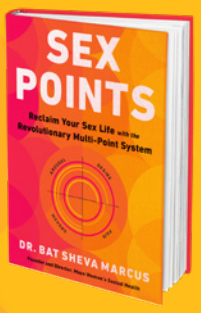
DR. BAT SHEVA
THE PLEASURE
OF BEING ALIVE



SEX POINTS

A GUIDE FOR THERAPISTS, EDUCATORS & COUNSELORS

I wrote this book because I felt frustrated that there were women who couldn't access state of the art, comprehensive sexual health information and care. Over the years, as I have fielded questions from individual therapists, couple's therapist, and sex therapists, I also realized how hard it was for professionals to keep up with the current science and developments in the field of sexual health. As a result, many of us end up relying on classic therapeutic treatments: trauma related, sensate focus, communication patterns. I have found through my work with thousands of women that often these techniques are not enough to be truly helpful to people who are struggling with sexual issues. I wrote this book to be able to help them.

AND I KNOW THAT IF YOU, THE THERAPISTS, USE IT WITH THEM, IT CAN BE EXPONENTIALLY MORE HELPFUL FOR THEM.

I TRULY FEEL THAT A VARIETY OF THERAPISTS CAN BENEFIT FROM USING THIS BOOK WITH THEIR CLIENTS

INDIVIDUAL AND COUPLE'S THERAPISTS: Let's face it. Most of us did not get thorough training in sex therapy. We were never given much guidance in how to approach sexual issues, how to disentangle the myriad complexities that arise and how to bring in helpful techniques that can work in real time with real clients. This book will give you a framework for approaching many issues with your clients and for helping you (and them,) parse out which approaches may be most helpful to start with. It will give them helpful language to be able to communicate more thoroughly with you so that you can use what you are trained in, drilling deeper, gaining understanding, normalizing, supporting, and providing guidance for sexual issues.

STARTING SEX THERAPISTS, EDUCATORS, AND COUNSELORS: You have more training on sex than your colleagues who aren't focused on this issue. But let's face it, who doesn't like a road map when you are starting out? Hopefully, this book, read in conjunction with your clients, will help jump start your further exploration of these issues and help your clients with a language that will just make your job easier.

EXPERIENCED SEX THERAPISTS: You probably have your own approaches that work well for you already. I'm hoping this book will just make your job easier, giving you already developed and ready-made reading and "homework assignments" to use with clients as a springboard for in-session work. Finally, I hope the physiological information and the medical approaches that are now available, will help you help your clients. Accessing a world that marries both the physiologic and psychological issues may give you more options or more "tools in your tool-kit".

USING SEX POINTS WITH YOUR CLIENTS

1) **IF YOU HAVEN'T ALREADY, FAMILIARIZE YOURSELF WITH THE STRUCTURE OF THE BOOK.**

2) **HAVE YOUR CLIENT TAKE THE ASSESSMENT QUIZ.** The 32 question self-assessment for your clients can be done manually or on-line at SexPointsBook.com/Quiz. I highly suggest that you take the quiz as well, perhaps even once a year as you continue to use the book.

3) **PROCESS THE SCORE:**

   a. Assume clients will have varied reactions to the outcome of the questionnaire.

   b. Was it what they expected?

   c. How are they experiencing the results? Are they angry? Impatient? Disbelieving? Validating?

4) **NOW, BASED ON THE SCORES, DETERMINE WITH YOUR CLIENT WHICH QUADRANT(S) MIGHT BE YOUR STARTING POINT.**

   a. The scores are broken into four quadrants: pain, arousal, desire and orgasm. And those are the "diagnostic areas" with which you might want to begin treatment.

   b. Chapters 4-7 provide a deep dive into how each of the quadrants manifest and how and why they effect the other quadrants.

   c. None of these "problem areas" exists in a vacuum and they all impact on each other. I make that point clearly in the introduction and again in each chapter, and that will be critical to your job in the therapeutic process.

   d. Clients are often convinced that there is "one problem." Your work with them will often include helping them come to terms with the fact that sexual issues are rarely the result of one isolated problem. Even if there was one primary cause, the secondary issues that arise as a result have to be addressed as well.

