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Chapter 22

Quickies:
Single Session Sex Therapy

Douglas Flemons and Shelley Green

As brief therapists, we are committed to working as efficiently as possible (Watzlawick, Weakland, & Fisch, 1974), facilitating change in client conundrums in a way that underscores clients' resources, expertise, and capacity for transformation. Although we don't restrict our practice to single session appointments (we are comfortable with therapy unfolding over multiple visits if it makes sense to us and is experienced by the clients as helpful), we are attuned to the importance of expectancy in potentiating and orienting therapeutic change (Kirsch, 1999). Thus, we approach each session with clients as a singular opportunity for initiating a significant shift in their experience.

We are known for our application of brief therapy ideas and methods to individuals and couples with sexual concerns (Flemons & Green, 2007, 2013), so other clinicians will sometimes send (or more often accompany) their clients to us for one-session sex therapy consultations. This chapter describes one such case. It illustrates how we think about and practice therapy (particularly our single session work), how we make sense of sexual experience, and how we involve ourselves in resolving clients' sexual difficulties.

Therapeutic Principles and Practicalities

We recognize that minds are embodied (Lakoff & Johnson, 1999) and bodies are mindful (Varela, 1979), and, following Bateson (2000, 2002), we consider mind a quintessentially communicational phenomenon that is best understood systemically, in terms of circular patterns of relationship within and between individuals. As therapists, and particularly as sex therapists, we act so as to preserve and protect the integrity and change-ability of minds and bodies, and so we are always taking into consideration and exercising curiosity about the challenges and possibilities inherent in relationships—relationships within and between bodies and minds, between the individuals in a couple or family, between the clients and their complaint, and between the clients and us.

Practically speaking, this means that when clients come to us with a worry or concern about some problematic part of their personal or interpersonal experience, we

accord respect to and curiosity about both the person(s) and the problem itself. Clients may think of the problem as an isolable entity, as something that, with our help, could perhaps be better controlled or even eradicated from their experience. But we assume that problems are composed of and contribute to mindful networks of relationship. Such patterns don't obey the same laws as entities. It is possible to toss a problematic thing—a broken lamp, an empty bottle—into the trash or recycling bin and be done with it, but if you try to eradicate a problematic relationship—with a spouse, with a substance to which you're addicted, with a sexual difficulty—you risk rendering the relationship more complex and the problem more entrenched. You can't throw the problem away, but you *can* alter the patterns of relationship that constitute and contextualize it. This realization, and the relational ideas underpinning it, inform and infuse the therapeutic principles that guide our single session work and the therapeutic techniques that characterize it.

Our orientation to change respects the communicational properties and relational integrity of bodies and minds. You can't do sex therapy without having a realistic understanding of how bodies work, how desire and arousal work, how orgasm works. We go in search of our clients' intra- and interpersonal resources, rather than their deficits, and we invite resolutions to problems via connections, rather than negations (Flemons, 1991, 2002; Flemons & Green, 2007). We are always curious to explore how a resourceful pattern in one area of a couple's mind-body experience could be relevant and helpfully transported to a problematic area. Have they already found some success in dealing with the problem? If so, what were they doing at the time? Have they solved analogous problems? How so? What skills, abilities, talents do the clients have? When and how do they access these? What essential element in these resources could be helpful in responding differently to the problem?

We also listen for how our clients' well-intentioned efforts to resolve their problem may have been unintentionally contributing to its maintenance or even exacerbating it (Watzlawick, et al., 1974). This can happen when the focus is on eliminating or controlling the problem, so we keep an ear open for whether this is the case, and we explore possibilities for an alternative orientation.

This search for and grasp of the complexity of clients' struggles helps us to develop our empathic understanding. If we can recognize clients' challenges and opportunities, and if we can communicate this understanding to the clients, they will be better equipped to decide whether they can trust the connection with us enough to be safely vulnerable. You have to feel safe if you're going to divulge intimate sexual concerns to a stranger and risk asking for help in changing them. We suspect that the relative anonymity that accompanies the "one-night-stand" aspect of a single session appointment allows some clients to feel more comfortable speaking frankly about their sexual relationship; however, others are tentative about opening up when they "really don't know us that well." Empathy is particularly important when working with those who are cautious or shy.

