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TELEPHONIC SERVICE INTERVENTION
for
FEMALE SEXUAL DYSFUNCTION
by
WOOLF SOLOMON
A Dissertation submitted in partial fulfilment
of the requirements of the Degree
DOCTOR OF LITERATURE AND PHILOSOPHY
in
PSYCHOLOGY
in the
FACULTY OF ARTS
at the
RAND AFRIKAANS UNIVERSITY
Promoter: Professor E Wolff
March 1993
TO

MY MOTHER

AND TO

MY WIFE, BARBARA

"A woman of valour who can find...?

...many woman have excelled but you outshine them all!"

Proverbs 31:10-31
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OPSOMMING

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daarstelling van h Premiumtarief - telefooninligtingsdiens
vir h wye verskeidenheid onderwerpe van toepassing op
essensiële hulpverlenende inligtingsdienste het daar die
vraag onstaan of hierdie telefooninligtingsdienste hoe
genaamd h doel dien vir die gemeenskap. Aan die anderkant
het die vraag onstaan of hierdie telefooninligtingsdienste
effektiief is, gegee die kostes verbonde aan die maak van so
h telefoonoproep. Daar is voorts ook vrae gestel rondom die
moonlike benadeling van inskakelaars na sodanige programme.
Dit is veral die programme met h seksuele inhoud wat onder
die loep geneem is, en daar is in die pers aangedui dat
hierdie programme waarskynlik nadelig is.

Teen die agtergrond van hierdie inligting, is h studie
onderneem ten einde te bepaal of daar wel h behoefde vir
sodanige diens is, en of hierdie diens enigsins effektiief
sou kon wees. Om dit te bereik is h Premiumtarief-
telefooninligtingsdiens met h wye verskeidenheid seksuele
onderwerpe daargestel onder die skuilnaam van h kliniese
sielkundige wat op h plaaslike radiostasie en op die
televise seksuele inligtingsprogramme en seksuele
gespreksprogramme onderneem het.

Die eerste analise het oorweldigend aangedui dat daar h
behoefte is vir sodanige inligtingsdiens. Die hoë oproep-
volume na hierdie diens het duidelik aangetoon dat daar die
behoefte vir sodanige diens by die plaaslike bevolking
bestaan. Dit sou dan beteken dat die positiewe, en of
negatiewe invloed van sodanige diens besonder sterk kan
wees. Nadat dit vasgestel is dat hierdie program h bepaalde
behoefde vervul, is die tweede deel van die studie
onderneem, naamlik om die effektiwiteit van hierdie diens
te evalueer in vergelyking met h biblioterapeutiese groep
en h kontrolegroep. Deur middel van h radioprogram op h
plaaslike radiodiens is 91 proefpersone verkry en lukraak
togewys aan een van vier groepe. Dié was eerstens h
eksperimentele groep, wat blootgestel is aan h Premiumtarief-telefooninligtingsdiens, en ook aan voortoetsing en natoetsing van relevante veranderlikes onderwerp is. Die tweede eksperimentele groep is ook aan h Premiumtarief-telefooninligtingsdiens blootgestel, maar het geen voortoetsing ontvang nie, ten einde h "voortoetsingseffek" uit te skakel. h Derde eksperimentele groep is aan biblioterapeutiese diens met dieselfde strekking as die Premiumtarief-inligtingsdiens onderwerp, en die vierde groep was h kontrolegroep. h Voortoets-natoets navorsingsontwerp is gebruik. Die afhanklike veranderlikes was seksuele opwekbaarheid, seksuele inligting, subjektiewe seksuele ervaring, seksuele dryfveersterkte, seksuele fantasering, seksuele bevrediging, globale seksuele bevrediging, frekwensie van vroulike anorgasmie, aanvaarding van vroulikheid, ervaring van seksuele genieting en die aanvaarding van die lewensmaat. Hierdie afhanlike veranderlikes is getaksereer deur die Sexual Arousability Inventory, die Derogatis Sexual Functioning Inventory en die Sexual Interaction Inventory. Proefpersoone het hierdie instrumente vol toooi en is daarna aan h agt-weke ingreep onderwerp, waarna hulle weer getaksereer is. Ten einde aan die vereistes van h Solomon viergroep ontwerp te voldoen is een van eksperimentele groepe nie aan h voortoets onderwerp nie ten einde vas te stel of die takserings h effek sou vertoon op die uitkoms van verandering op hierdie ingreep.

Die essensiële hipotese was dat die Premiumtarief-telefooninligtingsdiens en biblioterapeutiese intervensie sou lei tot h verbetering in seksuele funksionering soos getaksereer deur die veranderlike afhanklikes. Daar was gehipotetiseer dat hierdie telefooninligtingsdiens nie net tot h verbetering in die afhanklike veranderlikes sou lei nie maar dat dit h groter hoeveelheid verbeterings sal vertoon in vergelyking met die biblioterapeutiese groep en die kontrolegroep.
Die inligting hierdeur gekry is onderwerp aan meer veranderlike, en enkele veranderlike statistiese analises.

Oor die algemeen was daar geen globale verskille tussen die groepe nie, wat aangetoon het dat die ingrepe minder kragtig was as wat gehipotetiseer was. Waanneer voormetings van afhanklike veranderlikes statisties beheer is, was daar bepaalde veranderinge te wyte aan die ingreep aangetoon. In die breë is daar gevind dat die Premiumtarief-telefooninligtingsdiens h bepaalde verbetering op sekere areas van seksuele funksionering veroorsaak het. Hierdie verbetering ten opsigte van bepaalde afhanklike veranderlikes is ondersteun deur subjektiewe verslaggewing ten opsigte van persoonlike ervaring van seksualiteit.

Hierdie studie het duidelik aangetoon dat daar h behoefte bestaan vir die instel van h Premiumtelefoonodiens ingrepe en toon onomstootlik aan dat hierdie hulpmiddens in die toekoms bepaalde voordele vir die bevolking as geheel sal inhoud van h goedkoper verskaffing van h geestesgesondheidsdiens.
CHAPTER 1

INTRODUCTION AND REVIEW OF THE LITERATURE

1.1 Introduction

In South Africa there has been a proliferation of so-called Premium Rate Service (PRS) "sexual advice lines". The PRS phenomena, new to South Africa, started over 12 years ago in the United States of America. Today, many countries worldwide make use of such a service. Although certain countries offer "clinical" sexual advice lines, compared to the more frequently encountered "sleaze" or "porn" lines, it is evident from a review of the literature that none have been scientifically and empirically validated (Davis, 1992; LoPiccolo, 1992; Whipple, 1992a).

In South Africa the emergence of these sexual advice lines operated on the PRS system has been met with a mixed response. Certain reservations have been expressed regarding the outrageous claims made by the so-called "experts" offering these sexual advice services. Their qualifications, their clinical and theoretical knowledge and experience working in the field have all been questioned (London Times, 1992; Sunday Star, 1991). Furthermore, no scientific evidence is available to back up their claims as to what is being offered and what can be achieved.

This indicates a serious and urgent need to conduct a study to assess both the need and effectiveness of a PRS Sexual Self-help Programme.

The aim of the present study was as follows: Firstly, to establish a "professional" adult sexual self-help service to be run on the PRS system. The information to be offered on this service, would be supplied by "Dr. Paul", a practising clinical psychologist/sexologist. By monitoring call volumes to the service, the need for such a service would be assessed over the initial six-month period.
Secondly, the effectiveness of such a service for sexual dysfunction would be assessed in a scientific and empirical manner.

Today, the availability of various self-help programmes, whether in books and manuals, audiocassettes or videotapes is widespread. These cover a wide variety of currently popular techniques and topics, eg., from anxiety and stress management (Girdano and Everly, 1986) to sleep disorders (Coates and Thoreson, 1977) and eating disorders (Kano, 1985; Orbach, 1988).

In the area of sexual dysfunction numerous self-help or "how-to" manuals and books are available to the general public (eg. Barbach, 1984; Heiman et al, 1976; McCarthy & McCarthy, 1984; Nowinski, 1988; Stoppard, 1991; Swift, 1993; Westheimer, 1986; Williams, 1988; Zilbergeld, 1978). Some of these describe highly credible therapy programmes based on treatment that has shown to be effective, whilst others have been written by therapists working in the field without having tested the effectiveness of their self-help programmes.

The vast majority of the self-help programmes remain untested. Already back in 1976, Rosen expressed concern over the possible risks involved with the self-administered programmes which had not been adequately validated (Rosen, 1976).

Owing to the fact that some of these programmes may in fact be ineffective or perhaps even harmful, there was a need for some professional control or regulation regarding the content of self-help manuals and books.

In 1978 the American Psychological Association (APA) Task Force on Self-help Therapies was set up. They made various recommendations regarding self-help books. They set
various guidelines governing self-help therapies, in an attempt to establish some control and to set professional standards.

Fifteen years later it would appear that these recommendations and guidelines set by the APA Task Force have largely gone unheeded. One just needs to look at the vast self-help industry that has emerged, in various formats, eg. books, audiocassettes, videotapes, radio and television talk shows, computer-based programmes - most of which remain untested and lacking in empirical validation.

Moreover, self-help books have taken on an important role in the practice of psychotherapy (Pardeck, 1990; Riordan and Wilson, 1989). Many psychologists recommend various self-help books to be used as an adjunct to the actual therapy (Althof and Kingsberg, 1992; Starker, 1988b). Despite the proliferation of these untested "do-it-yourself" books, it is clearly evident that they do play an important role in our present "popular psychology culture".

Over the past 20 years the field of sex therapy has also changed dramatically. Today sex therapy is a well accepted treatment modality for many different sexual problems. Previously sexual problems were treated by traditional insight-orientated therapy (Henersey, 1988). Masters and Johnson's (1970) publication of Human Sexual Inadequacy markedly changed the approach to the treatment of sexual problems. They introduced a relatively brief, symptoms orientated approach - indeed at the time, a completely untraditional mode for the treatment of sexual problems.

Today specific therapeutic components are offered in "sex therapy packages", for example, correcting deficits in information on sexual anatomy and physiology, sensate focus exercises, directive masturbation, systematic desensitisation and communication skills, to mention but a few. The techniques and formats that are available, and which are used by therapists, are wide ranging.
The limitations of various "sex therapy treatment packages" has been well documented (Kilmann and Mills, 1983; LoPiccolo and Stock, 1986). It is clear that sex therapy, for many, is complex and is not the panacea as had previously been expected (Zilbergeld and Evans, 1980). Levay (1983) claimed that the unmodified Masters and Johnson's approach may be applicable to only 20% of the current patient population.

Over the years there has been a trend towards an integrated approach in treating sexual problems - particularly the complex sexual problems, including disorders of sexual desire (Greenspan, 1975; Kaplan, 1974; Sollod, 1988; Wachtel, 1977). This approach has gained widespread acceptance largely owing to the fact that many of the limitations of the Masters and Johnson's approach, as well as the traditional sex therapy approaches, can be overcome.

Female orgasmic dysfunction is one of the most common difficulties presented to sex therapists and to sex clinics (Derogatis et al, 1986; Frank et al, 1976; Hite, 1976; Kaplan, 1974; Renshaw, 1988).

In the 1970's and early 1980's, a vast amount of research took place, examining the reasons contributing to female orgasmic dysfunction as well as the development of various treatment approaches to deal with this difficulty.

Numerous reasons that contributed towards the problem of female orgasmic dysfunction include, simple lack of adequate information to negative sexual attitudes and pervasive psychological disturbance (Darling et al, 1991b; Fisher, 1973; Klein-Graber and Graber, 1975).

Today cognitive-behavioural approaches in the treatment of female sexual dysfunction have been shown to be effective (Darling et al, 1991a; Fichten et al, 1986; Heiman and LoPiccolo, 1988; LoPiccolo and Stock, 1986).
Specific techniques that are included in this broad approach include the following: systematic desensitisation (Husted, 1975; Sotile and Kilman, 1977), directed masturbation (Lobitz and LoPiccolo, 1972; LoPiccolo and Lobitz, 1972), and group procedures (Barbach, 1974; Barbach and Flaherty, 1980).

In addition, self-help or bibliotherapy approaches in the treatment of female orgasmic dysfunction have also been shown to be effective (Dodge et al, 1982; Heiman et al, 1976; Libman et al, 1984; Morokoff and LoPiccolo, 1986).

As can be seen, the current status of sex therapy has changed dramatically when compared to treatment approaches available many years ago. Today sex therapists have a wide range of therapeutic techniques available - to help numerous individuals experiencing sexual dysfunction.

The question now arises: Can the Premium Rate Telephone Service sexual self-help lines be regarded as a valid form of "self-help therapy"? Furthermore, could this form of intervention be regarded as a new and innovative cognitive-behaviourally orientated approach to treating various sexual dysfunctions?

In order to answer these questions, it would first be necessary to analyse some aspects of self-help programmes and bibliotherapy, the scope and effectiveness of sex therapy and the treatment of female orgasmic dysfunction.

1.2 Self-help Programmes and Bibliotherapy

1.2.1 Overview

The term bibliotherapy in its broadest sense refers to the use of any literary work, including fiction, in the treatment of physical or emotional problems (Glasgow and Rosen, 1978). An important dimension of bibliotherapeutic materials includes self-help treatment programmes that give
readers specific instructions to carry out therapeutic procedures.

Today the availability of self-help books and "how-to" programmes is immense. These self-help books cover a wide variety of currently popular psychological techniques and topics. For example, Anxiety and Stress Management: (Benson, 1975; Breton, 1986; Girdano and Everly, 1986; Weiner, 1986); Assertiveness and Social Skills Training: (Bolton, 1986; Bramsen, 1988; Phelps and Austin, 1987); Depression: (Burns, 1989; Madow, 1988; Powell, 1989; Preston, 1989); Eating Disorders and Weight Concerns: (Freedman, 1989; Hall and Cohn, 1986; Hirschmann and Munter, 1989; Kano, 1985; Orbach, 1988); Alcohol and Drug Problems: (Mueller and Ketchman, 1987; Rosellini and Warden, 1985); Relationship Problems: (Kritsberg, 1989; Miller, 1989; Prather and Prather, 1988); Parenting Skills: (Becker, 1971; Gordon, 1975); Divorce: (Ahrons and Rodgers, 1989; Fisher, 1981; Krawitz, 1987); Sleep Disorders: (Maxmen, 1981; Thoresen and Coates, 1977); and Smoking Control: (McKean, 1987). [The above is based on Quackenbush (1991)].

Over the years, there has been a noted trend for behaviourally-orientated therapists to translate or record their treatment procedures into written self-help manuals. In addition to written behavioural programmes, self-directed videos and audio programmes as well as television programmes of behaviour treatments, have been developed (Mikulas, 1976).

Behaviour therapy manuals have been applied with varying degrees of therapeutic contact, for example:-

1) The Self-Administered Format:
Here a written programme constitutes the sole basis for treatment. Clients administer treatment with no therapeutic contact. In other words, they assume full responsibility for completion of the programme.
2) Minimal Contact Format:
Here the client relies primarily on a written programme or manual. Although there may be therapist contact, usually this is kept to a minimum. This contact could be in the form of phone calls, mail correspondence or infrequent sessions (Lowe and Mikulas, 1976; Trudel and Proulx, 1987; Zeis, 1978).

3) Therapist Administered Format:
Here clients have regular contact with a therapist. Sessions focus on clarifying or elaborating the information presented in a self-help guide or manual (Heiman et al, 1976; Heiman and LoPiccolo, 1988).

Riordan & Wilson (1989) claim that behaviourally based reading material generally meet at least minimal empirical validation. When non-behavioural programmes are considered, the situation becomes even more complex. There are literally thousands of self-help or self-improvement books available today.

Rosen (1976) expressed concern over the proliferation of these untested, do-it-yourself treatment books. It was the possibility of the risks involved when self-administering therapeutic instructions, that prompted his concern. He noted that behavioural techniques were being marketed as do-it-yourself therapies. These had been marketed without adequate validation under self-administered conditions.

Consequently, consumers ran the risk of purchasing treatment programmes that may be ineffective or harmful when used on a totally non-prescription basis (Rosen, 1976).

Rosen (1976) also added that such do-it-yourself books were there to make money, in other words for financial gain for the author, and that consumers ran the risk of purchasing ineffective or potentially harmful programmes.
All of this prompted Rosen to suggest that the American Psychological Association (APA) establish a committee to investigate self-administered behaviour therapies. The problem with this, was clearly, that if the APA committee were to check out under specific conditions the claims of the authors, there was no guarantee of similarity of conditions in practice. Can those holding non behaviourist methods ethically sanction their own professional organisation? Psychologists of different persuasions would find this problematic because there would be the problem as to who would do the sanctioning.

Rosen (1976) suggested that the designation of certain programmes as professionally approved, may introduce a desirable element into the market. Economic considerations which govern publishers would also be affected. He claimed that effective programmes that can be purchased in book stores and that were totally self-administered, may very well eliminate the necessity of professional treatment. To some extent, they do already. Books on dieting, exercise, child management, popular psychology and so on, probably owe some of their popularity to their effectiveness - with some people (Rosen and Fox, 1977).

Goldiamond (1976) in response to Rosen’s argument, pointed out that it was unfair to single out behavioural treatments in this regard. In truth, self-administered books had appeared in virtually every applied area of psychology and were marketed as opposed to validated. Whilst Rosen called for some professional oversight or regulation of self-help, Goldiamond was content to let the public decide on the merits of these works.

Largely due to Rosen’s insistence and in response to the failure of psychologists to review adequately do-it-yourself treatment books, a task force on self-help therapies, sponsored by the American Psychological
Association, was set up.

The APA Task Force on Self-Help Therapies (1978) concluded that psychologists were in an unique position to contribute towards a self-help movement. The Task Force outlined the following principles with regard to self-help therapies:

1) "Self-help therapies can help people to understand themselves and may provide one of the most effective, instructional modalities for promoting human welfare. However, psychologists bear a heavy professional responsibility in developing such programmes. This is particularly the case in light of the influence that psychologists have on the behaviours of others".

2) "The quality of self-help therapies that are developed by psychologists should meet recognised standards as in the case of all therapeutic modalities".

3) "The development of self-help therapies should not be compromised by financial pressures or other factors. Public statements, announcements or promotional activities pertaining to a commercially published self-help book should be informative. Sensationalism is to be avoided in such statements. The limitations as well as the benefits of a self-help therapy should be clearly stated" (APA Task Force on Self-Help Therapies, 1978. Reported by Rosen, 1987 p.49).

The APA Task Force on Self-help Therapies (1978) noted that properly developed programmes, accompanied with accurate claims, have great potential for helping individuals to understand themselves and others to promote human welfare through the amelioration of emotional and behavioural problems.

These programmes are able to reach large numbers of individuals on an extremely cost efficient basis. The programmes can help individuals to maintain their autonomy
and individuality by decreasing reliance upon professionals. Self-help programmes can also serve important educational and preventative functions.

Rosen (1987) comments on the fact that the APA also made the following suggestion: "The Journal of Contemporary Psychology may wish to consider a special section devoted to the review of self-help therapies. These reviews would be expected to be data based and could meet a set of standards developed by the Journal editors" (p.50).

Rosen (1987) gave certain guidelines for such reviews of self-help programmes in terms of the APA recommendations:

1) What claims exist in the title or contents of the book that define the text as a do-it-yourself treatment programme?

2) Has the author attempted to convey accurate information regarding empirical support for the programme? Has the author determined if readers develop accurate expectations?

3) Does the book provide a basis for self-diagnosis? Have the methods for self-diagnosis been evaluated to establish rates of false positives or false negatives?

4) Have the techniques in the book received empirical support?

5) Has the book itself been tested in its clinical efficacy?

6) Under what conditions of usage have the tests been constructed?

According to Rosen (1981; 1987) an involvement of psychologists in the development and assessment as well as the marketing of do-it-yourself treatment programmes has
often been less than responsible. Psychologists have published untested material, made exaggerated claims and accepted the use of misleading titles that encourage unrealistic expectations regarding outcome.

Even more discouraging for Rosen was the fact that the quality of do-it-yourself treatment books was decreasing while manuals were on the increase. According to Rosen (1981), "little care has been taken to evaluate do-it-yourself treatment books, the titles and claims that accompany these books have been incredible if not outrageous" (p. 189).

Rosen (1987) asserts that although self-help books may be beneficial, certain risks should not be overlooked. For example, do-it-yourself therapies may be applied inappropriately. Subsequent to diagnosis, there is the possibility that an individual could misunderstand instructions or fail to comply fully with the therapeutic programmes and instructions. Furthermore he says "no other professional group combines a clinical and research experiences that form the educational background of a clinical psychologist. In addition, they are in a position to assess do-it-yourself treatment systematically and to educate consumers in the proper use of these programmes" (p. 46).

Psychologists who provide self-help programmes to the public seem to be making a beneficial contribution. As George Miller stated "give Psychology away" (Miller, 1969, p. 1074). Rosen (1987) contends that what Miller was in fact saying, is that it was the social responsibility of psychologists to learn how to help people help themselves. He claims, that these do-it-yourself treatment books are representative of a general decline in the standards applied by psychologists to the development and marketing of self-help materials.
Millions of people worldwide regularly look to self-help books for advice on matters such as diet, exercise, cholesterol control, sleeping disorders, sexuality, relaxation, stress management, personal growth, parenting skills, self analysis, divorce and separation, family problems, academic problems, study skills, time management, career development, womens' and mens' issues, minority concerns, anxiety and stress management, obsessive compulsive tendencies, assertiveness and social skills, anger management, grief and loss, eating disorders, weight concerns and weight management, alcohol and drug problems, child abuse and so on (Quackenbush, 1991).

Little is known about the value of such do-it-yourself books. It is evident that the principles as outlined by the APA Task Force (1978) are clearly being violated. Rosen (1987) asserts that it is now time for psychologists to re-examine their contribution to the development and marketing of self-help materials. The failure of psychologists to see to it that proper development and marketing of self-help treatment programmes should not detract from the important role these programmes can play in meeting public health needs.

In the years since Rosen and Goldiamond debated the self-help phenomena, there has been no noticeable lessening in the publication of self-help books. As Starker (1988b) comments "self-help books, then, has come to occupy a prominent niche in our culture and its role in health care can no longer be ignored" (p.143).

Starker's (1988) findings suggested that self-help books have assumed a little documented but increasingly important role in the practice of clinical psychology. Some important questions still remain. Does the prescription of self-help works indicate the increasing recognition of patient responsibility in the treatment process, or does it represent "the progressive bankruptcy of our treatment offerings?" (Starker, 1988b, p.145).
Over the past decade or so, we are witnessing the emergence of "media therapists". Can radio and television talk shows be effective and in what way are they affecting individuals? What about the possible harm and the possible benefit? These programmes also need to be empirically evaluated to assess their impact.

There has also been a proliferation of audiocassettes claiming to teach relaxation techniques, smoking control, weight loss, sexual enhancement and so on. Over the past decade, self-help video programmes have also gained prominence. The latest trend is computer based self-help programmes. For example, the Sexpert programme (Binik et al, 1989). In addition to the computer system programme, the Premium Rate Telephone Service is relatively new and is an additional self-help medium which now also needs to be empirically evaluated.

Rosen (1987) asserts that psychologists and psychiatrists have a shared interest in preserving the integrity of their professions and the integrity of psychotherapy. Miller (1969) had encouraged psychologists to learn how to help people help themselves, implying the systematic development and assessment of effective self-help methods, not the frantic rush to publish that has characterised psychologists more recently (Rosen, 1987).

Glasgow and Rosen (1978) reviewed 75 self-help manuals, published over a five year period which offered specific self-administered treatments for obesity, phobias, smoking, sexual dysfunction, lack of assertiveness and child behavioural problems. Very few had been tested in the self-selected, self-administered mode.

Although many self-help therapies can be effective, and they offer tremendous potential, they clearly do not help everyone (Glasgow and Rosen, 1978). Extensive validation work is needed before treatment manuals can be used with confidence.
The following suggestions regarding self-help programmes were made by Glasgow and Rosen (1978):

1. Investigators should agree on common definitions for such terms as self-administered, minimal contact and therapist administered.

2. Subjects should be recruited and treated in a manner that is compatible with the treatment being offered.

3. The relevant and effective components of current self-help programmes have generally not been identified. Attempts to clarify such process issues are particularly important when component programmes are used.

4. Research on maintaining subjects' participation in self-help programmes is clearly needed because subjects frequently drop out of treatment or fail to follow through on assigned procedures.

