

Psychotherapy Guidebook

# SEXUAL THERAPY OF MASTERS AND JOHNSON

Alexander Runciman

**Sexual Therapy of  
Masters and Johnson**

**Alexander Runciman**

e-Book 2016 International Psychotherapy Institute

From *The Psychotherapy Guidebook* edited by Richie Herink and Paul R. Herink

All Rights Reserved

Created in the United States of America

Copyright © 2012 by Richie Herink and Paul Richard Herink

## Table of Contents

[DEFINITION](#)

[HISTORY](#)

[TECHNIQUE](#)

[APPLICATIONS](#)

# Sexual Therapy of Masters and Johnson

*Alexander Runciman*

## DEFINITION

Before the publication of Masters and Johnson's books *Human Sexual Response* (1966) and *Human Sexual Inadequacy* (1970), therapy for sexual dysfunction was basically the same as for any other psychological dysfunction: it dealt with the individual's early childhood conditioning and with repressed emotional trauma. The research reported in *Human Sexual Inadequacy* provided a factual basis for a form of short-term therapy that was unique and more effective than previous approaches. Basically, treatment involves a sequence of sexual tasks to be followed by both partners of a couple. The treatment is used for impotency, nonorgasmic response, premature ejaculation, vaginismus, or ejaculation incompetency.

## HISTORY

The treatment procedures evolved from the physiological studies of human sexual response done by Masters and Johnson at the Reproductive Biology Research Foundation. The therapy itself does not fit neatly under the heading of any of the current forms of therapy, although most professionals

associate it with behavior therapy.

In years past, therapy for sexual dysfunction in a marital unit was often provided for only one of the partners. This approach was seldom successful. For example, if a man goes through analysis for a long period to try to solve his impotence problem and his wife is not included in the treatment, he obviously keeps returning to the same marital situation that contributed to or even caused the impotency in the first place.

## TECHNIQUE

The basis of success of treatment is that the couple is treated as a unit. The second principle is that there be a male-female therapy team. This is for the purpose of having someone of the same sex with whom both the husband and the wife can identify. They need to feel that there is someone there who can understand their unique feelings as a man or a woman.

The first step in therapy is usually for the male therapist to take a thorough medical and sex history of the husband and for the female therapist to do likewise with the wife. On the second appointment this process is reversed — the woman therapist takes the husband's history and the male therapist takes the wife's. This is not a repeat of information but provides a means of checking to make sure that nothing has been left out, and of identifying attitudes that may be expressed differently, depending upon

whether the therapist is a male or a female. This may be important in determining unrecognized or unspoken attitudes. For example, if a wife is able to talk freely with the woman therapist, and becomes nervous, inhibited, and tense relating to the male therapist, this expresses her degree of comfort or anxiety with persons of her own or the opposite sex.

A medical examination is a standard requirement before sexual therapy. It is important to determine use of medications or any physiological problems that could affect the central nervous system. The vast majority of sexual dysfunctions in both sexes result from psychological rather than organic factors.

After the sex histories and the medical examinations are completed, there is a roundtable discussion. During this session, the male and female therapists discuss with the couple their initial opinions of the marital interaction. This does not necessarily deal with sexual function, but primarily concerns how the husband and wife are seen to affect each other by their attitudes and actions in the overall dyad situation. This information is used as the basis for the specific program of therapy appropriate for each particular couple.

At the roundtable, the parties have the option of disagreeing with the therapists' observations. There is no obligation for them to continue; in fact,

the therapy cannot be beneficial if they don't agree that changes are needed in the relationship itself.

Following the roundtable, the couple begins a program of sexual tasks, the first stage of which is called "sensate focus." This is used with every couple, no matter what the presenting problem. Sensate focus simply consists of learning to touch one another and to communicate what feels good or what doesn't feel good. During this stage the couple is told specifically to avoid intercourse, and the touching of genital regions or the breasts of the female is prohibited. The purpose is to allow the husband and wife to discover the numerous sensitive and sensual parts of their bodies, other than genitals and breasts, and to begin to communicate with each other about the parts of the body that may be easier to talk about than the genital areas. The therapists need to carefully evaluate when a couple is ready to proceed to the next stage.