5) **PART II OF THE BOOK OUTLINES SOLUTIONS: BASED ON THE SCORE AND THE INITIAL ASSESSMENT, YOU AND YOUR CLIENTS WILL DETERMINE TOGETHER WHICH CHAPTERS TO START WITH.**

6) **DIVE DEEP INTO THE TREATMENTS.**

QUADRANT I – PAIN

MOST SALIENT ISSUES

When you have clients who are struggling with pain in their vulva and vagina, it is critical that they see you as a support in finding a physical solution to a physical problem, rather than seeing you as someone else who believes "it is all in their head." It is critical to bear in mind that just because a physician, or 2 or 3 don't "see" anything wrong, it does not mean that there is not a physical problem. As a rule, the medical community is not good at saying "I'm so sorry. We don't know," and as a result these women have been told so often that their problems are in their head that they start to believe it themselves.

Your role is as critical as any physiological help they will receive. However, it is not to find the "root cause" of the pain in their history or subconscious. Rather it is to support their search for a solution, explore whether they may be exacerbating the pain with anxiety and "catastrophizing", while encouraging a modified but vibrant sex life in the current situation and addressing any secondary issues that have arisen because of the pain.

"INTERCOURSE HURTS"

"SOMETIMES, THE IDEA OF THE PAIN OF INTERCOURSE IS SO SCARY, I CAN'T EVEN GO THERE."

HAVE THE PATIENT READ CHAPTER 4 to gain an overview of the complexity of vulvar/vaginal pain and to give them a vocabulary with which to talk to you about it. Make sure you are educated as to the various pain conditions so that you can give appropriate advice and support in helping them find a practitioner to address their symptoms.

EXPLORATION

IMPORTANT QUESTIONS TO ASK

Understanding the pain:

- What does the pain feel like? (It is critical that you educate yourself to have at least a basic understanding of the different pain syndromes. **READ CHAPTER 4 AND FURTHER READING IN THE "RECOMMENDED READING" SECTION IN THE BACK OF THE BOOK.**
- Around when did the pain start?
  - Pay particular attention to the addition of medications here if this is not something they have always had: OCPs or other birth control are common culprits and don't necessarily start immediately upon beginning usage. **(HAVE THEM READ CHAPTER 11)**
  - Pay attention to life-stage physiological changes: birth of a child, nursing, perimenopause, menopause. They all have dramatic impact on hormone levels as well as blood flow and neurological changes and the vulva/vagina are most sensitive to these changes.
- What do *they* think is causing the pain? It is striking what good diagnosticians women can be when we actually listen to them. It also gives you an important window into the secondary messages or the narrative that they have created around the pain. You can't help them navigate a solution without understanding their current narrative.
- What solutions have they already explored?

Understanding how it has affected their sense of self and their sex life:

- Are they currently having any kind of sex? You will find that often clients will say "no," when they are having non-intercourse sex. This is actually a strength which can be built upon. So, make sure you are really clear on the current situation.
- What does their sexual repertoire look like?

- If they are not having sex at all, why not? I have found that starting to approach the issue from this position helps normalize non-intercourse sex most effectively.
- Do they believe it is possible to have a sex life without intercourse? It may seem rather obvious to say this, but it is critical that you as the sex therapist truly believe this yourself.
- How have they talked to their partner if there is one?
- How has their partner reacted? Is this a situation where you need to bring the partner in for a discussion and further education?
- How has the situation impacted their self-identity in general, their sense of themselves as sexual beings and their relationship?

TREATMENT

HAVE THE PATIENT READ THE RELEVANT PARTS OF CHAPTER 8, CHAPTER 10- 12.

- Support an active search to find a solution to their pain syndrome. One exists. **RECOMMEND APPROPRIATE BOOKS FROM THE "FURTHER READING" SECTION.**
- Do not become an unwitting ally in the avoidance and denial which is so prevalent in vaginismus clients. Vaginismus will improve with a combination of therapy and physical treatment. Often vaginismus clients are so scared that they use talk therapy as an avoidance technique. Many therapists, in an attempt to be supportive, inadvertently collude in this avoidance tactic. I see it all the time. Don't fall into this trap!
- Exploring and processing the feelings of "brokenness," "aloneness" and "hopelessness" so many women experience.
- Support their search for a physiological solution, while not buying into their narrative that painful intercourse means the end of a sex life. To do that you have to believe that is possible. And it is.

- Work with them to understand that while the pain did not start because of "psychological" reasons or because of issues in the relationship, it may still have significant secondary effects that may do damage to both and those need to be addressed as well.

- Guide your client and partner, if there is one, to rebuild their sex life.