Recognizing that meaning is dependent on context and that problems are held in place by assumptions held about them, we invite our clients to make sense of their

problem in a way that allows them and us to orient to it differently. We define it as a pattern that is mutable, which helps create an expectancy for some kind of therapeutic movement. Not only do we assume that the problem can shift in some meaningful way, but we are open to discovering that it has already started changing or that it can begin changing now or soon. Such an attitude or expectancy lies at the heart of all reframing—in keeping with a change in how the problem is understood, the couple can find themselves responding to their situation and each other with a shift in thoughts, emotions, and/or behaviors.

When it comes to sex, at least part of any change will be non-volitional in nature. Desire, arousal, and orgasm can't be consciously controlled and thus don't respond well to willful efforts to change them. We normalize dilemmas and desires and pleasures and anxieties, as this can help clients relax their ineffective efforts to negate or to *other* whatever they hate or fear, and we invite non-volitional shifts in attitude, effort, response, belief, or anticipation.

Although we teach in the same university family therapy program, team up at times on workshop presentations, and co-direct a private practice, we don't regularly get a chance to see clients together. We look forward, then, to requests for one-session joint consultations, particularly sex therapy cases, as they offer us an opportunity to think and improvise together, combining our perspectives to see and offer more than we might, were we working individually.

We don't charge any more for Quickies consultations involving both of us than for therapy sessions with just one of us. If we were solely dependent on our income from private practice, then such an approach probably wouldn't be economically viable, but our private practice is a secondary part of our professional lives, and we enjoy the opportunity to collaborate, so our clients get the benefit of two heads for the cost of one. (In fact, we saw the case discussed here in our university's family therapy training clinic, the *Brief Therapy Institute*, so we collected no fee.)

Referrals come primarily from other therapists, who often, but not always, accompany their clients to the session. The clients know coming in that we will be meeting with them just once—we are clear that we will not take over the therapy from the referring clinician—and that the time involvement will be 1 ½ to 2 hours. We like the pun of referring to our one-session sex consultations as a "Quickie," but we generally keep this play on words to ourselves (and to the readers of our work). Before arriving, the clients have been told by their therapists that we have the necessary expertise and experience to perhaps be helpful with their sexual difficulty in the course of a one-shot consultation.

When clients aren't brought in or sent by another clinician for a consultation but, instead, contact us on their own for therapy, they often ask how many sessions they should anticipate attending. We tell them that as brief therapists, we are committed to seeing them for the fewest number of appointments necessary. We offer the possibility that they may not need to come more than once, but add that if they do wish to return, we will welcome them back (should they and we believe that it would be helpful to do so). This way, we orient them to the possibility of attending a single session *and* protect

them from being anxiously concerned before and during that first appointment that they might need more time. We aim for them to feel comfortably expectant that significant change is within easy reach.

Case Study

We would like to tell you about a Quickies consultation that was initiated by a therapist, Lauryn, a few months into her working with a couple in their forties, whom we'll call Ed and Michelle. The three of them had been addressing a variety of complaints, and the couple had made significant headway; however, Michelle had recently voiced the concern that the core of their problems had a sexual origin that needed to be addressed if they were to save the marriage. Lauryn responded by telling the couple about us, and with their encouragement, she contacted us for an appointment. The resulting video-recorded session, which was attended by Ed, Michelle, and Lauryn, lasted close to two hours.

Inspired by de Shazer (de Shazer & Dolan, 2007), we typically inquire at the beginning of our consultations about whether the clients have recently initiated or noticed any changes in their relationship or their problem. If they have, we explore the implication that such a head start can expedite our work together. In response to our posing such a question, we learned straight away that Ed and Michelle worked together in a small business they jointly owned; however, after 5 years of marriage (Ed's first, Michelle's second) and much contentious fighting, Ed had recently moved out of their house and stopped drinking. They both asserted their deep love for each other, despite the fighting and Michelle's experiencing Ed as abusive.

Ed: I started AA [Alcoholics Anonymous] four weeks ago, thinking there were some issues there . . . and I go every day. I come from a family of alcoholics. . . I never believed I was, but now I've started that path.

Douglas: That's a huge change. What other changes have you made since [starting therapy with Lauryn]?

If you think of a marriage (or any system) as a complex pattern of interactions, then you will assume that a positive alteration in one part of the pattern will possibly be occasioned by an analogous shift somewhere else—ramifying the significance and helpfulness of the change.

Michelle: We communicate now.

Ed: Yeah, we talk a lot better now; our communication has opened a lot. . .

