



Sensate Focus for Sexual Concerns: an Updated, Critical Literature Review

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Abstract

Purpose of review Despite the fact that Masters and Johnson's Sensate Focus has informed the sex therapy field for decades, there has been a lack of clarity about its updated description, and its use with sexual dysfunctions versus facilitating optimal sexual interaction. The authors suggest separating Sensate Focus into two components: Sensate Focus 1 for resolving dysfunctions; and Sensate Focus 2 for optimizing intimacy. Six specific questions are addressed: Does the literature continue to reference Sensate Focus? What is its efficacy? In what types of journals is it referenced? How do recent publications define Sensate Focus? Is it referenced as a general citation or are details included? Are details consistent with different phases of Sensate Focus (1 and 2)?

Recent findings Sensate Focus: continues to be referenced in the literature especially with diverse clientele; continues to be an effective sex therapy technique; is increasingly referenced in medical journals; is increasingly defined as having two components (Sensate Focus 1 and 2); is increasingly referenced in greater detail; and details increasingly reflect a nuanced understanding of differences between Sensate Focus 1 and 2.

Summary The complexities of Sensate Focus are being recognized in terms of phases of treatment, application to diversified populations, and as incorporated in biopsychosocial models for treating sexual problems.

Keywords Sensate Focus · Sex therapy · Sexual dysfunction · Sexual health · Sexual intimacy · Biopsychosocial model

Introduction

Sensate Focus was developed by William Masters and Virginia Johnson [1] in the 1960s. It is a therapeutic technique based on the efficacy of touch for minimizing sexual

performance anxiety [2•, 3, 4••]. It is foundational to the treatment of all manner of sexual dysfunctions and disorders including those of a psychosocial and/or medical etiology [5–8]. Sensate Focus appears in human sexuality textbooks for students [9–12] as well as leading books on sex therapy [13•]. On the conceptual level,

Sensate Focus is the core feature of Masters and Johnson's sex therapy, and it serves two primary functions: allowing clients to focus on something over which they have voluntary control (attending to tactile sensations) instead of focusing on that over which they have no voluntary control (generating arousal); and providing an opportunity for generative intimate connection. [2•, p., 167]

In more practical terms,

Sensate Focus is a series of structured touching and discovery suggestions that provides opportunities for experiencing your own and your partners' bodies in a

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non-demand, exploratory way... Non-demand exploration is defined as touching for your own interest without regard for trying to make sexual response, pleasure, enjoyment or relaxation happen for yourself or your partner. [4••, p. 9]

The authors use Sensate Focus on a regular basis in our practices, but we were trained and worked at Masters and Johnson Institute in the 1980s. We were interested in determining the utilization of this powerful technique into the twenty-first century so we conducted an initial literature review [14••] from the time of Masters and Johnson's original publication of *Human Sexual Inadequacy* in 1970 [1] through 2014. The results were primarily twofold.

First, the results indicated health professionals have applied Sensate Focus to a wide variety of sexual distresses of psychosocial and/or medical etiologies. It has been used with more diverse populations than when Masters and Johnson did their initial work: clients diagnosed with a variety of intellectual and developmental challenges; those on the autism spectrum; individuals suffering alcohol abuse; non-heterosexual couples; sexual trauma survivors; and Orthodox Jewish couples. Innovations in technology were also represented. Mental health professionals have interlaced Sensate Focus with other clinical approaches including psychodynamically oriented psychotherapy, depth-oriented approaches, cognitive-behavioral programs, Systemic Sex Therapy, and Mindfulness Practice.

Second, clear, detailed, and accurate information about the underlying concepts, intent, and specific wording associated with the implementation of Sensate Focus have been limited in the literature, appearing primarily in private presentations and professional training programs. This has caused understandable confusion and interpretative difficulties. These emanated from Masters and Johnson's original descriptions of Sensate Focus that unwittingly used language that conflated short-term goals and suggestions intended for sexually dysfunctional couples (those for whom Masters and Johnson originally intended Sensate Focus), and the longer-term goals and suggestions aimed at couples optimizing intimacy (not the couples originally targeted for the use of Sensate Focus).

To resolve this confusion, the authors have published several articles, a book chapter, and a book suggesting a distinction between two phases of Sensate Focus, emphasizing *the importance of the language used in the suggestions* [2••, 3, 4••]. We strongly believe that *the wording is critical in initial Sensate Focus instructions for facilitating client compliance with, progress using, and completion of Sensate Focus*.

We refer to the first phase as Sensate Focus 1, aimed at couples with dysfunctions and disorders. The goals and implementation include language that suggests *mindful focus on touch sensations for one's interest in the moment*, thereby reducing anxiety associated with any expectation for arousal or pleasure either on the part of oneself and/or for the partner.

The second is Sensate Focus 2, for couples wishing to enhance their sexual relationship, and includes wording that emphasizes *sexual communication about individual and partner arousal, pleasure, and enjoyment to optimize intimate engagement in the long run*. We contend that Sensate Focus 1 is what Masters and Johnson meant by *Sensate Focus*. Unfortunately, the words they used to describe what we define as Sensate Focus 1 have been understandably interpreted as more consonant with our Sensate Focus 2. The significance of this distinction will be discussed in more detail subsequently.