5. Studies should include cost effectiveness indications so that the relative efficacy of self-help and therapist-directed programmes can be assessed.

6. Issues of maintenance and generalisation of treatment effects require the inclusion of follow-up assessment in future published studies.

Rosen (1987) claimed that self-help books are generally deficient in the areas of diagnosis monitoring and compliance, as well as lacking individual follow-up. Over the years he has consistently called for greater research to evaluate the effectiveness of self-help books (Starker, 1988a). Looking at the situation today it is clear that what they had hoped for, has not been achieved.

As noted by Goldiamond (1976) it is not only behavioural self-help programmes which fail to offer validation. Self-
help books in all areas of psychology provide readers help with their problems and the vast majority lack any attempt at validation.

Concern has been expressed from time to time regarding the potential harm done by psychological self-help books (Halliday, 1991). Given the potential for harm from psychological self-help books, as perceived by professionals, what is the role and extent of harm as perceived by clients? Halliday (1991) in a study, looked at the perceived harm and benefits of psychological self-help or self-improvement books. Subjects were 100 adult psychotherapy patients who described their use of self-help books. Only four reported mild harm or distress. 86% reported improved benefit without harm. His study showed that the reported harm and distress appeared to be minimal. Most people reported some benefit.

Starker (1986) in a preliminary investigation of self-help consumers, psychologists and psychiatrists, found highly positive attitudes regarding self-help works. Not one psychologist surveyed considered these to be generally harmful or unhelpful and more than 88% reported prescribing self-help books to supplement their treatment. A follow-up survey carried out by Starker (1988a) examined the attitudes, experiences and prescriptive practices regarding self-help books amongst psychologists. Results confirmed earlier findings i.e. that most psychologists considered the self-help books to be helpful and over 60% of those questioned, prescribed self-help books and manuals to patients. Although his sample was small and confined to a specific demographic location, it seems clear that many practising psychologists are reading self-help books and are prescribing them to patients, although these may not all be professional in design (Starker, 1988a).

Furthermore, from the literature, it appears that self-help books have taken an important place in the practice of psychotherapy (Riordan and Wilson, 1989).
Self-help titles are by and large, unproven advice on matters of considerable importance and complexity. Questions have been raised as to whether psychologists have "sold out" their professional values and abandoned their scientific standards in favour of popular psychology (Starker, 1988a).

Are psychologists reading popularised works as opposed to research literature? This seems unlikely. The studies undertaken by Glasgow and Rosen (1978) and Starker (1986a) are exploratory and do not allow for definite answers to this question. It may well be that psychologists prescribing self-help books have very limited goals in mind. Self-help books may be seen as an aid to involving clients more actively in the treatment process (Lenkowsky, 1987; Pardeck, 1990; Riordan and Wilson, 1989).

These goals and practices reflect a rational-educational approach to treatment which has emerged in the last two decades to challenge the psychodynamic perspective.

According to psychodynamic theory, prescribing anything, whether it be drugs, activities or books was seen as potentially damaging to the therapist-patient relationship. In fact, Starker (1988b) in his study found psychotherapists with a psychodynamic orientation, less inclined to prescribe self-help books. However, the general shift towards a cognitive-behavioural approach in psychotherapy, has left many psychotherapists free of such restraints. Suggesting reading various materials and books is now considered quite normal and legitimate as any behavioural or cognitive prescription.

The vast majority of self-help books are self-selected and self-applied. Only a small percentage are prescribed by psychotherapists. There appears to be a very real and genuine need for psychological understanding and knowledge for what psychologists and sexologists write in books or present in other media (Halliday, 1991; Starker, 1988a).
Although not all self-help books are written by psychologists, it does not mean that non-professionals writing these books cannot be helpful.

In keeping with developments in the behaviour therapy literature (Rosen, 1982), some investigators have explored the effects of self-help and minimal therapist contact bibliotherapy programmes in the treatment of sexual dysfunction.

An uncontrolled study of no-therapist contact bibliotherapy for mixed sexual dysfunction was conducted by Kass and Strauss (1975). They concluded that a behavioural sex therapy programme in written format was effective for those couples who followed the programme, at least in the short term.

However, data was not systematically collected, outcome criteria were unclear and the drop-out rate was considerable—19 out of an original 30 couples.

In a component analysis study of sex therapy for erectile problems, Takefman and Brender (1984) found in a sample of 16 couples, that a four week minimal therapist contact treatment resulted in significant improvements pre to post therapy.

In a comparison of treated and untreated waiting-list control subjects, Lowe and Mikulas (1978) assessed the effects of a bibliotherapy programme plus twice weekly telephonic contact with a therapist in a sample of 10 couples, where the presenting problem was premature ejaculation. Their results indicated significant improvements in treatment couples compared with waiting-list controls. However, their sample was very small (five per condition). Their programme lasted an average of only three weeks. The measure of improvement was a time estimate by the male only of latency to ejaculation and no follow-up data were reported.
The comparative effectiveness of individual couple therapy, minimal therapist contact (six minutes per week telephone contact) and no-therapist contact bibliotherapy was investigated by Zeiss (1978). In his sample of 18 couples presenting with premature ejaculation, 12 to 20 weeks of bibliotherapy plus minimal therapist contact was almost as effective as in individual couple treatment. No-therapist contact bibliotherapy, however, was totally ineffective.

More recently, Trudel and Proulx (1987) reported treating premature ejaculation successfully under minimal therapist contact conditions.

1.2.2 Bibliotherapy For Sexual Problems

Sexual advice books and manuals have been in existence for many years. As far back as 1930, Van der Velde wrote a sex manual called *Ideal Marriage*.

Some of these describe highly credible therapy programmes, often based on treatment shown to be effective when delivered via individual or couple therapy, but how effective, and perhaps more important, how harmful are such programmes without therapist supervision or with minimal therapist supervision? (Fisher, 1984).

Today there is an abundance of sexual advice books and manuals that can be purchased by the public. (For example Carnes, 1985; Hodson and Hooper, 1991; Kitzinger, 1983; Knopf and Seiler, 1990; Kramer and Dunaway, 1991; McCarthy and McCarthy, 1991; Nowinski, 1988; Raley, 1985; Silber, 1981; Stoppard, 1991; Swift, 1993; Westheimer, 1986; Westheimer and Lieberman, 1991 and Williams, 1988). Although many make great claims as to what the individual can expect to achieve, very few have been validated.

Patients often ask therapists to recommend books relevant to the sexual or marital problems for which they seek help (Althof and Kingsburg, 1992). They claim that reading may
help patients to:
1) Feel less alone, stigmatised and helpless about their problems;
2) Develop a better understanding as to the way a problem developed;
3) Learn about sexual function and how it can be compromised;
4) Give permission to experiment with new sexual behaviours or communication patterns;
5) Offer treatments and suggestions;
6) Supplement information learnt during psychotherapy.

Althof and Kingsberg (1992) compiled a list of books helpful to patients with sexual and marital problems. Owing to the fact the psychologists and professionals do not have the time to review all books available, the authors were often unknown and no further information about them was available. Very often patients ask for these materials of popular works. Due to this response Althof and Kingsberg (1992) drew up an updated bibliography. (See Althof and Kingsberg, 1992 for the comprehensive bibliography).

Specific programmes have also been developed for the treatment of female orgasmic dysfunction (Barbach, 1975; Heiman et al, 1976; Klein-Graber and Graber, 1975); and general sexual dysfunctions (Hawton, 1985; Williams, 1988).

Other programmes primarily written for professionals could potentially be used by non-professionals on a self-administered basis (Kaplan, 1974; Kaplan, 1979; Masters et al, 1982).

Unlike many of the self-help sexuality books that overemphasize sexual variations and performance, the most useful sex literature attempts to:
1) Provide information
2) Set reasonable expectations
3) Reduce the negative emotional states of anxiety, guilt and anger
4) Establish guidelines for functional communication and stimulation techniques (McCarthy and Perkin, 1988).


It is unfortunate that self-help therapy books have not been adequately assessed. It may be possible that the advice and instructions set out in certain manuals could increase behavioural complaints (Glasgow and Rosen, 1978). Glasgow and Rosen (1978) go on to say that Barbach (1975) advised women with inhibitions about masturbation, to prolong self-stimulation and experience exaggerated reactions. This advice is based on a flooding strategy to reduce anxiety.

Yet there is no evidence to demonstrate that individuals can successfully self-administer procedures based on prolonged exposure. Should the strategy not be successful, a reader could become sensitised and this could lead to her inhibitions being made worse.

The actual studies of Barbach (1974) and Barbach and Flaherty (1980) do not support Glasgow and Rosen’s (1978) concern. Moreover, from the research literature, Barbach’s (1974) programme seems to one of the most popular, successful and widely applied in the field of treating female orgasmic dysfunction.

Glasgow and Rosen (1978) state "it is hoped that future authors of self-help sex therapies will follow a
conservative and empirical approach in developing their programmes" (p.18).

Looking at the abundance of sex therapy manuals that are available today, this obviously is not the case. It would now be important to review the scope and effectiveness of sex therapy and then review the nature and treatment of female orgasmic dysfunction.

1.3 The Scope & Effectiveness of Sex Therapy

1.3.1 Overview

The field of sex therapy has grown and changed remarkably during the past decade. The issues and treatment approaches dominating the practice of sex therapy today, are different from those that concerned theorists and clinicians ten to fifteen years ago (Leiblum and Rosen, 1989). Approaches to assessment and treatment have become increasingly sophisticated and comprehensive. Sex therapy has become a well accepted treatment modality for many problems that up to now had been dealt with by traditional insight-orientated therapy (Sollod, 1988).

It would appear that today there is a return focus to longer marriages and to work out how to maintain sexual excitement and interest over a lengthy, monogamous period, and to handle creatively problems of reduced sexual desire. The presence of Aids has also directly and indirectly influenced many aspects of treatment (Leiblum and Rosen, 1989).

The increasing medicalisation of sex therapy, a trend commencing in the late 1970's continues today. Pharmacological and surgical interventions are also becoming more popular. Sex therapy has also profited from the explosion in medical and psychological information. Gynaecology, endocrinology, urology, psychiatry, social work, education, anatomy, sociology and other disciplines
have contributed to the field and to our present understanding of sexual behaviour (Leiblum and Rosen, 1989).

Leiblum and Rosen (1989) list four major trends that have characterised sex therapy over the past decade:

1) A trend towards greater medicalisation, and the appreciation of the role of biological factors and sexual dysfunctions.

2) An increasing emphasis on pharmacological intervention, particularly in the treatment of erectile dysfunctions as well as for other sexual dysfunctions.

3) Greater attention to the dilemmas posed by desire disorders, and inhibitions in the experience and expression of sexual interest.

4) A therapeutic focus that relies more on interpersonal and systems concepts and theories.

The prevailing psychotherapeutic approach to the treatment of sexual dysfunction was markedly changed by the 1970 publication of Masters and Johnson's *Human Sexual Inadequacy*. Prior to Masters and Johnson, a small number of non-analytic clinicians were reporting effective therapy results (Erickson, 1958; Lazarus, 1963; Semans, 1956; Wolpe, 1958). Owing to the small number of cases and the novelty of their methods, they did not receive wide acceptance and publicity (Zilbergeld and Kilman, 1984). With the exception of a few behavioural therapists, the field was dominated previously by a psychodynamic long term insight-orientated approach. Masters and Johnson's programme which focused on short-term, directive, action-orientated therapy, produced outcome statistics that for the first time offered promise of a rapid, highly effective treatment.

Although most sex therapists have in common a concern with changing overt behaviour, a tendency for brief therapy, and to be directive and give homework assignments, they are
also influenced by a number of other therapeutic orientations including behaviour therapy (Wilson, 1982); psychoanalysis (Kaplan, 1974); hypnosis (Araoz, 1982) and systems approaches (Sager, 1976).

There are also a number of different treatment formats, namely couples, individual and group; the involvement of one or more therapists; time-limited or open-ended programmes; different spacing of sessions from daily to once or twice a week, to once or twice a month. The use of surrogate partners, despite all the publicity, is generally rare.

The term "sex therapy" refers to the relatively brief directive, symptoms orientated approach; based in one way or another on the works of various pioneers like Ellis (1966); Kaplan (1974); Lazarus (1963); Masters and Johnson (1970); Semans (1956); Wolpe (1958) - regardless of format, frequency of sessions, number of therapists or specific technique.

Sex therapy has proven itself to be effective with various sexual dysfunctions with which the traditional therapies often did not succeed. LoPiccolo and Friedman (1988) noted that a change in the characteristics of sex therapy occurred during the 1970’s. In the early 1970’s, most couples seeking sex therapy were basically very naive about sex. For those individuals, sex education and training was largely appropriate. Today this has changed (LoPiccolo and Friedman, 1988). Desire disorders are presenting more frequently. Treatment for these problems is generally more complex (Beck and Barlow, 1984). Sex therapy is not a panacea. It does help a large proportion of clients improve their sexual functioning but, it does not help everyone (Zilbergeld & Kilman, 1983).
1.3.2  Sex Therapy: Prior to Masters and Johnson

Prior to the pioneering work of Masters and Johnson (1970), the major psychotherapeutic approach to sexual dysfunction was psychoanalytic. In this approach, the sexual dysfunctions were seen within the framework of Freudian and other psychodynamic theories, as being caused by deep-seated developmental problems or by unconscious conflicts.

In either event, the sexual dysfunction was viewed not as the problem to be addressed, per se, but rather as a symptom of a more pervasive disorder. Sexual difficulties were viewed as being indicative of longstanding psychopathology and therapy focused on resolution of intrapsychic conflicts. Symptomatic improvement without indication of more fundamental changes in personality make-up or in individual psychodynamics, was viewed suspiciously within this conceptual framework (Crown and D’Ardenne, 1982; Hott, 1974; Pryde and Woods, 1985).

Psychodynamic therapy conducted with individuals or with partners concurrently did not produce good results with sex problems and the length of treatment was exceptionally long (Kaplan, 1979).

In addition, psychoanalytic theorising was not congenial to the treatment of female sexual dysfunction because there was a devaluation of orgasms that were attained in whole or in part through clitoral stimulation (Barbach, 1980; Fisher, 1973).

The psychoanalytic view of sexual dysfunction as indicative of a more profound problem contributed to the intense concern and sense of helplessness that an individual with a sexual dysfunction might often have experienced.
Masters and Johnson for close on twenty years studied the sexual behaviour of men and women under scientific laboratory conditions. They observed and recorded approximately 14,000 sexual acts (Kaplan, 1974).

Their observations included a wide spectrum of sexual behaviour under every imaginable condition. These studies finally yielded an accurate picture of the basic psychophysiology of human reproductive functioning. This included the following:

1) Clinicians were provided with a framework within which to conceive the sequence of the sex act, namely arousal, plateau, orgasm and resolution.

2) Certain sex differences were objectified as in the capacity of the female compared to the male for multiple orgasm.

3) Important details of sexual functioning became more empirical. For example, the psychoanalytic tendency to undervalue clitoral as apposed to vaginal orgasm was put in its correct perspective (Masters and Johnson, 1966).

Prior to 1970, little attention was paid to the interpersonal setting of the sexual behaviour. Generally the couple was not seen together. After Masters and Johnson (1970), this changed. Their basic premise was that sexual dysfunction was a "relationship problem". In 1970 Masters and Johnson published *Human Sexual Inadequacy* which was a landmark book, radically changing the manner in which sexual problems were conceptualised and treated. Masters and Johnson challenged the old psychodynamic view. They provided a new conceptual and clinical approach to the treatment of sexual difficulties.

Masters and Johnson (1970) looked at conscious factors including performance anxiety, spectatoting, lack of
knowledge, lack of skill, misinformation, negative attitudes and experiences, in dealing with sex. In general, the role of unconscious factors in the etiology and maintenance of a dysfunction was thought to be absent unless proven otherwise. The therapeutic approach was designed to minimize or bypass such factors even when present (Levay and Kagle, 1978).

The relationship as opposed to the individual was considered to be the patient. Marital discord was not considered a necessary component for the presence of sexual problems. Masters and Johnson developed a short-term therapy which required treatment of the relationship by a dual-sex co-therapy team on a daily basis for a two-week period. It was a multi-model approach which integrated behaviour therapy, learning therapy, and marital counselling. Sexual activity was divided into component parts and assigned a series of behaviours which the couple was instructed to engage in privately. The function of these exercises was to decrease anxiety and desensitise the couple who had previously experienced sexual activity as stressful, unpleasant or even painful. At the same time these exercises served as corrective emotional experiences for the couple and a new way of their being sexually related (Masters and Johnson, 1970).

In this therapy the co-therapists actively participated as role models for good communication, educators for new information and instructors in new sexual attitudes and behaviours.

The advent of Masters and Johnson brought a new direction for the treatment of sexual problems. Cure rates of 80% – 90% were reported with their techniques for treating couples (Masters and Johnson, 1970).

Therapists were initially optimistic and enthusiastic as they began to provide Masters and Johnson type sex therapy. Initial results likewise were largely favourable. With
adaptations and modifications a whole new description of "sex therapy" began to emerge with increasing elaboration and professionalisation over the years. There is no question that their treatment model represented a major contribution to the successful treatment of sexual dysfunction (Levay and Kagle, 1978).

Few therapists could convincingly challenge the results that Masters and Johnson achieved in their work. Erectile dysfunction, ejaculation problems and problems with orgasm were seemingly successfully resolved during an intensive two-week period with the assistance of the dual-sex therapy team and focus on re-learning, utilising sensate focus and other directive techniques, including education.

Experimental studies of sex therapy outcome have generally adapted Masters and Johnson’s approach and have evolved multi-faceted treatments variously labelled "directive sex therapy", "modified Masters and Johnson" or "sexual skills training" (Kaplan, 1984).

Treatment programmes generally are designed to alter etiological factors presumed to be causing or maintaining the dysfunction, such as sexual ignorance, conflicts, anxiety, ineffectual sexual technique and communication difficulties.

Specific therapeutic components in "sex therapy packages" incorporate a variety of techniques to deal with these problems. These include correcting deficits in knowledge, information on sexual anatomy and the nature of sexual responding is provided, myths and misconceptions related to sexual functioning are clarified and self and partner exploration is frequently recommended. To improve sexual skills, therapy programmes may assign sensate focus exercises, caressing exercises or directive masturbation. In order to reduce performance anxiety, relaxation training, systematic desensitisation, erotic readings, fantasy and a ban on problematic sexual acts, eg., sexual
intercourse, may form part of the therapy programme. Communication skills and assertiveness training are commonly included in sex therapy packages.

Occasionally, chemotherapy in the form of tranquillizers or hormones have been used, either alone or in conjunction with the components mentioned above. The techniques by which these therapeutic components are prescribed are wide ranging and may include verbal directions, modelling, role play, homework assignments, bibliotherapy, audiovisual materials, contracting and reinforcement of progress by the therapist. To add to this varied list, a number of specific techniques for a particular disorder may be included. For example, Kegel’s exercises for female orgasmic dysfunction (Kegel 1952; LoPiccolo and Lobitz, 1972), and the "squeeze" technique for premature ejaculation (Zeis, 1978).

Mode of therapy delivery also varies. Directive sex therapy might be carried out in the traditional individual or couple context, or via group therapy or bibliotherapy. Both spouses or only one partner might be present. The timing of the therapy sessions themselves may also vary. Sessions might be massed or spaced and the programme might be time-limited or continue until the goals of therapy have been realised.

Now, over two decades later, the optimism and excitement that surrounded Masters and Johnson’s initial findings have lessened. Their approach to the management of sex problems, which revolutionised the field and which is credited even by its critics (Levay and Kagle, 1978), has been subject to attacks on its effectiveness, range of application and even its scientific validity (LoPiccolo and Stock, 1986).

Few clinicians are claiming such great two-week cures especially for chronic problems. While published results have generally supported the effectiveness of sex therapy outcome, wide variations in success have been reported both
within and between diagnostic categories (Cole, 1985; Zilbergeld and Kilman, 1984).

None of Masters and Johnson’s (1970) "data" included any standardised test scores and objective quantifiable measurements of treatment effect on either the sexual and non-sexual aspects of the couple’s relationship. Limitations have been cited specifically with regard to couples with relationship difficulties and individuals with personal, psychological problems. A further criticism has been the generalisability of Masters and Johnson’s results. The patients were primarily well educated, affluent and highly motivated. The majority of their patients were treated by Masters and Johnson themselves. One could question the effectiveness of their techniques when used by other therapists who are not directly associated with Masters and Johnson’s expertise and who do not carry possible halo or positive expectation effects (LoPiccolo, 1980; Zilbergeld and Kilman, 1984).

Questions have also been raised, not only about the effectiveness and range of application of the traditional sex therapy but also its safety (Kaplan, 1987; Kilman and Mills, 1983; Levay, 1983). Specifically, it has been suggested that the intense feelings raised by unmodified sex therapy can, unless skilfully managed by the therapist, lead to overwhelming conflict and anxiety in the individual.

Levay (1983) goes so far as to say that without integration with other psychotherapies, the original unmodified Masters and Johnson’s approach may be applicable only to 20% of the current patient population. It would appear that unmodified sex therapy works well only with people who lack sexual information, who have difficulty in communicating with their partners about sexual matters and whose anxieties and sexual performance exist only on the conscious level, rather than being rooted in unconscious sexual and interpersonal conflicts.
In some couples, a complex of interrelated marital problems or unconscious individual conflicts or both, give rise to, and maintain the sexual problem and also impede the treatment, hence needing more long-term therapy, which was not advocated by Masters and Johnson. Treatment is often blocked, sabotaged or discontinued because of factors within a couple or within one or both of the individuals. Sex therapy alone cannot help a couple deal with marital problems that may be causing the presenting sexual dysfunction. The deep-seated individual problems that may be causing and even sustaining a sexual dysfunction can undermine symptomatic improvement and the treatment process itself (Levay and Kagle, 1978; Sager, 1976).

Hence from the literature, the emerging consensus is that while the Masters and Johnson’s contribution to the understanding and treatment of sex problems has been exceptional, the format of sex therapy they suggested does have its limitations, particularly as regards relationship and individual psychological issues (Hartman, 1983a; Hartman and Daley, 1983; Kilman et al, 1981).

1.3.4 Sex Therapy: Systems Approach

The association which generally exists between sexual and relationship issues in life and in therapy is important. The coexistence of sexual and marital problems in particular couples is common (Barker, 1984; Berg and Snyder, 1981; Elkaim, 1986; Frank et al, 1978; Hawton, 1985; Sager, 1976; Watson, 1984; Zimmer, 1987).

Systems theorists contributed a view of the marital unit in which sexual problems reflected the state of the relationship as a whole. They argued that to remedy the sex problems the relationship must be treated (Cole, 1979; Elkain, 1986; Sager, 1976).

According to Ables and Brandsma (1977), Arbes (1977) and Hawton (1985), it is very uncommon to find no relationship
problems in people with sexual dysfunction. The significance of relationship factors in the development and treatment of sexual dysfunction is strongly endorsed by those who believe in a systems approach. Evidence that sexual symptoms are frequently part of the marital interaction system have been reported by Cole et al (1979) and Kaplan (1987).

The significance of relationship issues, both in the development and in the treatment of sexual dysfunction, is widely recognised (Heiman, 1986; LoPiccolo and Hogan, 1979; Pryde and Woods, 1985; Watson, 1984; Zimmer, 1987).

It is reported that failure to resolve relationship issues can result in the failure of sex therapy (Kaplan, 1974; Kilman and Mills, 1983).

While sexual dysfunction and marital discord are frequently associated, they are not inevitably so (Hartman, 1983b, 1983; Hartman and Daly, 1983). They put forward the view that sexual functioning and overall relationship factors can operate independently of each other. In such cases, the sexual dysfunction can be treated in isolation from the general marital system by a directive approach and in such cases probably obtain good results. In deciding on a direction for treatment, the issue of evaluation of the relationship is central (Arbes, 1977; Cole, 1985; Elkaim, 1986; Hartman, 1983b; Hawton et al, 1986; Kaplan, 1988).

1.3.5 The Effectiveness of Sex Therapy

Despite the widespread growth of sex therapy as a valuable therapeutic strategy, its lasting effectiveness remains an open question.

Outcome and follow-up evaluations in the sexual therapy literature have technically been short-term, ranging from a few weeks to several months or one to several years post

Longer term evaluations, have been with small sample sizes or with a single diagnostic dysfunction (Chapman, 1968; Johnson, 1965; Obler, 1973).