  - During the search for a treatment, work with them to create a good sex life despite the fact that the pain may necessitate limiting certain activities.

  - Work with them to understand that reincorporating intercourse (or whatever was "off limits" for a while) will be significantly easier if they have a regular ongoing sex life during this time and they and their partner haven't moved away from each other physically.

  - Explore the fear that surfaces when they hear "you can go ahead and try", once they have gotten the pain under control. It is powerful.

  - Support them while they tentatively build back the part of their sex life that they had cut out. It won't necessarily happen by itself. They will need you as a spirit guide and cheerleader.

  - Don't forget the partner. Their partners may have developed secondary problems as a result. You will need to help them navigate that reality as well. (E.g. Classically, husband of vaginismus clients develop erection or ejaculation issues.) These problems are usually remedied fairly quickly with support and guidance. Sometimes PDE 5 inhibitors in the short term can be extremely helpful.)

- Celebrate these accomplishments and help them see themselves in a new way when that is the reality!

HAVE THEM RE-TAKE THE QUIZ TO SEE IF YOUR WORK NEEDS TO MOVE INTO ANOTHER QUADRANT

QUADRANT II – AROUSAL

MOST SALIENT ISSUES

Like everything else to do with sex, most problems with arousal are an interesting combination of the body's responses and the brain's ability to activate. Make sure you have distinguished this from desire. **HAVE YOUR CLIENT READ CHAPTERS 5 AND 7** and discuss it with you. I find that arousal is best treated with more emphasis on physiological and behavioral changes in the beginning. This appears to be a more effective starting approach and psychosocial exploration can continue as you start to see what problems may have occurred as a result of the issue.

EXPLORATION

IMPORTANT QUESTIONS TO ASK

This is how you might start your exploration. Obviously, exploration doesn't end when you start treatment. You are always exploring, but this is where you may want to begin.

- "If I could wave a magic wand and you would get turned on and have good sex" would you want to have sex? If they look at you like you are crazy and say "of course", bingo, you have isolated arousal. If they look sad and say, "I am not sure or I don't think so", re-explore desire. They are obviously intertwined and best addressed separately.

"I DON'T GET PHYSICALLY TURNED ON"

"I CAN'T SEEM TO QUIET THAT PERPETUAL LAUNDRY LIST RUNNING IN MY HEAD ONCE I GET GOING"

- Are the problems with arousal negatively affecting desire? Listen for: "I want to have sex, but it's just so much damn work, and for so little payoff, it's almost not worth it."
- Around when did this start?
  - ➤ Pay particular attention to the addition of medications here if this is not something they have always had: SSRIs, OCP are common culprits and don't necessarily start immediately upon beginning usage of the drug.

- Also, pay attention to life-stage physiological changes: birth of a child, peri-menopause, menopause. They all have dramatic impact on hormone levels as well as blood flow and neurological changes.

- Are the arousal issues present in solo sex as well?

- What do they think about when they are having sex? Gently push here. Lack of fantasy life can have significant impact on arousal. Do they fantasize? Explore gently. People and many therapists are uncomfortable moving into this arena, but it is critical to understand their current state of desire.

TREATMENT

More than with desire, I find that treatment for problems with arousal are best started with less psychosocial exploration and more emphasis on physiological and behavioral changes.

- Explore medications. **HAVE THEM READ CHAPTERS 9-11, AND 13** to jump start the conversation with you and to educate them about issues that they didn't consider as possibilities before. If you and they have concerns about specific medications they are using, make sure they see a physician who will take the time to listen to them and take their concerns seriously. You may want to offer to speak to the physician.

- Explore vibrators! If they are not currently using a vibrator, this might be an easy starting solution. **HAVE THEM READ CHAPTER 8 AND 14, AS THE BASIS OF A DISCUSSION WITH YOU**.
  - Introducing vibrators is not as simple as it appears. Some women have to be guided there because somehow it feels "unnatural". Make sure you have addressed this issue in your own mind so that you are approaching it as something normal.
  - Normalize their fear and concerns.
  - Guide them to a specific vibrator. It can be overwhelming when they start. (I have a free 3-part free vibrator course at MazeWomensHealth.com/how-to-choose-a-vibrator-video-series/)
  - Help them introduce the vibrator into partnered sex, if they are having it. For many women that is a difficult hurdle to overcome.