Since re-introducing Sensate Focus as a foundational technique in sex therapy, and since suggesting updates to the definitions of the two Sensate Focus phases, we were curious about the impact our publications may have had on the literature in terms of the two primary results from our original literature review. We decided to conduct an updated literature review from the year following the publication of our original review (2015) through the present (June 2018).

Questions Addressed

1. Does the Literature Continue to Reference Sensate Focus?

We were interested in whether Sensate Focus continues to be referenced in the literature. If it is, to which sexual concerns is it referenced? To which populations? And to which other therapeutic approaches?

2. What Do Recent Research Results Suggest About Its Efficacy?

The original review suggested Sensate Focus techniques continue to be used effectively by many sexuality professionals with a variety of psychosocial and bio-medically based sexual dysfunctions and disorders. Data gathered from an online survey of 80 sexologists on the list serves of the American Association of Sexuality Educators, Counselors and Therapists, and the Society for Sex Therapy and Research, revealed that 85% of reporting clinicians use Sensate Focus in their work and found it effective with some or many dysfunctions and client populations (Weiner L, Stiritz S. Sensate Focus today: Results of a survey of current practitioners. Society for Sex Therapy and Research Annual Meeting, Pittsburgh, PA. 2014). Lesbian and gay couples, ultra-orthodox religious couples, cancer patients and their partners, clients with intellectual and developmental disabilities, individuals with Asperger's syndrome, alcoholics, and other people experiencing sexual concerns have been treated effectively with Sensate Focus [14••]. What do research results from the last two and a half years suggest about the efficacy of Sensate Focus?

3. In What Types of Journals Are Sensate Focused Referenced?

As we conducted our original survey, and heeding Kleinplatz [15], we observed that a variety of mental health professionals have used Sensate Focus. However, Sensate Focus has also become part of the therapeutic repertoire of medical professionals, suggesting an expanding emphasis on biopsychosocial models to address sexual difficulties. Is this reflected in an increased number of medical journal articles referencing Sensate Focus?

4. How Do Recent Publications Define Sensate Focus?

Our original literature review indicated that the intent of and instructions for Sensate Focus have caused confusion in the field. This is due in large measure to Masters and Johnson original publication in which they used this language to describe the goals and techniques of Sensate Focus:

The partner who is pleasuring is committed first to do just that: give pleasure... The giver is to explore his or her own component of personal pleasure in doing the touching... and, finally, the somewhat indescribable aura of physical receptivity experienced by the partner being pleased. After a reasonable time...the...partners are to exchange the roles of pleasuring (giving) and being pleased (getting). [1, 68, p.]

This language conflates two different aspects of sex therapy. It is ostensibly directed at resolving immediate sexual difficulties, but the words are suggestive of longer-term goals of enjoyment, pleasure, intimacy, and partner communication. While these are the ultimate goals of any couple's therapy, they are not the immediate goals of sex therapy with sexually dysfunctional couples where any expectation of arousal, pleasure, or enjoyment for oneself or one's partner interferes with immediate sexual functioning by contributing to performance anxiety. To clarify this confusion, we have suggested distinguishing between two phases of Sensate Focus: Sensate Focus 1, designed for couples with the immediate goal of resolving sexual dysfunctions and disorders; and Sensate Focus 2, aimed at couples wishing to optimize an already functional relationship over the long run. Although Kaplan [16, 17] differentiated between Sensate Focus I and II, she did so within the purview of treatment for sexual dysfunctions, what we refer to as Sensate Focus 1.

We suggest that Sensate Focus 1 emphasizes language aiming at the resolution of sexual dysfunctions, words promoting mindfully attending and re-attending to tactile sensations in the moment for each participant's *own, individual* interest. The power of this language is that it directs clients toward activities in which they can engage without fear of failure; one can always voluntarily direct

attention. It is impossible not to succeed and, therefore, sexual anxiety is reduced. On the other hand, the instructions for Sensate Focus as outlined in the 1970 description above use language that emphasizes goals and skills consonant with Sensate Focus 2 in which partners more actively communicate their interests to one another, exploring together to enhance sexual intimacy. These are not goals that can be accomplished voluntarily in the moment, in the initial stage of Sensate Focus 1; they are not under direct control. They have the potential for engendering rather than reducing sexual anxiety until and unless the couple has already learned to manage anxiety by cultivating the doable skills of Sensate Focus 1 for attending in the here-and-now to tactile sensations for oneself without expectations or judgment.

It was not until 1995 that Masters and Johnson published modified instructions using language that actually reduces pressure not only to respond sexually but also to respond physiologically or emotionally in any particular way at all [18]. Compare these modified Sensate Focus suggestions below with the original ones above:

The point of this exercise, as the term sensate focus implies, is to zero in on the sensations you are experiencing as you touch. There is no right way or wrong way to do this, and the point of this touching opportunity is *not* to try to turn your partner on, or to make him [or her] feel good, or to give him [or her] a massage; the point is to try to live through your fingertips, taking in each and every physical sensation they provide, while doing whatever happens to interest you at the moment. (p. 361)

These modified directions use language aimed at assisting couples experiencing sexual difficulties by directing them to *touch for self in the moment* rather than pleasuring themselves or their partners. This is eminently doable.