The work of Masters and Johnson (1970) and that of Dekker and Everaerd (1983) are exceptions reporting not only longer follow-up, five to eight years respectively, but also evaluations of multiple diagnostic categories.

With the general criticism of Masters & Johnson's outcome statistics (Zilbergeld and Evans, 1980), clinicians and researchers alike are more carefully evaluating outcome research and calling for more stringent methodologies to measure treatment effects over longer periods of time (D'Amicis et al., 1985).

Today there is enough data from the studies and case reports to reach some conclusions as regards the effectiveness of sex therapy. Relatively new as it is, sex therapy has failed to live up to its expectations (Ansari, 1976; Levine and Agle, 1978). It has become apparent that many patients do not maintain the gains made in therapy and relapses are possible (D'Amicis et al., 1985; Hawton et al., 1986; Kilman et al., 1986; Levay and Kagle, 1978).

Levay and Kagle (1978) assessed 19 couples out of 35 who improved but returned for further treatment, following a standard Masters and Johnson sex therapy programme. They complained of deterioration of sexual functioning and failure to progress.

Reasons put forward for lack of progress included "too intense time frame" resulting in treatment overload, as well as the effects of relationship and intrapsychic issues which generally were ignored in the therapy.
Kilman and Mills (1983), reviewing the evidence for the effectiveness of sex therapy, observed that although sex therapy could have very beneficial effects, it is likely to be ineffective in producing long term change for many people, regardless of the problem.

It seems that brief sex therapy, works best for those sexual problems which have their roots in mild anxieties and conflicts that are relatively circumscribed. When there are more profound individual and marital difficulties, the standard approach may be both inappropriate and ineffective (Hawton et al, 1986; Kaplan, 1979; Levay, 1983; Levay and Kagle, 1978; Zilbergeld and Kilman, 1984). There is some evidence that sex therapy achieves an acceptable rate of success in the short term but there is very little evidence that such improvement is maintained in the long term (Cole, 1985). Hartman (1986) and D'Amicis et al (1985) found recurrence of sexual difficulties relatively common on long term follow-up. Three years after therapy, patients had regressed to near or below pre-therapy levels in their studies. However, In both of these studies, a general improvement in the level of satisfaction with the couples' sexual and marital relationship was found. Lack of desire in men and women had the poorest long term outcome and premature ejaculation, contrary to Masters and Johnson's claims, was also disappointing (LoPiccolo and Stock, 1986).

According to research reports, sex therapy is also most effective when dealing with women who have never had an orgasm. Studies have shown that between 70 - 100% of these women are able to achieve orgasm, usually through masturbation training, after eight to 15 sessions of therapy (Kilman, 1978; Kilman and Mills, 1983; Sotile and Kilman, 1977; Zilbergeld and Kilman, 1984).

The majority of successful clients learn to reach orgasm with partner stimulation. A small proportion are able to achieve orgasm during sexual intercourse without simultaneous manual stimulation of the clitoris.
The success rate of premature ejaculation in the short-term is also high, depending on the sample and criteria employed. Between 50% - 100% success rates are reported by clients in their ability to delay orgasm in sexual activity with a partner (Nowinski and LoPiccolo, 1979; Zeis, 1978; Zilbergeld and Kilman, 1984).

With erection problems the results range widely and are generally not as encouraging as the female orgasmic dysfunction and premature ejaculators. Studies indicate that anywhere from zero - 75% of men improve their ability to get and maintain erections after twenty or fewer sessions of therapy (LoPiccolo and Stock, 1986).

A similar range, zero - 75% success, is obtained for women who are secondary or situationally non-orgasmic (LoPiccolo and Stock, 1986).

Problems of desire disorder, desire discrepancies, deficient or excessive sexual interest have become more and more commonly encountered (Kilman et al, 1986; LoPiccolo and Friedman, 1988). The partners usually function well enough but have different sexual appetites or libidos - which they cannot resolve themselves. One partner usually feels deprived and the other is constantly pressured (Kaplan, 1979; Williams, 1988; Zilbergeld and Kilman, 1984).

Initially, presenting problems of inhibited sexual desire, challenged Masters and Johnson type formulations that emphasised performance anxiety and negative conditioning as the major deterrents to sexual expression. This has led to investigation into the psychodynamics and interpersonal aspects of these patients' lives i.e. patients whose sexual appetite seemed to be lacking.

This has led to the necessity for the more integrated approach to sex therapy. In other words, the biological,
intrapsychic and interpersonal determinants (Leiblum and Rosen, 1989).

Kaplan (1979) labelled this problem "inhibited sexual desire" while other therapists label this problem "desire discrepancies" (Zilbergeld and Ellison, 1980). Treatment methods for this condition vary considerably ranging from several years of psychoanalysis (Kaplan, 1979) to a combination of behavioural sex therapy and hormonal therapy (Carney et al, 1978). At present there is not enough information to draw firm conclusions as to treatment effectiveness. Kaplan (1979) states that results are less favourable because this problem and the issues involved are far more complex, compared to other dysfunctions.

The label of "desire problems" is applied in different ways and as a result there is little consensus regarding outcome. Rates from 25% - 95% success have been reported. It is not really known how effective sex therapists or any other therapists are in treating problems of sexual desire with any certainty (Kaplan, 1979; Zilbergeld and Ellison, 1980).

There is also insufficient data to say anything definitive about the outcome of treatment for two comparatively rare disorders, namely, ejaculatory inhibition i.e. the inability to ejaculate in the vagina; and dyspareunia i.e. painful sexual intercourse in women.

Case reports are usually of successes but controlled research is not widely reported (Cole, 1985; LoPiccolo and Stock, 1986). In addition, not much information and research studies concerning follow-up is available.

As regards follow-up studies, Zussman and Zussman (1977) found long-term relapses reported in 30% of the sample and another in 50% of successful clients (Levay and Kagle, 1978). On the other hand, Masters and Johnson reported an
almost non-existent relapse rate (Masters and Johnson, 1970). A three year follow-up study discovered widespread regression, even with premature ejaculation - a problem thought previously to be unlikely to relapse (Goldberg and D'Amicis, 1981).

A controlled study by Kilman et al (1983) found that significant pre to post-test treatment gains in orgasmic frequency and sexual harmony reported by 57 women with secondary orgasmic dysfunction and their partners became non-significant at a six month follow-up. Clearly a great deal more needs to be learnt about the long term effectiveness of sex therapy (Payn and Wakefield, 1982).

In evaluating the effectiveness of sex therapy, one needs to keep in mind that although words like "cure" and "resolution" are commonly found in the literature and frequently heard when therapists talk, the fact is that most of the improvement produced in therapy, falls far short of complete cure or resolution (Zilbergeld, 1983).

To summarise, it appears that brief sex therapy is generally effective in dealing with premature ejaculation and primary orgasmic dysfunction. Sex therapy is less effective with situational orgasmic dysfunction and erectile problems - but it seems to be at least as effective as any other method and usually in less time. Sex therapy often does effect more than just symptoms and overt behaviour.

For many clients, even some whose dysfunctions are subsequently improved, there are positive changes in sexual communication and satisfaction, decrease of sexual anxiety and in some cases improvement in marital adjustment (Kilman et al, 1983; Sotile and Kilman, 1978).

Controlled research has more recently begun to explore the relevance of client characteristics, such as direction of the problem and relationship adjustment to sex therapy
outcome (Kilman et al., 1983). However, there seems to be some consensus among therapists on some salient characteristics that lead to success or failure. In general, these elements are similar to what was found in most other therapies (Kilman and Mills, 1983; Zilbergeld, 1983). The best results are achieved with clients who have circumscribed and limited complaints; are in reasonably strong and committed relationships; and who are willing and able to actively participate in therapy by providing information and doing homework assignments. Clients who have had their problem for a long period of time are unlikely to reach the level of success of clients whose complaints were of shorter duration.

"Distressed relationships" do not do well in sex therapy (Munjack and Kanno, 1977; Snyder and Berg, 1983; Wilson, 1982). Often such couples do not stay in therapy very long and many leave early whilst some end their relationships (Arentewicz and Schmidt, 1983).

Although some therapists are strongly committed to a particular format, there is no conclusive evidence that superior results are produced by group, couple or individual therapy (Mills and Kilman, 1982; Zilbergeld, 1980). All of these formats yield similar outcomes with similar problems.

The evidence does not support Masters and Johnson’s (1970) contentions that two therapists are more effective than one therapist in working with couples, and that daily sessions are, in general, any more or less effective than weekly sessions (Arentewicz and Schmidt, 1983; Heiman and LoPiccolo, 1983; LoPiccolo et al., 1985).

When it comes to exactly what produces change, one important generalisation has emerged. Directly working on a problem by doing tasks relevant to bringing about change is more effective than just talking about the complaint or dealing with presumed causes (Zilbergeld and Kilman, 1984).
While traditional sex therapy has been subject to increasing criticism in the last decade, it is not without its supporters. There are many who still support the traditional brief sex therapy methods (Hartman, 1983b; Hartman and Daly, 1983; Kilman et al, 1981).

Even those who are most critical of its practices and results express appreciation for the contribution which Masters and Johnson have made in regard to the treatment of sexual dysfunction (Kilman & Mills, 1983; Levay, 1983).

As treatment failures and relapse rate became an issue in sex therapy, it has become obvious to dynamically trained therapists working in the field that components of marital and psychoanalytic therapy could be integrated into sex therapy in order for treatment to be truly effective.

The original work of Masters and Johnson's represents a major breakthrough in the treatment of sexual dysfunction, if further refined and integrated with the dynamic therapy. When properly integrated this can result not only in symptom removal, but in a lasting cure (Levay and Kagle, 1978).

One method or approach to the treatment of sex problems that deserves special mention is hypnosis. There is little doubt that hypnosis which shares many of the characteristics of sex therapy, i.e. brevity, symptom orientation, directive therapy, can be a very effective change agent. The literature on hypnotherapy is full of reports of the successful treatment of sex problems (Alexander, 1974; Arouz, 1982; Beigel and Johnson, 1980; Crasilneck and Hall, 1975; Fabbri, 1976; Ward, 1975).

There are many gaps in our knowledge of how best to use methods of sex therapy. Although the diagnostic labels employed seem fairly specific, they are in fact of little use in the planning of treatment. Clients with the same problem are different in many other important ways, for
example, how long have they had the problem, their physical
and medical condition, whether they are in relationships
and if so the strength of these relationships, their
motivation for change, the goals they hope to achieve and
their receptivity to various methods of techniques and
therapy.

Some clients do very well with a standard series of
exercises now available in many books (Barbach, 1975;
require work on non-sexual aspects of their relationship as
well as sex therapy (McGovern et al, 1976), whilst others
need methods different from the standard exercises (Clement
and Pfafflin, 1980; Cooper, 1981).

Similar things can be said as regards the format and
frequency of therapy. Although sex therapy is not as
effective or as universally applicable as sometimes claimed
and although there are many gaps in our knowledge, of how
it works and what procedure should be used with what
clients, it is clearly the most cost effective treatment
for a number of common sexual complaints (LoPiccolo and
Stock, 1986).

1.3.6 New Approaches in Sex Therapy

In view of the limitations of the traditional approach in
sex therapy, particularly as regards individual and
relationship issues, an encouraging development in the
field of sex therapy has been the increasing
acknowledgement of the value of a broader conceptualisation
and approach to the treatment with more emphasis on the
unique client and couple characteristics (Cole, 1985;

Sexual dysfunctions often consisting of specific
behavioural complaints that are presented by individuals in
the context of an interpersonal relationship are well
suited to an "eclectic psychotherapeutic approach".
Generally such eclecticism consists of the application of concepts and/or of methods from a variety of schools or traditions of psychotherapy (Sollod, 1988).

Over the years there has been a trend towards integrated approaches in treating sexual problems (Feather and Rhoads, 1972; Garfield, 1980; Goldfried, 1982a & 1982b; Greenspan, 1975; Marks and Gelda, 1966; Silverman, 1974; Wachtel, 1975 & 1977; Woody, 1968).

Perhaps the best exponent of an integrated approach to sexual dysfunction, combining behavioural, psychodynamic and pharmacological methods in treatment is Kaplan (Kaplan, 1974; Kaplan, 1979). Her approach in many ways epitomizes the general characteristics of an integrated or systematic eclectic approach to psychotherapy (Sollod, 1975; Sollod and Kaplan, 1976; Sollod, 1988).

In Kaplan's view the behavioural and psychodynamic approaches compliment and enhance each other. Their combination makes possible the successful treatment of people whose symptoms are to be found in more profound sexual and marital conflicts (Kaplan, 1979).

Kaplan (1979) recommended that sex therapy as an isolated behaviour intervention be abandoned. She described the treatment modality that integrates prescribed sexual experiences with psychotherapeutic exploration of intrapsychic and interactional defences and resistances.

Her greatest contribution is a formulation of a "new sex therapy". A therapy that granted permission for therapists to be pragmatically eclectic. The "new sex therapy" as developed by Kaplan (1974) was designed to overcome many of the limitations of the Masters & Johnson approach.

Couples are usually seen for between five and twenty weekly one hour sessions in an outpatient clinic or private office. They carry out various behavioural exercises in
their homes. The "new sex therapy" is a systematic integration of behavioural and psychodynamic elements, including informational and educational components and a specific focus on dyadic or interpersonal aspects of behaviour. Disorders treated include lack of sexual desire, general sexual dysfunction, vaginismus, orgasmic dysfunctions, primary and secondary erectile dysfunctions, premature ejaculation and retarded ejaculation.

When there is resistance or great difficulty in the successful completion of the behavioural exercises, the therapeutic focus is shifted towards the intrapsychic or interpersonal causes of such resistance or difficulty. The focus consists of intrapsychic or interpersonal processes in as much as they prevent the successful completion of the behavioural tasks (Hartman, 1983a; Weissberg and Levay, 1981).

In Kaplan’s eclecticism, although there is a behavioural structure that guides therapeutic progress, any major intrapsychic or interpersonal processes that might impede such progress are acknowledged by the therapist and are often the focus of therapeutic exploration.

In cases of significant resistance, the therapist assumes a flexible approach and may often engage in exploration of intrapsychic conflicts, interpersonal factors or other material.

Kaplan treating 1000 patients over a five year period, found that approximately 63% were cured of their sexual symptoms. Seven percent improved and 30% were treatment failures (Kaplan, 1979).

Another aspect of Kaplan’s argument for an integrated therapeutic approach to sexual dysfunctions, is that marked improvement in sexual functioning may have a major impact on the overall personality. Considerable therapeutic skill and understanding of the individual dynamics involved is
necessary to enable the client to adjust or accommodate to a real or anticipated improvement in sexual functioning.

In addition to the behavioural, psychodynamic and interpersonal aspects of Kaplan's eclectic approach, is an awareness of the importance of the physical or biological causes of dysfunction and the necessity of adequate information or education about sexual functioning. Many cases of sexual dysfunction have an organic rather than psychogenic cause, so appropriate medical examination is necessary. In addition an inventory of all medication should be made because a wide variety of drugs may have a negative impact on sexual functioning (Kaplan, 1974; 1979).

The "new sex therapy" as developed by Kaplan is thus a very sophisticated and well described example of eclectic integration. This therapeutic approach makes many demands upon the therapist's judgment, skill and creativity. This approach requires a broad base of knowledge and therapeutic experience. The therapist who is to be trained in this approach should have a good background in the behavioural, psychodynamic and interpersonal or couples' therapy principles and techniques and a thorough understanding of personality theory and psychopathology and a knowledge of the causes of sexual dysfunctions and their treatments (Kaplan, 1974).

Supporters of Kaplan's integrated approach to sex therapy come from a variety of authors (Chesney et al, 1981; Crown and D'Ardenne, 1982; LoPiccolo and Hogan, 1979; Zilbergeld and Evans, 1980).

To summarize, in many respects sex therapy today is more challenging and more difficult than ever before. Indirectly the presence of AIDS has prompted heterosexual monogamous couples to find new ways of maintaining sexual intimacy and satisfaction over a lifetime. Couples are increasingly committed to monogamy despite the wish for passion and intensity that characterises new relationships. Therapists
need to find ways to teach couples methods of sustaining sexual desire over a lifetime when the excitement and the early passion have declined (Leiblum and Rosen, 1989).

The present is a period of reappraisal, realising that helping people with sexual difficulties is often difficult, although the relatively gratifying results justify the effort. Human sexuality is far more complex than was anticipated years ago (Zilbergeld and Elison, 1980).

The hope and promise of the early years of sex therapy based on the so-called high success rates may be based on a sample of clients not representative of the clients presenting to sex therapists today (Zilbergeld and Evans, 1980). Currently, presenting cases are often more deep-seated, having negative attitudes about sexuality and relationship problems and other problems not fully dealt with in standard educational sex therapy programmes.

Already back in 1978, Levay and Kagle stated that it is time for sex therapy to return to the fold of psychological practice and to renew its knowledge and understanding of interpersonal and intrapersonal dimensions of sexual dysfunction and its treatment. "...The wheel has turned full circle" (Levay and Kagle, 1978). Fifteen years later this still holds true, the wheel still turns...

1.4 Female Orgasmic Dysfunction

1.4.1 Definition

Orgasmic dysfunction in women has traditionally been divided into two major categories:

i. Primary Orgasmic Dysfunction
   This describes the condition in which a female has never experienced orgasm in response to any form of stimulation (Masters and Johnson, 1970).

ii. Secondary Orgasmic Dysfunction
   This describes the condition in which a woman who was
previously able to achieve orgasm, from some means of stimulation, is currently rarely orgasmic, and also describes a woman who is currently able to attain orgasm only in response to restricted types of stimulation (Masters and Johnson, 1970).

The label of secondary orgasmic dysfunction has thus been applied to women with a wide range of sexual functioning including those women who attain orgasm only with strong interfemoral pressure, or while lying face down in bed; women who are orgasmic only with vibrator stimulation; or women who are multiply orgasmic through partner stimulation, but not with sexual intercourse (LoPiccolo and Stock, 1986).

Secondary anorgasmia is a non-specific term that has been used as a diagnosis for women who may be functioning in a completely adequate and normal manner. It is quite difficult to avoid making value judgements in the treatment of such cases, as patients may define unrealistic goals, i.e. orgasm during intercourse without clitoral stimulation for therapeutic intervention.

Enabling a woman to experience orgasm through some means of partner stimulation, if she has only experienced orgasm through masturbation, is perhaps a more realistic goal to adopt (LoPiccolo and Stock, 1986).

Thus, secondary orgasmic dysfunction refers to women who are not orgasmic during sexual intercourse but in the more recent clinical literature, also describe women who only have orgasm during masturbation and not through any type of partner stimulation, or who define their limited repertoire of stimulation techniques leading to orgasm as problematic (LoPiccolo and Stock, 1986).
1.4.2 Incidence of Female Orgasmic Dysfunction

Female orgasmic dysfunction is typically cited as the most common sexual difficulty presented to practitioners (Burnap and Golden, 1967; Derogatis et al, 1986; Kaplan, 1974). In sex therapy clinics, the frequency of inhibited female orgasm as a presenting problem for females ranges from 18% (Bankroft and Coles, 1976) to 76% (Frank et al, 1976). The Bankroft and Coles' (1976) study was replicated subsequently by Hawton (1982) in the same clinic using the same assessment procedures. Hawton found an inhibited female orgasm rate of 24%, suggesting a slight increase in this dysfunction over the six years. However, the differential prevalence rates of Bankroft and Coles (1976) and Hawton (1982) compared to those of Frank et al (1976) are puzzling. Both the Frank et al (1976) and the Bankroft and Coles (1976) studies were carried out in the same year, hence it is unlikely that the different rates reflected change over time. One difference between the Bankroft and Coles (1976) and Hawton (1982) studies compared to the Frank et al (1976) study was the method of assessment, i.e. mainly interview compared to a self-report questionnaire. Unfortunately reliability and validity data were not reported for either of the techniques used by either of these authors.

A second difference between these studies involves the samples. Frank et al (1976) conducted their study in the United States, whereas Bankroft and Coles and Hawton completed their evaluation in the United Kingdom.

Another study of a sex clinic sample was conducted by Renshaw (1988), over 15 years, between 1972 and 1987. Her study revealed life long orgasmic dysfunction rates at 32.2% and acquired orgasmic dysfunction rates at 37.4%. These rates are also slightly higher than those of Hawton (1982) and Bankroft and Coles (1976).
In community studies, the rate of inhibited female orgasm has also varied. In a pioneering study, Kinsey et al (1953) found that 10% of all women, by their mid-thirties, reported that they had never experienced orgasm, i.e. lifelong orgasmic dysfunction.

Levine and Yost (1976) in their study, found that five percent of their sample was anorgasmic. The rate of other studies conducted, which focused on women who never or infrequently experienced orgasm, ranged from 15% to 50% (Ard, 1977; Athanasiou et al, 1970; Garde and Lunde, 1980; Gebhard, 1978; Heiman and LoPiccolo, 1983; Hunt, 1974). Data collected by Shover (1980) from a sample of 92 couples in stable relationships, indicated that nine percent of women reported global orgasmic dysfunction, whereas 18% reported situational difficulties. Somewhat lower figures (4.3 and 8.7 percent respectively) were obtained in the retrospective study of the pre-morbid sexual adjustment in cancer patients (Shover et al, 1987).

Hite (1976) in her study reported that four percent of women are anorgasmic during masturbation, whereas as many as 70% fail to reach orgasm during sexual intercourse. It is important, however, to include operational definitions of dysfunction and to use a representative sample, otherwise results cannot be compared across studies.

1.4.3 Causes of Female Orgasmic Dysfunction

Since no two people are physiologically or psychologically alike, experience of orgasm is unique to each person. Women vary not only in the type of stimulation they require for orgasm but in the intensity of the experience and the number of orgasms necessary for satisfaction. Each orgasmic response may be affected by a wide range of relationship and environmental factors and influences (Barbach, 1980). There are many theories that have suggested why some women have difficulty or are unable to orgasm. The factors listed
include, lack of information and misinformation to negative sexual attitudes and pervasive psychological disturbance (Darling et al, 1991a; Fisher, 1973; Whipple, 1992).

According to Barbach (1980), there seems to be a number of interacting factors compared to one single factor that is responsible for women not being able to experience orgasm. She notes that lack of information and a negative attitude is a major contributory factor. A popular viewpoint that appears to explain those causes of orgasmic dysfunction, that can be reversed with minimal intervention, is the lack of information or negative sexual attitudes (Swift, 1993).

The psychoanalytic writings of Caprio (1953); Fenichel (1945), Kaplan (1974) and Lorand (1939) note that sexual ignorance, prudishness, misinformation about normal sex and inadequate understanding of stimulation techniques contribute towards creating orgasmic dysfunction.

The behaviourists (for example Lazarus, 1963; Wolpe, 1969) blame sexual problems on faulty attitudes and sexual practices.

Masters and Johnson (1966) pointed out that negative parental attitudes and a failure to transmit information, greatly contributes to orgasmic dysfunction.

Women who are not orgasmic commonly report that they learnt nothing at all from their parents or at school. Many have no idea of what is involved in having sex. Others do not know that women can and do masturbate or that women experience orgasm. When women are given even minimal information, many women in this category seem to be able to stimulate themselves to orgasm rapidly (Barbach, 1980).

Lack of information is just one contribution to female sexual problems. Strict sexually disapproving religious environments have also been found to affect sexual
Without accurate anatomical and physiological information, women often expect that one "right" way to be sexual is to have orgasms as a result of penile thrusting in and out of the vagina. This common misunderstanding arises in large part due to Freud's distinction between vaginal and clitoral orgasms. Freud presented a theory of psychosexual development that described sexuality as a life-drive in both men and women from birth onward. His view on female sexual inadequacy has had many harmful repercussions. Freud developed the notion that there are two types of orgasm experienced by females: less immature clitoral orgasms and more mature vaginal orgasms (Freud, 1943).

Although Hite (1976) found that 70% of her sample of women required direct clitoral stimulation in order for orgasm to occur, most continued to feel abnormal if the so-called "vaginal orgasm" did not occur. Sherfey (1972) stated that "more and more women and men accept the equation that vaginal orgasm equals normality hence, there is an ever increasing incidence of guilt, fear and resentment in otherwise healthy women who find themselves unable to achieve the desired prize" (p.26). Convincing women about the normality of clitoral stimulation requires considerable attitudinal change, a process that generally takes time to solidify (Barbach, 1980; Swift, 1993).