- Help them discuss this with a partner. This is particularly complicated for women who have been leading their partners to believe that they are enjoying sex when they are not.

- Help them turn on the erotic part of their brain. **HAVE THEM READ CHAPTER 16.** Working with their fantasy life is critical:
  - Help them to understand that fantasizing is not spontaneous magic for many women. They may have to work at it, but can get better at it.

  - Gently probe to see if they are feeling guilt with regard to their fantasies, either because they are not about a regular partner or they are not what they feel is acceptable.
  - Normalize and gently help them to accept their fantasies in all their realities and stop editing them. You may have to do some work on yourself here to be able to be fully present and accepting.
  - Provide resources to get them started: books, video links, websites.
  - Once they have access to their fantasies, they can use them when they are having sex by themselves or with partnered sex. Normalize that.
  - If the problem seems partner specific, normalize using private fantasies during partnered sex.

- Explore techniques. Have they masturbated? Have they explored what turns them on by themselves? While I don't include directions for masturbation in my book, the "Further Reading" under Orgasm includes many excellent works on this. Choose one or two of the books and have them read them with you.
  - Support their work doing this and help them process the self-consciousness and sense of "it's wrong" that so many have.

- Explore practical lifestyle changes that can help. **IF THEY HAVE YOUNG CHILDREN, HAVE THEM READ CHAPTER 19.** What is getting in the way practically? If I had a nickel for every woman who says "I would use a vibrator but there's no plug next to my bed…" This is fertile ground.
  - Help them brainstorm solutions, but also use this as an opportunity to better understand if there is general resistance.

- If they have a male partner, explore what is happening with the partner and how/if there is a missing piece of the puzzle regarding his issues. **HAVE THEM READ CHAPTER 18 IF THAT IS RELEVANT.**
- Give concrete tasks and assignments as the arousal improves. Getting the gears moving in the right direction again won't necessarily happen by itself. They will need you as a spirit guide and cheerleader.
- Help them see small accomplishments and celebrate them. Arousal is one of those areas where, as there is improvement, it feels so natural, they might not even notice and appreciate it. Help them to become more aware.

HAVE THEM RE-TAKE THE QUIZ TO SEE IF YOUR WORK NEEDS TO MOVE INTO ANOTHER QUADRANT

QUADRANT III – ORGASM

MOST SALIENT ISSUES

This section follows the exploration of arousal because it is most closely connected to it. Much like with arousal, I find that orgasm issues are best treated with less psychosocial exploration and more emphasis on physiological and behavioral changes. It is critical that your clients see you as a support in finding a solution to a physical problem, rather than seeing you as someone else who believes "it is all in their head." In order to do this effectively you need to be clear about "the problem", because primary, secondary, universal and situational orgasm problems all need to be addressed slightly differently! *So, the exploration process has to be thorough*. **MAKE SURE YOU HAVE READ AND CLEARLY UNDERSTAND CHAPTER 6 AND THE DIFFERENT CATEGORIES OF ORGASMIC ISSUES.**

Many of these women, primarily ones who are experiencing secondary universal anorgasmia (e.g someone who has started SSRIs or someone

who is perimenopausal or menopausal) have been told so often that their problems are in their head that they start to believe it themselves. Or, worse, they feel like the situation can't be helped. I will go out on a limb here and say that for women who have been having regular orgasms and they suddenly stop, or the orgasms have slowly ebbed away after childbirth or heading into menopause, the problem is most often physiological and talk therapy will not help. But the good news is, that it is almost always reversible!

That does not in any way minimize your role. It just shifts your role to support, guidance, cheerleader, solution finder and a container for holding sadness and grief. **HAVE THEM READ CHAPTERS 5 AND 6 AS A STARTING POINT FOR DISCUSSION.**

"I HAVE NEVER HAD AN ORGASM, OR EVEN GOTTEN CLOSE"

"IF I GET CLOSE, I DON'T SEEM TO BE ABLE TO FINISH"

"I USED TO HAVE ORGASMS, BUT THEY SEEM TO HAVE DISSAPEARED"

EXPLORATION

IMPORTANT QUESTIONS TO ASK

- What is their history with orgasm? Have they ever had orgasm? Can they have them in specific situations i.e. through masturbations but not with a partner? With direct clitoral stimulation but not with a partner? With a vibrator? You need to be incredibly specific because women obfuscate. They start with a whole host of assumptions and mythology around orgasm. All of their information then stems from that misinformation and it may be completely misinformed or wrong.
- Around when did the problem start? Was it a sudden disappearance? A gradual decline?
  - ➤ Pay particular attention to the addition of medications here if this is not something they have always had: SSRIs, OCPs are common culprits and don't necessarily start immediately upon beginning usage of the drug. Other drugs can also be a problem, even if they are "not supposed to be."
  - ➤ Pay a great deal of attention to life-stage physiological changes: birth of a child, peri-menopause, menopause. They all have dramatic impact on hormone levels as well as blood flow and neurological changes.