Our recent book, *Sensate Focus in Sex Therapy: An Illustrated Manual*, contains a detailed description of the wording associated with the concepts and implementation of Sensate Focus 1 versus 2. These are not rigid or stagnant categories. However, we have found that it is very helpful to keep them in mind particularly when it comes to the *initial Sensate Focus 1 suggestions* if only because it is easy to fall into a Sensate Focus 2 vocabulary and mindset. Falling into this negates the intention and effectiveness of the initial component of Sensate Focus, which is to reduce *all* performance pressures, not simply sexual ones. Here is a summary of the distinctions.

Defining Sensate Focus 1 Sensate Focus 1 is what Masters and Johnson meant by the term *Sensate Focus*. It involves the *initial* Sensate Focus exercises. It is intended for people experiencing sexual difficulties who need to master skills for managing pressures interfering with sexual response. The essential wording includes *touching for one's interest in the moment without regard for arousal,*

pleasure, or enjoyment for self or partner, as opposed to communicating about pleasurable or arousing experiences for oneself or one's partner (Sensate Focus 2).

Sensate Focus 1 highlights immediate, short-term goals over which individuals have immediate, voluntary control, namely, *focusing on sensations for one's interest in the moment*, and managing pressure to pursue longer-term goals of desire, arousal, and orgasm and other emotional reactions. These longer-term goals are what Masters and Johnson referred to as *natural functions* (all vegetative and emotional responses). None of these are under direct voluntary control, but *will spontaneously occur* when conscious attempts to control them are managed. It is understandable that the first goal of Sensate Focus 1 is to teach clients to manage consciously trying to control sexual responsiveness and other emotions by having them mindfully refocus attention on touch sensations (temperature, pressure, and texture). This mindful, attentional body awareness is the gateway to natural sexual responsiveness.

Sensate Focus 1 involves an “emphasis on nonverbal communication” [19, p., 449]. Non-verbal communication is protective of the partner's doing anything that is uncomfortable to the person being touched. Verbal communication is often limited to a *code word* when either partner is distracted by anxiety and needs to change the action. Despite the fact that intimacy, emotional connection, and verbal communication are not the expressed goals of Sensate Focus 1, and because focusing on touch may have the effect of triggering comfort, intimacy, and sexual and pleasurable responses, Sensate Focus 1 often results in enhanced partner intimacy and connection. In this way, Sensate Focus 1 spills over into Sensate Focus 2, and the two form a feedback loop potentially enhancing one another.

Defining Sensate Focus 2 Sensate Focus 2 is oriented toward people who are *not* experiencing formal, sexual dysfunctions or disorders per se, or who have resolved these difficulties but want to enhance sensual interaction, satisfaction, and intimacy. Sensate Focus 2 language is about the long-term desire for sexual variation, intimate communication, and transcendent sexual experience. The attitude of touching for one's interest is relaxed, and the suggestions for couples to communicate in whatever manner works for them are emphasized. Focus is increasingly on verbal interaction, more intricate non-verbal communication, and expanding sexual engagement and exploration.

The Conflation of Instructions Sensate Focus 1 and 2 are frequently conflated because of the obscurity of the updated wording, and because they are not discrete categories. In this second literature review, we were interested in whether recent publications note the distinction in language for instructions for sexually distressed couples as opposed to those wishing to enhance intimacy.

5. When Sensate Focus is Referenced, Is It As a General Citation or Are Details Included?

When Sensate Focus was referenced in publications in our initial review, specific information about its applications were often lacking. Have other sexologists recently published research incorporating the specific details of Sensate Focus 1 and its language of touching for one's interest in the moment?

6. If details Are Included, Are They Consistent with Masters and Johnson's Updated Sensate Focus (Our Sensate Focus 1), or Do They Conflate Sensate Focus 1 and Sensate Focus 2?

We were curious whether any detailed descriptions clarified the distinctions between the language of Sensate Focus 1 and 2. Do detailed descriptions identify the expressed goal of Sensate Focus 1 as providing non-demand touching opportunities for sexually distressed couples? Do they identify the wording as touching for one's interest? Do they include managing distractions by refocusing on tactile sensations?