Kaplan (1974) and Hite (1976) found that lovemaking techniques that are not suited to the needs of the individual women are often responsible for the inability to climax. Kinsey (1953) stated that orgasm can be considered a learned response and that failure to achieve it is not necessarily a sign of neurosis but of possible faulty and inadequate learning. It is difficult to change women's perceptions about normal female sexual functioning in a way that makes them more accepting of both the need for clitoral stimulation and their own physiological
uniqueness. In our society, men and women are taught that men are the "so-called experts" on sex. With no instruction, each man is somehow expected to understand each women's unique sexuality. Owing to a lack of information, many women do not know or have not learnt about themselves sexually and do not take responsibility for their sexuality. They expect the male partner to do all of this for them (Barbach, 1980).

Fear of loss of control appears to be the fundamental problem of women who require more than simple permission and information in order to reach orgasm. These women need to experience sexual arousal gradually so that they can steadily become familiar with sexual intensity and thus feel more in control. The process of learning to reach orgasm by approaching new sexual situations in carefully graduated steps, helps such women to develop a sense of internal control, thereby eliminating the need to over-control. To become orgasmic, a woman must test levels of sexual intensity slowly and over time, until she feels more secure in the knowledge that she can control these feelings (Andersen, 1983; Darling et al, 1991a).

Slowly she can learn to trust her feelings of control as the intensity increases and other feelings experienced to build up to the point of orgasm, she can then experience orgasm without losing control, by self stimulation and then by stimulation with a partner. Then she can communicate her needs, sexual likes and dislikes to her partner, to enable the sexual experience to be more satisfying (Barbach, 1980; Heiman et al, 1976).

In some rare cases, deep-seated problems may cause orgasmic dysfunction. Women who do not respond to short-term behaviourally-orientated treatment may require intensive psychotherapy. Fischer (1973) indicates that for the most part, lack of orgasm and psychological disturbance are not correlated. Psychological concerns that may effect orgasmic response include fear of pregnancy, childbirth, sexually
transmitted diseases, children, illnesses, finances and so on, creating anxiety and lack of responsiveness during sex.

While it is important for researchers and therapists to understand sexual and orgasmic behaviour and to be effective communicators about sexuality, care must also be taken so as not to overemphasize and overvalue the orgasmic experience. Such a position would likely create unneeded pressure, frustration, and unrealistic expectations. Instead, it is critical to help individuals become aware of the normality of orgasmic inconsistency, as well as the many pleasurable aspects of sexual interaction which do not necessarily have to include orgasm as an ultimate goal (Barbach, 1980; Kaplan, 1974).

Definitions of normality with respect to female sexual functioning have a long and controversial history (Ellis, 1903; Levin, 1981). Perhaps the most significant influence in this century was Freud's clitoral-vaginal transfer theory (Freud, 1943). In brief, this theory argues that the psychosexually mature woman, given an adequate partner, should be able to orgasm from the stimulation provided by the penis during intercourse.

This opinion was refuted by the study of Kinsey et al (1953). They indicated that in most females, the vaginal walls were quite insensitive to light touching, in contrast to the great tactile sensitivity of the clitoris.

The vaginal-clitoral orgasm controversy appeared to have been laid to rest by the work of Masters and Johnson's (1966) who asserted that; the "primary focus" for the female sexual response is the clitoris; that vaginal and clitoral orgasms are inseparable entities; and that during sexual intercourse, the clitoris is stimulated through traction on the labia minora.

Some studies, for example, Clarke (1970); Fox (1969); Singer and Singer (1972), continued to support the
existence of several types of female orgasm and the erotic relevance of the vagina.

In recent years, many researchers have rejected Freud's view that women must progress from clitoral to vaginal orgasm in order to achieve their full sexual maturity (Barbach, 1980; Hite, 1976; Kaplan, 1974).

Feminists in particular have labelled this idea as sexist since it implies that women need penile stimulation during sexual intercourse in order to experience the appropriate type of orgasmic response (Bentler and Peeler, 1979; Levin, 1981; Singer and Singer, 1972).

In the 1980's, sex researchers questioned the idea that the sole potential source of orgasm in women is through clitoral stimulation (Alzate, 1985a; Alzate and Hoch, 1986; Hall et al, 1985; Hoch, 1980; Ladas et al, 1982; Zilbergeld, 1982).

This view has been further challenged by sex researchers who argue that orgasm obtained by direct digital or oral stimulation is just as "mature".

Addiego et al (1981); Kaplan (1974); Ladis et al (1982) and Perry and Whipple (1981) have described a clear erotic response to strong tactile stimulation of the anterior vaginal wall. They claim having precisely located the zone involved and have named it "The Gräfenberg Spot" (G-Spot), after the German-American gynaecologist Ernst Gräfenberg, who first described the definite erogenous zone on the anterior vaginal wall in 1952 (Gräfenberg, 1952).

Alzate and Londono (1984) in their study, supported the findings of Addiego et al (1981); Gräfenberg (1950); Hoch (1980); and Ladis et al (1982), indicating that the anterior vaginal walls of most women possess a zone or zones of erotic sensitivity whose appropriate stimulation can lead to orgasm. With regard to the exact point of
maximum erotic response, Gräfenberg (1952) located it either along the course of the urethra or at the neck of the bladder, i.e., either on the lower anterior vaginal wall or on its middle path. The same location has also been described by Ladis et al (1982). The discovery of the G-Spot was seen by female sexuality researchers as an invitation to go "back to the drawing board" (Alzate and Londono, 1984).

Davidson et al (1989) in their study reported that respondents reported pleasurable sensations with the stimulation of this sensitive area (G-Spot) and 75% of the women, in their sample also reached an orgasm, through G-Spot stimulation.

Controversy over the G-Spot is part of the original larger controversy whether women have one orgasmic response, centred in the clitoris, or two separate orgasmic responses, one based on clitoral stimulation and the other based on vaginal stimulation. Moderate to strong rhythmic pressure applied to various areas of the vagina certainly can lead to orgasm in some women, without any need for simultaneous clitoral stimulation (Quadagno, 1988; Whipple and Komisaruk, 1992).

1.4.4 Multiple Orgasm

Despite the lack of a precise and consistent definition of multiple orgasms, women continue to report experiencing this phenomena through masturbation and sexual intercourse. Various researchers have reported that 14% to 16% of women experience multiple orgasms (Athanasiou, 1970; Kinsey et al, 1953). Despite these relatively low percentages, most women supposedly have the potential to experience multiple orgasms (Denney and Quadagno, 1988).

Under what circumstances do women experience multiple orgasms? Although some women indicate that they occur regularly through sexual intercourse, others report that
they occur more frequently via clitoral stimulation during masturbation, due to ease of sexual stimulation, no distraction with partner concerns, greater use of sexual fantasy and among a group of women, with heightened breast and vaginal awareness (Fisher, 1973; Kinsey et al, 1953; Masters and Johnson, 1966; Masters et al, 1988; Whipple et al, 1992). Although some women who experience multiple orgasms choose to utilize alternating sexual patterns, which include single or multiple orgasms at various times, other multi-orgasmic women often feel satisfied with having only one orgasm during sexual activity (Kilman et al, 1986; Offir, 1982). Darling and Davidson (1986) in their study, reported that 26% of women wanted to experience multiple orgasm as a desired change in their sexual lives.

As indicated by the range and variability of female orgasmic experiences, opinions continue to be divided over the perceptions of female orgasms. In particular, the convictions and theorising of those investigators emphasising greater "satisfaction or performance" associated with various orgasm types (Rosen and Beck, 1988). Considerable debate has centred around whether women perceive orgasm as a necessary ingredient for marital and/or sexual satisfaction.

Many years ago a positive correlation was found between frequency of orgasm and the perceived enjoyment of sexual intercourse. However experiencing orgasm was not perceived to be necessary for the enjoyment of sexual intercourse (Wallen and Clarke, 1963).

More recently, greater marital happiness has been found to be associated with a higher percentage of sexual intercourse episodes leading to orgasms for women (Gebhard, 1966; Lief, 1982; Rosen and Beck, 1988). Thus it appears that individual and partner related variables which may include both physiological and psychological components are central to sexual satisfaction for women.
The findings of the Darling et al (1991b) study indicated that women who experienced multiple orgasms were more explorative in their sexual activities. Furthermore, their awareness of pleasurable sensations of the clitoris via masturbation and orgasm occurred at an earlier age than for the single orgasmic woman.

Since multiply orgasmic women experience pleasurable genital sensations earlier than single orgasmic woman, it is not surprising that they employed creative ways to experience orgasms including mental stimulation with sexual fantasies, erotic literature and erotic films. Multiply orgasmic women appear to have overcome some societal norms and pressures that might otherwise restrict their sexual experimentation (Darling et al, 1991b; Whipple, 1992b).

In Darling et als' (1991b) study, the role of the partner interaction indicated further dynamics between multi-orgasmic women and their partners. They were more likely than single orgasmic women to experience orgasm through partner related behaviour such as giving and receiving oral-genital stimulation as well as manual-oral stimulation of the nipples.

They were also more likely than single orgasmic women to report simultaneous clitoral stimulation during sexual intercourse, whether or not carried out by their partners or by themselves. In addition, some specific positions and stimulation techniques were more often reported by multi-orgasmic women in comparison to single orgasmic women (Darling et al, 1991b; De Bruijn, 1982).

It appears likely that once multi-orgasmic women have identified what is pleasurable for them, they are able to choose for themselves and sometimes with a sexual partner, the techniques and variations that provide the maximum pleasure they are seeking.
This approach may be seen as the "timing of orgasms", since multi-orgasmic women are more likely to have partners who delay their first orgasm during sexual intercourse until after the women had experienced their first orgasm. Their orgasmic pattern may have resulted from communication between the partners and with the multi-orgasmic women conveying what elevates her arousal. Or it may have simply evolved from a partner's tendency towards needing a prolonged period of stimulation prior to experiencing orgasm (Darling et al, 1991b).

The positive findings of Darling et al (1991b), that women who experience multiple orgasms are more sexually adventurous, could be that being more explorative, they continued stimulation after single orgasm and thus learnt to reach multiple orgasms, i.e. being adventurous led to multiple orgasms. Alternatively, a desire to reach multiple orgasms may also have led women to experience a great variety of sexual activities. Thus, being multi-orgasmic, led to being more adventurous.

A third factor is that greater sexual desire might account for being both more adventurous and experiencing multiple orgasms. This contention does not imply that these women are more sexually satisfied, understand their sexual needs better, or in any sense, are sexually healthier than women who are less adventurous (Darling et al, 1991b).

1.4.5 Faking Orgasm

There is considerable emphasis on sexuality and especially on orgasmic responsiveness in the popular press. In other words, societal expectations currently exist which conclude that merely being in love and engaging in sexual intercourse is not good enough - you must also be a "good lover". As a result, social pressure is internalized and experienced by both males and females to provide adequate stimulation and then to respond sexually as if they are being graded on "some invisible score card" (Swift, 1993).
Due to this stress, as well as a variety of other reasons a large number of females believe that it is necessary to pretend orgasm. This is both a widespread and common practice (Darling and Davidson, 1986).

According to the popular press, in order to be a "good lover", one is supposed to both satisfy one's partner and experience orgasm during each sexual encounter, in a variety of ways, for an extended period of time, and in a multiple sequence. Consequently, it is not surprising that the phenomenon of pretending to experience orgasm also is becoming a greater part of the relationship for many couples, resulting in much greater stress on both partners to "perform" sexually (DeBruijn, 1982; Steiner, 1981).

Although our society encourages the idea that individuals should experience orgasm during each sexual encounter, sexual intercourse does not always culminate in orgasm for both partners, even if both persons are usually orgasmic. Some females who do not experience orgasm all the time, not only resent the expectation that they should, but also greatly enjoy intercourse for its own sake (Butler, 1976; Knox, 1984; Rancaur-LaFerrier, 1983).

According to a study by Butler (1976) only 63% of the female respondents achieved orgasm in more than half of their sexual intercourse experiences.

However, when a female is not consistently orgasmic during sexual intercourse, she is often considered to have orgasmic dysfunction. In reality, the relatively low frequency with which females actually experience orgasm during sexual relations needs to be understood as normal behaviour, rather than being judged as abnormal by male standards (Kaplan, 1974).

While it is perfectly acceptable not to achieve orgasm consistently, a large number of females choose to pretend to experience orgasm, which can be defined as intentionally
behaving as though one has experienced an orgasm when, in reality, one has not. Several studies have revealed that nearly two-thirds of females and one-third of males have pretended to experience an orgasm from time to time (Darling and Davidson, 1986).

However, Butler (1976); Evans (1978); Geer et al (1984) and Hite (1976) contend that no one really knows precisely how many females pretend to experience orgasm on a regular basis. Furthermore, it is those females who usually experience orgasm who are considerably more likely to pretend orgasm in comparison to those who have seldom or never experienced orgasm (Shope, 1968).

The most frequent reason given for pretending orgasm is the female's desire to please her partner, to avoid disappointing or hurting him. In other words, the female feels that she is under scrutiny and that an orgasm is expected of her. She is afraid that her inability to meet this expectation will adversely affect her partner's masculine self-esteem. Not reaching orgasm may suggest sexual failure or incompetence by either one or both partners (Diamond and Karlen, 1980; Knox, 1984; Rosenbaum, 1970).

Other reasons for pretending to have an orgasm include fear of inadequacy as a female, inability to ever achieve orgasm, prevention of one's current partner from seeking another sex partner, or when sex is boring or painful (Knox, 1984; Rosenbaum, 1970).

From a relationship perspective, part of the pressure to pretend orgasm results from the common practice of males asking their female partners if they have reached an orgasm after having just experienced sexual intercourse.

Some individuals believe that asking females about whether an orgasm was achieved will cause feelings of discomfort and will thus create pressure to perform well during sexual
activity. A female may also become confused and not understand what information her partner is really seeking. Is the male partner needing feedback on the level of sexual pleasure she experienced, his skill as a lover, or her feelings about him and their relationship? Some females believe that the question, "Did you have an orgasm?" is a demand that they either have an orgasm or that they should be responding during sexual activity in some specific way. Furthermore, the question could be viewed as a signal that he is bored and wants to get the sexual activity over with, whereby he purposely or inadvertently breaks her concentration level and ability to experience an orgasm (Darling and Davidson, 1986; Ottenheimer et al, 1971).

On the other hand, it would be beneficial if a male could communicate, hopefully in an atmosphere of emotional tenderness, that he cares about whether the female is enjoying sexual intercourse and that he wants to be helpful. Carson et al (1979) suggest that discussions about sexual matters should take place at a neutral time and place and not during lovemaking. However, her orgasm is not her partner’s responsibility, it is her responsibility, thus, the female needs to communicate with her partner about her own sexuality. Furthermore, this communication should be mutual and reciprocal (Barbach, 1980).

Pleasure should be the goal of partner-related sexual activity, not orgasm. When both individuals are able to share their feelings about sexuality, they can, according to Knox (1984), then abandon themselves to their sexual passion and their resultant pleasures.

Pretending orgasm not only could result in an orgasm being less likely to occur on future occasions, but also could leave one partner feeling sexually inadequate, or distort the relationship through dishonesty.

Thus, pretending to experience orgasm can potentially produce negative dynamics in intimate relationships, which
detract from both communication and pleasure during sexual intercourse.

Darling and Davidson (1986) in their survey assessed the responses of 805 professional nurses who participated in a study on self-perceptions of the female sexual response. The most significant aspects of their findings indicated the following: females who have pretended orgasm have been more explorative in their sexual behaviour than non-pretenders. Not only have the pretenders of orgasm more frequently examined their clitoris and engaged in masturbation, but they also have more frequently experienced orgasm in several different ways. Furthermore, they have experienced sexual intercourse, as well as orgasm via masturbation and petting, at an earlier age than non-pretenders.

1.4.6 Psychoanalytically Orientated Therapy in the Treatment of Female Orgasmic Dysfunction

Prior to the pioneering work of Masters and Johnson (1970), in treating problems or anorgasmia, the therapist would view the condition as a symptom of underlying problems or conflicts and would propose years of psychoanalysis as a solution. After years of treatment, she might leave the therapy still anorgasmic but perhaps feeling happier with other aspects of her life (Bergler, 1947; Lorand, 1939).

O'Conner and Stern (1972) in their study of 61 partially or totally "frigid" women, treated four times a week, for a minimum of two years, found 25% of these cases were "cured" and an additional 35% showed some improvement.

The relative ineffectiveness of early psychoanalytic treatment may have resulted from a number of factors, including false assertions such as that made by Freud (1965) and his followers, regarding the superiority of vaginal orgasm compared to clitoral orgasm.
However, it must be noted that no other form of therapy available before the 1960’s was any more successful in reversing female orgasmic dysfunction.

1.4.7 The Masters and Johnson Approach in the Treatment of Female Orgasmic Dysfunction

In 1970 Masters and Johnson published Human Sexuality, describing their innovative approach to the treatment of sexual dysfunction, including female orgasmic dysfunction.

Masters and Johnson have been criticised for their clinical samples, in the absence of objective measures of treatment outcome (Zilbergeld and Evans, 1980). However, in comparison to the research samples of investigators using other treatment techniques, the Masters and Johnson’s approach appears comparable if not superior due to the wide age range and geographic distribution and the presence of multiple sexual difficulties complicating the treatment process. A high percentage of couples who had failed previous treatment, the numerous replications and the long follow-up periods, strengthens the confidence in their data despite the absence of control and objective measurement (Andersen, 1983).

Despite the popularity of the sensate focus techniques, few empirical investigations have been carried out and at present have only received correlational support for their effectiveness with primary non-orgasmic women.

Several variable domains require further description, quantification and control or manipulation in this research area. Within the domain of client characteristics, detailed clinical descriptions of the primary non-orgasmic population have not been provided and are necessary.

Within the domain of therapist characteristics, the individuals conducting treatment have come from the professions of psychology, psychiatry medicine and social-
work, although further descriptions of such variables as clinical experience or therapeutic orientation is lacking. With the exception of one report, namely, Carney et al., (1978), a male-female co-therapy model was always used. The settings for treatment included university clinics in the department of psychology or psychiatry in medical schools. At present there is suggestive evidence that greater gains were achieved by the couples treated by Masters and Johnson themselves.

Since sensate focus can include a variety of components, future investigators are encouraged to replicate their strategies or replicate those detailed by Masters and Johnson (1970).

At present, sensate focus exists as a clinical technique without ties to other treatments or theoretical notions of the female response or sexuality. Although discussions of partner interactions leading to sexual dysfunction has been made, study of the mechanisms of treatment effectiveness, conditions for success or client or therapist variables has not begun.

The Masters and Johnson approach consisted of varied components such as re-education, skill training and couple communication which was conducted for an intensive two week period. The couples were highly motivated, well educated and representative of the middle socio-economic class.

However, couples with serious marital and psychological difficulties in addition to the sexual problem were not accepted for their treatment. Their approach was designed to change behaviour and communication patterns in order to reverse the sexual dysfunction.

Couples with orgasmic dysfunction are first encouraged to create a non-demanding climate for completing the sexuality exercises. The non-orgasmic woman is given permission to express her sexual feelings without focusing on her
partner. In a step by step sequence, the couple is guided through a programme of body touching exercises, designed to teach each person his or her own sexually sensitive body areas, those of the partner and ways to exchange this information in order to heighten sexual tensions. Specific activities developed for primary orgasmic dysfunction include non-demand genital touching by the partner, female guidance of her partner’s hand to the sensitive genital areas, penile stimulation with direction by the woman, coital positions maximizing stimulation potential and stop-start pelvic thrusting to enhance the female’s pleasure.

Masters and Johnson (1970) reported outcome data on women who reflected various forms of orgasmic dysfunction. They treated 193 women with primary orgasmic dysfunction; 11 women with masturbatory orgasmic inadequacy; 106 women with coital orgasmic inadequacy and 32 women with random orgasmic inadequacy. The criterion for short term treatment success was the disappearance of the pre-treatment symptomatology directly after treatment. The criterion for long term treatment success was a maintenance of symptom reversal for five years after treatment.

The success rates for women with orgasmic difficulties were as follows:

- **Primary orgasmic dysfunction**: 83.4%
- **Masturbatory orgasmic inadequacy**: 90.9%
- **Coital orgasmic inadequacy**: 80.2%
- **Random orgasmic inadequacy**: 62.5%

(From Masters and Johnson, 1970).

However, as noted by Sotile and Kilmann (1977) less than half of these women were followed up and no follow-up data was obtained on couples that originally did not respond to treatment.

Blakeney et al (1976) reported outcome data on 10 couples in which the female partner had primary orgasmic dysfunction and on 28 couples in which the female partner
had secondary orgasmic dysfunction. The male in an unspecified number of couples also reflected a sexual dysfunction. However, the exact number of primary or secondary women having a partner with a given dysfunction was not mentioned.

The treatment conducted for an intensive two and a half day period was patterned after Masters and Johnson's (1970) and Hartman and Fithian (1972). Follow up data on most of the couples was gathered up to two years after treatment, through personal contact and through mail questionnaires. Total symptom reversal was attained by 70% of the primary anorgasmic women and 51% of the secondary anorgasmic women. Nevertheless, the failure to identify the outcome of couples in which both partners had a sexual dysfunction versus the outcome of couples in which only the female partner had a sexual dysfunction, limits the generalisability of the data. It should be noted that different treatment strategies may be necessary for couples in which the male partner also has a sexual dysfunction. These strategies need to be specified and evaluated in controlled research.

1.4.8 Cognitive-Behavioural Approaches in the Treatment of Female Orgasmic Dysfunction

The goals of cognitive-behavioural sex therapy are to promote cognitive change, shift attitudes, reduce anxiety, increase orgasmic frequency and increase the connection between positive feelings and sexual behaviour (Fichten et al, 1986; LoPiccolo and LoPiccolo, 1978).

An essential component of behaviour therapy is to help the woman feel less anxiety during sex and unlearn the primary stimulus configuration and re-learn a more appropriate one (Lazarus, 1963; Madsen and Ullman, 1967; Wolpe, 1969).

Kinsey et al (1953) made the important assumption that orgasm is a learned response and that failure to achieve
it, may be the result of inadequate learning.

Cognitive-behavioural therapy works with individuals, couples or groups. Variables such as the sex of the therapist, single therapist versus a co-therapist team and spacing of sessions have been demonstrated not to influence sexual and marital outcome measures (Ersner-Hershfield and Kopel, 1979; Heiman and LoPiccolo, 1983; LoPiccolo and Stock, 1986).

The hallmark of cognitive-behavioural therapy is the prescription of privately enacted behavioural exercises. Treatment is generally brief, averaging about 15 to 20 sessions.

The therapist is an educator and facilitator who defines and assesses the problem and then prescribes learning situations to remedy it (Heiman and Grafton-Bekker, 1988).

A review of the most common cognitive-behavioural approaches in the treatment of female orgasmic dysfunction follows.

1.4.9 Systematic Desensitisation in the Treatment of Female Orgasmic Dysfunction

Husted (1975) examined the effects of group imaginal systematic desensitisation and in-vivo desensitisation on primary and secondary non-orgasmic women.

Treatment was conducted for a maximum of fifteen sessions. Across both treatments the secondary non-orgasmic subjects reported an increased frequency of coital orgasm while the primary non-orgasmic subjects showed no such increase.

Subjects who received group imaginal systematic desensitisation showed a significant reduction in sexual anxiety, a significant increase in the frequency of extra-coital orgasm and coitus, greater satisfaction with the
frequency of extra-coital orgasm and coitus, greater satisfaction with personal sexual performance and increased sexual communication with their partners. Partner participation did not significantly influence the number of treatment sessions.

Jones and Park (1972) combined systematic desensitisation conducted under drug induced relaxation and couple re-education in the treatment of 69 non-orgasmic women. The women were not able to obtain orgasm during intercourse. As the criteria for success, these investigators required that the women be able to discuss sexual material with the therapist and with their spouses without experiencing anxiety and that they experience pleasure in sexual behaviour. Each subject's spouse was present during the desensitisation procedure. They found that 82% of the 55 primary non-orgasmic women and 71% of the secondary non-orgasmic women responded to treatment successfully, after an average of 14 sessions and six sessions respectively.

Owing to the fact that female orgasmic dysfunction is often caused by performance anxiety, Sotile and Kilmann (1977) reasoned that systematic desensitisation should be an effective procedure with women who have anxiety reactions to sexual situations. They examined the impact of group systematic desensitisation on various aspects of sexual functioning in primary and secondary non-orgasmic women. Significant positive treatment effects were found on measures of general and specific sexual adjustment and in extra-coital orgasmic frequency. Treatment also enhanced sexual communication amongst subjects and their partners, increased the female's acceptance of their mate as being satisfactory sexual partners, and increased the female's self-acceptance as sexual beings.