Michelle: But it's awful hard, given some of the stuff that's being said, to not let the emotions come in and get hurt.

Shelley: Yeah, because you do love him.

Shelley's comment acknowledged that Michelle's pain was heightened by the depth of her feelings for her husband.

Douglas: Who made the decision to live separately?

Ed: I did.

Michelle: Oh yeah, he did. It got real bad.
Douglas: Is it working?
Ed: Yeah, in a sense, it is.
Michelle: He says it is; in my eyes it isn't.

We look for resources everywhere, while simultaneously acknowledging the severity of our clients' concerns. Because Ed made the decision to live separately, we were able to later acknowledge his willingness to take responsibility for creating a context for safety. If Michelle had made the decision, we would have been able to remark on her willingness to take a stand to protect herself. Throughout the session, in interchanges not always included below, we managed on several occasions to do both—to discover instances where Ed was initiating efforts to protect Michelle and where Michelle was "putting her foot down" to protect herself. But first we needed to know the nature of the danger. From what was Michelle needing to protect herself? Safety is a foundation for everything we do.

Shelley: You said "it got real bad." Was there physical violence?
Michelle: Oh no. He would never do that. But he would yell at me, just scream and holler at me.

Ed's commitment not to hit could be construed as a strength, as could Michelle's firm trust that she was physically safe. With that reassurance, we felt comfortable proceeding to explore other possibilities for trust.

Shelley: [Ed] has a mindset right now not to drink, and to be committed to that. Do you have faith in that, and believe him?
Michelle: Yes I do.
Shelley: He sets his mind to something and that's what he's going to do. So you have trust in that?
Michelle: Oh yes. I see a lot of changes in him.

Shelley highlighted that Michelle trusted Ed's ability to commit to change and to follow through on it. We saw this as a hopeful sign that they would be able to follow through on any changes to their sexual relationship that might arise from our consult.

The couple proceeded to describe painful conversations they'd been having about past betrayals and disappointments. Rather than get caught up in the details of the problems and the distress they had caused, Shelley commented on the couple's ability to forthrightly address the hurts, and she sought to establish whether this was also a recent development.

Shelley: You guys have had some brutally honest conversations. Is that new and different?
Michelle: We sure have!
Ed: Yeah, and that's one of the good things, one of the good positive changes I see.

As much as we inquire about, attend to, and underscore strengths and positive changes, our relational approach dictates that we never take up residence on only one

side of an important distinction (Flemons, 1991). We honor what's been working and what's better and hopeful, *and* we pay close attention to and acknowledge what's been causing pain and distress. During a discussion of the couple's many arguments, Michelle gave additional examples of lingering anger and resentment. Shelley was able to legitimize her concerns without getting caught up in the details:

Shelley: Well, it sounds like there is . . . both hostility and lack of forgiveness in some cases, *and then* there is some sort of love and deep caring that brought you guys here.

Michelle: Oh, yeah! I mean, if we didn't care, we wouldn't be trying to do this.

Ed: Absolutely.

About 25 minutes into our consultation, we asked the couple what they'd like to get out of their session with us. We don't always wait so long to pose this essential orienting question, but, like Eve Lipchik (1994), we assiduously avoid the *rush* to be brief, lest it slow us down and obscure what could turn out to be vital contextualizing information about the clients and their struggles. Allergic to recipe-focused therapy, we don't impose a rigid structure on our sessions. For us, there's no one place to start and no particular order of queries to pose when letting our curiosity roam. Instead, we're organized by two commitments. First, we want to flesh out a relational understanding of how the problem *makes sense*—how it fits within the complex of intra- and interpersonal relationships of which it is a part and that contribute to its meaning. And second, we want to invite one or more small changes in the fabric of one or more of those relationships. The session ends once we've offered a comprehensive empathic grasp of the complexities the clients are facing, followed by some imagined possibilities that sketch out alternatives to trying to constrain or negate the problem.

Douglas: How were you thinking that we could be helpful? I don't know [turning to Ed], was it your idea that we would meet with you?

Michelle: It was my idea to meet with you! I was done, and she [Lauryn, the therapist] asked me, "Are you going to divorce [me], too?" [laughter] I was just done with the marriage and the therapy. And I said, "No one's getting it." 'Cause we were talking about the kids, we were talking about all the little things . . . . [but] we haven't been talking about the major thing.