- Check in if the problems with orgasm have been negatively affecting desire. “I want to have sex, but it’s just so much damn work, and for so little payoff, it’s almost not worth it.” If it is, tuck that away for further exploration on desire.

- What do they think about when they are having sex? Gently push here. Lack of fantasy life can have significant impact on arousal.
- Explore their specific technique: how long do they spend? Do they engage their brain first? Are they using a hand, a vibrator? What kind of vibrator? Where do they use it?
- Explore if it is “frustrating” to them when they’re “finished. Some women may be having orgasms although they are not experiencing them as such. If they are feeling like the arousal builds and then it is “over” and they know when they have finished even though they never “felt” the orgasm, that is a very different experience from women who describe a constant build that goes nowhere, gets painful or just plateaus. The latter experience usually involves a level of frustration that the former does not.

TREATMENT

- It is critical that you now understand whether the anorgasmia is Primary vs Secondary and Universal vs Situational. This will guide your treatment plan.
- Education: More than any other quadrant, the myths surrounding orgasm are ever-present, ubiquitous, and destructive. **REVIEW THE MOST IMPORTANT POINTS FROM CHAPTER 6.**These are the “easy fixes.”
  - Are they aware that only 30% of women can orgasm from vaginal penetration? Are they aware that only 70-80% can orgasm from a hand or a mouth?
  - Are they clear that the clitoris is the driving force behind female orgasm?

- If they are having orgasms on their own but not with a partner, is that because they are unwilling to use a hand or a vibrator with a partner? Can you process and help them with that?

- Explore medications. **HAVE THEM READ CHAPTERS 9-11** to jump start the conversation with you and to educate them about issues that may not have been considered as possibilities before. If you and they have concerns about specific medication, make sure they see a physician who will take the time to listen to them and take their concerns seriously. You may want to offer to speak to the physician!

  - Wellbutrin, (bupropion) and Vyleesi (bremelanotide) as possible remedies.

- Explore vibrators! If they are not currently using a vibrator, this might be an easy starting solution. **HAVE THEM READ CHAPTER 8 AND 14**, as the basis of a discussion with you.

  - Introducing vibrators is not as simple as it appears. Some women have to be guided there, especially when you suggest using vibrators in partnered sex, because somehow it feels "unnatural". Make sure you have addressed this issue in your own mind so that you are approaching it as something normal.
  - Recommend specific vibrators with link and descriptions. Most women don't know where to start and end up getting a vibrator which is internal, too small or too weak. You may want to watch my 3-part (free) introduction to vibrators on MazeWomensHealth.com/how-to-choose-a-vibrator-video-series/
  - Normalize their fear and concerns. There will be many. Help them get past those concerns.
  - Help them discuss this with a partner. This is particularly complicated for women who have been leading their partners to believe that they are having orgasms when, in fact, they are not.

- What is getting in the way practically? If I had a nickel for every woman who says "I would use a vibrator but there's no plug next to my bed…" This is fertile ground. Help them brainstorm a solution but use this as an opportunity to better understand any general resistance.

- Help them, turn on the erotic part of their brain. **HAVE THEM READ CHAPTER 16**. Working with their fantasy life is critical:

  - Help them understand that fantasizing is not spontaneous magic for many women. They may have to work at it, but they will get better at it.
  - Gently probe to see if they are feeling guilt with regard to fantasies, either because they are not about a regular partner or they are not what feels "acceptable."
  - Normalize and gently guide them to accept their fantasies in all their realities and stop editing them. You may have to do some work on yourself here to be able to be fully present and accepting.
  - Provide resources to get them started: books, video links, websites.
  - Once they have easier access to fantasies, they can use them when they are having solo or partnered sex. Normalize that.
  - If the problem seems partner specific, normalize using private fantasies during partnered sex.
- Acknowledge that there are 5% of women who do not orgasm. If this is true of your client, your job becomes critical:
  - Do not spend months pursuing a holy grail that may not be possible. Do better than the classic medical establishment, acknowledge what we don't know and that currently there may not be a solution.
  - Do not let them destroy the rest of their sex life in a quest for an orgasm. Help them see and build on the strengths in of their sex life.
  - **HELP THEM PROCESS THE SADNESS THAT MAY COME AT THIS TIME. YOUR SUPPORT, HONESTY AND ABILITY TO HELP CONTAIN THE EMOTIONS OF LOSS MAY BE YOUR MOST IMPORTANT ROLE.**