All but one of the treatment effects i.e. degree of pleasure experienced during extra-coital stimulation, were maintained at the six-week follow-up. Secondary non-orgasmic women reported significantly greater pleasure from
coital and extra-coital stimulation compared to primary non-orgasmic women.

Lobitz and LoPiccolo (1972) and McGovern et al (1975) found greater positive changes in orgasmic responsivity to extra-coital stimulation for primary anorgasmic subjects compared to secondary anorgasmic subjects. By contrast, Sotile and Kilman (1977) found that in comparison with primary subjects, secondary subjects reported significantly higher frequency of orgasm from extra-coital stimulation. Sotile and Kilman (1977) noted that this discrepancy could be due to the fact that they used imaginal systematic desensitisation while Lobitz and LoPiccolo (1972) and McGovern et al (1975) used directed masturbation training. Sotile and Kilman’s (1977) findings also do not agree with Husted’s (1975) finding that secondary anorgasmic women show a significant increase in coital orgasm over primary subjects from desensitisation, or with the fact that Masters and Johnson (1970) found large percentages of both primary and secondary subjects increased their orgasmic frequency.

From an integration of the results of these studies, Sotile and Kilman (1977) suggest that systematic desensitisation may be effective for women whose sexual anxiety contributes to secondary orgasmic dysfunction, while masturbatory training (for example, Lobitz and LoPiccolo, 1972; McGovern et al, 1975) may be more appropriate for primary orgasmic dysfunction.

While the inclusion of a control condition in the Sotile and Kilman (1977) study is a noteworthy improvement over past studies, the control condition was actually a waiting-list group.

The absence of a true control group which shares the same expectancy for treatment as the experimental group, leaves unanswered the question of whether the group process was the critical factor and not the desensitisation procedure.
Munjack et al (1976) examined the effects of a multiple technique behavioural therapy programme on 12 primary non-orgasmic and 10 secondary non-orgasmic women. The women were treated without their partners approximately 70% of the time for an average of 22 sessions. The treatment package included systematic desensitisation, assertiveness training, modelling, behavioural rehearsal and education. The criteria for successful treatment included the ability to attain orgasm during at least 50% of coital attempts and to report satisfactory sexual relations at least 50% of the time. The results showed that a significantly greater percentage of women in the treatment group increased their ability to experience orgasm during at least 50% of their sexual relations and reported significantly greater satisfaction in their sexual relations at least 50% of the time, compared to the control group. The treated women also reported significantly more positive reactions to various sexual behaviours and were rated significantly higher on global clinical ratings than the control.

No significant differences in outcome were found between primary non-orgasmic and secondary non-orgasmic women at the post-test, although the follow-up assessment revealed that secondary non-orgasmic women were rated significantly better than primary non-orgasmic women on both feelings and performance.

Obler (1973) contrasted the effects of a psychoanalytic therapy group, and a modified form of systematic desensitisation presented in individual sessions and a no-treatment control group. The subjects in the systematic desensitisation condition were shown graphic aids and also received four sessions of assertiveness and confidence training.

The subjects were women diagnosed as having primary or secondary orgasmic dysfunction. A methodological strength of this study is that the subjects in each condition were matched on the type of disorder, marital status and
duration of the symptoms. The therapy group was conducted in weekly, one and a half hour sessions for 10 weeks. The desensitisation treatment was conducted for weekly, 45 minute sessions for 15 weeks.

Obler (1973) found that women in the desensitisation condition showed positive changes which did not occur for women in the group therapy or control conditions. These results were maintained over a one and a half year follow-up.

1.4.10 Directed Masturbation in the Treatment of Female Orgasmic Dysfunction

The most effective treatment, to date, for lifelong lack of orgasm in women is a programme of directed masturbation developed by LoPiccolo and Lobitz (1972). Masturbation has shown to be the most probable method of producing an orgasm as well as producing the most intense orgasm (Masters and Johnson, 1966).

Although Masters and Johnson did not rely on masturbation as a learning technique, others have accepted their methods and include masturbation as a way for a woman to experience her first orgasm (Swift, 1993).

LoPiccolo and Lobitz (1972) developed a nine step, masturbatory desensitisation programme. The women practice each step until they have successfully completed it before proceeding to the next step. This has become an extremely popular treatment, whether used completely or in part.

The nine steps of the LoPiccolo and Lobitz (1972) directed masturbation programme are as follows:-

Step 1: Nude bath examination; genital examination; Kegel exercises (Kegel, 1952).
Step 2: Tactile as well as visual genital exploration with no expectation of arousal.
Step 3: Tactile and visual genital exploration with the object of locating areas that produce pleasurable feelings when stimulated.

Step 4: Manual masturbation of the areas identified as "pleasurable".

Step 5: Increased duration and intensity of the masturbation, if no orgasm occurs in Step 4.

Step 6: Masturbation with a vibrator if no orgasm occurs as a result of Step 5.

Step 7: After orgasm has occurred through masturbation, the husband observes his wife masturbating.

Step 8: The husband stimulates the wife in the manner described in Step 7.

Step 9: Sexual intercourse with husband stimulating wife manually or with a vibrator.

The programme developed by LoPiccolo and Lobitz (1972) is based on a sexual skills learning model, and is an adjunct to a behavioural, time-limited treatment programme involving both the male and the female partner. The basic components of the treatment programme for lack of orgasm include education, self-exploration and body awareness and directed masturbation. The directed masturbation component of treatment involves self-exploration, body awareness, effective self-stimulation training and the use of "orgasm triggers" (Heiman et al., 1976; LoPiccolo and Lobitz, 1972). The programme developed by LoPiccolo and Lobitz (1972) also forms the basis of the self-help manual Becoming Orgasmic (Heiman et al., 1976).

There is a progression from education on basic sexual physiology and anatomy, visual and tactile self-exploration, directed masturbation, development of sexual fantasy and imagery, sensate focus individually and with a partner and eventually to sharing effective techniques of masturbation with a partner. Stimulation is encouraged in order to facilitate orgasm during intercourse. Although female orgasm during intercourse should not be stressed as a goal for all couples, as this is not always a realistic
expectation, concurrent clitoral stimulation may maximize this occurrence if so desired by a couple in treatment.

Results based on 150 women treated in LoPiccolo's clinic with this programme, show 95% success in terms of the woman being able to reach orgasm during her own masturbation. Eighty-five percent of these women were also able to have orgasm during direct genital stimulation by the male partner. Forty percent of these women have been able to obtain orgasm during penile-vaginal intercourse following this programme (LoPiccolo, 1978).

The use of directed masturbation has been questioned by some and is not a component of all treatment for primary anorgasmia. Masters and Johnson (1970) instead stressed performing couple focused sensate exercises and addressing historical issues that result in a negative sexual functioning, whilst a number of studies (for example, Kohlenberg, 1974; Riley and Riley, 1978) have shown that a programme of directed masturbation training is generally a more effective method for the woman who has never had an orgasm.

Lobitz and LoPiccolo (1972) in their study used a combination of sexual skill training, sexual re-education, couple communication training and in-vivo desensitisation of sexual anxiety. While their programme was similar to Masters and Johnson’s (1970) procedure, Lobitz and LoPiccolo used weekly sessions and emphasised masturbatory re-training.

The criterion for treatment success was that the women be satisfied during at least 50% of their sexual intercourse encounters. The results showed a 100% success rate in treating 13 primary non-orgasmic woman, but only a 33% success rate with nine secondary non-orgasmic women.

In another study, LoPiccolo and Lobitz (1972) used their programme of directed masturbation with eight primary non-
orgasmic women. Although this programme centred around sexual skill training, modelling and role-play techniques were also used to enhance the partner’s acceptance of her masturbation. The criterion for success was that the women attain orgasm through concurrent, manual and coital stimulation by her partner. After 15 sessions, the eight women gained the ability to achieve orgasm. This outcome persisted at the six month follow-up. However, the method for attaining orgasm and the regularity of the experience varied across women.

McGovern et al (1975) used the same treatment procedure as Lobitz and LoPiccolo (1972) with six primary non-orgasmic and six secondary non-orgasmic women. The women and their partners were treated for 15, hourly sessions. Both subject types showed increased satisfaction with their sexual and marital relationships following treatment. However, while all of the primary anorgasmic women increased their frequency of orgasmic response to genital caressing and to sexual intercourse, the secondary anorgasmic women showed no such improvements. From these results, McGovern et al (1975) suggested that primary non-orgasmic women may respond best to a treatment approach focused on sexual matters. The authors recommend additional treatment time for secondary non-orgasmic women in order to focus on marital issues that may be interfering with these women’s orgasmic responsivity.

Snyder et al (1975) reported on the treatment of one couple in which the woman reflected secondary orgasmic dysfunction. The woman could obtain orgasms through masturbation but not through genital manipulation by her husband or through intercourse. The treatment focused on three aspects concurrently: sexual technique; breaking the stimulus control of orgasm; and marital problems. Outcome data at the post-test and at the three month follow-up revealed that the couple reported positive changes in all aspects of the marital and sexual relationship.
Snyder et al (1975) suggested that a combination treatment approach may be necessary in cases where marital problems contribute to secondary orgasmic dysfunction. This is in line with Kaplan’s (1974) new integrated approach to the treatment of sexual problems.

Riley and Riley (1978) compared a group of twenty patients following a masturbation programme used as an adjunct to the sensate focus technique of Masters and Johnson’s (1970) and supportive counselling, with a control group of 15 patients who were treated only with a sensate focus technique and supportive counselling. All these patients were married and were seen with their husbands. Of those who followed the masturbatory programme, 90% gained orgasmic capacity compared with 53% of those treated conventionally. Eighty-nine percent of the patients treated by the masturbation programme were able to attain orgasm during intercourse on at least 75% of occasions, compared with 47% of the control group. These gains were maintained twelve months after treatment. This study in a more controlled fashion, replicated the results reported by Kohlenberg (1974) and by Lobitz and LoPiccolo (1972).

The directed masturbation procedure has also been successful in a variety of other treatment modalities including minimal therapist contact of four sessions at monthly intervals and the viewing of a film, and reading matter (Morokoff and LoPiccolo, 1986).

McMullen and Rosen (1979) carried out a controlled study which differs from the others in that the six week masturbation training programme was self-administered. Information was given either through written instructions or videotaped modelling.

Sixteen non-orgasmic women who included an equal number of married and single women were randomly assigned to three groups, 1) videotaped modelling; 2) written instruction and 3) waiting-list control group. Subjects in both treatment
groups were supplied with an electric vibrator during the fourth week of treatment. They found that 50% of their subjects became orgasmic by the end of the treatment period but there was no significant difference between the videotape modelling condition and the written instructions condition.

Other outcome studies have indicated that orgasm during intercourse did not improve significantly from pre to post-treatment (Fichten et al, 1986; Kilman et al, 1986; Libman et al, 1984).

Additional studies have indicated lower success rates for orgasms with partner, especially for secondary anorgasmia. They range from 30% (Spence, 1985) to 66% (Weiss and Meadow, 1983).

The problem is partly one of definition in that partner related activity can mean masturbation in front of the partner rather than sexual intercourse. Couples need to be educated that additional stimulation is normal for many women to experience orgasm during sexual intercourse (Hoch et al, 1981; Kaplan, 1974; LoPiccolo and Stock, 1986). Directed masturbation and eventually partner stimulation may be positively incorporated into the desired outcome of orgasm with partner during sexual intercourse.

Other investigators, Kohlenberg (1974) and Reisinger (1974; 1978) have also found success using various masturbation procedures with non-orgasmic women.

To sum up, directed masturbation is used in group, individual and couples therapy. Generally, most studies report fairly high success rates with more than 80% of women being able to experience masturbatory orgasm after completion of therapy and a lower percentage, 20% - 60%, able to have orgasm with their partner.
Most women report increased enjoyment and satisfaction of coital activities, a more relaxed attitude to sex and life and increased acceptance of their bodies (Ersner-Hershfield and Kopel, 1979; Leiblum and Ersner-Hershfield, 1977; Nairne and Hemsley, 1983; Riley and Riley, 1978; Wallace and Barbach, 1974).

1.4.11 Group Procedures in the Treatment of Female Orgasmic Dysfunction

Another format that has demonstrated effectiveness in the treatment of primary and secondary orgasmic dysfunction in women is group treatment.

Group treatment has varied on a number of dimensions in the literature, eg. the inclusion of male partners, number of treatment sessions, the inclusion of primary versus secondary anorgasmic women and which treatment techniques are presented in each group.

In general, the literature indicates that group treatment can provide a cost-effective and supportive type of intervention that seems most effective for clients without severe psychopathology, relationship distress or other major psychological problems.

Barbach’s (1974) contention was that this group method was available to women regardless of their relationship status. It was short-term, relatively inexpensive and economical as regards therapist’s time. Furthermore, it enabled a large number of women to benefit, yet it was a programme that could be tailored to meet the unique needs of each woman.

According to Barbach (1974) the "preorgasmic group process" accomplishes the following:-

1. The programme involves six to seven women who meet together for ten sessions of two hours each. The groups are held weekly or twice weekly.
2. Each woman is required to do on her own a series of given sexual and non-sexual tasks and to report back to the group as to the progress made or concerns encountered.

3. The initial assignments follow Lobitz and LoPiccolo's nine step masturbatory programme (Lobitz and LoPiccolo, 1972).

4. The assignments are modified to meet each individual's particular needs.

5. The therapist helps each woman design her particular home assignments.

By gradual stages, the woman learns to gain control over, and feel good about her body. She then learns to take responsibility for her own orgasm through masturbation. Finally, she learns to ask for what feels best with her partner.

Barbach (1974) used the term "preorgasmic" referring to women who do not experience orgasm as not being psychologically disturbed but lacking the necessary information and experience for orgasm to take place.

Masters and Johnson (1970) asserted that a sexual problem is a "relationship problem". However, Barbach's contention was that more often the problem results from some of the individual's sexual history, values and expectations. She felt that for women who had infrequently experienced orgasm with any partner and not with masturbation, it seemed that orgasm might be an issue to be resolved, first by the woman herself and later as part of the relationship (Barbach 1974; 1980).

The group programme is behaviourally orientated in that it uses a graduated systematic desensitisation approach. It incorporates the methods of body orientated therapies by
providing a way for women to explore and learn to become more comfortable with their bodies. This exploration often leads to the uncovering of fears, conflicts and relationship problems which are examined through individual exploration within the context of the group. The women learn that they are deserving of pleasure, including sexual pleasure, that it is their responsibility to obtain such pleasure, if and when they desire it. The group process eliminates feelings of isolation and abnormality as each person works with and learns from others like themselves (Mills and Kilman, 1982).

Considerable research has been conducted and shown that women who participate in these preorgasmic groups feel far better about their bodies and feel that they have better control over their lives after therapy has been successfully completed (Barbach, 1974; Heinrich, 1976; Kuriansky et al, 1976; 1982).

For many people, sex is equivalent to intercourse. However the indirect clitoral stimulation afforded through intercourse alone is often insufficient to enable many women to reach orgasm. Rather than stressing orgasm through intercourse as a goal for the woman, Barbach (1974) in her group treatment, tried to expand the women's repertoire of sexual activities by encouraging them to seek sexual satisfaction in whatever manner is mutually acceptable.

Therefore, rather than attempting to fit a woman into a mould that may not fit her specific physiological requirements for orgasm, they attempted to broaden the acceptable sexual practices to meet her unique needs or capabilities (Barbach, 1974).

Nevertheless, this method may not bring about change in attitude towards sex and sexuality of the partner or in the sexual interaction. When the woman's relationship is seriously disturbed by poor communication, unexpressed or indirectly expressed anger, unresolved power struggles or
any other of the problems that are reflected in the bedroom, treating the woman alone may not be sufficient. In certain relationships, treatment of only one member may unbalance the system in such a way that the relationship will suffer if these dynamics are not taken into account by the therapist.

There has been some criticism of the group format and of directed masturbation because of its emphasis on auto-erotic technique and response (Wakefield, 1987), and because these experiences may not transfer into partner related activities (Kuriansky et al, 1982; Wakefield, 1987).

Barbach (1974) examined the effects of a group treatment programme on 83 women with primary orgasmic dysfunction. Male partners were excluded from treatment because she felt that their presence might be distracting to the women. No restrictions were placed on intercourse for the duration of treatment.

The treatment included re-education, masturbation training and an individually tailored component which included the use of sexual communication with the woman's partner through homework assignments. Treatment was conducted in a group which met ten times; for one and a half hour sessions, twice a week for five weeks. Two female co-therapists were used.

Barbach found that 91.6% of the 83 women attained orgasm consistently through masturbation. Seventeen of these women were followed up eight months after the treatment. As reported by Barbach (1974), these women remained orgasmic through masturbation. All but two of the women who had partners achieved orgasm with them, although with varying frequencies. The women also reported improvement in their level of happiness, relaxation and communication with their partners.
Wallace and Barbach (1974) demonstrated 100% success in attaining orgasm through masturbation within a five week treatment programme. Within eight months post treatment, over 87% of the women were capable of orgasm in partner-related activities. Seventeen primary anorgasmic women were included in their study.

In order to determine the appropriateness of sex therapy for younger and older women, Schneidman and McGuire (1976) used group therapy for the treatment of primary anorgasmic women, comparing treatment effects for ten women below age 35 and ten above 35. Treatment combined a Masters and Johnson's style behavioural therapy and a programme of directive masturbation. Seventy percent of the women in the under 35 group reported that they were orgasmic with vibrator stimulation, masturbation or partner stimulation by the end of the ten week programme. None were orgasmic with intercourse. In the group of women over age 35, only 40% were orgasmic in any way at the termination of therapy.

None were orgasmic with intercourse. During the treatment programme, some of the women from both groups reported that the therapy appeared to be a potential threat to their partners. As they became more sexually assertive the men became increasingly anxious in response to their partner's new behaviours.

Before therapy, the men in these relationships generally had been the sole initiators of the sexual experience and the women had usually been passive. Once the women were instructed to initiate sexual activity as homework exercises, male partners reacted either by being very supportive of their partner's activities or as in four couples, by becoming increasingly resistant and refusing to cooperate fully with the exercises. Most couples found that the sexual relationship continued to improve after therapy. This is consistent with the findings of Barbach (1974) and Barbach and Flaherty (1980) with women's preorgasmic groups, that the transfer of orgasmic capacity to partner
related activities usually occurred within eight months of termination.

Leiblum and Ersner-Hershfield (1977) assessed the effects of a sexual enhancement group on five women with primary orgasmic dysfunction. The treatment was conducted by one female therapist in eight weekly, one and a half hour group sessions. The treatment programme included a description of the female genital anatomy and physiology, education on sexual myths and misconceptions, LoPiccolo and Lobitz' (1972) masturbation training, Kegel's (1952) pubococcygeous muscle training and Masters and Johnson's sensate focus exercises. Weekly homework assignments were also given. Positive changes in the ability to achieve orgasm through masturbation were reported by four out of the five subjects. Only one subject achieved orgasm through partner stimulation.

Leiblum and Ersner-Hershfield (1977) raised the question as to whether orgasm during intercourse for all women is a necessary or even reasonable goal. Kaplan (1974) has suggested that given the variations in such factors as genital anatomy, type of stimulation provided and length of stimulation prior to ejaculation, coital orgasm, as a goal, is highly unreliable.

Other research with women's therapy groups has supported the finding that transfer of orgasm to coitus is low, regardless of treatment format (Heinrich, 1976; Kuriansky and Sharp, 1976; Schneidman and McGuire, 1976). Leiblum and Ersner-Hershfield (1977) also emphasised that the extent to which the male partner is himself dysfunctional, either in terms of negative sexual attitudes or performance inadequacy, must be considered in evaluation of treatment outcome.

The issue of inclusion of male partners in group therapy for women with orgasmic dysfunction was addressed by Ersner-Hershfield and Kopel (1979) who evaluated the
effects of partner participation on treatment. In their study they demonstrated the effectiveness of the treatment for preorgasmic women both with and without the inclusion of partners, for female and male participants, across multiple measures of self-sexuality and for couple-sexuality. The maintenance of gains through follow-up also showed the effectiveness of such treatment. The success rate of women who achieved orgasm via self-stimulation (91%) compares well with other group treatment programmes (Barbach, 1984; Heinrich, 1976). Furthermore, the percentage of women who experienced orgasm via couple activity (73% at post treatment, 82% at ten week follow-up) appeared to be better than that for the other group treatment evaluations (Barbach, 1974; Heinrich, 1976).

The majority of measures revealed no long-term significant differences between formats, thereby questioning assumptions made by advocates for either excluding or including partners in treatment. The outcome for mass versus distributed spacing of sessions also showed no significant difference, although the participants ratings of helpfulness of spacing was significantly higher for the distributed compared to the massed spacing.

The fact that the womens' groups exhibited comparable improvement to the couples' groups, supports Barbach's (1974) notion that treatment focused on women alone can have beneficial effects on the couple's sexual relationship.

This finding opposes the position that destructive sexual communication aspects of the couple's relationship must be treated directly (Kaplan, 1974; Leiblum and Ersner-Hershfield, 1977; LoPiccolo and Lobitz, 1972; Masters and Johnson, 1970). On the other hand the success of the couples' groups contradicts the notion that partners should be excluded because they interfere with womens' self-exploration and communication with her body and with her sense of control, and with the assumption of personal
responsibility for own sexuality (Barbach, 1974). It would appear that both formats have demonstrated benefits.

1.4.12 Bibliotherapy in the Treatment of Female Orgasmic Dysfunction

In the area of sexual dysfunction, many self-help books have been written. Bibliotherapy may be a very simple and economical way to modify behaviour. However, therapists generally do not really know the extent of which these books are effective in the treatment of sexual problems (Trudel and Proulx, 1987).

Heinrich (1976) explored the effects of treatment with and without a therapist in a sample of women complaining of primary orgasmic dysfunction. The relative efficacy of therapist run groups was compared with a self-help bibliotherapy treatment programme. The results indicate that improvement occurred in both conditions but the therapist led form of treatment was clearly more effective.

Research has indicated the utility of social learning programmes involving directed masturbation in the treatment of dysfunctions (LoPiccolo and Lobitz, 1972; Reisinger, 1974).

The most well known directed masturbation programme is a graduated nine step procedure developed by LoPiccolo and Lobitz (1972). Their programme involves a series of exercises including visual self-exploration, Kegel's exercises, self-stimulation to produce orgasm and generalising the orgasmic response to coital activities. This intervention has been shown to be effective with primary anorgasmic women but has been shown to be less successful with women reporting secondary orgasmic dysfunction. This programme is also available in a self-help manual format, Becoming Orgasmic, (Heiman et al, 1976).
McMullen and Rosen (1979) carried out a controlled study which differs from other studies in that the six week masturbation training programme was self-administered. Information was given either through written instructions or videotape modelling.

Sixteen non-orgasmic women, including an equal number of married and single women were randomly assigned to three groups, 1) videotaped modelling; 2) written instruction; 3) waiting-list control group. Subjects in both treatment groups were supplied with an electric vibrator during the fourth week of treatment. They found that 50% of their subjects became orgasmic by the end of the treatment period but there was no significant difference between the videotape modelling condition and the written instruction condition.

Dodge et al (1982) evaluated the effectiveness of the Heiman et al (1976) manual with only minimal therapist contact. This level of contact was chosen in preference to complete self-administration as it allowed periodic contact and monitoring of subjects' progress. Their sample consisted of thirteen secondary anorgasmic women.

Following the seven week intervention, the manual condition was found to be superior to an information control condition. The significant improvements made by treated subjects were maintained at a follow-up. The consistency of results across measures of sexual satisfaction, arousal and behaviour was impressive particularly given the small sample size employed and the brevity of the treatment. Generalisability of these results is limited by the small sample size of the treatment and control groups, as well as the somewhat questionable method of evaluating differences within and between groups.

Libman et al (1984) in their study assessed the effectiveness of a 15 session cognitive-behavioural sex therapy programme which was administered using either
individual couple, group therapy or minimal contact bibliotherapy formats. Their sample consisted of 23 couples with orgasmic dysfunction. Therapeutic outcome was evaluated by both subjective satisfaction and reported behavioural frequency measures. Subjects in all three conditions improved on a wide range of subjective satisfaction and behavioural outcome measures and there were few differences between groups. Such differences as were found, tended to favour the individual couple therapy condition. Group and minimal contact bibliotherapy appeared to be equally effective. In this study, the duration of the problem was ten years which suggests that the observed positive changes were related to the therapy process. Nevertheless, the experimental design would have been strengthened by an inclusion of a no-treatment or placebo control group.

