couple problem. Avoidance increases anxiety and, over time, intensifies the problem of sexual pain. You can rebuild positive anticipation. You deserve sexual pleasure.

13. Be aware of the sexual pain cycle: anticipatory anxiety, tense and painful intercourse, followed by avoidance. Keep your focus on the cycle of sexual anticipation, pleasure-oriented sexual encounters, and a regular rhythm of intimate sexual experiences. Develop a variable, flexible sexual repertoire, which includes intercourse, but is not limited to intercourse.

14. Some women who experience sexual pain create a dichotomy between intercourse and non-intercourse sex. You enjoy manual/oral/rubbing/vibrator sexual expression, but are afraid of intercourse and come to view it as strictly for the man's pleasure rather than your own. Cooperate to make intercourse comfortable and pleasurable for both of you.

15. You deserve to feel comfortable with your body, with intercourse, and with erotic scenarios and techniques. Use all your resources; relaxation, lubrication, mindfulness, pelvic floor therapy, eroticism, transitioning to intercourse at high levels of erotic flow, and using intercourse positions and types of thrusting which facilitate pleasurable intercourse.

16. Your partner has an integral role in helping you manage pain and build sexual comfort. He is your intimate and erotic ally. Focus on sharing pleasure, not pressure or performance.

17. Your intimacy and sexual needs are as important as his. It is not healthy for you or your relationship to endure painful sex in an attempt to placate your partner.

18. Remember, few women experience desire/pleasure/eroticism/satisfaction at each sexual encounter. A healthy approach emphasizes "Good Enough Sex" (GES). With GES, approximately 85% of sexual experiences will be comfortable and enjoyable. A "perfect" performance goal of achieving 100% pain-free intercourse is self-defeating and subverts the change process.

19. Healthy sex involves desire, non-demand pleasuring, erotic scenarios and techniques, and positive, realistic expectations. Accept and enjoy the flexibility, variability, and complexity of female and couple sexuality.

Resource: McCarthy, B. & McCarthy, E. (2012). Sexual Awareness (5th edition)

Guidelines - Learning Ejaculatory Control - 2021

1. Premature (rapid) ejaculation is the most common male sexual problem. The majority of men begin as early ejaculators. Twenty-five percent of adult males complain of premature ejaculation, i.e. ejaculating within two minutes of intercourse and not feeling in control of when you ejaculate.

2. "Do it yourself" techniques to reduce arousal (biting your lip, focusing on non-sexual thoughts like how much money you owe or your mother-in-law, using two condoms or a penile desensitizing cream, masturbating before couple sex) do not help you learn ejaculatory control. Instead, they can cause erectile dysfunction or couple alienation.

3. The keys to learning ejaculatory control are first to identify the point of ejaculatory inevitability (after which ejaculation is no longer a voluntary function) and then build comfort and awareness at moderate levels of arousal.

4. Ejaculatory control can be learned through self-stimulation as well as during partner stimulation. Practicing new psychosexual skills develops awareness, comfort, and confidence. The major psychosexual skills involve whole body relaxation, specific relaxation of the pelvic muscles, using self-entrancement arousal rather than partner interaction arousal, and slowing down the sexual process with a focus on pleasure.

5. The strategy in learning ejaculatory control is counterintuitive. Increase comfort, awareness, and pleasure—do not decrease stimulation. Ejaculatory control during intercourse is complex and challenging.

6. The most effective technique is stop-start. Signal your partner to stop stimulation as you approach the point of inevitability. Stimulation stops for 30-60 seconds until you no longer feel you are going to ejaculate. Then resume stimulation with a focus on relaxation and pleasure. This is superior to the traditional squeeze technique, which is awkward and mechanical, especially for the woman.

7. Stop-start is used first with manual stimulation, then oral stimulation, and before and during intercourse. Learning ejaculatory control is a gradual process requiring practice and feedback. It takes most couples 3-6 months to master ejaculatory control during intercourse.

8. Realistic expectations and goals are crucial. The typical lovemaking session extends between 15-45 minutes, of which 3-9 minutes involve intercourse. Contrary to male bragging and media myths, intercourse seldom lasts more than 10 minutes.

9. One in six women have the same response pattern as males, i.e. a single orgasm during intercourse. One in three women is never or almost never orgasmic during intercourse. Improved ejaculatory control is to increase pleasure and eroticism for the man and couple, not to make the woman orgasm during intercourse. Enjoy intercourse as an involving, pleasurable, erotic experience.

10. Typically, couples begin ejaculatory control exercises for intercourse using the woman on top position with minimal movement (the quiet vagina exercise). She guides intromission and controls thrusting.

11. The stop-start technique can be used before and/or during intercourse. He can either stop movement or withdraw. As comfort and confidence with ejaculatory control increases, the technique is to slow thrusting or use circular thrusting.

12. With continued practice, other intercourse positions are added. Utilize longer, slower thrusting or circular thrusting. You can switch which partner controls the thrusting rhythm. Ejaculatory control is most difficult in the man on top position with short, rapid thrusting.

13. The focus is maintaining ejaculatory control for 5-10 minutes with non-intercourse stimulation (manual or oral) and 3-7 minutes of intercourse.

14. When you ejaculate, whether rapidly or voluntarily, enjoy the feelings and sensations. "Beating up" yourself or blaming your partner does not facilitate ejaculatory control.