Methods

A systematic database search was conducted on 21 June 2018 to identify contemporary scholarly works referring to Sensate Focus. We identified papers published from January 2015 (the year after our previous literature review) to June 2018, using the search term “Sensate Focus” in social science and medical science databases (see Fig. 1). We specified that the publications must include “Sensate Focus” at least once in the full text, and that the language must be in English. The initial search yielded 124 results using the following databases: PsycINFO (13 results), PubMed (eight results), EBSCOhost-Psychology & Behavioral Sciences Collection (32 results), MedLINE (eight results), Academic Search Premiere (49 results), and Web of Science (14 results). After duplicate articles ($n = 64$) and articles written by Constance Avery-Clark and Linda Weiner ($n = 2$) were excluded, the search yielded 58 unique results (see Fig. 1). The titles and abstracts of these 58 results were reviewed. Results without an abstract or without any content related to psychology, sexuality, medicine, or sex therapy in the abstract were removed ($n = 11$). The authors assessed and reviewed the full text of the remaining 47 results. We then excluded three of these articles for relevance (only had mention of Sensate Focus in reference section, not discussing Sensate Focus therapy, could not access full text, etc.). An additional four scholarly works (one article and three books) were identified from the reference section of these articles or from other sources. These 48 works met full criteria for review and were grouped by their relevance to the six questions being considered in this literature review for discussion.

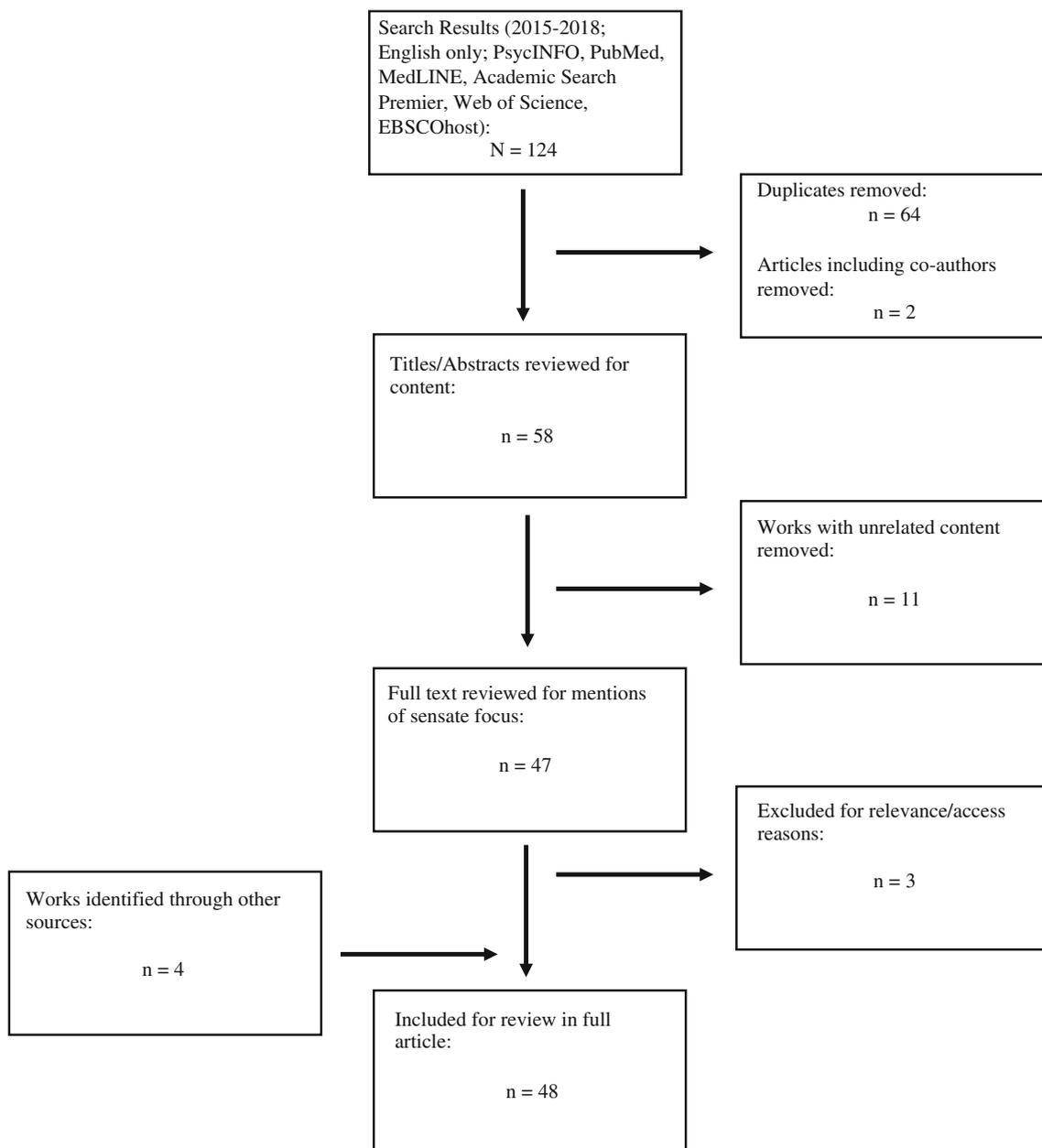


Fig. 1 Flow chart of systematic database search, 21 June 2018, identifying scholarly works referring to Sensate Focus from January 2015 through June 2018 and using the search term “Sensate Focus” in social science and medical science databases. Forty-eight works met full criteria for review

Results

Question 1: Does the literature continue to reference Sensate Focus?