Shelley: What is the big thing that we need to talk about?

Michelle: The major thing is, well, he drank a lot, and when he drinks, he has this thing about strip clubs. . . . He's told me, off and on, that he's not sexually attracted to me.

Douglas: So this is the major thing for you that had you thinking it would be good for you to come in to us to talk about?

Michelle: Yes. Because a lot of things he does, it's like he *needs* to see strippers, he *needs* to go on porn sites. . . . We'd be in bed together and be all lovey-dovey, and he told me that "something's wrong, you know, it's just not working" [i.e., he couldn't maintain an erection]. And then I find out later, he gets up and goes

and takes a shower and he's jerking off. Well, I'm sorry, that bothers me. That hurts me, because he can't be with me, he can only be with himself.

If we were traditional sex therapists, and if we had agreed to be organized by Michelle's description of the problem, then we probably would have focused the session on issues of sex addiction and erectile dysfunction. But as brief, relationally focused therapists, we endorse Haley's (1991) advice to define the problem interactively, in a way that leaves open the possibility for change.

Shelley: So is that a betrayal for you?
Michelle: It's just, it was a lie. Because he told me there was something the matter with him and there really wasn't. So I'm sitting there saying, I mean, I have a libido, you know? So I pushed my feelings off to the side, and I love him for who he is, so if we can't do that [have intercourse], I'll accept that. . .
Shelley: But [now] knowing that physically . . . [it is possible for him to] be sexual, then you want it to be with you.
Michelle: Yeah, that was a kick in my face.
Douglas: So, then, if you could be sexual *together*. . .
Ed: That would be fantastic.
Shelley: [turning to Ed] For you, too?
Ed: Absolutely.

The goal of the session was now defined, for us, for the clients' therapist, and for the clients themselves, as finding the means for the couple to "be sexual together." We pursued that direction by finding out more about what had drawn Ed to strip clubs. He told us that he started visiting them over 20 years earlier, at a time when he was struggling to cope with several devastating losses. Ed puzzled about the fact that he had always found the strip-club environment "soothing." Shelley offered a way of making sense of it.

Shelley: You weren't interacting physically in the strip clubs . . . right? Just observing?
Ed: No, well, sometimes I would get a lap dance, but mostly . . .
Shelley: In a strip club, there were no demands on you . . . It's sort of a passive activity. You can watch, be aroused, enjoy; there was no one really expecting anything from you. So there was nothing directed at you in terms of your performance.
Ed: Right, nothing was expected of me.
Shelley: So I can see how that would be soothing and arousing.
Douglas: Talk about stuff put on your lap. You'd been handed the death of [three of the most important people in your life], and you're [just] 18. . . .

Douglas referred back to Ed's getting lap dances as a means of empathically elaborating on the idea that for Ed, arousal and emotional safety went hand in hand.

Michelle: See, that was the thing I told him, I mean, I'm not a counselor or anything, but it seems like he was looking for something, and that's what he found.
Shelley: That was his comfort. . . .
Douglas: So what triggers your need for comfort?

Ed: My need for comfort?

Shelley: When do you need to soothe yourself?

Ed: Interesting question . . . Ummmm, actually *after* we have sex. *After* we have sex! Not when we're having sex. And I don't understand it.

Shelley: So that's when you would usually go check out a porn site?

David: Right, afterwards.

We strive to normalize our clients' experiences, to make sense of them in non-pathologizing, non-othering ways. Behaviors are easier to change when you're not consumed with or defending yourself against recriminations from yourself or significant others. When we offer such understandings, we credit the clients themselves with having inspired them, and we offer them tentatively. We don't want to impose our views on clients, as we're committed to the therapy being a collaboration.

Michelle speculated further about the timing and meaning of Ed's attraction to porn and strip clubs, to which Douglas responded.

Douglas: So, if Michelle's got her finger on something, the need for soothing happens after sex with someone you love, and it happens when you're afraid that if you get too close you could lose the whole thing. Is that . . . [accurate]?

Ed: Yeah . . .

Shelley: And I'm thinking, after sex with someone you love, you're probably at your most vulnerable moment . . . potentially. Maybe not . . .

Ed: Yeah . . .

Ed was a little hesitant in affirming Shelley's idea, so we continued exploring it. We didn't want to move on without being sure that it fit for him. Douglas mentioned as a possible example the erection problems Michelle had alluded to earlier.