15. The feelings and sensations of orgasm begin at the point of ejaculatory inevitability and last three to ten seconds, which includes ejaculation.

16. The woman's emotional and sexual feelings are integral in the learning process. Her role is an intimate, involved partner. You can pleasure her to arousal and orgasm with manual, oral, rubbing, or vibrator stimulation before or after ejaculatory control exercises.

17. Some men use an anti-depressant medication, at a low dose on a daily basis, to promote ejaculatory control. New medications are being developed and are effective for the majority of men. Success is dependent on remaining on medication.

18. The preferred strategy is to use medication as an additional resource. Integrate the medical intervention into your couple style of intimacy, pleasuring, and eroticism. Practice ejaculatory control exercises while taking medication and then gradually phase out the medication. Be aware that 2-3% of males have a physiological need to remain on medication in order to maintain ejaculatory control.

19. Remember, do not try to reduce stimulation or arousal. This can lead to developing erectile or desire problems. Focus on awareness, comfort, pleasure, and arousal without moving rapidly to ejaculation.

20. The essence of sexuality is sharing pleasure, not a perfect individual performance. Couple sex is inherently variable. The Good Enough Sex (GES) model is that 85% of the time you maintain ejaculatory control during intercourse. Enjoy and share the entire sexual experience—intimacy, pleasure, eroticism, intercourse, and afterplay.

    Resource: Metz, M. & McCarthy, B. (2003). Coping with Premature Ejaculation.

Extra-Marital Affairs (EMA) T-F Test 2021

1. EMA is always a symptom of relationship dissatisfaction.

2. EMA results in divorce for the majority of couples.

3. Paid sex (massage parlor and prostitutes) is the most common male EMA.

4. Religious couples - including born-again Christians, orthodox Jews, traditional Catholics - almost never have EMA.

5. EMA is usually driven by sex addiction.

6. Men plan an EMA to give him courage to leave his marriage.

7. Sexually functional couples seldom have EMA.

8. Most people practice safe sex during an EMA.

9. Married men who have sex with men are always gay.

10. Women who are homemakers have more EMA because they have more time.

11. The longer the couple is married, the more likely they will have an EMA.

12. Couples who cohabitate have lower rates of EMA than married or dating couples.

13. Women who have Comparison (love) EMA usually plan to do so.

14. Problems of low desire are frequent in EMA sex.

15. After divorce and remarriage, there is never sex with the ex-spouse.

16. Swinging or triadic sex is a very common type of EMA.

17. Most EMAs are not disclosed and should not be disclosed.

18. EMA is very rare in the first 2 years of marriage.

19. When the man divorces, he almost never marries the EMA partner.

20. The most common reason women leave their marriages is for an EMA.

21. Men who have a variant arousal pattern act this out in their marriage, almost never during an EMA.

22. Cybersex EMA is almost always high opportunity/low involvement.

23. The traditional approach to treating EMA-understand the cause of the EMA, focus on the spouse's remorse and penance, rebuild trust over the next 2 years, and lastly focus on couple intimacy-has been empirically validated.

24. Very few couples recover sexually from an EMA.

25. Individual therapy for the offending spouse is mandatory.

Resource: Allen, E., Atkins, D., Baucom, D., Synder, D., Gordon, K., & Glass, S. (2005). Intrapersonal, interpersonal, and contextual factors in engaging in and responding to extramarital involvement. Clinical Psychology: Science and Practice, 12(2), 101-130.

Extra-Marital Affairs – 2021

1. High opportunity/low involvement

2. Compartmentalized, ongoing

3. Comparison

Resources: Allen, E., Atkins, D., Baucom, D., Snyder, D., Gordon, K., & Glass, S. (2005). Intrapersonal, Interpersonal, and contextual factors in engaging in and responding to extramarital involvement. Clinical Psychology: Science and Practice, 12 (2), 101-130.

Overview of EMA Treatment Model - 2021

Although the treatment program needs to be applied flexibly with respect for individual, couple, cultural, and value differences, it reassures and motivates the couple to know there is a plan and structure.

I. Four session assessment—initial couple session, individual psychological/relational/ sexual histories, and a couple feedback session to create a new, genuine narrative and therapeutic plan.
II. Reduce the intensity of conflict about EMA, focus on self-care, and create a therapeutic letter to the injured partner.
III. Work together to end the EMA, deal with flashbacks, rebuild trust and touching, respect the struggles of both the involved and injured partner, and develop a genuine understanding of the EMA which acknowledges both positive and negative learnings.
IV. Make a "wise" decision of whether to rebond the marriage or have a "good divorce."
V. The challenge is to create a new couple sexual style with strong, resilient sexual desire.
VI. Develop an individualized relapse prevention agreement. Most couples reaffirm a stronger monogamy commitment. Be aware of the need for a clear agreement for non-traditional couples who choose consensual non-monogamy.

Resource: Synder, D., Baucom, D. & Gordon, K. (2007) Getting Past the Affair.