Sensate Focus continues to be increasingly referenced in the literature. Our original review generated 84 usable citations for Sensate Focus between 1970 and 2014. This represented approximately 1.91 publications a year during that time. Our updated review produced 48 usable references between January 2015 and June 2018, for an average of 13.71 publications per year, an

increase of greater than 700%. The usable references generated by this review suggest that Sensate Focus is being used to treat an even wider variety of sexual concerns, is being applied to ever more diverse populations, and dovetails with an increasing number of other therapeutic approaches.

Sexual Concerns Sensate Focus has been used to treat interest, desire, and intercourse frequency concerns [20–22•]; arousal disorders [22•, 23]; female orgasmic disorders [20, 22•]; sexual anxiety and PTSD [24, 25]; vulvodynia, vestibulodynia/vulvar vestibulitis, and vulvovaginal dysfunction [26–29]; vaginismus

[30, 31]; dyspareunia and sexual pain disorders [20, 24, 26, 32]; erectile dysfunction [33–36]; premature ejaculation [37, 38]; and hypersexuality [39]. Male partners of vaginismic women have been researched [30], as well as sexually dysfunctional sex offenders [40].

Populations Sensate Focus was originally used with a limited population, but our first literature review suggested its use had been expanded. Since that publication, its application has included ever more diverse populations including medical concerns such as hypoestrogenism and vaginal atrophy [35, 41]; breast, prostate, and other forms of cancer [35, 42]; urinary incontinence and ostomies [35]; multiple sclerosis and spinal cord injuries [43, 44]; acquired disabilities [45]; vulvovaginal dysfunction [26–28]; vestibulodynia [29]; and even chronic pain and opioid users [46].

Sensate Focus is being used to treat additional psychological problems. Ghizzani, Bruni, and Luisi [41] include clients struggling with body image concerns. Other populations are adult survivors of sexual and other types of trauma [47–49], hypersexual individuals [39], French women [50], and those defined as violent sexual predators [40]. Ethnic and religious diversity has expanded to another Orthodox Jewish couple [51], and Catholic clients [52]. McCoy et al. [53] have worked with a polyamorous couple, while Al-Abbadey et al. [26] include surrogates.

Therapeutic Approaches Sensate Focus is increasingly integrated with Mindfulness Practice [54•], including clients with chronic pain and opioid misuse [46]. Some sex therapy programs conceptualize Sensate Focus in mindfulness terms [20, 24], noting that both emphasize focusing on sensory experiences whenever attention drifts [55].

Cornell [56] utilizes touch and sensory experience in psychoanalytic psychotherapies. Adam, Heeren, Day, and de Sutter [50] and Seal and Meston [22•] reviewed research combining Sensate Focus with strategies for increasing sensory and body awareness. Baggett et al. [47] interweave Sensate Focus with Emotionally Focused Therapy, and Derby, Peleg-Sagy, and Doron [34] integrate sex therapy in general, and Sensate Focus in particular, with Schema therapy. Yadave et al. [57] combine play therapy with Sensate Focus, cultivating a here-and-now mindset.

Several clinicians affirm adaptations to modern technology. Blanken et al. [58] describe an internet-based sex therapy program for heterosexual male sexual dysfunctions. Hucker and McCabe [20] outline an online cognitive behavioral therapy program for female sexual difficulties.

Question 2: What Do Recent Research Results Suggest as to Its Efficacy?

Dysfunctions Almås [59] reported on a study in which Sensate Focus sex therapy, combined with CBT, resulted in 74% improvement in female sexual and marital satisfaction; progress

was maintained in 64% at one year compared to minimal improvement in a control group. Trigwell et al. [60] reported a modified Masters and Johnson cognitive-behavioral approach utilizing Sensate Focus with a variety of sexual dysfunctions. 82.99% of those who remained in therapy improved, with no change in 15.97%. This biopsychosocial approach integrated Sensate Focus with other treatments and appropriate medical devices. They conclude that brief therapy of six to eight sessions “is beneficial in most patients” (p. 32).

Cooper et al. [38] reviewed a randomized control study to treat premature ejaculation including Sensate Focus and other behavior therapies. While the behavioral interventions did not have much effect on latency, these therapies combined with drug treatments resulted in better outcomes than drug treatment alone.

Al-Abbadey et al. [26] reviewed positive results of a study with a Sensate Focus approach for vaginismic women. Baggett [46] describes a single case of a female sexual trauma survivor treated effectively with a combined cognitive-behavioral and Sensate Focus treatment program.

Psychological Concerns Zoldrob [49] utilized a form of Sensate Focus in treating trauma survivors. She uses a body map to identify trauma-sensitive body areas, and builds a hierarchy of touch, before suggesting Sensate Focus. This honors the individualized approach recommended by many in the field, including the authors.

Combined with Mindfulness Practice and Body Awareness Seal and Meston [22•] published a literature review on Sensate Focus, Mindfulness Practice, and body awareness from 1997 to 2017. They describe Sensate Focus as one of the most examined forms of sex therapy, and report an efficacy rate of between 34 and 100%, depending on the sexual distress treated. Additional gains in sexual satisfaction and relationship factors were reported in most of the reviewed studies.