Morokoff and LoPiccolo (1986) state that the effectiveness of the self-help book and film "Becoming Orgasmic" (Heiman et al, 1976), when used in a limited therapist contact self-help programme, was found to be equally effective to a complete programme of therapist administered sex therapy. Their study suggests that for clients who have no other major clinical presenting complaints, an approach that relies on education, information and systematically progressing through the programme of directed masturbation, will be an effective approach with respect to the treatment of anorgasmia.

Trudel and Saint-Laurent (1983) compared bibliotherapy and a control group in the treatment of anorgasmia. Their study indicated that bibliotherapy combined with a minimal telephone contact may be useful to improve some aspects of the sexual life of women diagnosed as primary or secondary anorgasmics. Significant changes were observed in sexual arousability and sexual repertoire of the subjects and their partners. Significant changes were also observed in general sexual satisfaction and in their clinical
questionnaire, although this change was not observed in a sexual interaction inventory. No significant changes were observed in the orgasmic response. They concluded that the treatment suggested by Heiman et al (1976) in the book *Becoming Orgasmic*, may modify many aspects of the sexual life of women and their partners and may be a useful part of the treatment of anorgasmia.

Many of these studies reviewed, suggest some kind of individual or couple treatment should be included together with the bibliotherapy approach to treat anorgasmia.

The above research results suggest that bibliotherapy self-help programmes may be effective for female orgasmic dysfunction and further work with larger samples is clearly needed. Given the prevalence of sexual dysfunction and the potential cost efficiency of the self-help approach to treatment, future studies are needed to compare varying degrees of therapist contact; to assess recently developed videotape, computer-based and Premium Rate Service (telephonic) interventions and to compare the effectiveness of these different self-help formats for sexual dysfunctions.

1.4.13 The Use of Audiovisual Material and Sex Education

Janovitch and Miller (1978) examined the effects of an audiovisual presentation on 17 women suffering from primary orgasmic dysfunction. Their results suggested that audiovisual materials may aid women with primary orgasmic dysfunction in achieving orgasm. The failure to control for expectancy or the effects of group treatment and the total reliance on the single self-report obtained during group discussion, make these results tentative. They suggested that explicit audiovisual materials were the major influence on the change of sexual behaviour.
Their results suggested that wider dissemination of accurate information about sex, whether in classrooms, books, films or magazines could be significant for enhancing sexual response of members of our society (Neidigh and Kinder, 1987).

Kilman et al (1983) evaluated the effects of sex education on the sexual functioning of 48 couples, in which the female reported secondary orgasmic dysfunction. Couples participated in a group format in which they received two hours of sex education during one week. Sexually explicit slides and photographs were used as instructional aids during didactic instruction. While results indicated that the sex education package resulted in reduced sexual anxiety and increased orgasmic frequency, there was not a significant reversal of the secondary orgasmic dysfunction.

Kilman et al (1983) concluded that "future studies should contrast the relative meaningfulness of the various components of the sex education package. This might include a comparison of an audiovisual format with the same information presented in a lecture format" (p.87).

1.4.14 **Generalisation of Orgasmic Ability**

Masturbatory experience is no longer looked upon as conditioning "clitoral fixation". Rather, it is appreciated as a factor which contributes positively to a woman's ability to enjoy sexual relations. But, in what way does this condition work? After a woman has learnt to pleasure herself, then what? The transfer of this learning to interpersonal situations does not follow automatically. Some researchers (Hite, 1976; Kinsey et al, 1953) have reported a positive relationship between masturbation experience and orgasm during sexual intercourse, but others (Clifford, 1978; Fischer, 1973) do not corroborate this finding. There is one thing on which these investigations more or less agree. About one out of every two women, with
masturbatory experience, still does not orgasm regularly during sexual intercourse.

Clinical data leads to the same or possibly even more pessimistic conclusions. Orgasmic inhibition as such, is reported to be virtually 100% curable, if the sole criterion for cure is the ability to reach orgasm. That is, almost any woman can learn to masturbate to orgasm if she wants to, but the transfer to a sexual relationship is another matter.

Such orgasms may result either from manual stimulation or, during sexual intercourse. Lobitz and LoPiccolo (1972); Reisinger (1979); Riley and Riley (1978) built generalisation into the programme and reported favourable results although it is not always clear whether concurrent manual stimulation during intercourse was necessary for the woman to achieve orgasm.

In contrast, McMullan and Rosen (1979) report that of 24 women becoming orgasmic, 11 failed to transfer to intercourse, often due to a problem on the part of the partner.

Leiblum and Ersner-Hershfield (1977) indicate that generalisation of an orgasm to partner stimulation was unreliable. Barbach (1974) claimed that transfer to the partner relationship usually occurs in women that have satisfactory emotional relationships. It has been argued by DeBruijn (1982) that individually designed programmes may often be necessary, to effect this transfer.

Kaplan (1974) reports that the prognosis for a woman who is highly responsive but who suffers from coital orgasmic inhibition is less favourable, possibly around 50%. In a later publication, Kaplan (1979) reports that only relatively few women are successful in achieving coital orgasm without concomitant clitoral stimulation.
Research has shown that women taking part in masturbation training programmes, without concurrent partner involvement, do learn to orgasm. However, the percentage of women that transfer this "learning" to coital orgasm ranges only between nine and 55% (Leiblum and Ersner-Hershfield, 1977; McMullan and Rosen, 1979; Schneidman and McGuire, 1976). This clearly indicates that bridging the gap between solitary and shared pleasure does not happen by itself.

De Bruijn (1982) concluded that one of the strongest inhibitors of the female's orgasmic reflex may be the couple's belief or their strong emotional wish that orgasm should happen during sexual intercourse and preferably during the male's thrusting.

This belief or wish directs the couple's behaviour during lovemaking and it may shorten or interrupt a type of sex play which is more likely to trigger the female's orgasm. Her data supports the insight of many sex therapists, that for most women, joining the male's thrusting pattern is one of the least efficient techniques that they can use if they want to orgasm.

Contrary to popular belief, the marriage bond doesn't seem to make it work any better. De Bruijn (1982) goes on to say that ignorance may be the cause of a couple's not engaging in a sex play which is likely to facilitate the women's orgasm. In other cases, the problem may not be a lack of technical knowledge but rather a deep emotional resistance, again accepting what one knows and applying it. This of course is a problem, or a resistance, only if orgasm is what the woman wants. For many people, the joy of sex does not depend primarily on orgasm. A sexual encounter without orgasmic release is a problem only if it is experienced as such. In De Bruijn's (1982) sample, only eight percent indicated that they usually feel dissatisfied and 22% felt that something was missing after sex without orgasm. In fact, Kaplan (1979) has clearly pointed out that a sexual
encounter with orgasmic release may be unsatisfying because other things are missing.

No studies have systematically examined whether continued intercourse during treatment or abstinence has differential effects on treatment outcome, nor have studies attempted to identify characteristics of women who would benefit from this procedure (Kilman, 1978; Lipsius, 1987). Madsen and Ullman (1967) have suggested that permitting sexual activity during the course of treatment provides a direct means for couples to assess progress in their sexual functioning and thus may serve as a source of reinforcement. Others, on the other hand, claim that repeated sexual intercourse without orgasm or perhaps without arousal for the woman is anxiety producing and expose the women to repeated failure experience, counteracting treatment gains in other areas (Masters and Johnson, 1970).

The most common outcome criterion for treatment success has generally been each woman’s self-report of orgasm responsivity (Andersen, 1983; Kilman, 1978). However, different criteria for treatment success have been used across studies.

Some authors do not mention criteria or use more than one criterion for successful treatment. Treatment goals vary regarding coital orgasm and orgasm through self or partner masturbation. In addition, partner variability in sexual functioning introduces an unavoidable aspect in the evaluation of the impact of treatment on orgasm through partner stimulation or through sexual intercourse. This variable, however, is not present in the attainment of orgasm through masturbation.

Only a few researchers have reported whether the woman attained greater satisfaction in their sexual functioning, regardless of changes in orgasmic responsivity. (Snyder et al, 1975). The issue of whether orgasmic responsivity
translates to sexual satisfaction in women has been raised by Jayne (1981), who found that more women engaged in and preferred intercourse to masturbation because intercourse was associated with a greater feeling of intimacy and closeness with their partners, although masturbation was a much more reliable means of achieving orgasm. Thus it would be mistaken to equate only frequency of orgasm with sexual satisfaction in women without considering other variables, including effective responses.

One factor that appears to determine treatment success is marital happiness prior to therapy. McGovern et al (1975) treated six cases each of primary and secondary orgasmic dysfunction. Although the primary anorgasmic cases improved dramatically, the secondary anorgasmic women generally did not report increased frequency of orgasm with genital caressing by partner or during intercourse.

It was proposed that secondary anorgasmic women may respond better when traditional marital therapy is combined with sex therapy. Whereas primary anorgasmic women may respond best to therapy that is focused specifically on sexual matters (McGovern et al, 1975).

Snyder et al (1975) found a combination treatment approach to be successful in cases where marital problems contributed to secondary orgasmic dysfunction. Another possible explanation for differences in treatment outcome is that among many secondary anorgasmic women, a long history of exclusive reliance on one particular and narrow technique of self-stimulation tends to bring orgasm under very narrow stimulus control. In this sense, the primary anorgasmic woman can simply be taught a new and adaptive response pattern, whereas the secondary anorgasmic woman must first unlearn maladaptive habits.
Kegel (1952) also supported the notion that increased vascularity increases orgasmic potential. Kegel found that patients who strengthened the pubococcygeous muscle through systematic exercise experienced an increase in their frequency of orgasm. As exercising a muscle leads to increased vascularity, it is quite possible that the increased vascularity in the pubococcygeous could also cause an increase in orgasmic frequency. Thus, on both physiological and psychological grounds masturbation is a logical treatment for anorgasmia in women. It has also been suggested that an intense orgasm leads to increased vascularity in the vagina, labia and clitoris (Bardwick, 1971). Moreover, an increased number of orgasms lead to the psychological anticipation of pleasure in sex (Bardwick, 1971). The findings of Kegel (1952) and Swift (1993) further support this notion.

Roughan and Kunst (1981) found no difference in orgasmic frequency amongst groups who used Kegel exercises, relaxation training or attention control, although the pubococcygeous muscle group had increased muscle tone. These findings have since been supported by Chambless et al (1984); Messe and Geer (1985); Roughan (1981); Trudel and Saint-Laurent (1983).

Tensing the vaginal musculature has been found to be less arousing than use of fantasy on both physiological and subjective measures of arousal. However, tensing plus fantasy was most arousing (Messe & Geer, 1985). These results suggest that Kegel exercises have arousal enhancement value. However, it is also possible that they facilitate orgasm by increasing women's awareness and comfort with their genitals.
The use of erotic fantasy as a distraction from performance concerns and self-monitoring and as an enhancer of sexual arousal has been advocated by a number of therapists (Heiman et al., 1976; Kaplan, 1974; Nims, 1975; Nutter and Condron, 1983; Whipple, 1992b; Wish, 1975).

Flowers and Boorem (1975) developed a programme of imagination training to be used as an adjunct to sex therapy to treat their sexually dysfunctional clients who reported minimal sexual fantasy or fantasies of sexual failure.

In a sexual enhancement workshop of orgasmically dysfunctional women and their partners, Sotile et al. (1977) encouraged participants to develop their own sexual fantasies and to use these whenever they experienced difficulty in becoming aroused. The workshop which followed systematic desensitisation for anxiety, included other cognitive-behavioural components and resulted in an increase in the frequency of extra-coital orgasm from 10% to 100% of attempts.

The use of fantasy and other erotic materials to increase sexual arousal was part of the behavioural procedures employed by Spence (1985), to assist women to generalise orgasm from self-stimulation to orgasm during intercourse.

Therapy focused on the reduction of sexual anxiety, reducing stereotype means of masturbation, communication and relaxation training, education to enable the transfer of orgasmic skills to coital situations and the increasing of sexual arousal. There were also homework assignments, the content of which was not reported. At the conclusion of therapy, three of the eight women receiving individual therapy had achieved the goal of orgasm during intercourse and this increased to six at the time of follow-up three months later. Actual frequency of orgasm during intercourse
was not reported. The group therapy format was not as successful with only two of the seven women attaining their goal.

1.4.17 Summary

In addition to directed masturbation for treatment of primary orgasmic dysfunction, other treatment programmes consist of a combination of sexual technique training, systematic desensitisation, communication technique training and re-education procedures.

Various studies have involved different treatment formats, including individual, couple and group therapy. The existing studies may be criticised for incorporating a number of interventions that are never systematically evaluated. For example, inclusion of the partner in treatment, directed homework assignments and efficacy of different assignments. Consideration of the specific type of anorgasmia - primary or secondary, is important to treatment planning (Kilmann, 1978).

Directed masturbation is most effective in treating primary anorgasmia and the success rate is at least 80% to 90% (LoPiccolo and Stock, 1986; Riley and Riley, 1978).

The success rate of secondary anorgasmia treatment ranges from 10% to 75% (Fichten et al, 1986; Kilman et al, 1986; Kuriansky et al, 1982; Kuriansky and Sharpe, 1976; Mills and Kilman, 1982).

Generally, younger, emotionally healthier, and more happily married women have a higher probability of success (Libman et al, 1984; LoPiccolo and Stock, 1986; Schneidman and McGuire, 1976).

LoPiccolo and Stock (1986) suggest a combination of marital and sexual treatment. Several studies have shown an increase in sexual and relationship satisfaction without a
significant improvement in the presenting sexual symptom (DeAmicis et al, 1985; Everaerd and Dekker, 1982; Heiman and LoPiccolo, 1983; LoPiccolo et al, 1985).

In general the treatment prognosis for women experiencing secondary orgasmic dysfunction is less positive than for women who have never reached orgasm. Often because non-sexual relationship problems are likely to be maintaining the orgasmic dysfunction (Kilman, 1978; Kilman and Mills, 1983; Sotile and Kilman, 1977; Zilbergeld and Kilman, 1984).

Research has explored whether certain aspects of treatment are more beneficial than others for women with secondary orgasmic dysfunction. For the most part, the findings have not revealed any clear trends. Heiman and LoPiccolo (1983) found no significant difference between treatment presented within a daily versus weekly time format.

Trudel and Saint-Laurent (1983) found no significant difference in changes of orgasmic responsivity between a self-treatment which focused on pubococcygeal exercises and a self-treatment which consisted of sexual awareness, relaxation and breathing.

Libman et al (1984) found that all three behavioural sex therapy formats i.e., standard couple therapy, group therapy and minimal contact bibliotherapy i.e. self-help, brought about positive changes in subjective satisfaction and on behavioural measures.

The standard couple condition reflected slightly more positive changes than did the other two formats, although not to a great extent.

Kilman et al (1986) examined the impact of four group treatment formats, consisting of components typically used to treat women with secondary orgasmic dysfunction. Fifty five couples first received four hours of basic sex
education then participated in one of six experimental conditions: communication skills training, sexual skills training, a condensed combination of both of these formats presented in either of two sequences, a series of didactic lectures on the material presented in the combination treatment or a waiting-list control.

All treatment was conducted in groups for two hours, twice weekly for five weeks. No significant difference was found between the four treatments at any of the testing periods - suggesting their relevant equivalent impact. It is possible that if there was a more intensive individualised focus which is characteristic of individual therapy, and/or increased treatment hours which focused on the specific aspects of sexual interactions, this may in fact have led to greater and more lasting gains (Kilman et al, 1987).

Leiblum and Ersner-Hershfield (1977) raised the question of whether orgasm during intercourse is a necessary or even reasonable goal for all women. Kaplan (1974) has suggested that given the variations in such factors as genital anatomy, type of stimulation provided and length of stimulation prior to ejaculation, coital orgasm is highly unreliable.

Other research with women’s therapy groups have supported the findings that transfer of orgasm to sexual intercourse is low, regardless of treatment format (Heinrich, 1976; Kuriansky and Sharpe, 1976; Schneidman and McGuire, 1976).

Leiblum and Ersner-Hershfield (1977) also emphasised that the extent to which the male partner is himself dysfunctional either in terms of negative sexual attitudes or performance inadequacy, must be considered in evaluation of treatment outcome.

Hence, as regards treating female orgasmic dysfunction, it would seem that a careful assessment for each individual is needed to identify those elements that would comprise the
most effective intervention. The research evidence is unequivocal that a programme of directed masturbation is an effective treatment for primary orgasmic dysfunction. Other elements of treatment may be used in conjunction with directed masturbation including systematic desensitisation, education information, body image work, sexual technique training and couple's communication training.

Intercourse should be restricted during early stages of treatment if it generates anxiety or perpetuates a goal orientation. When a male partner is available, incorporating him into treatment is indicated as follows: to treat him if he suffers from a sexual dysfunction himself; to work on the couple's communication and relationship problems; to avoid feelings of threat or being left out on the part of the male partner; and to perhaps neutralize potential resistance.

Finally, although orgasm achieved during intercourse may be an unrealistic goal of treatment, there is no reason to expect that achieving orgasm with a partner through some form of genital stimulation will not occur for most women in relationships with cooperative partners (Andersen, 1983).

Future research directed at non-genitally focused criteria for sexual satisfaction is needed. The importance of emotional commitment, communication, tenderness and caring should never be overlooked (Davidson et al, 1989).

What for example is the goal of sex therapy for secondary orgasmic dysfunction? Is it to increase the frequency of interpersonal orgasms - a behavioural outcome, or to increase the enjoyment of sexual activities - a cognitive affective outcome.

How should behavioural or cognitive affective outcomes be measured? Is ongoing assessment through self-monitoring on a daily basis or retrospective evaluation by questionnaires
administered at pre-selected assessment times more accurate? Whose outcome should be taken into consideration? Those of the female only or should those of the male partner also be considered (Fichten et al, 1986).

It appears that despite the tremendous amount of research already conducted in the area, many unanswered questions still remain and much research still needs to take place.

1.4.18 Conclusion

Today self-help books and "how to" programmes are part of our culture. These self-help programmes are widely available and cover many different areas (Quackenbush, 1991).

Although most of these self-help books and programmes have not been scientifically assessed, it would appear that they play an important role in our society (Starker, 1988). In fact, not only does the consuming public purchase such material, but psychologists often recommend them as an adjunct to the psychotherapeutic process (Quackenbush, 1991).

Back in 1976, Rosen expressed great concern about the proliferation of these do-it-yourself books and self-help programmes. Rosen (1976) was concerned with the risks that may be incurred when self-administering therapeutic instructions. He was further concerned with the fact that these books make great claims, particularly regarding misleading titles, which created unrealistic expectations concerning their effectiveness. He questioned whether self-help books could in fact be harmful or ineffective.

Rosen was instrumental in motivating the American Psychological Association to establish a Task Force to investigate self-help therapies. The APA Task Force on
Self-Help Therapies (1978) made certain recommendations and outlined various principles and standards, regarding self-help therapies. These suggestions have over the years largely gone unheeded. Rosen (1987) stated that some self-help programmes may be useful but they still required adequate validation. The fact is that self-help books and programmes appear to cause little harm or distress to those using them (Starker, 1988a; 1988b).

Self-help programmes are available in many different formats for example, books and manuals, audiocassettes, videotapes, computer-based programmes and more recently the telephone, i.e. Premium Rate Telephone Services. Glasgow and Rosen (1978) claim that self-help therapies could be effective and that they offered tremendous potential - yet they still needed to be evaluated. This was their main argument.

The practice of sex therapy over the past 20 years has changed remarkably. Before Masters and Johnson published their pioneering work *Human Sexual Inadequacy* (Masters and Johnson, 1970) the main focus of sex therapy was psychoanalytically orientated. The shift in focus from the traditional psychoanalytic methods to a largely cognitive-behavioural orientated approach was prompted largely due to the poor results obtained from the psychoanalytically orientated approaches (Kaplan, 1979).

Today the practice of sex therapy is generally eclectic in nature. Although cognitive-behavioural methods are extremely popular with reported success rates for different sexual dysfunctions favourable (Delaney and McCabe, 1988; LoPiccolo and Stock, 1986), the move today is towards an integrated approach, owing to the difficulties and the complexity often experienced in treating sexual dysfunction (Kaplan, 1974; 1979; 1983; Sollod, 1988; Sollod and Kaplan, 1976).
Sex therapy "treatment packages" come in different formats for example, individual, group and couple therapy (Barbach, 1974; 1984; Blakeney et al., 1976; Bogat et al., 1987; Masters et al., 1982) utilising different treatment modalities, for example, directed masturbation (Lobitz and LoPiccolo, 1972; LoPiccolo and Lobitz, 1972; McGovern et al., 1975; Reisinger, 1974), systematic desensitisation (Husted, 1975; Jones and Park, 1972; Sotile and Kilmann, 1977), minimal contact bibliotherapy (Dodge et al., 1982; Heinrich, 1976; Libman et al., 1984; McMullen and Rosen, 1979; Trudel and Proulx, 1987), group format (Barbach, 1974; 1980; 1984; Barbach and Flaherty, 1980; Schneidman and McGuire, 1976; Wallace and Barbach, 1974), audiovisual and educational approaches (Jankovich and Miller, 1978; Kilmann et al., 1983).

Two innovative treatment modalities used in sex therapy include computer-based programmes and the use of Premium Rate Telephone Service interventions. This would certainly indicate a marked shift in the focus of sex therapy today, compared to the traditional psychoanalytical approaches employed years ago. Together with this change in the scope and direction of sex therapy, successful treatment formats have been used in the treatment of femaleorgasmic dysfunction. These have largely been cognitive-behaviourally orientated, for example, systematic desensitisation, directed masturbation, group, individual and couple therapy approaches (Barbach, 1974; Husted, 1975; LoPiccolo and Lobitz, 1972).

Several sex researchers have made particularly valuable contributions towards these successful treatment programmes, for example, Barbach (1974; 1980), LoPiccolo (1978), Masters and Johnson (1970).

Some of the newer approaches in the treatment of female orgasmic dysfunction include self-administered bibliotherapy interventions and minimal therapist contact interventions - enabling women to take responsibility for...
improving their sexual functioning (Heiman and LoPiccolo, 1988; Libman et al, 1984; Trudel and Saint-Laurent, 1983).

Previous studies have shown that sex therapy for female orgasmic dysfunction in various formats and using various treatment outcomes have been successful (Delaney and McCabe, 1988; LoPiccolo and Stock, 1986; Renshaw, 1988).

The aim of the present study was to investigate an innovative treatment format for the treatment of female sexual dysfunction. The rationale behind the present study was to investigate whether a completely self-administered treatment modality i.e. the Premium Rate Telephone Service intervention would be effective in bringing about changes in general sexual functioning and in orgasmic responsivity for women experiencing sexual difficulties. The specific hypotheses for the study are:-

1. A Premium Rate Service intervention would lead to a significant improvement in sexual arousability, sexual satisfaction and quality of sexual interaction for women with reported orgasmic dysfunction.

2. A Bibliotherapy intervention would lead to a significant improvement in sexual arousability, sexual satisfaction and quality of sexual interaction for women with reported orgasmic dysfunction.

3. A Waiting-list Control group would show no significant improvement in sexual arousability, sexual satisfaction and quality of sexual interaction for women with reported orgasmic dysfunction.
4. A Premium Rate Service intervention would lead to a greater degree of sexual arousability\(^1\) compared to a Bibliotherapy intervention and a non-intervention Control group for women with reported orgasmic dysfunction.

5. A Premium Rate Service intervention would lead to a greater degree of sexual satisfaction\(^2\) compared to a Bibliotherapy intervention and a non-intervention Control group for women with reported orgasmic dysfunction.

6. A Premium Rate Service intervention would lead to a greater improvement in the quality of sexual interaction\(^3\) compared to a Bibliotherapy intervention and a non-intervention Control group for women with reported orgasmic dysfunction.