Causes of EMA - 2021

Contrary to traditional beliefs about EMA, there is not one cause or one outcome. EMA is an example of multi-causal, multi-dimensional behavior which is influenced by individual, couple, cultural, and value issues.
Among the possible causes of EMA are:

1. High opportunity
2. For personal change or to resurrect a cut-off part of yourself
3. To see if you are sexually functional since you are sexually dysfunctional in your marriage
4. A symptom of depression or alcohol/drug abuse
5. For courage to leave a fatally flawed marriage
6. To act out a variant arousal pattern (males)
7. Falling in love with a friend or work colleague
8. Revenge EMA
9. To be sexual with someone of the same gender
10. To deal with boredom or loneliness

Of course, there are many other possible causes

Dimensions of EMA - 2021

1. Is this primarily a sexual EMA, emotional EMA, or a comparison EMA?
2. Is this a single incident, compartmentalized, or continuing EMA?
3. Does the EMA increase desire for marital sex or negate marital sex?
4. Level of emotional involvement- one-night stand, acquaintance, friend, lover, potential life partner?
5. Is the spouse aware or is it a “don’t ask/don’t tell” situation?
6. Is this a massage parlor, prostitute, or ongoing paid EMA?
7. Does the EMA involve interaction on the internet, cybersex, phone sex, or a second life?
8. Is this a work EMA, neighborhood EMA, involve a religious or community group?
9. Does the EMA involve triadic, group, swinging or polyamory?
10. Does the marriage involve a traditional or non-traditional agreement about EMA?

In making meaning of the EMA, the clinician needs to explore and help the couple understand the EMA from the perspective of the involved partner, injured partner, and their relationship.

EMA – Specific Questions - 2021

1. What was happening in your individual; and couple life six months before the EMA began?
2. Did you have an implicit or explicit couple agreement about monogamy?
3. Was the EMA planned or did you fall into it?
4. Emotionally and sexually what did you expect from the EMA?
5. How did the EMA end, or if ongoing, how do you expect it to end?
6. What is the most important thing you want your partner to understand about you and the EMA?
7. What are your positive and negative learnings from the EMA?
8. What are your hopes and intentions about intimacy and sexuality in your marriage?

EMA – Genuine Forgiveness - 2021

Forgiveness is an integral component of EMA treatment, and can be therapeutic whether the couple stays together or not. A genuine apology is very different than the politically correct “I’m sorry and let’s not talk about this again” on one extreme or “I am a bad person, sex is destructive, and what I did is unforgiveable” on the other extreme.

The apology session is part of a process where the involved partner clearly recognizes and acknowledges the distress and pain caused by the EMA, takes responsibility for the impact on the injured partner, and apologizes for the emotional injury. The involved partner makes a genuine commitment to trust, intimacy, and sexuality. The apology session is a face to face process, usually accompanied by an apology letter. The injured partner’s acceptance of the apology does not mean forgetting about the EMA, but it does mean that the relationship is no longer controlled by the hurt/anger of the EMA. The injured partner is no longer driven by punishment or revenge. The apology frees both partners to move on with the therapeutic process and their lives.

The apology session has value whether you recommit to your marital bond or decide to terminate the relationship. If you choose to recommit to building trust, intimacy, and sexuality, the apology is a crucial component in making meaning of the EMA and freeing energy to create a stronger marriage, a new couple sexual style, and a trustworthy relapse prevention plan. If you terminate the marriage, the foundation has been set for a “good divorce” with each person free to create a new life and relationship.

Sexual Recovery from EMA - 2021

We focus on a largely ignored issue- sexual recovery from EMA. The traditional model was a hierarchical approach: 1. understand what caused the EMA, 2. focus on the role of the "infidel" and effects on the "victim", 3. recovery from betrayal, 4. work to rebuild trust, 5. after a period of months or years explore couple intimacy, 6. resume sexuality. The new therapeutic model is a time-focused "both-and" approach of making meaning of the EMA for the involved partner, injured partner, and marriage as well as rebuilding trust, intimacy, and a new couple sexual style. This is a positive, integrative process.

You cannot compare EMA sex and marital sex, it's "apples and oranges". EMA sex is more dramatic and exciting - the limerence phase multiplied by 3. The healthy comparison is the new couple sexual style with couple sex before the EMA. Your challenge is to build strong, resilient sexual desire and reinforce the desire/pleasure/eroticism/satisfaction mantra.

You cannot change the past nor can you have a "do-over". You can learn from the past, but your power to change is in the present and the future. You can process past experiences and "honor" EMA learnings, but do not be controlled by the EMA. We do not advocate EMA as a way to change couple sexuality, but given the reality of the EMA a positive outcome is to create a new couple sexual style which reinforces the 15-

20% role of sexuality to energize your bond and enhance feelings of desire and desirability. Rather than anguishing about the past and obsessing about the details of EMA sex, the injured and involved partners integrate intimacy, pleasuring, and eroticism as intimate and erotic allies. Although individuals and couples are different (sexually one size never fits all), the EMA is best understood as a wake-up call and a challenge to create a vital desire/pleasure/eroticism/satisfaction relationship. Many couples treat sex with benign neglect until the crisis of an EMA. In sexual recovery, a vital component is putting time and energy into maintaining desire, intimacy, pleasuring, eroticism, and a vital couple sexuality.

Traditional EMA Prevention Agreement - 2021

Couples would rather create a relapse prevention plan than have to deal with a second EMA. The traditional EMA prevention agreement involves three components. This is based on the assumption that EMA can occur with all people and all marriages.

First, recognize and process individual and couple vulnerability factors. Specifically, each spouse identifies what type of situation, mood, or person would make you vulnerable to an EMA. These vulnerabilities are shared with the spouse so that both are cued into potential high-risk people, situations, and moods. Interestingly, few people share the same vulnerabilities. Sharing and processing personal vulnerabilities is therapeutic itself as well as increasing each partner's awareness.