Pain-Related Disorders Al-Abbadey et al. [26] described Sensate Focus for sexual pain disorder treatment using surrogates. A biopsychosocial approach proved most efficacious, but the efficacy of Sensate Focus was not specifically addressed.

Online Treatment Hucker and McCabe [20] created an online program for treating female sexual difficulties. Sensate Focus, mindfulness, and other techniques were included. The treatment group showed three-month follow-up improvements in all sexual dysfunctions except pain.

Question 3: In What Types of Journals Are Sensate Focused Referenced?

In our original literature review from 1970 through 2014, there were 78 useable journal articles, one dissertation, and 13 books. Taking into account only the 71 journal articles that referred to

Sensate Focus (see Table 1), the number of articles in medical journals was 21, or 27.3%. In our updated literature review from 2015 through June 2018, there were 42 useable articles, one dissertation, and five books. Taking into account only the 42 journal articles referring to Sensate Focus, the number of articles in medical journals was 12, or 28.5%. This suggests a stable interest in Sensate Focus in the medical field, with a moderate increase in the rate of publications to 4.4%.

Question 4: How Do Recent Publications Define Sensate Focus?

This review suggests some researchers and clinicians are making distinctions between different components of Sensate Focus. Brotto [53] identifies Sensate Focus using language aligned with our definition of Sensate Focus 1:

Sensate focus puts people back into physical contact with one another, without any specific goals related to sex. It involves a structured series of touching exercises in which the giver of the touch uses their own curiosity to touch all parts of the other partner's body in a non-sexual and nongoal-oriented way. The touch is not meant to elicit sexual pleasure or orgasm. (p. 42)

Brotto clarifies that although the long-term goal of sex therapy is “mutual pleasure in the absence of anxiety” (p. 44), this is not the goal or language of Sensate Focus 1.

Baynes [27] distinguishes between stages of treatment with the first emphasizing touching, and processing this with the therapist. The goal of the initial stage is reducing anxiety that interferes with sexual responsivity. Baynes defines a second component of Sensate Focus, expressly aimed at the emergence of a more intimate experience, greater sexual satisfaction, and increasing communication. Weeks, Gambescia, and Hertlein [61], paraphrasing our work, describe Sensate Focus 1 flowing over into a Sensate Focus 2-like phase:

Sensate focus involves touching for one's own interest, curiosity and exploration, but not for pleasure or arousal and not for the partner's pleasure or arousal. Our view of sensate focus incorporates the aforementioned principles and expands the practice to gradually include erotic touch. (p. 158)

Al-Abbadey et al. [26] also differentiate between two parts of therapy, one emphasizing mastering touching skills, and another including general communication skills. Hucker and McCabe [20] describe a program for female concerns emphasizing touch followed by communication. McCarthy and Wald [21] encourage practicing touching skills in the moment, and then attending to partner feedback. However, their

emphasis is on communication, connection, and touch in a fully actualized sexual relationship, suggestive of Sensate Focus 2.

None of these researchers/sexologists use the terms *Sensate Focus 1* and *Sensate Focus 2* to distinguish different components except Boddi et al. [33]. They use “Sensate Focus 1” and “Sensate Focus 2” to categorize, respectively, the fourth week of therapy during which partners touch each other avoiding breasts and genitals, and the fifth week of therapy emphasizing touching breasts and genitals. This is consistent with Kaplan's Sensate Focus I and II [16, 17] and the original Masters and Johnson [1] instructions: the emphasis is on *both* touching in the moment for one's self rather than for one's partner, *and also* caressing for the purposes of desire, pleasure, and couple's communication. The first approximates our Sensate Focus 1, and the second our Sensate Focus 2.

The distinction between two different components of Sensate Focus has begun to appear in the literature. More research is needed to determine the power of instructional language to affect client compliance, progress, and completion of Sensate Focus therapy.

Question 5: When Sensate Focus Is Referenced, Is It as a General Citation or Are Details Included?

General Citation Sensate Focus was most often referenced as a general citation with minimal descriptions of underlying concepts or language associated with specific technique and skill instructions [23, 28, 29, 31, 32, 34–37, 39–41, 43, 45, 51, 52, 55, 57, 58]. Some researchers reserved mention of Sensate Focus for their tables only [43, 44]. Others cite it when discussing modifications with specific populations [53].

More Detailed Descriptions The publications providing detailed information fell into two groups, those that described something about the underlying goals and concepts associated with Sensate Focus, and those that delineated specific information about the actual application of, and wording associated with, this technique. With regard to the first, Weeks, Gambescia, and Hertlein [61] and Atwood [19] suggest that Sensate Focus is essentially a cognitive-behavioral approach integrated with conjoint behavior therapy. Baggett et al. [47] assert, “Sensate focus assists individuals in decreasing sex-related anxiety by emphasizing sensations and not performance through a graduated behavioral process” (p. 271). Baynes [27] describes the primary goal of Sensate Focus as the reduction of anxiety that impedes sexual responsivity.