HAVE THEM RE-TAKE THE QUIZ TO SEE IF YOUR WORK NEEDS TO MOVE INTO ANOTHER QUADRANT

QUADRANT IV – DESIRE

MOST SALIENT ISSUES

Make sure you separate low desire from problems with arousal. They often get confused and that is not helpful. **USE CHAPTERS 5 AND 6 WITH CLIENT TO FRAME THE DISCUSSION**.

Remember that low desire is often a combination of several components. Your job is going to be helping them sift through numerous preconceived notions and narratives they might have, as well as present various treatment options that may address those concerns. Here are some of the most common components to low desire.

Often patient's low desire is:

- A product of an overly romanticized, unrealistic, or magical thinking approach to sex.
- An inability to access the part of the brain that is needed in order to have an erotic relationship with themselves. This could be a history of trauma or, just as commonly, a result of disuse, self-editing, lack of know-how.
- A problem in the relationship. (But in that case, it's not universal, it's relationship specific.)
- A secondary problem created by one of the other quadrants. (In that case, start by addressing the underlying problem first.)
- Exacerbated by a physiological component.

Traditionally, sex therapy has not been particularly effective at treating low desire for more than the short term. To be most successful you need to give them *a variety of approaches and tools that they can use in the future when the issue arises again.*

"I REALLY AM NOT VERY INTERESTED IN HAVING SEX, EVEN IN THEORY"

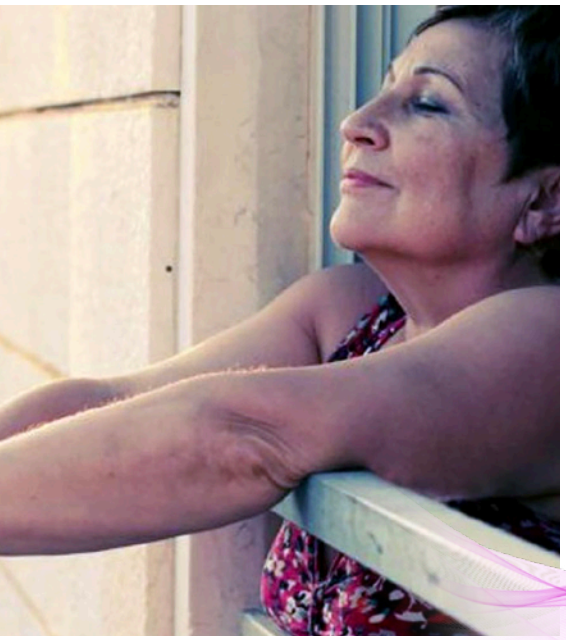
"HONESTLY, IF MY PARTNER DIDN'T CARE, I COULD GO MONTHS, OR EVEN FOREVER WITHOUT THINKING ABOUT SEX"

EXPLORATION

IMPORTANT QUESTIONS TO ASK

- How often are they having sex (including solo sex)? Be extremely specific. You are not merely looking for intercourse. Sometimes, it is more helpful to ask when was the last time they had sex? Tread carefully here because the shame and guilt can lead to less than honest answers.

- Do they ever think about having sex with their partner and do they, even theoretically, want to have sex with their partner?
- Do they think they would want to have sex with other people? (Again, tread carefully and gently. It is difficult for people to be honest with themselves, let alone their therapist) but it is critical to understand if this low desire is partner specific or universal.
- Do they fantasize? Explore gently. People and many therapists are uncomfortable moving into the arena, but it is critical to understand their current state of desire.