Second, the couple make an emotional commitment to alert the spouse if you are in a high-risk situation rather than impulsively and secretly acting out the EMA opportunity. This agreement makes clear the importance of an emotional cost-benefit assessment of the potential EMA and its impact on the person, spouse, and marriage. This makes the EMA a conscious and planful process, robbing it of secrecy and illicit transgression. EMA is approached as you would other important individual and couple decisions.

The third component is the commitment to tell the spouse within 72 hours if there has been an emotional or physical EMA incident. As in politics, the cover-up is more damaging than the actual incident. With EMA, the injured spouse's feelings about lying and betrayal grow over time. This results in giving the EMA more power than it deserves.

A major challenge for couples who successfully heal from an EMA is to create a genuine narrative about the EMA which empowers you to make meaning of the EMA, identify positive and negative personal and couple learnings, create a new trust bond, and a new couple sexual style with strong, resilient sexual desire. This is easier if the involved and injured partners deal with the EMA in a timely and efficacious manner.

The key to an EMA prevention agreement is to confront denial ("it could never happen to us") and make a clear agreement, which recognizes personal and couple vulnerabilities while affirming the value of your trust bond, couple sexual style, and commitment to a satisfying, secure, sexual marriage.

Relapse Prevention for Non-Traditional Couples - 2021

Approximately 8-15% of couples adopt a non-traditional approach to fidelity and monogamy. These couples deserve high quality clinical services to help them clarify personal and couple understandings, boundaries, and goals. You create clear and wise emotional agreements about sexuality in your relationship.

The first issue is to clarify what you value about your relationship-what is the core of your emotional fidelity agreement. It might be family, home, social acceptance, finances, a respectful bond, a solid attachment. Especially important is to be clear whether both partners value satisfaction, security, and sexuality.

The second element is what type of sexual relationships are acceptable for each partner. The boundary between autonomy (privacy) and secrecy deserves careful exploration. A common guideline is the right to emotional and sexual autonomy and privacy, but not secrecy which is at the expense of the partner or relationship.

The most common agreement involves an open relationship. The second most common is swinging relationships (either closed or open). The third is polyamorous relationships involving emotional and sexual involvements with other individuals or couples. It is crucial to have a clear and genuine dialogue/emotional agreement about what types of sexual relationships work for each partner and your relationship. Other

couples follow the "don't ask, don't tell" guideline. An important guideline is to practice contraception and safe sex with EMA partners.

The third element is the issue of "red line" boundaries. What type of person or relationship would be harmful to your partner or your relationship? Common red lines include not falling in love with the EMA person, not having sex with the brother-in-law or next door neighbor, and not compare the EMA person with your spouse.

Many clinicians have a bias against non-traditional couples. The clinician questions their motivation and emphasizes the risk of destabilizing the person or primary relationship. The role of the clinician is to help the client make a "wise decision" about sexuality so that it has a positive rather than destructive role in your lives. It is not to judge or make decisions for the client or couple.

What is the Right Couple Sexual Style for You? - 2021

Most people begin as a romantic love/passionate sex/idealized couple. This very special phase (limerence) lasts between 6 months and if you're lucky 2 years. The challenge is to create a couple sexual style which will enhance desire/pleasure/eroticism/satisfaction. The challenge for couples, married or cohabitating, straight or gay, is how to integrate intimacy and eroticism into your relationship, and how to balance your "sexual voice" (autonomy) with being an "intimate sexual team". You develop a mutually comfortable level of intimacy, share non-demand pleasuring, value erotic scenarios and techniques, and maintain positive, realistic sexual expectations.

The four most common couple sexual styles (by order of frequency) are:

- Complementary—mine and ours
- Traditional—conflict-minimizing
- Best Friend—soul-mate
- Emotionally Expressive—fun and erotic

Contrary to "pop psych" there is not a "right" style which is best for all couples. Be aware that usually your couple sexual style is different than your relational style. Each partner needs to be aware of your preferences, feelings, and values and choose the balance of intimacy/eroticism and autonomy/coupleness which enhance sexual desire and satisfaction. Be aware of strengths and vulnerabilities of each couple sexual style so you choose which is right for you.

Complementary Couple Sexual Style

Complementary is the most common couple style because it balances each person's sexual voice with being a securely bonded team. Each partner has the freedom to initiate a sexual encounter, say no, offer an alternative way to connect, value both intimacy and eroticism, and play out your preferred erotic and intercourse scenarios. What are the vulnerabilities (traps) for this sexual style? The two major traps are treating sex with "benign neglect"—sex falls into a routine pattern. The second trap is that when life changes, for example, having a baby, rather than valuing couple time, you fall into traditional parenting roles and lose erotic playfulness.

Traditional Couple Sexual Style

These couples follow traditional gender roles where sexual initiation and intercourse is the man's domain while intimacy and affection is the woman's domain. This is the most stable couple style, high on clarity and security, and low on drama and the need to negotiate sexual issues. The vulnerabilities are role rigidity and with aging the man finds it difficult to function sexually without her stimulation. Another trap is not dealing with sexual problems until they are chronic. The woman feels her need for intimate connection and validation are ignored and overwhelmed by his sexual agenda.