\(^1\) As measured by the Sexual Arousability Inventory (SAI); the Derogatis Sexual Functioning Inventory (DSFI): Information; Sexual Drive and Sexual Fantasy sub-tests; and the Sexual Interaction Inventory (SII): Female-Pleasure sub-test

\(^2\) As measured by the DSFI: Sexual Satisfaction and Global Sexual Satisfaction sub-tests; the SII: Female Dissatisfaction and Female Self-Acceptance sub-tests

\(^3\) As measured by the DSFI: Experience sub-test; the SII: Total Disagreement and Mate Acceptance - Female of Male sub-tests
CHAPTER 2

METHOD

2.1 Introduction

Owing to the proliferation of the Premium Rate Service (PRS) "sexual advice" lines in South Africa, and taking into account the possibility that such services may in fact be considered a valid form of "sexual self-help", it appeared necessary to determine the need and effectiveness of a PRS sexual self-help service. The present study was conducted to test the need and effectiveness of the "Dr. Paul" sexual self-help lines and was carried out in two Parts.

2.1.1 Part 1.

In order to determine the extent to which a need exists for an adult sexuality self-help programme to operate on a Premium Rate Telephone Service, it was firstly necessary to establish such a service and then assess the need thereof. Firstly, specific topics that would be incorporated into the adult sexuality self-help programme, would be chosen. These topics would then be researched and compiled into scripts, which would then be recorded, to be used on the Premium Rate Service. Based on the response to such a service i.e. assessing the call volume made to each topic, over a period of six months, the need for such a service could then be determined.

2.1.2 Part 2.

Following the completion of Part 1 of the study, the effectiveness of a PRS sexual self-help programme for a specific sexual difficulty could then be assessed.

This argument is based on the premise that theoretically various self-help programmes used either in a minimal
contact or self-administered format can be effective in affecting certain sexual difficulties (Dodge et al., 1982; Heiman et al., 1976), in various formats i.e. manual, videotape or audiocassette. However, the popular literature abounds with examples of self-help programmes for sexual dysfunctions that have not been adequately assessed (Delvin, 1974; McCarthy and McCarthy, 1991; Stanaway, 1992; Williams, 1988).

The aim of the present study was thus twofold:
1) To establish a professional and clinically based adult sexuality self-help programme to operate on the Premium Rate Telephone Service and to assess the response to this service i.e. the need; and
2) To assess the effectiveness of such a Premium Rate Service sexual self-help programme of intervention for specific sexual dysfunctions.

The specific hypotheses for this study as formulated in Chapter 1 are as follows:

1. A Premium Rate Service intervention would lead to a significant improvement in sexual arousability, sexual satisfaction and quality of sexual interaction for women with reported orgasmic dysfunction.

2. A Bibliotherapy intervention would lead to a significant improvement in sexual arousability, sexual satisfaction and quality of sexual interaction for women with reported orgasmic dysfunction.

3. A waiting-list Control group would show no significant improvement in sexual arousability, sexual satisfaction and quality of sexual interaction for women with reported orgasmic dysfunction.

4. A Premium Rate Service intervention would lead to a greater degree of sexual arousability, compared to a Bibliotherapy intervention and a non-intervention
Control group for women with reported orgasmic dysfunction.

5. A Premium Rate Service intervention would lead to a greater degree of sexual satisfaction compared to a Bibliotherapy intervention and a non-intervention Control group for women with reported orgasmic dysfunction.

6. A Premium Rate Service intervention would lead to a greater improvement in the quality of sexual interaction compared to a Bibliotherapy intervention and a non-intervention Control group for women with reported orgasmic dysfunction.

This Chapter will in detail explain the procedure that was followed in the study in order to substantiate or refute the hypotheses. Subject selection criteria will be described and a description of the particular apparatus used to measure the dependant variables being tested, will be presented. Lastly, the experimental design and analysis will be discussed. The results of the investigation will be presented in Chapter 3.

2.2 Subjects

Subjects consisted of listeners to Radio 702’s Sexually Speaking programme who responded to an announcement to participate in the study. Subjects selected met the specific selection criteria. They completed all the required questionnaires as well as the Self-help Programme. In total 91 female subjects were initially involved in the study. Forty two out of the initial 91 subjects completed the Self-help Programme.
Table 1. below shows a breakdown of the baseline subject data.

Table 1. Baseline Subject Data

<table>
<thead>
<tr>
<th>GROUP</th>
<th>N</th>
<th>MEAN AGE (YEARS)</th>
<th>RELATIONSHIP DURATION (YEARS)</th>
<th>SUBJECTS FAKING ORGASM</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREMIUM RATE SERVICE 1 (PRS 1)</td>
<td>14</td>
<td>38.3</td>
<td>11.3</td>
<td>4</td>
</tr>
<tr>
<td>PREMIUM RATE SERVICE 2 (PRS 2)</td>
<td>11</td>
<td>36.6</td>
<td>13.5</td>
<td>3</td>
</tr>
<tr>
<td>BIBLIO THERAPY (BIB)</td>
<td>8</td>
<td>33.3</td>
<td>9.9</td>
<td>4</td>
</tr>
<tr>
<td>CONTROL</td>
<td>9</td>
<td>31.9</td>
<td>10.1</td>
<td>3</td>
</tr>
</tbody>
</table>

The age range of the subjects is from 20 - 61 years with a mean age of 35 years.

All subjects had completed a standard nine education level or equivalent. This fact was important as both the questionnaires and instructions needed a certain education level to be fully understood. The readability level of the tests used in the study required that at least a standard nine or equivalent had been obtained (Thompson and Cranwell, 1984).

The mean relationship duration was 11 years and 2 months. One third of all subjects reported faking orgasm on occasion. Two subjects had been living with their respective partners for over six months and one subject was involved in a stable sexual relationship for over six months. The remaining subjects were married.

Further data of the subjects can be seen in Table 2.
Table 2.

Subject Data

<table>
<thead>
<tr>
<th>GROUP</th>
<th>ENGLISH SPEAKING</th>
<th>AFRIKAANS SPEAKING</th>
<th>WHITE</th>
<th>ASIAN</th>
<th>PARTNER COMPLETING THE SII *</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREMIUM RATE SERVICE 1 (PRS 1)</td>
<td>14</td>
<td>1</td>
<td>14</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>PREMIUM RATE SERVICE 2 (PRS 2)</td>
<td>11</td>
<td>2</td>
<td>11</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>BIBLIOTHERAPY (BIB)</td>
<td>8</td>
<td>0</td>
<td>7</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>CONTROL</td>
<td>9</td>
<td>0</td>
<td>7</td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>

* Sexual Interaction Inventory

From Table 2. it can be seen that 93% of the subjects were English-speaking Whites. The subject population can be regarded as homogeneous in terms of primary culture and language.

Specific inclusion criteria included the following: Subjects were required to be experiencing either primary or secondary orgasmic dysfunction which was defined as follows:

Primary Orgasmic Dysfunction: This refers to women who have never experienced orgasm in response to any form of stimulation (Masters and Johnson, 1970).

Secondary Orgasmic Dysfunction: This refers to women who previously were able to achieve orgasm from some means of stimulation but are currently rarely orgasmic, and who are also currently unable to attain orgasm in response to restricted types of stimulation (Masters and Johnson, 1970).

In addition, women who define their limited repertoire of stimulation techniques leading to orgasm as problematic, i.e. being dissatisfied with their frequency and/or the
nature of their orgasmic response, were also placed into this category. (This is in accordance with the secondary orgasmic dysfunction definition of LoPiccolo and Stock, 1986. See page 44).

Subjects were required to be married or living together or involved in a stable sexual relationship for the past six months and who were not experiencing any major depressive illness. Furthermore subjects need to be between the ages of 20 and 65; having reached a standard nine level of education; presently not on any psychotropic medication which may be adversely affecting their sexual functioning; currently not receiving treatment for any physical, psychological or sexual problem; primary heterosexual in their sexual orientation; and who were willing to commit themselves to the Self-help Programme as outlined in the Introductory Letter (see Appendix A).

Selection was made from the Initial Biographical Questionnaire sent to the listeners who responded to the announcement on one of Radio 702's Sexually Speaking programmes, in August 1992, detailing aspects of the Female Sexuality Project (see Appendix A for Introductory Letter; see Appendix B for Initial Biographical Questionnaire). All subjects were required to complete an "Informed Consent" form (see Appendix C).

The subjects selected were randomly assigned to one of the three Experimental and the one Waiting-list Control Group viz., Experimental Group One: Premium Rate Service 1 (PRS 1); Experimental Group Two: Premium Rate Service 2 (PRS 2); Experimental Group Three: Bibliotherapy (BIB); and Waiting-list Control Group: (CONTROL).

It was decided to use the Sexually Speaking programme to make the announcement and to recruit volunteers for participation in the study for several reasons. Firstly this had been done successfully in other major female
sexuality research projects (Barbach, 1974; Wallace and Barbach, 1974); secondly, the high profile of "Dr. Paul", as well as the fact that Sexually Speaking had been on the air for over four years, lent itself to the assumption that many listeners would respond; thirdly, "Dr. Paul" had built up credibility with the listeners over the years; and lastly, Sexually Speaking is one of South Africa's most popular talk-back radio programmes (Sunday Times Magazine, 1990). Hence, this was a logical way of recruiting subjects.

As can be seen in Table 2., the women in the study were White and Asian middle-class. Demographic variables were controlled for in that all subjects lived in Johannesburg or within 100 kilometres of Johannesburg.

2.3 Apparatus

In order to measure the widest degree of representational variability in female orgasmic dysfunction, a selection of the most widely used sexuality-related measures was made for the purposes of this study (Davis et al., 1988). These tests together with their relevant sub-scales were categorised into three broad areas, namely, sexual arousability, sexual satisfaction and quality of sexual interaction.

The specific sub-scales of the tests that measure these three broad areas are as follows:

1. Sexual Arousability was measured by the Sexual Arousability Inventory (SAI); the Derogatis Sexual Functioning Inventory (DSFI) Information, Sexual Drive and Sexual Fantasy sub-scales and the Sexual Interaction Inventory (SII) Female Pleasure sub-scale.

2. Sexual Satisfaction was measured by the DSFI Sexual Satisfaction and Global Sexual Satisfaction sub-scales
and by the SII Female Dissatisfaction and Female Self-Acceptance sub-scales.

3. Quality of Partner Interaction was measured by the DSFI Experience sub-scale and the SII Total Disagreement and Mate Acceptance - Female of Male sub-scales.

The dependant variables namely, sexual arousability; information; sexual experience; sexual drive; sexual fantasy; sexual satisfaction; global sexual satisfaction; female dissatisfaction; female self-acceptance; female pleasure; total disagreement and mate acceptance - female of male, were measured by the following sexuality-related assessment devices, because of their theoretical relevance to the goals and purpose of the study. These tests will be discussed below, not in the context of the broader categorised constructs but as sub-tests of the various sexuality-related test measures used for the purposes of the present study.

2.3.1 Sexual Arousability Inventory (SAI) (Hoon et al, 1976)

The SAI is a 28-item self report inventory measuring perceived arousability to a variety of sexual experiences, developed by Hoon et al (1976). The items are descriptions of sexual experiences and situations which are rated along a seven-point Likert scale on the basis of "how sexually aroused" the respondent feels, or would feel when engaged in the described activity. The respondent makes a rating on a seven-point scale ranging from -1; "adversely affects arousal" to +5; "always causes arousal", for items concerned with foreplay, erotic visual and verbal stimuli, breast stimulation, preparation for and participation in sexual intercourse and genital stimulation.

Sexual arousability was defined as the sum of an individual's ratings of how she believes she would think or
feel in 28 erotic situations, reflecting five dimensions assessed to underlie sexual responsivity in women. The arousability score is obtained by summing the arousability ratings, and subtracting any negative ones. Using a paper and pencil format, respondents circle the number indicating the degree of arousal during each of the described activities. The Inventory takes an average of 10 minutes to complete. (see Appendix D for an exhibit of the Sexual Arousability Inventory).

The Inventory was specifically designed to assess the sexual arousal dysfunction of women whether occurring in the presence or absence of relationships with either men or women.

The SAI was developed and cross-validated on samples of women representing educated middle-class and upper middle-class North American women. It's norms therefore may or may not be useful for differing ethnic or socio-economic groups. Owing to the nature of the sample in the present study, this did not pose a problem.

Studies successfully using the Sexual Arousability Inventory include those of Andersen (1981); Chambless and Lifshitz (1984); Coleman et al (1983); Dodge et al (1980); Hoon and Hoon (1978); Hoon and Hoon (1982) and Murphy et al (1980).

The SAI was developed with a sample of 151 women who rated themselves on the item pool of 131 items. On the basis of item analyses and statistically questionable factor analyses given, the number of items were reduced to a final set of 28. The 28-item version was then cross-validated on a second sample of 134 women. Alpha coefficients for the two samples were +0.99 and +0.92 and on an eight-week retest, the reliability coefficient was +0.69. A test-retest coefficient on a sub-sample (N=48) with an eight-week interval was 0.69. Split-half reliability was later confirmed by Chambless and Lifshitz (1984).
They obtained a Spearman-Brown split-half coefficient of .92 using a sample from another geographic location (N=252). Cumulative percentile norms have remained remarkably consistent (Chambless and Lifshitz, 1984).

Flax (1980) has provided reliability information on the 14-item shortened version of the Arousability Scale for women. In a sample of 158 White, married women, half with ileostomies, she obtained Cronbach-alpha coefficients of .88. Test-retest coefficients after a three week interval was .97 (N=39).

Data are presented that show the SAI to possess concurrent validity in terms of sexual experience and activity, satisfaction with sexual responsivity, and awareness of physiological changes during sexual arousal (Conte, 1983).

The SAI has the advantage of being short and easy to administer and of being appropriate for either heterosexual or lesbian woman. The SAI is clinically useful for diagnosing sexual arousal dysfunction and for the assessment of changing arousability during therapy (Hoon et al, 1976). However, although the items are reported to correlate highly with present satisfaction and frequency of sexual behaviour, the scale does not provide direct measures of current sexual functioning. For this reason the Sexual Interaction Inventory and the Derogatis Sexual Functioning Inventory were also used in the present study.

Construct validity has been demonstrated by consistently high correlations for criterion variables viz., awareness of physiological changes during sexual arousal; satisfaction with sexual responsivity; frequency of sexual intercourse; and total episodes of intercourse before marriage (Hoon et al, 1976). Separate factor analyses of the original SAI data and the subsequent independent heterosexual female sample, resulted in five highly interpretable solutions with similar factor loadings on the respective factors (Chambless and Lifshitz, 1984).
Burgess and Krop (1978) found a significant correlation between SAI scores and satisfaction with intercourse frequency in heterosexual women ($N=74$).

Discriminant validity has been demonstrated between normal and sexually dysfunctional women, the mean score of the sexual dysfunctional women performing at a fifth percentile of the normal group. The SAI therefore has exceptionally high internal consistency and compares favourably with that of the MMPI scales (Hoon et al., 1976). Other studies using the SAI reporting high validity and reliability, include those of Andersen (1981) and Dodge et al. (1980).

The SAI was chosen for use in the present study for the following reasons:

1. It is an extremely widely and frequently used assessment measure of sexual arousability (Thompson and Cranwell, 1984; Jensen et al., 1987).
2. Owing to the nature of the Self-help Programme of intervention used in the present study, changes in levels of sexual arousability were deemed important to assess as one of the dimensions of sexual functioning.
3. As Hoon et al. (1976) point out this measure is useful for the assessment of change in arousability during therapy – in this case, the Self-help intervention.

2.3.2 The Derogatis Sexual Functioning Inventory (DSFI) (Derogatis, 1975)

The DSFI is a self-report psychological inventory that is comprised of 10 distinct sections, and is designed to measure the quality of sexual functioning. It is an "omnibus" test with separate scores on the 10 sub-tests, which provide both a profile of the individual's sexual functioning, and also contribute to a total or global score, termed the Sexual Functioning Index. The DSFI is an appropriate instrument for estimating the frequency and quality of sexual behaviour and attitudes towards sexual behaviour.
Originally the DSFI was composed of 245 items that reflected an individual's functioning in eight areas (Derogatis, 1975).

In 1975 a revised version was published that included two additional sub-tests and a total of 258 items that reflect sexual functioning in the following 10 areas:

1. Information
2. Experience
3. Drive
4. Attitudes
5. Psychological symptoms
6. Effect
7. Gender role definition
8. Fantasy
9. Body image
10. Satisfaction

Scores derived from each of these sub-tests are standardised and may be scored to produce an overall score, the Sexual Functioning Index, which indicates an individual's global level of sexual functioning. There is also a Global Sexual Satisfaction Index (GSSI) that reflects the individual's subjective judgement concerning the quality of his or her sexual activities on a nine-point scale ranging from "could not be better" to "could not be worse".

For general clinical use, the DSFI appears to be one of the most comprehensive and potentially useful inventories, also providing the most complete psychometric data (Conte, 1983). However, as Conte (1983) points out "considering its length, the DSFI unfortunately does not have a scale for current relationship satisfaction" (p.153).

In the present study, this problem was overcome by using the Sexual Interaction Inventory. It appears that the DSFI is useful not only for measuring the current sexual functioning of a wide variety of individuals including
males, females, couples, heterosexuals and homosexuals but that it has clinical relevance and utility as well. Because it provides a quantitative summary of the quality of an individual's current functioning, it can determine changes in sexual functioning occurring after or during treatment.

Hence, this measure was considered appropriate and theoretically relevant for inclusion in the present study.

The following sub-tests were chosen for inclusion in the present study as they were deemed most appropriate, taking into account the other dimensions of sexual functioning that were assessed by the different measures:

1. Information
2. Experience
3. Drive
4. Fantasy
5. Satisfaction
6. Global Sexual Satisfaction

Descriptions and details of the sub-tests used in the present study are as follows: (From the DSFI Manual, Derogatis, 1975).

1. Information

There is consistent evidence from numerous sources that failure to understand and appreciate the fundamental facts about the anatomy, physiology, psychology or general hygiene of sexual functioning can be and often is, detrimental to a completely fulfilling sexual experience (Kaplan, 1974; LoPiccolo, 1983; Masters and Johnson, 1970).

The Information sub-test seeks to measure the persons general understanding regarding sexual functioning. It consists of 26 items in a "True/False" format which the respondent is required to complete. It is difficult to estimate how many people are adequately informed regarding sexual functioning, largely because there is no consensus
regarding the minimum level of sexual information that is required to conduct oneself adequately sexually.

Masters and Johnson (1970) cite lack of accurate information as one of the major causes of sexual dysfunction in their experience.

It would appear that the quality of information available regarding sexual behaviour correlates to some positive degree with the degree of success one enjoys engaging in it (Derogatis and Melisaratos, 1979). For this reason it was decided to incorporate this particular sub-test into the present study. The Information sub-test score is defined as the sum of the number of correct answers and ranges from 0 to 26.

2. Experience

With a certain range of sexual dysfunction there is often an associated limiting or rigidity of sexual behaviour in terms of the variety of sexual experiences the dysfunctional individual has engaged in. The level of experience an individual has had sexually correlates positively with reported degrees of success and satisfaction in sexual relationships.

It is important data to have in assessing the nature and the magnitude of a dysfunction and it is essential information in evaluating the impact of any intervention.

In light of the above it was decided to incorporate this scale into the present study. The experience sub-test consists of 24 distinct sexual behaviours that reflect the spectrum of sexual experience from fundamental to relatively advanced i.e. from very basic sexual activities to various forms of intercourse and oral-genital behaviours, providing a reasonable spectrum of experiences across which to conduct a clinical evaluation.
The Experience sub-test score is defined as the number of sexual experiences endorsed as positive that the respondent has engaged in. The range is 0 - 24.

3. Drive

The level of interest or energy in sexual activities and relationships has often been referred to as libido or sex drive. There has been a tendency to directly equate drive level with sexual adequacy. Such a view is not totally valid since as far as can be determined drive is not normally distributed within the adult population. It is true that mismatched levels of drive between sexual partners can contribute to the development of sexual disorders.

The concept of sexual or erotic drive is fundamental to any consideration of sexual functioning. The scale measures explicit sexual behaviour recognising that the assessment of drive would of necessity be imperfect (Derogatis, 1975).

The Drive sub-test is modelled after Kinsey's (1953) concept to the extent that it is a summary measure composed of five components i.e. sexual intercourse, masturbation, kissing and petting, sexual fantasy and ideal frequency of sexual intercourse. The Drive scale reflects the frequency of these five activities.

Information concerning age of onset of sexual interest and age of first sexual intercourse are also recorded but do not contribute to the total drive score. For this reason the latter two were not included in the present study as they were not relevant. Although this measure does miss some of the more subtle manifestations of drive, it is highly correlated with clinical impressions and has revealed high discriminant sensitivity (Derogatis and Melisaratos, 1979). For the above reasons it was decided to include the Drive sub-scale into the present study to
determine whether the intervention had any marked change on the drive level of each subject.

Each of the five items are scored on a 9-point scale by assigning a "not at all" response a value of 0 and progressing sequentially to "four or more times a day" which is assigned a score of eight. The sub-test score is the sum of scores assigned to each of the response items 1 - 5, the range is from 0 - 40. Each class of behaviours is measured on a 9-point frequency scale and these values are summed to produce a total score.

4. Fantasy

The area of sexual fantasy has been identified as a valid area of research for the behavioural and clinical sciences for a long time. Research information suggests that sexual fantasy is almost universal although not everyone experiences these fantasies under the same condition.

Some individuals have explicit detailed sexual fantasies many times a day whilst others merely have conscious sexual fantasies. Clinically, it has been observed that within a certain range, individuals with sexual dysfunction tend to be constricted in the variety of sexual themes they entertain. In other cases the quality of the dysfunctional individual’s sexual ideation may be found to be incompatible with healthy sexual functioning. Fantasy is important because it provides a window on the sexual wishes and drives of the person.

The sub-test measuring fantasy level is assessed via a series of 20 fantasy themes that had been selected from clinical and interview material. These 20 major sexual themes have been compiled from material on normal sexual functioning as well as clinical variations on sexual activities. The Fantasy score is the number of positively endorsed fantasies. The range is from 0 - 20.
Taking into account that one aspect of the Self-help Programme included the use of sexual fantasies, it was decided to incorporate this sub-test.

5. **Satisfaction**

On the surface the issue of sexual satisfaction appears quite straightforward, i.e. either a person is or is not satisfied with his or her sexual relationship. However, sexual satisfaction has a number of distinct but related facets.

Frequency of sex and the degree of variation in sexual activities are the major themes regarding sexual satisfaction that are often presented. Often an individual desires sex more frequently than his or her partner or wishes to be more adventurous than his partner likes to be. Although the communication between sexual partners or lack thereof is a frequent theme of sexual dissatisfaction, often a partner will complain that foreplay was not arousing or did not last long enough or that sexual intercourse was too brief.

Failure to achieve orgasm is a very frequent complaint amongst women (Barbach, 1980; LoPiccolo and Stock, 1986; Renshaw, 1988). In still another instance the problem with sexual satisfaction exists at a broader level. The individual may feel that his or her partner is no longer sexually gratifying as a person reflecting a problem at an interpersonal level. Although the issue of sexual satisfaction is complex the scale provides some insight into it.

This scale has been used in the present study because it was considered an important variable. The effect of the Self-help Programme on the subjects’ level of sexual satisfaction needed to be assessed. The Sexual Interaction Inventory, in addition, provided further insight into the
degree of satisfaction that subjects felt in their relationships, pre and post-intervention.

6. Global Sexual Satisfaction Index

The Global Sexual Satisfaction Index is a unidimensional 9-point scale in which the person makes a simple evaluation of his or her present sexual relationship. The ratings vary from "could not be worse" to "could not be better".

Further data on the DSFI is presented in Table 3 below.

Table 3.

Internal consistency and test-retest reliability coefficients for the DSFI sub-tests.

<table>
<thead>
<tr>
<th>SUBTEST</th>
<th>INTERNAL CONSISTENCY (N=325)</th>
<th>TEST-RETEST** (N=60)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Information</td>
<td>.56</td>
<td>.61</td>
</tr>
<tr>
<td>II. Experience</td>
<td>.97</td>
<td>.92</td>
</tr>
<tr>
<td>III. Drive</td>
<td>.60</td>
<td>.77</td>
</tr>
<tr>
<td>IV. Fantasy</td>
<td>.82</td>
<td>.93</td>
</tr>
<tr>
<td>V. Satisfaction</td>
<td>.71</td>
<td>-</td>
</tr>
</tbody>
</table>

**Test-retest coefficients are based on a 14-day retest interval.


From Table 3, the coefficients demonstrate acceptable levels of reliability for the DSFI sub-tests, although there are variations in the tests from scale to scale. Test-retest coefficients for the DSFI are also good on the whole, although there are some exceptions, viz, only the Information sub-test demonstrates a coefficient below 0.70.