Hummel, et al. [42] accurately define what we would label Sensate Focus 1 as “a hierarchically structured exercise program” (p. 2). Wohl and Kirschen [48] emphasize Sensate Focus involves “steps to reduce sexual performance anxiety using a progressive step-by-step protocol” (p. 157). When examining additional materials that provided details about

Table 1 Distribution of journal articles specifically referring to Sensate Focus in original and current literature review

Original Sensate Focus literature review [14], 1970–2014 (71 journal articles referring to Sensate Focus)	Current, updated Sensate Focus literature review January 2015–June 2018 (42 journal articles referring to Sensate Focus)
General Scientific Journals <i>Journal of Technology in Human Services</i> <i>New York Times</i>	<i>Andrology Journal</i> <i>PLOS One</i>
Medical Journals <i>Acta Psychiatrica Scandinavica</i> <i>British Journal of Psychiatry</i> (2) <i>British Journal of Medical Psychology</i> <i>British Medical Journal</i> (2) <i>Cancer Practice</i> <i>Clinician Reviews</i> <i>Comprehensive Psychiatry</i> <i>Current Sexual Health Reports</i> <i>Fertility and Sterility</i> <i>International Journal of Impotence Research</i> <i>International Journal of STD & AIDS</i> <i>Journal of Sexual Medicine</i> (3) <i>Journal of Urology</i> (2) <i>Primary Psychiatry</i> <i>Psychiatriki</i> <i>Urologic Nursing</i>	<i>BMC Cancer</i> <i>BMC Health Services Research</i> <i>Current Sexual Health Reports</i> (2) <i>Gynecological Endocrinology</i> <i>International Journal of Impotence Research</i> <i>Journal of Family Medicine and Primary Care</i> <i>Journal of Sexual Medicine</i> (2) <i>Sexual Medicine</i> <i>Sexual Medicine Reviews</i> <i>Sexuality and Disability</i>
Psychology Journals <i>American Journal of Psychotherapy</i> <i>Australian Journal of Psychology</i> <i>Behavior Modification</i> <i>Behavior Therapy</i> <i>Behaviour Research and Therapy</i> (3) <i>British Journal of Learning Disabilities</i> <i>Counseling Psychologist</i> <i>Counseling Psychology Quarterly</i> <i>Individual Psychology: Journal of Adlerian Theory Research & Practice</i> <i>Journal of Consulting and Clinical Psychology</i> <i>Journal of Psychosomatic Research</i> <i>Psychological Bulletin</i> <i>Psychological Reports</i> <i>Psychotherapy: Theory, Research, & Practice</i> <i>Psychotherapy: Theory, Research, Practice, Training</i> Trauma Journals	<i>Adultspan Journal</i> <i>Journal of Behavioral Medicine</i> <i>Journal of Clinical Psychology</i> (3) <i>Psychoanalytic Perspectives</i> <i>Psychotherapy: Theory, Research and Practice</i> <i>Psychophysiology</i>
Sex & Relationship Therapy Journals <i>Archives of Sex Behavior</i> (2) <i>Canadian Journal of Human Sexuality</i> <i>Contemporary Sexuality</i> (2) <i>Journal of Homosexuality</i> <i>Journal of Sex Education and Therapy</i> (2) <i>Journal of Sex & Marital Therapy</i> (10) <i>Journal of Sexual and Relationship Therapy</i> (2) <i>Journal of Sex Research</i> (2) <i>Sexologies: European Journal of Sexology and Sexual Health</i> <i>Sexual & Marital Therapy</i> <i>Sexual and Relationship Therapy</i> Family Journals <i>Family Journal</i> (2) <i>Family Process</i> <i>Journal of Family Psychotherapy</i> (2)	<i>Journal of Child Sexual Abuse</i> <i>Contemporary Sexuality</i> (3) <i>Journal of Sex & Marital Therapy</i> (6) <i>Journal of Sex Research</i> (2) <i>Sexual and Relationship Therapy</i> (8)
Women's Journals <i>Women & Therapy</i>	<i>Hecate - An Australian Feminist Academic Journal</i>

Sensate Focus, there were sufficient overlaps with the same materials addressed in Question 5 such that they are considered together in the next section.

Question 6: If Details Are Included, Are They Consistent with Masters and Johnson's Updated Sensate Focus, or Do They Combine Our Sensate Focus 1 and 2?

Details Consistent with Masters and Johnson's Updated Sensate Focus (Our Sensate Focus 1) Some of the literature clarifies the Sensate Focus 1 goal of the exercises: "Sensate focus is a multiple-step intimacy process focusing on touch with the understanding that the exploration of their partner's body is based on the texture of the skin, versus letting the erogenous touch zones drive the focus" (26, pp. 73–74). Atwood [19] and Ghizzani, Bruni, and Luisi [41] emphasize language that cultivates an attitude of exploration in the moment rather than a goal-oriented mentality. Adam, Heeren, Day, and de Sutter [50] reiterate that "patients are encouraged to focus on the sensations they experience" (p. 623).