Best Friend Couple Sexual Style

Best Friend is the cultural ideal—the most intimate relationship. Sharing intimacy and eroticism with the same person, feeling accepted and loved for who you really are (warts and all), and maintaining a secure bond, are powerfully validating emotionally and sexually. However, this is a very risky sexual choice. You feel so close that you de-eroticize your partner. The woman feels disappointed in the man and relationship because he fails to meet unrealistically high expectations. There is so much emphasis on mutuality that you don't take sexual risks and thus have low sexual frequency. The Best Friend sexual style is unable to be resilient when dealing with hard issues, such as an affair.

Emotionally Expressive Couple Sexual Style

Emotionally Expressive is the stuff of movies and love songs—vibrant, playful, erotic, high-energy sex. These couples use sex to heal emotional conflicts, take sexual risks, are experimental, and enjoy sexual fun and intensity. The traps are too much emotional and sexual drama drain your bond and threaten relationship stability, overemphasize sexual experimentation and eroticism at the expense of intimacy and security, use sex to avoid dealing with problems, and this level of intensity wears the partners out.

Choosing the Right Style for You

A "wise" choice of a couple sexual style challenges you to weigh both emotional and practical factors, choosing not just for the short term but what brings sexual satisfaction over the long term. Choose a mutually acceptable sexual style which facilitates desire/pleasure/eroticism/satisfaction. You want sexuality to play a 15-20% role in enhancing relationship vitality and satisfaction. Emphasize the strengths of your chosen couple sexual style and be mindful of traps/vulnerabilities so these don't subvert sexuality. You want to celebrate yourself as a sexual person and experience bonding as a sexual couple. Usually the relational and sexual styles are different. For most couples, the Best Friend relational style and the Complementary sexual style is the best decision.

Resource: McCarthy, B. & McCarthy, E. (2009). Developing Your Couple Sexual Style.

Three Styles of Arousal/Eroticism - 2021

Arousal/eroticism is an integral component in the desire/pleasure/eroticism/satisfaction mantra. There are three sexual arousal/eroticism styles (by frequency): (1) partner interaction arousal, (2) self-entrancement arousal, (3) role enactment arousal.

Partner interaction arousal is based on the principle that the major aphrodisiac is an involved, aroused partner. This type of arousal is portrayed in R-rated movies; each partner's arousal enhances the other's. Partner interaction arousal is like a sexual dance where each partner has an integral role. It is an example of the "give to get" pleasure guideline. Almost all couples utilize partner interaction arousal.

Self-entrancement arousal is the second most common arousal/eroticism pattern. It is best illustrated by the traditional sensate focus exercises. The giving partner touches for himself rather than trying to second guess the preferences of the receiving partner. The receiving partner is actively focused on her pleasure. She is active not passive, aware of her receptivity/responsivity pattern. As couples age, they are likely to increasingly utilize self-entrancement arousal. They are open to asynchronous scenarios, realizing that not all sex needs to be mutual.

Role Enactment arousal/eroticism is the most advocated (especially on the internet and in self-help articles) and contentious style. Role enactment arousal involves external resources to heighten the erotic charge including X-rated videos, sex toys,

playing out erotic fantasies, and using BDSM scenarios. Clinically, the issue is whether role

enactment arousal is the right fit for that couple. It is a good fit for the Emotionally Expressive couple sexual style, and a poor fit for the Best Friend and Traditional couple sexual styles. Many couples find role enactment arousal scenarios are intimidating rather than empowering. It raises self-consciousness, and there is nothing more anti-erotic than self-consciousness.

A majority of married men and women use erotic fantasies as a bridge to desire and to build erotic flow to orgasm. A common misunderstanding is that fantasy is an indicator of what the person really wants. In the great majority of cases, fantasy and behavior are very different domains. Commonly, acting out an erotic fantasy results in a "sexual dud", and can rob the fantasy of its erotic charge.

The key is making a wise decision of what arousal/eroticism style (s) is the best fit for you. Some couples use all three styles. Commonly, couples use partner interaction arousal and augment that with self-entrancement arousal. On occasion some couples use role enactment arousal, but others are uncomfortable with that arousal style. Choose what enhances eroticism for your relationship.

Resource: Metz, M., Epstein, N., & McCarthy, B. (2018). Cognitive-Behavioral Therapy for Sexual Dysfunction.

Sex Therapy with Individual Clients - 2021

Individuals -single, divorced, widowed-deserve for sexuality to have a 15-20% positive role in their lives, not a problematic or destabilizing role. The choice to marry or create a life partnership is a decision, not a mandate.

In terms of helping individuals make wise decisions about an emotional/sexual relationship there are two core concepts-"circles of intimacy" and "guidelines for choosing a partner".

Circles of intimacy involve the concept of five levels of relationship:

1. anonymous sex
2. acquaintance sex-"hooking up" or "friends with benefits"
3. sexual friend
4. lover
5. marriage or life partner

All five levels require effective contraception and practicing safe sex. The more intimate the relationship the more likely there will be stability and satisfaction, but also a higher risk of disappointment and hurt. A sexual friendship can be an important growth-

inducing, meaningful relationship even though it does eventually end (some sexual friendships do evolve into a life partnership/marriage).

A woman dealing with recovery from breast cancer or a man dealing with a stroke or traumatic brain injury needs to accept the "new normal". Doing that in the context of a sexual friendship is more likely to be therapeutic than throwing yourself into a potential life partnership. This is also true of a client returning to dating after a divorce. You are not ready for a major life commitment.