Douglas: [I imagine that] if you're making love and you're finding . . . that you're not able to perform, that [would have to be] a very vulnerable place to be.

Ed: Right . . . because she would try to stimulate me, and it wasn't working. I was starting to think, and like [Michelle] said, I made her believe there was something physically wrong. I, physically, myself, was starting to think there *was* something wrong. . .

If, like us, you consider bodies to be mindful, then when you hear that a body part like a penis is reluctant to participate wholeheartedly in an enterprise like sex, then your first thought won't be, "What's wrong with the penis?" Sex and analogous activities—creative brainstorming, improvisational theater or music, playing a team sport—necessitate integrated engagement and interactive communication and cooperation. So, instead of going in search of a deficiency, you'll look for how the body part's reluctance *makes sense*, given the demands it is facing from other parts within the whole. Arousal and pleasure and orgasm are automatic body responses that can't be imposed or dictated by a person's or partner's conscious mind. Bodies are much too systemically wise to permit such attempted interference.

Douglas: It also would make sense to me, if you're with Michelle, and [your erection's] not happening, and you're starting to worry about that, if there's something wrong, [then a] great way to reassure yourself [would be] to jack off in the shower, or go to a strip club, to reassure yourself, "I guess I am OK."

Ed: Good, right. Because I was doing that for a while to make sure it was working, because I thought, wait a minute, why is it not happening here? And she got upset about it one night, and said, "What's wrong?" And I'm like, "I don't know what's wrong!"

Shelley: But then would that be reassuring to you, when you'd go to porn site or strip club?

Ed: Yeah,

Shelley: So then it's like, "Whew! At least we know that's working."

Ed: Yeah.

This reframe of Ed's attraction to porn and strip clubs cast Ed in a respectful light. Instead of a sex addict in search of alienated stimulation, he became a vulnerable man in anxious need of reassurance about his sexuality. He had been trying unsuccessfully to solve this problem by withdrawing into non-demand opportunities to feel sexually successful. His attempts to resolve his sexual anxiety and thus to "soothe himself" enough to be sexual with Michelle unintentionally alienated her. A therapeutic alternative to turning away from Michelle was to turn toward her, to make intimacy possible. We noted that Ed was attracted to strong, assertive women, but we distinguished between the pseudo strength of a stripper and the real strength of Michelle—a strength that offered both challenges and possibilities.

Douglas: [to Michelle] I was just thinking about the frightening part [for Ed] of your being the strong woman that you can be. . . . [to Ed] It's very arousing [when] a stripper [is] making eye contact and being overtly sexual towards you. That's a very assertive thing [for her] to do. But when Michelle is being strong, that places demands on you; the difference is the stripper doesn't place demands.

Shelley: The stripper doesn't come home with you and need you emotionally.

Both Ed and Michelle felt betrayed by the other, and each talked about wanting to forgive the other in order to move forward. We explored the idea with them, but we tied the desire and effort back to the theme of vulnerability, remarking on the benefits of not letting go of resentment too soon and normalizing the conflict that had plagued their relationship.

Douglas: Forgiving is . . . a very vulnerable thing to do. 'Cause as long as you can hold resentment, it's okay to have a wall you can retreat behind.

Shelley: And the [person you resent] can't hurt you. [You can feel safe behind] a wall of "maybe she's not the right one for me."

Douglas: Ed, if you were to, I don't know if you have yet, but if you were to fully forgive Michelle, [then] at that point, you're vulnerable again, because you can't retreat behind a wall of resentment. It sure seems to me that you're

experimenting with some incredibly important ways to be safe: [You're reaching out] without alcohol to protect you, without resentment to protect you, without other relationships to protect you. It means you're raw.

Ed: I am . . .

Shelley: So right now you're in a place of kind of letting all that go, and questioning every bit of it. And you don't know what it's gonna look like on the other side yet.

Ed: Right.

Shelley: It's kind of a scary place to be, to be willing to put yourself in this place. Scary not to know where you're headed. It's kind of amazing that you're willing to do this.

Ed: I'm not completely convinced that we're going to make it through this. I hope we do, but uh, but with my desire for sexuality, we just may not be compatible.

Ed expressed one of many uncertainties that he and Michelle were facing. Shelley bridged from the possibility that they wouldn't make it as a couple to other uncertainties that necessarily followed from Ed's willingness to experiment with making so many changes.