McCarthy and Wald [21] reinforce this wording: Sensate Focus "emphasizes touch" (p. 289). Khaddouma, Gordon, and Bolden [55] describe the significance of using words such as "paying attention to here-and-now sensations" (p. 271). Baggett et al. [47], Garland, Froeliger, and Howard [46], and Seal and Meston [22•] highlight this same language.

Klein et al. [30], O'driscoll and Flanagan [25], Pulverman et al. [23], and Seal and Meston [22•] reiterate the focus on sensations, and also liken the Sensate Focus experience to mindfulness. Kimmes et al. [24] underscore the importance of using language that emphasizes managing distractions by mindfully refocusing. However, it is difficult to determine whether these researchers define "sensations" in terms of touch or emotional responses.

Wohl and Kirschen [48] reinforce using Sensate Focus 1 language: the "partner...is touched from head to toe in a variety of ways (light to firm, slow to fast)" (p. 157). Baggett et al. [47], Baynes [27], Boddi et al. [33], Cooper et al. [38], and McCarthy and Wald [21] move from breasts and genitals off limits to breasts, genitals, and eventually insertion on limits, but only as patients are able to manage goal-oriented pressure. Klein et al. [30] presents useful language describing the sequence of Sensate Focus exercises, using the labels "Stage 1," "Stage 2," etc., therefore not constraining each step to a specific number of exercises.

Atwood [19] emphasizes non-verbal communication, and provides specific information about the *hand-riding* technique to non-verbally communicate with the partner. Referring to partners in general, Masters and Johnson emphasized, "There is no such thing as an uninvolved partner" (1, p. 2). Likewise, Klein et al. [30] stress the importance of having both members of the couple involved. O'driscoll and

Flanagan [25] remind us that, as important as partner participation may be, Sensate Focus 1 may be used with individuals, particularly in cases of trauma or PTSD.

Details Conflate Sensate Focus 1 and 2 The main confusion continues to be that the language of Sensate Focus 1 is conflated with that of Sensate Focus 2. The wording used to describe Sensate Focus 1 goals is still more consonant with the language of Sensate Focus 2 goals: engaging in tactile stimulation; relaxing; concentrating on sensual experience; non-genital pleasuring; focusing on enjoyable touch feelings; achieving sexual intimacy; cultivating new approaches to sexual stimulation; love-making; mutually reinforcing erotic pleasure; increasing sexual arousal; reconnecting with pleasure; exploring non-coital pleasuring techniques; developing new sexual behaviors driven by mutual arousal and pleasure; and communicating about sexual desires. While these experiences will naturally emerge from touching and mastering skills for managing dysfunctions by touching for one's interest in the moment, we contend they will be less likely to emerge if they are the expressed goals of the initial, Sensate Focus 1 suggestions.

The updated literature also contains Sensate Focus directions combining Sensate Focus 1 and 2 wording. Examples include some of the aforementioned descriptions and phrases: touch for your own and your partner's pleasure; give and receive pleasure; verbalize how the touching feels and what you like; fondle each other to give pleasure; explore the enjoyment of sensations; coach the partner on enjoyable touch; spend time caressing; build intimacy; and massage your partner. Much work needs to be done to distinguish between, and effectively integrate, the wording of Sensate Focus 1 and 2 suggestions.

Discussion and Conclusion

Sensate Focus continues to be referred to in the literature. There is solid evidence about its efficacy treating a wide variety of sexual distresses. It is used by health professionals, including medical personnel, with ever more combined, medically and psychosocially based sexual dysfunctions, with more diverse populations, and in innovative ways. It is increasingly compared with Mindfulness Practice and somatic awareness therapies.

Concerns with Sensate Focus are twofold. Confusion continues about the goals and implementation of Sensate Focus aimed at sexually distressed clients (Sensate Focus 1), and the subsequent phase devoted to clients wishing to enhance sexual satisfaction (Sensate Focus 2). This is apparent in the ongoing convergence of the language of instructions for Sensate Focus 1, touching for one's interest in the moment, and for Sensate Focus 2, communicating for the enhancement of sexual satisfaction in the longer-run. While these are not discrete entities,

we contend that making these distinctions may be critical for client progress, compliance, and treatment completion.

The second concern pertains to Sensate Focus research. Often, it is combined with other interventions, making efficacy interpretation difficult. Client knowledge of result assessment, being part of a therapy group, and forming treatment relationships have been additional confounding factors [20].

In conclusion, Sensate Focus remains foundational to the field of sex therapy. Interest in the use of Sensate Focus has risen on the part of medical professionals, and interest by mental health practitioners has greatly increased. The distinction between Sensate Focus 1 and 2 appears to be important especially when it comes to the words used when offering the initial instructions, and when couples regress during treatment. Future research needs to investigate the effect of these language distinctions in the instructions. In general, more rigorous investigations are required including randomized control trials, long-term follow up, operational definitions of variables, accepted standards for use in clinical trials and outcome assessment, and isolating Sensate Focus from other treatment modalities.

Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subjects performed by any of the authors.

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