Be aware that there are sexual friends who would be a disaster as a spouse. Likewise a lover relationship is great for 2 years, but trying to convert this to a life partnership leads to disappointment and anger. Accept and enjoy the relationship for what it is, don't make it into something that is not the right fit.

In choosing a sexual friend we suggest the guidelines of someone you are comfortable with, trust, and are attracted to (in that order). Especially when you are experiencing sexual dysfunction, choose a partner you are comfortable with rather than feeling pressure to perform for. Also, trust that she (or he) has your best interest in mind and would not do something intentionally to hurt you. Finally, choose a sexual friend you are attracted to. A special trap for males is a relationship with a woman he is not attracted to so he can blame her for the sex problem. This is a self-defeating strategy and unfair to the sexual friend.

Choose a sexual friend you are comfortable with, trust, and are attracted to so you can rebuild sexual confidence. You deserve for sexuality to have a 15-20% positive role in your life and relationship.

In individual therapy, the positive role of masturbation and fantasy is emphasized as well as enhanced self-acceptance as a single person.

Resource: McCarthy, B. (2015). Sex Made Simple.

Sexual Trauma: Levels of Victimization - 2021

1. Sexual abuse incidents

2. Dealt with at time or kept secret

3. Proud Survivor vs. shameful, anxious, or angry victim

Resource: Maltz, W. (2012). The Sexual Healing Journey (3rd edition).

Fatally Flawed Marriages - 2021

1. Hidden Agenda

2. Negative Reasons to Marry

3. Core Incompatibility

Guidelines for Sex After 60 - 2021

1. You are a sexual person throughout your life, no matter what your age. Age does not cause sexuality to end.

2. Key to maintaining vital sexuality is to integrate intimacy, pleasuring, and erotic scenarios and techniques.

3. Contrary to popular mythology, when couples stop being sexual it is the man's choice in over 90% of cases because he has lost confidence with erection, intercourse, and orgasm. Sex is frustrating and embarrassing. He makes the decision unilaterally and conveys it non-verbally.

4. Sexuality remains satisfying when both the man and woman value a variable, flexible, pleasure-oriented couple sexual style rather than sex as an individual performance, a pass-fail intercourse test.

5. With aging your hormonal, vascular, and neurological systems function less efficiently, so psychological, relational, and psychosexual skill factors become more important in maintaining healthy, resilient sexuality.

6. The best aphrodisiac is an involved, aroused partner—you turn toward each other as intimate and erotic allies.

7. The "give to get" pleasuring guideline has particular value for the aging couple. This promotes mutual stimulation, multiple stimulation, and accepting asynchronous sexual experiences.

8. The major physiological changes in male sexual response are that it takes more time and direct penile stimulation to obtain an erection, your erection is not as firm and more likely to wane, and there is a lessened need to ejaculate at each sexual opportunity.

9. The major physiological changes in female sexual response are diminished vaginal lubrication that necessitates using a vaginal lubricant, thinner vaginal walls, increased time and stimulation required for arousal and orgasm, and less intense orgasmic response.

10. Estrogen replacement for women, use of pro-erection medications for men, and testosterone for both men and women are not "magic cures." They can be positive resources for sexual function when integrated into your couple intimacy, pleasuring, and eroticism style. These need to be prescribed and monitored by a physician, not purchased from the internet or over the counter.

11. Positive, realistic expectations are crucial in maintaining a healthy sexual relationship. Do not compare sexuality in your 60's to the sexuality you experienced when you were 20. Focus on quality and pleasure, not quantity and performance. The good news is you can be sexual in your 60's, 70's, and 80's.

12. Sexuality is more than genitals, intercourse, and orgasm. Sexuality also involves sensual, playful, and erotic touch. Not all touch can or should result in intercourse. Couples who accept the Good Enough Sex (GES) approach report high levels of desire and satisfaction.

13. A crucial factor, especially for women, is accepting your body image. Traditionally, female sexual desire and sense of attractiveness was contingent on everything being perfect. Self-acceptance, especially for aging people, promotes partner acceptance and vital, resilient sexuality.

14. Maintaining a regular rhythm of sexual contact is crucial. The average frequency of sexual activity after 60 is once a week. When couples are sexual less than every 2 weeks, self-consciousness and anxiety replace comfort and positive anticipation. A key to satisfying sexuality is to maintain a pleasure-oriented connection, which includes intercourse and orgasm, but emphasizes a broader, more flexible approach to pleasure, eroticism, and satisfaction.

15. Satisfying sexuality requires partners to maintain a focus on pleasure. The variable, flexible couple sexual style advocated by the GES approach includes valuing sensual, playful, erotic, as well as intercourse touch.

16. Couples who cling to the traditional male-female double standard are vulnerable to unsatisfying and dysfunctional sex. Emphasize female-male equity and being an intimate sexual team.

17. You can appreciate and enjoy the role reversal where female sexual response becomes easier than male response. He learns to "piggy-back" his arousal on hers, a crucial psychosexual skill. Remember, sex is about sharing pleasure. not a competition or performance.

18. Most women use a lubricant to facilitate intercourse and reduce the likelihood of dyspeurnia (painful intercourse). Additionally, you can guide intromission, which makes sense since you are the expert on your vagina. This also reduces male performance anxiety.