- What does it mean to them to have desire? And how do they understand it fitting into the sexual response cycle? Do they feel it should be regular and spontaneous (a classic myth in our society) or do they understand that one can have good sex without spontaneous desire if they are not aversive?
- Is this really a new problem for them or is it a secondary result of a problem that their partner is having?
- **YOU SHOULD "RANK" THE CLIENT IN YOUR MIND AS A 1-4 (SEE CHAPTER 7).**

TREATMENT

- For the woman who comes in distraught at how she never wants sex and feels tremendous guilt about it, **THE MOST HELPFUL TOOL IN THE BOOK IS SCHEDULING NOT SEX IN CHAPTER 8 AND APPENDIX I.** I do not want you to mix this up with scheduling sex, which so many sex therapists use and which backfires. Women who come in with this type of distress normally have clocks running in their heads. They are constantly feeling guilty and overwhelmed with how long it has been since they had sex. They are typically ranked as a 3-4, but still having sex sometimes. **YOU WANT TO TAKE PRESSURE OFF BOTH PARTIES** by scheduling sex at certain intervals which they find manageable but taking sex off the table the rest of the time in a clear, fully articulated plan with both partners, so that the stress comes off!
  - This is one of my most helpful tools, but it has to be presented clearly and specifically and there needs to be "buy in" from both parties.
  - You need to find a schedule that the woman can commit to with a positive attitude, and without her partner dragging her into it.

- If the partner is resistant, that will give you some deep insight into the relationship.
- Usually, reasonable partners are okay with having regular scheduled sex and committing to no pressure during other times. If they are not, there is couple's work that needs to be addressed.

- Help them turn on the erotic part of their brain. **HAVE THEM READ CHAPTER 16.** Working with their fantasy life is critical:
  - Help them understand that fantasizing is not spontaneous magic for many women. They may have to work at it, but they will get better at it.
  - Gently probe to see if they are feeling guilt with regard to fantasies, either because they are not about a regular partner or they are not what feels "acceptable."
  - Normalize and gently guide them to accept their fantasies in all their realities and stop editing them. You may have to do some work on yourself here to be able to be fully present and accepting.
  - Provide resources to get them started: books, video links, websites.
  - Once they have easier access to fantasies, they can use them when they are having solo or partnered sex. Normalize that.
  - If the problem seems partner specific, normalize using private fantasies during partnered sex.

- Explore medications. **HAVE THEM READ CHAPTERS 9-11, AND 13** to jump start the conversation with you and to educate them about issues that they didn't consider as possibilities before. If you and they have concerns about specific medications they are using, make sure that they see a physician who will take the time to listen to them and take their concerns seriously. You may want to offer to speak to the physician.
  - This is particularly important if you hear:
    - — I've tried for weeks but I just can't seem to fantasize at all.
    - — I want to want sex… I really do… but…
    - — I love him to pieces and I find him attractive but…
- If their desire for others is 1-2, but their desire for her partner is a 3 or 4, **HAVE THEM READ CHAPTERS 15 AND 17 AND DISCUSS.**

- This is where your traditional expertise can be invaluable. What are elements of their relationship that they have not explored? What are elements of their partner that scare them or worry them? That is often a sign of differentiation and while it can cause anxiety it can also be incredibly powerful to find the erotic in the other. Let's be clear here, I am not talking about "scary" elements that can harm, but rather strong elements that we have perhaps "scrubbed clean" from our partners in our current PC environment.
- Explore ways they can learn to see their partner in a different light.
- Avoid falling into the trap of "they need more communication," "he needs to do the dishes more." While I have truly seen those things advance a relationship, they are also often not the things women think are sexy.

- Explore practical lifestyle changes that can help. **IF THEY HAVE YOUNG CHILDREN, HAVE THEM READ CHAPTER 19.** What is getting in the way practically? If I had a nickel for every woman who says "I would use a vibrator but there's no plug next to my bed…"
  - This is fertile ground. Help them brainstorm solutions, but also use this as an opportunity to better understand if there is general resistance.
- If they have a male partner, explore what is happening with the partner and how/if there is a missing piece of the puzzle regarding his issues. **HAVE THEM READ CHAPTER 18, IF THAT IS RELEVANT.**
- Give concrete tasks and assignments as the desire improves. Getting the gears moving in the right direction again won't necessarily happen by itself. They will need you as a spirit guide and cheerleader.
- Help them see small accomplishments and celebrate them. Desire is one of those areas where, as there is improvement, it feels so natural, they might not even notice and appreciate it. Help them become more aware.

HAVE THEM RE-TAKE THE QUIZ TO SEE IF YOUR WORK NEEDS TO MOVE INTO ANOTHER QUADRANT