The second stage, after the couple has learned how successfully to communicate what is pleasurable to them, consists of mutual stimulation of the genitals, but again without any attempt to engage in intercourse. The wife and husband are specifically told not to strive for orgasms but to learn to communicate with each other what feels pleasurable in regard to genital stimulation.



After a couple has completed these two stages, the therapy can take various directions, depending upon the presenting problem.

In the case of impotence there is a series of procedures used in which the female learns to stimulate the penis in specific ways as instructed by the therapist. When her partner does get an erection, it is she who makes the insertion. The woman learns what to do and when to initiate insertion and movement. In this way the pressure to perform that leads to impotence is reversed — i.e., the woman assumes some of the responsibility. This release from performance pressure enables the man to relax and enjoy, and, incidentally, “perform” successfully.

For premature ejaculation, the “squeeze technique,” which requires communication and cooperation between the partners, has been found to be very effective. With the squeeze technique, the man must let his partner know when he is about to ejaculate. She then squeezes the tip of the penis, thereby inhibiting ejaculation. This process can be repeated as many times as needed. Couples usually have to use the squeeze technique for several weeks before the male’s tendency toward premature ejaculation is reversed.

If the presenting problem is a nonorgasmic response in the female, there is a step-by-step process the couple is instructed to follow. At the third step the female takes the superior mounting position. The reason for this is

that many women have been passively underneath their partners, and have never really learned to know what their response system requires. In this step, with the penis fully erected and the vaginal area well lubricated, the woman inserts the penis under instructions to remain still and experience the pleasurable feel of vaginal insertion without orgasmic demand. The process continues over days of repetition through phases of mild female thrusting, mild male thrusting under female verbal control, mutual thrusting with a period of separation for general caressing, and attempts to break the pattern of unilaterally initiated and demanding pelvic thrusting.

The central theme in the Masters and Johnson therapy program is the necessity for continued communication between the partners. While physical instruction and practice are important elements, greater stress is placed upon the relationship between the partners and reeducation of the ways of satisfying sexual functioning. These elements of the therapeutic process are in evidence from the start of history taking and discussion, but they come into focus when some improvement has been shown as a result of the physical practice, when the couple has overcome certain negative feelings and becomes amenable to this focus.

Perhaps another key to success of this type of therapy is that the therapists consciously take the role of authority figures. When patients' sex histories indicate ignorance, misinformation, and negative conditioning —

and everyone who comes for therapy falls into this category to a degree — the therapists make a point of identifying these sources of difficulty and then explaining that the patients do not need to let these things from the past continue to be negative influences.

And, as necessary, attitudes and mutual behavior are explored in such areas as religious and early childhood conditioning, drinking habits, general inadequacy and dependence, use of sex as a weapon or as a tool for ulterior purposes, and unrealistic sex fears.

## APPLICATIONS

In their treatment of impotency, Masters and Johnson (1970) reported a 73.8 percent success rate. Premature ejaculation is the easiest of the male dysfunctions to treat; treatment has resulted in a 97.8 percent success rate.

Of 342 nonorgasmic women, Masters and Johnson reported a success rate of 80.7 percent. In some of the failures the marital relationship was considered hopelessly destructive.

High success rates were reported, too, for two sexual inadequacies not covered in this description: ejaculatory incompetence (the inability to ejaculate while the penis is in the woman's vagina) — 82.4 percent, and vaginismus (a condition in which any sexual approach produces a powerful

and often painful contraction of the vaginal muscles) — 100 percent.

The therapy has the best application with couples who view the problem as a shared one and are willing to cooperate as a team in reversal of the inadequacy.