19. The man needs to accept his mature penis and its response rather than compare it to the easy, predictable, autonomous erections of his twenties. Enjoy your body, your partner's body, and the sexual experience rather than maintain an emphasis on erection and intercourse as a test of manhood.

20. Replace the concept of perfect intercourse performance with the GES model. Eighty-five percent of encounters will flow to intercourse. Both partners can be comfortable with at least one and ideally both alternative scenarios:
    A. Erotic, non-intercourse scenario to high arousal and orgasm for one or both partners
    B. A warm, sensual, cuddly scenario

21. Sex after 60 is more intimate, genuine and human than sex in your 20's. Enjoy these feelings and experiences and focus on being intimate and erotic friends.

    Resource: McCarthy, B. & McCarthy, E. (2021). Couple Sexuality after 60.

Relapse Prevention Strategies and Guidelines - 2021

1. Set aside quality couple time and discuss what you need to do individually and as a couple to maintain a satisfying and secure sexual relationship.

2. Every 6 months have a formal follow-up meeting either by yourselves or with a therapist to ensure you remain aware and do not slip back into unhealthy sexual attitudes, behaviors, or feelings. Set a new couple sexual goal for the next 6 months.

3. Every 4-8 weeks plan a nondemand pleasuring, playful, or erotic date where there is a prohibition on intercourse. This allows you to experiment with sensual stimuli (alternative pleasuring position, body lotion, or new setting), a playful scenario (sex play in the shower), or an erotic scenario (a different oral sex position or engaging in an asynchronous scenario rather than mutual sex). This reminds you of the value of sharing pleasure and developing a broad-based, flexible sexual relationship rather than focusing on intercourse as an individual pass-fail performance test.

4. Five to fifteen percent of sexual experiences are mediocre, dissatisfying or dysfunctional. That is normal, not a reason to panic or feel like a failure. Maintaining positive, realistic expectations about couple sexuality is a major relapse prevention resource.

5. Accept occasional lapses, but do not allow a lapse to become a relapse. Treat a dysfunctional sexual experience as a normal variation which can provide an important learning. Remember, you are a sexual couple, not a perfectly functioning sex machine. Whether once every 10 times, once a month, or once a year, you will have a lapse and experience dysfunction or dissatisfaction. Laugh or shrug off the experience and make a date in the next 1-3 days when you have the time and energy for an intimate, pleasurable, erotic experience. A relapse means giving up and reverting to the cycle of anticipatory anxiety, pass-fail intercourse performance, and frustration, embarrassment, and avoidance.

6. The importance of setting aside quality couple time—especially intimacy dates and a weekend away without children—cannot be over emphasized. Couples report better sex on vacation, validating the importance of getting away, even if only for an afternoon.

7. There is not “one right way” to be sexual. Each couple develops a unique style of initiation, pleasuring, eroticism, intercourse, and afterplay. Do not treat your couple sexual style with benign neglect, be open to modifying or adding something new or special each year.

8. Good Enough Sex (GES) has a range from great to disappointing. The single most important technique in relapse prevention is to accept and not overreact to experiences that are mediocre, dissatisfying, or dysfunctional. Take pride in being sexually accepting and having a resilient couple sexual style.

9. Develop a range of intimate, pleasurable, and erotic ways to connect, reconnect, and maintain connection. These include five gears (dimensions) of touch.
    1. Affectionate touch (clothes on)—kissing, hand-holding, hugging.
    2. Non-genital sensual touch (clothed, semi-clothed, or nude)—massage, cuddling on the couch, touching before going to sleep or on awakening.

3. Playful touch (semi-clothed or nude)—mixing non-genital and genital touch—romantic or erotic dancing, touching while showering or bathing, "making out" on the couch, whole body massage.
4. Erotic, non-intercourse touch—using manual, oral, rubbing, or vibrator stimulation for high arousal and/or orgasm for one or both partners.
5. Intercourse—View intercourse as a natural continuation of the pleasuring/eroticism process, not a pass-fail individual performance test. Transition to intercourse at high levels of erotic flow and utilize multiple stimulation during intercourse.

10. Keep your sexual relationship vital. Continue to make sexual requests and be open to exploring erotic scenarios. Maintain a flexible sexual relationship that energizes your bond and facilitates desire and desirability. Couples who share intimacy, non-demand pleasuring, erotic scenarios, and planned as well as spontaneous sexual encounters, have a vital sexual relationship. The more ways in which you maintain an intimate sexual connection, the easier it is to avoid relapse.

    Resource: McCarthy, B. (2015). Sex Made Simple.

What Predicts Satisfying, Secure, and Sexual Marriages - 2021

A healthy marriage is satisfying, secure, and sexual. The following factors are predictive of a healthy marriage.