Shelley: But also, you don't really know what your and Michelle's potential is—[you've] never [before] put yourself in this place of emotional vulnerability, with no anesthesia, no alcohol, all the other ways that you . . . [in the past, went in search of] comfort. You don't really know what's gonna be there.

Perhaps one of the primary constraints of offering one-session consultations is that we as therapists don't have the luxury of allowing understandings and shifts in perspective to happen gradually, over the course of multiple appointments. This means for us that when we're seeing people only one time, we tend to be more actively involved in the construction of such changed meanings. One of the primary delights in this highly efficient mode of working is that we are sometimes privileged to witness the therapeutic equivalent of time-lapse photography—a relational transformation in an individual's sexual experience or a couple's sexual relationship that unfurls in the space of one or two hours.

We see it as our responsibility to offer anticipation for change in an open, yet compelling way. Therapeutic opportunities are easier for clients to embrace if expectancy for them to occur is heightened.

Douglas: It seems to me that you're on the verge of discovering the strength of vulnerability, of being with an assertive woman, and what it means to lose yourself in her eyes. You're experimenting with that, in a sense for the first time. And that's, that's huge.

Shelley: That's huge, and I think that, we talked a lot about the role of pornography, and it sounded to me like you were thinking somehow if you were going down to a porn site and jacking off, before, during, or after sex—or instead of having sex—with Michelle, that that said something about whether you guys

were compatible. And the more I've listened to what you've said, the more I think [that your attraction to porn and strip clubs] tells us a lot about what's been soothing and comforting to you in the past, and that makes a lot of sense. But I think right now, you guys are really experimenting with . . . moving way beyond stuff that's worked for you in the past. It doesn't tell us about what's going on between you now; it seems like it just says a lot about what's worked for you in the past. But what I'm hearing is you don't want the same things anymore.

Douglas reinforced Shelley's prediction by speculating about possible next steps.

Douglas: My guess is that [new ways of relating] are going to start to get invented. I don't know if it will be [to Michelle] you finding ways [to offer soothing to Ed] or you [to Ed] finding ways to ask [Michelle] for soothing, ah, some soothing after sex, so that you don't have to go down the hall to the computer.

Michelle: If we could sit there and talk and cuddle, he wouldn't have to go down there. I think it is a bad habit.

Shelley: It has been comfortable and familiar, whether it worked or not. And we don't know what's going to work now.

Douglas: Cause everything is unfamiliar now.

Michelle: Exactly.

Shelley: I'm really curious to talk to Lauryn later to find out what you guys have found that works, and where you have taken this. You have taken some amazing risks already, and that's a huge start.

The consultation ended at this point, with Lauryn feeling comfortable and confident that key points from our session could be used as organizing principles for future sessions with Ed and Michelle. If Lauryn hadn't been able to accompany the clients, we would have provided her with an in-depth letter that outlined our relational sense of what had been going on with the couple, where we saw potentials for change, and how, given this understanding, it might be helpful to focus future appointments. Just as we underscore the integrity of our clients, so too we are deeply respectful of therapists and the work they have been doing. We want to be sure that anyone willing to venture in a new direction, whether client or therapist, isn't, as a result of coming to see us, at risk of losing face. We thus don't propose changes that entail the negation of previous efforts but, rather, a *sense-able* reimagining of possibilities.

The couple continued to see Lauryn, so, with their permission, she was able to provide us with follow-up information. Three months after our seeing them, they reported that they were back living together, weren't arguing nearly as much as before, and were having "lots of sex," which Ed defined as "lovemaking." As he put it, "We made love this week. . . . [It was] more intimate, [with] no derogatory or kinky language. Just more natural—holding each other and telling each other we love each other." At a follow-up a year after that, they, no longer in therapy, were still living together and

doing well. Michelle was asserting herself and Ed wasn't having to distance from her as a means of handling her strength.

Our relational approach to single session consultations is grounded in an understanding of how relationships change: A small shift in part of a pattern can ramify throughout the rest of it, thereby altering the whole of it. We bring this sensibility into what we listen for, what we ask about, how we respond, and what we suggest. We begin by tuning into relevant relationships—between mind and body, between the couple and the problem, and between the two individuals—and then we invite small shifts in each or any of them. When our Quickies consultations are successful, they reorient a couple's efforts to solve their problem and alter the relationship between them, such that their future sexual relationship reflects or even enhances the changes initiated during our single session together.

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