A. Historical factors
    1. Growing up in an intact, functional family
    2. Parents were a good, not perfect, marital and sexual model
    3. Both parents functioned well psychologically
B. Pre-disposing factors
    4. At least 21 at time of marriage and not pregnant
    5. Marry for positive reasons—to share your life with your spouse. Marriage not driven by negative motivations such as fear of loneliness, parental or peer pressure, rescue a floundering life.
    6. Know partner for at least one year.
    7. Communalities in terms of socio-economic class, race, age, religion, education
    8. Physical attraction with potential to develop an intimate sexual relationship
    9. Discuss important life organization issues—work, money, children, where to live
    10. Support of family and friends
    11. Prospective spouse as a respectful, trusting friend
    12. If cohabitating, treating the marital decision as a proactive choice, not sliding into marriage
    13. Sharing important information about self, no major secrets
C. Process factors
    14. Marital bond of respect, trust, and intimacy grows stronger and more resilient in the first two years of marriage
    15. Develop a mutually agreed on couple style for handling differences and conflicts
    16. Wait at least two years before the birth of a planned, wanted child
    17. Develop a comfortable, functional couple sexual style which integrates intimacy, pleasuring, and eroticism
    18. Accept that approximately 30% of problems are resolvable, 50-60% are modifiable, and 10-20% need to be accepted and coped with
    19. Maintain positive, realistic personal and marital expectations
    20. Utilize the guideline of a 5 to 1 positive-negative set of thoughts, feelings, and behavior toward your spouse and marriage

We encourage each spouse (or partner) to honestly assess (don't give the socially desirable answer) each factor on a five-point scale:

++ A major strength
+ A positive factor
0 Neutral
- A vulnerability
-- A major vulnerability

Next, share and discuss these factors. Historical factors are to increase awareness, but are not in your control and are not changeable.

The pre-disposing factors are potentially changeable. You and your partner need to share strengths and vulnerabilities in assessing your challenges in creating and maintaining a healthy marriage.

The third category, process factors, is most in your control and the most changeable. Follow the guideline of factor 15, make wise decisions (those which make sense emotionally and practically and work in both the short and long term). A sign of an unhealthy marriage is choices which are emotional and short term, but not wise.

Remember, the focus of this assessment is to empower you to create a satisfying, secure, and sexual marriage. If you identify major personal and relational vulnerabilities, we encourage you to seek professional counseling to address these issues and give you the resources to create and maintain a healthy marriage. The sexual paradox is that sexual problems can destroy a loving marriage, but good sex cannot save a bad marriage.

Resource: McCarthy, B. & McCarthy, E. (2004) Getting It Right the First Time.

Personal Reflection Exercise - 2021

First, what are the sexual issues you are most interested in as a clinician?

Second, what kinds of clients and sex problems do you feel the most competent in addressing?

Third, in terms of professional values what kinds of clients and problems are you most comfortable with?

Fourth, in terms of personal values what kinds of clients and problems are you most comfortable with?

The hard issue is dealing with difficult clients and problems

First, what are the sexual issues and clients you are not interested in?

Second, what are the types of clients and sexual issues you are not competent to deal with?

Third, in terms of professional values, what kinds of clients and problems are you unable to deal with?

Fourth, and most difficult, in terms of personal values, what kinds of clients and problems are you unable to deal with?

Resources - 2021

I. Professional Books:
1. Hall, Kathryn & Binik, Irv (2020). Principles and Practice of Sex Therapy. (6th edition). Guilford.
2. Metz, Michael, Epstein, Norm, & McCarthy, Barry (2018). Cognitive Behavioral Therapy for Sexual Dysfunction. Routledge.
3. McCarthy, Barry (2015). Sex Made Simple. PESI publications.

II. Journals:
1. Journal of Sex and Marital Therapy
2. Sexual and Relationship Therapy

III. Professional Organizations and Referrals to Sex Therapists:
1. American Association of Sex Educators, Counselors, and Therapists http://www.aasect.org
2. Society for Sex Therapy and Research http://www.starnet.org

IV. Lay Public Books:
1. Brotto, L. (2018). *Better Sex Through Mindfulness*. Greystone.
2. Foley, Sallie, Kope, Sally, & Sugrue, Dennis (2012). *Sex Matters for Women*. (2nd edition). Guilford.
3. Kleinplatz Peggy & Menard, A. Dana (2020). *Magnificent Sex*. Routledge.
4. Maltz, Wendy (2012). *The Sexual Healing Journey*. (3rd edition). William Morrow.
5. McCarthy, Barry & McCarthy, Emily (2012). *Sexual Awareness*. (5th edition). Routledge.
6. McCarthy, Barry & McCarthy, Emily (2018). *Finding Your Sexual Voice.* Routledge.
7. McCarthy, Barry & McCarthy, Emily (2019). *Enhancing Couple Sexuality*. Routledge.
8. McCarthy, Barry & McCarthy, Emily (2020). *Rekindling Desire.* (3rd edition). Routledge.
9. McCarthy, Barry & McCarthy, Emily (2021). *Contemporary Male Sexuality* (2021). Routledge.
10. McCarthy, Barry & McCarthy, Emily (in press). *Couple Sexuality After 60*. Routledge.
11. Metz, Michael & McCarthy, Barry (2003). *Coping with Premature Ejaculation*. New Harbinger.
12. Metz, Michael & McCarthy, Barry (2004). *Coping with Erectile Dysfunction*. New Harbinger.
13. Mintz, Laurie (2018). *Becoming Cliterate*. Harper.
14. Nagoski, Emily (2015). *Come as You Are.* Simon and Schuster.
15. Perel, Esther (2006). *Mating in Captivity*. Harper-Collins.
16. Snyder, Doug, Baucom, Don, & Gordon, Kristi (2007). *Getting Past the Affair*. Guilford.
17. Snyder, Stephen (2018). *Love Worth Making*. St. Martin's.
18. Weiner, Linda & Avery-Clark, Constance (2017). *Sensate Focus in Sex Therapy*. Routledge.