The DSFI possesses both face and content validity. The former by virtue of the fact that the items of the test are
clearly about sexual behaviour, and the latter by a careful review of the domains critical to adequate sexual functioning. Within each domain, there is representative sampling of domain items.

Derogatis and Melisaratos (1979) discussed these aspects of validation, and in addition, report on a structure-confirming factor analysis based on a sample of 380 subjects. The analyses identified seven major factors that conformed in large measure to the primary sub-tests of the DSFI and provided strong support for the validity of the test.

As regards clinical discrimination studies, at present the DSFI has been used to discriminate males and females, male transsexuals from heterosexual males (Derogatis et al, 1978), female transsexuals from heterosexual females (Derogatis et al, 1981), males with psychogenic versus biogenic impotence (Derogatis et al, 1976) and male and female partners of patients with sexual dysfunctions (Derogatis and Meyer, 1979). In addition they have been able to distinguish distinct psychological subtypes of anorgasmia on the basis of DSFI profiles (Derogatis et al, 1986). These and continuing studies like them cumulatively contribute to the validation of the DSFI.

In evaluating the validity of a psychometric instrument, the evaluations of the performance of the instrument that are accomplished by other investigators are clearly as important as the validation studies done by the test authors (Derogatis et al, 1988).

Conte (1983; 1986) has completed two comprehensive reviews of psychometric measures of sexual functioning concerning the DSFI. Conte (1983) states in her first review "Derogatis' DSFI appears to be the most comprehensive of the inventories reviewed...it also provides the most complete psychometric data" (p.574). In a second comparative evaluation, Conte (1986), reports that for
general clinical use the DSFI appears to be the most comprehensive and potentially useful inventory. As regards test-retest coefficients the general conclusion is that in terms of stability of measurement, the DSFI "performs admirably" (Derogatis and Melisaratos, 1979). Experience and Fantasy coefficients are over .90, re-test coefficients for Drive is also relatively high at .77.

2.3.3 Sexual Interaction Inventory (SII) (LoPiccolo and Steger, 1974)

The SII as developed by LoPiccolo and Steger (1974) is a paper and pencil self-report instrument for differentiating dysfunctional from non-dysfunctional couples, and for the diagnosis of sexual dysfunctions. It is useful in measuring treatment outcome, and reflects the current nature of a couple’s sexual relationship with regard to both satisfaction and level of functioning (Nowinski and LoPiccolo, 1979).

The SII focuses on 17 specific sexual activities covering fairly comprehensively the range of marital heterosexual behaviours. Each member of a couple is asked certain information relative to each of the 17 activities (see Appendix F for an item list). Dysfunction is assessed in terms of a couple’s satisfaction with themselves and with each other as opposed to comparing each partner separately to some arbitrary external standard. This is because there is no objective standard for what is normal, adequate or functional sexual behaviour (LoPiccolo and Steger, 1974). For each of the 17 behaviours, both husband and wife separately answer six questions using a response format on a six-point rating scale with verbal labels, i.e. a total of 102 questions need to be answered. (For a sample page of the SII, see Appendix F).

The SII is self-administered and takes approximately 30 - 40 minutes for each person to complete. The SII can be scored easily by hand in approximately 10 minutes. A
scoring manual yields 11 raw scores and these scores are easily converted into standard scores and can be charted to produce a visible profile. Each SII scale has a mean of 50 and a standard deviation of 10.

The 11 scales were chosen on the basis of clinical experience in treating dysfunctional couples. This experience indicated that issues of dissatisfaction with frequency and range of sexual behaviours engaged in, self-acceptance, pleasure obtained from sexual activity, accurate knowledge of partner-preferred sexual activities and acceptance of partner were all crucial in determining sexual satisfaction (LoPiccolo and Steger, 1974).

Pictures of each of the 17 behaviours are included in the manual. Pictures are not included for the two intercourse questions. For these two, the respondents are asked to use their usual intercourse position as a source of reference.

A unique feature of the SII is that it provides ratings of real-ideal frequencies and satisfactions with various sexual behaviours for both partners. This permits the measurement of differences between partners and this gives the scale considerable diagnostic utility.

The SII also provides a relevant treatment outcome measure. It is a useful instrument because it is sensitive to treatment effects (Nowinski and LoPiccolo, 1979). This was one of the reasons the SII was chosen for use in the present study - the intervention was brief and relevant changes could be assessed. A further reason for choosing the SII was that it focuses on the actual sexual behaviours performed by a couple and the enjoyment and satisfaction obtained from the behaviours which acts as a direct measure of treatment outcome. The 11 clinical scales are as follows:- (From the SII Manual, LoPiccolo and Steger, 1974).
1. Frequency Dissatisfaction: Male
2. Self Acceptance: Male
3. Pleasure Mean: Male
4. Perceptual Accuracy: Male of Female
5. Mate Acceptance: Male of Female
6. Total Disagreement
7. Frequency Dissatisfaction: Female
8. Self Acceptance: Female
9. Pleasure Mean: Female
10. Perceptual Accuracy: Female of Male
11. Mate Acceptance: Female of Male

For the purposes of the present study, the following clinical scales of the SII were used:

Scale 6.: Total Disagreement

This is an index of the extent of sexual conflict and dissatisfaction in the relationship and provides a global index of sexual satisfaction.

Scale 7.: Frequency Dissatisfaction: Female

The actual frequencies of occurrence of the various sexual activities included in the SII, as reported by the female partner, are compared to the frequencies with which she says she would like these activities to occur. The scale is an index of the female partners relative satisfaction with the current repertoire of sexual behaviours that she and her partner are engaging in. It may be taken to reflect the strength of her motivation for change in the sexual sphere of the relationship.

Scale 8.: Self Acceptance: Female

This scale compares the female partner’s current level of enjoyment to her desired level of enjoyment of each sexual act listed in the SII.
Scale 9.: Pleasure Mean: Female

This is the female partner's average level of self-reported enjoyment of all 17 activities of the SII.

Scale 11.: Mate Acceptance: Female of Male

This scale compares the way the female currently perceives her partner's enjoyment of sexual activities to the reaction of her fantasised "ideal" sexual partner. In other words, her estimates of how much her partner enjoys an activity are compared to how much she would like him to enjoy it.

The SII scales have been shown to be internally consistent. For full details see Table 4.

Cronbach-alpha coefficients ranges from .79 to .93 for each of the 11 sub-scales. The SII scales are reliable on re-test (correlations ranging from .53 to .90), and is able to discriminate dysfunctional clients from non-clients (scale means range from 1.19 to 120.79 for clients and 3.89 to 70.55 for non-clients) and correlated with self-reports of sexual adjustment (r = -.35 and p = <.01) (LoPiccolo and Steiger, 1974). (See Table 4).

Significant correlations between the scales and global ratings of sexual satisfaction provided a measure of convergent validity and discriminant validity demonstrated for nine of the 11 scales that differentiated between normal and sexually dysfunctional couples. (See Table 5).
Table 4.

Sexual Interaction Inventory
Test Construction Statistics

<table>
<thead>
<tr>
<th>SII Scale</th>
<th>Test-retest</th>
<th>Cronbach coefficient</th>
<th>Correlation with self-report of sexual satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.893</td>
<td>0.886</td>
<td>-0.296&lt;sup&gt;a&lt;/sup&gt;</td>
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<tr>
<td>2</td>
<td>0.652</td>
<td>0.852</td>
<td>-0.188&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>3</td>
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<td>0.853</td>
<td>-0.204&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>4</td>
<td>0.713</td>
<td>0.895</td>
<td>-0.254&lt;sup&gt;b&lt;/sup&gt;</td>
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<tr>
<td>5</td>
<td>0.804</td>
<td>0.920</td>
<td>+0.207&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>6</td>
<td>0.891</td>
<td>0.933</td>
<td>+0.238&lt;sup&gt;b&lt;/sup&gt;</td>
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<tr>
<td>7</td>
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<td>+0.004</td>
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<tr>
<td>8</td>
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<td>0.795</td>
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<td>9</td>
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<tr>
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<td>11</td>
<td>0.818</td>
<td>0.881</td>
<td>-0.350&lt;sup&gt;a&lt;/sup&gt;</td>
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</tbody>
</table>

<sup>a</sup> P < 0.01.
<sup>b</sup> P < 0.05.

(From the SII Manual, LoPiccolo and Steger, 1974)
Table 5.

SII Validity Statistics

<table>
<thead>
<tr>
<th>SII Scale</th>
<th>Mean 1</th>
<th>SD 1</th>
<th>Mean 2</th>
<th>SD 2</th>
<th>Mean 3</th>
<th>SD 3</th>
<th>1 vs. 2</th>
<th>1 vs. 3</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>T</td>
<td>T</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>1</td>
<td>21.1</td>
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<td>9.88</td>
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<td>10.87</td>
<td>6.73</td>
<td>3.57b</td>
<td>6.30c</td>
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<tr>
<td>2</td>
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<td>2.00</td>
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<tr>
<td>3</td>
<td>5.16</td>
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<td>5.56</td>
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<td>5.28</td>
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<tr>
<td>4</td>
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<td>3.66c</td>
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<td>29.26</td>
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<td>6.97c</td>
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<td>6.82c</td>
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<td>5.98c</td>
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<td>0.54</td>
<td>3.12b</td>
<td>3.11b</td>
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<td>10</td>
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<td>6.59</td>
<td>6.88</td>
<td>3.69</td>
<td>9.59</td>
<td>6.08</td>
<td>3.49b</td>
<td>1.80a</td>
</tr>
<tr>
<td>11</td>
<td>8.98</td>
<td>6.47</td>
<td>4.00</td>
<td>4.98</td>
<td>8.56</td>
<td>7.65</td>
<td>3.05b</td>
<td>&lt;1.00</td>
</tr>
</tbody>
</table>

a \( p < 0.05 \).
b \( p < 0.01 \).
c \( p < 0.001 \).

(From the SII Manual, LoPiccolo and Steger, 1974).

The SII has also been shown to be sensitive to treatments that induced change in couples sexual behaviour and in their perceived levels of sexual satisfaction (LoPiccolo and Steger, 1974).
Conte (1983) states that clinicians who treat couples and want a direct measure of outcome of treatment for sexual dysfunction, would find the SII useful. The SII has been shown to be sensitive to post therapy changes with a range of sexual dysfunctions and in a variety of clinical and research context. Libman et al (1984) states that the SII is a widely used measure of assessing sexual satisfaction and functioning. Other researchers successfully using the SII include Abromowitz and Sewal (1980); Andersen (1981); D’Amicis et al (1985); Dodge et al (1982); Ersner-Hershfield et al (1979); Heiman and LoPiccolo (1983); Kilman et al (1986); Kilman et al (1987); McGovern et al (1975); Milan et al (1988) and Trudel and Proulx (1987). They all reported the SII as having acceptable levels of internal consistency and test-retest reliability.

It would appear that the SII is a generally useful instrument for clinical assessment in the sexual adjustment and sexual satisfaction of heterosexual couples (Conte, 1983). As Jensen et al (1987) and Thompson and Cranwell (1984) point out, the SII is one of the most frequently used measures for assessing marital and sexual adjustment and functioning. Even critics concede that the SII is the most promising instrument of its kind (McCoy and D’Agostina, 1977).

Fichten et al (1986) state that this is a very widely used questionnaire measure of global sexual harmony. For all of the above reasons, it was decided to incorporate the SII into the present study.

Research has demonstrated generally good reliability and validity. The scales are generally internally consistent, reliable on test-retest, able to discriminate clients from non-clients, reactive to treatment and correlated with self-reports of sexual adjustment.

While the SII is reliable in a statistical sense it appears to be a rather reactive test, its results are consistent
with other research, indicating that merely having people keep records of their sexual activity leads to marked changes in sexual behaviour (LoPiccolo and Steger, 1974; Mann, 1975).

Procedure

2.4 Introduction

The 64 "Dr. Paul" adult sexuality self-help lines were researched, scripted and recorded for use on the Premium Rate Service system by "Dr. Paul". All incoming calls to this service were computer-monitored, for the initial six-month period. This data reflected the need, in terms of call volume, for such a service. Thereafter, an assessment was made of the 24 most popular topics used on this service.

Based on this data, a specific sexual Self-help Programme for female sexual dysfunction was set up. Listeners to Radio 702's Sexually Speaking programme who volunteered for participation in the Research Project and who met the specific selection criteria, as determined through the Initial Biographical Questionnaire (see Appendix B) were randomly assigned to one of the three Experimental groups and one Waiting-list Control group. Prior to commencing the Self-help Programme all subjects completed the pre-intervention measures, excluding the PRS 2 group. As LoPiccolo and Steger (1974) and Mann (1975) pointed out, merely keeping records of one's sexual activity can lead to changes in sexual behaviour. To control for this possibility the PRS2 group did not complete pre-test measures. Subjects in the three Experimental groups completed the Self-help Programme over a period of eight weeks.

A post-intervention assessment was made of the effectiveness of the intervention, as assessed by various
test measures, over the eight-week period, for the three Experimental groups.

Part .1.

2.4.1 The Premium Rate Telephone Service (PRS)

Description

Any member of the public who has a telephone can dial a specific Premium Rate Service number and listen to a recorded message dealing with a particular topic that the caller has chosen. The topics available are wide ranging, for example, from health concerns to pet care, as well as advice about sexual matters. The individual calls a specific number which has been advertised offering this particular advice/information on the topic chosen. The recorded messages last a maximum of 10 minutes. Callers are charged at a rate, per minute, determined by Telcom (The South African Post Office).

The Premium Rate Service concept was first introduced in the United States of America approximately 12 years ago. The United Kingdom followed several years later and more recently, European and other countries world-wide have introduced Premium Rate Services. There are three main input levels before the general public can dial the service.

Telcom provides the nationwide telephone network and sets the call rates. Rates are assigned per minute of call time. The "service providers" have the computerised systems, also referred to as the audio-text systems and the technical back-up staff, and offer the service to the public. The "service providers" enter into a contract with the "information providers" who are experts in their particular fields to provide the information to be used on the system. In the case of the present study, "Dr. Paul" provided the information for the sexual self-help lines. The information
that was used on the Premium Rate Service system was researched, compiled and scripted by "Dr. Paul" who then recorded these scripts in a professional sound studio.

The "service provider" in this case, was one of the only independent Premium Rate Service companies in operation at the time. The benefits of such a Premium Rate Service to the callers include the following:-
1. They can obtain instant professional advice on specific problems.
2. The information can be obtained confidentially without any personal embarrassment on the part of the caller (Grumet, 1979).
3. It is available 24 hours a day, every day.
4. It is available to anyone who needs the service, anywhere in the country.
5. "Expert advice" can now be obtained by thousands of people who would otherwise be denied such an opportunity.

It must be noted that such advice lines can never replace the skills of a professional, whether a medical practitioner or a psychologist. This point was made clear in each of the recorded topics.

In South Africa, the sexual self-help lines provide sexual information and advice to the public. Such information was, until recently not so readily available, taking into account the fact that sexual repression prevails extensively, yet in South Africa extremely high rates of sexual abuse, marital discord and divorce are reported. Much of this important and valuable information was not so widely available until recently - a mere telephone call away.

An important factor which makes the use of such a service so valuable, is the tremendous shortage of sex therapists in South Africa (Solomon, 1993). Many longstanding misunderstandings and myths can now be clarified.
Furthermore, the sexual advice lines can be helpful if callers follow the unique self-help programmes, outlined for common sexual problems that have been developed and offered by "Dr. Paul".

The extensive "Dr. Paul" sexual self-help lines covered the following areas: Understanding Adult Sexuality (see Appendix G); Understanding Teenage Sexuality (see Appendix I); Understanding Childhood Sexuality (see Appendix H); Aids Information Line (see Appendix J); Understanding Marriage and Relationships (see Appendix K). For the purposes of the present study, the initial 64 Adult Sexuality topics were assessed (see Appendix G).

2.4.2 The Adult Sexuality Self-Help Topics

Description

For the purposes of the present study, the 64 adult sexuality self-help topics were assessed (see Appendix G). It must be pointed out that although certain guidelines were given, similar to that as outlined in various sex manuals, such guidelines and advice can never replace professional help - this aspect was made clear on each of the recorded topics. However, certain problems may not be so severe in nature that they warrant professional assistance (Lopicclo and Stock, 1986). It is for this particular group that the sexual self-help lines could be most helpful. For individuals experiencing more complex sexual problems, further insight into the nature of their problems could be gained from the information given, and this could prompt them to seek professional help as a result.

The adult sexuality self-help topics were essentially divided into two categories. The first category dealt with the most common adult sexual difficulties that have been identified, viz., rapid ejaculation; delayed ejaculation; erectile problems (psychogenic causes); concerns about the
The second category provided information of a more general nature and was designed as a means of helping individuals to improve their sexual techniques and skills and enrich their sexual relationships (McCarthy and McCarthy, 1991; Stoppard, 1991; Westheimer, 1991; Williams, 1988).

The adult sexuality self-help topics were chosen for the following reasons:

1. Various researchers list these as being the most common sexual problems presented to practitioners and sex clinics (Kaplan, 1974; LoPiccolo and Stock, 1986; Masters and Johnson, 1970; McCarthy and McCarthy, 1991; Renshaw, 1988; Stoppard, 1991). Various research studies list many of these topics and similar aspects as being common features of self-help programmes for sexual difficulties. Various sex manuals provide similar self-help guidelines to cope with these particular problems (Heiman et al, 1976; Klein-Graber and Graber, 1975; Masters and Johnson, 1970; McCarthy and McCarthy, 1991; Nowinski, 1988; Williams, 1988).

2. Over the past three and a half years, the Sexually Speaking programme hosted by "Dr. Paul" on Radio 702, revealed similar trends of the most commonly asked questions and concerns. Topics chosen for the self-help programmes covered most of these important areas.

Hence, from a perusal of the research and popular literature as well as an analysis of the most commonly asked questions and the most popular topics discussed on Radio 702's Sexually Speaking programme, the 64 Adult sexuality self-help topics were chosen. These topics were researched, compiled and scripted by "Dr. Paul" who then recorded them for use on the Premium Rate Service.
The "Dr. Paul" adult sexuality self-help service was advertised extensively, nationwide, over the initial six month period, by the Company providing the Premium Rate Service i.e. the "service provider", in both the English and the Afrikaans press, popular magazines and on radio stations. (The actual service was only available in English).

The response to these adult sexuality lines in terms of call volume was assessed over a period of six months i.e. from 15th October 1991 - 15th April 1992. (see Results, page 149, for further details). Briefly, the results indicated a substantial volume of calls to these adult sexuality lines. Some lines proved to be more popular than others. Hence, it was evident that there was a need for such a service provided by "Dr. Paul". The research and development as well as the entire setting-up of the adult sexuality self-help lines, together with the analysis of the response to the service, over the initial period of six months, constituted the first part of the present study.

Once the service had been established and the need ascertained, the author of the present study sought to determine whether in fact these lines provided mere curiosity value, or whether they could prove to be effective in improving various aspects of an individual’s understanding of his or her sexuality and relationship, and whether specific sexual dysfunctions could be successfully helped using this Premium Rate Service intervention, i.e. a self-administered self-help programme of telephonic intervention.

2.4.3 Radio 702’s Sexually Speaking Programme

Sexually Speaking is a talk-back radio programme broadcast on Radio 702, an independent radio station, serving the greater Johannesburg area, every Thursday 9 a.m. - 10 a.m., and on the first Monday evening of every month, 7 p.m. - 9 p.m. The programme is produced and hosted by "Dr. Paul".
The programme format is as follows. Each week a different topic is dealt with, the programme is broadcast live, an overview of the topic is given at the beginning of each programme ("information dispensing"), thereafter, listeners are invited to call in with their comments and particular queries and problems.

Sexually Speaking is the only regular, ongoing weekly open-forum in South Africa whose purpose is to educate and inform listeners on various aspects of human sexuality. When necessary, appropriate referral is made. Guests who are specialists in related fields of human sexuality, or who have some expertise that would enhance the Sexually Speaking programme, are periodically invited to participate on the programme with "Dr. Paul". Over 130 different topics have been dealt with in the past three and a half years (see Appendix L for a list of topics discussed on Sexually Speaking).

Sexually Speaking has one of the highest multi-racial listening audiences of any talk radio programme on a regular weekly basis in South Africa. Listenership is estimated to be between 100 000 to 250 000 per week. The programme has received tremendous positive publicity and comment in the national and overseas press (Sunday Star, 1991; Sunday Times Magazine, 1990; London Times, 1992).

It would appear that Sexually Speaking has made a significant and positive contribution in South Africa towards changing many individuals' attitudes, beliefs and thinking as regards human sexuality.

The Programme has brought into the open many topics previously regarded as taboo, hence providing a greater enlightenment, appreciation and awareness regarding various aspects of human sexuality. The success of the Sexually Speaking programme can be attributed in large part to the fact that it is presented in a professional and clinical manner.
The "Dr. Paul" phenomenon originated from Radio 702's Sexually Speaking programme. Owing to the popularity of the programme and the profile this gave "Dr. Paul", other media involvements followed, viz., 'Sex Talk with "Dr. Paul"' on National television, a sex education videotape (Sex Explained to Children) and the establishment of the most extensive Premium Rate Service sexual advice lines - all under the banner of "Dr. Paul".

"Dr. Paul" has been practising as a clinical psychologist and sex therapist for 12 years. He has been hosting and producing a weekly radio talk show called Sexually Speaking, broadcast on Radio 702, an independent radio station for the past three and a half years (see page 132 for details of the Sexually Speaking programme).

"Dr. Paul" was the first clinical psychologist/sexologist to co-produce and host a 13-part series on South African National television, entitled 'Sex Talk with "Dr. Paul"'. This has been regarded as a major breakthrough taking into account the existing South African culture and attitude towards sexuality. The television programme has been widely acclaimed (The Star Tonight, 1992). (See Appendix M for the 'Sex Talk with "Dr. Paul"' topics).

"Dr. Paul" has appeared regularly as an "expert guest" on many other local television programmes, for example "Good Morning South Africa"; "6 on One"; "Agenda"; M-Net's "John Berks Show"; "Carte Blanche" and Bop-TV's "Panorama" programme. He has also appeared on Swedish television and on French television, Channel 6 "Forbidden Fruits" programme. "Dr. Paul" has also produced and co-presented an educational video entitled "Sex Explained to Children".
"Dr. Paul" has the most extensive and comprehensive sexual self-help lines operating on the Premium Rate Service (see Appendix G, Appendix H, Appendix I, Appendix J, Appendix K).

"Dr. Paul" contributes regularly to many local magazine and newspaper articles and has lectured extensively on various aspects of human sexuality. He is also often quoted in various newspaper and magazine articles. "Dr. Paul" has presented scientific papers both locally and internationally.

Based on the above it could be accepted that the "Dr. Paul" PRS adult sexuality lines had a high standing and acceptability for the population at large.

Part 2.

2.4.5 Introduction

Owing to the fact that there was a need shown for the "Dr. Paul" adult sexuality self-help lines (see Results, page 149), it was deemed necessary to evaluate the effectiveness of the service. Part 2 of the present study was designed to assess the effectiveness of the "Dr. Paul" sexual self-help lines for female sexual dysfunction.

This empirical evaluation is in accordance with the recommendations made by Rosen (1976) and Rosen (1986) regarding self-help therapy. Self-help for female orgasmic dysfunction was the specific category chosen for assessment. The reasons for this include, inter-alia;

i) thirty-three percent of the most popular PRS "Dr. Paul" adult sexuality self-help lines, i.e. the topics receiving the highest call volume, dealt with "female orgasm";
ii) a further 33% of the most popular topics could be classified broadly as dealing with "female sexuality";

iii) many authors report problems in this area i.e. female orgasmic dysfunction, as extremely common (Burnap and Golden, 1967; Derogatis et al, 1986; Frank et al, 1972; Kaplan, 1984; Masters and Johnson, 1970; Renshaw, 1988);

iv) various other studies have assessed the effectiveness of self-help interventions in the treatment of female orgasmic dysfunction (Dodge et al, 1986; Heiman et al, 1976; Heinrich, 1976; Libman et al, 1984; Morokoff and LoPiccolo, 1986; Trudel and Saint-Laurent, 1983), hence certain comparative analyses could be made;

v) the high percentage of calls to these topics may have suggested mere curiosity value. Notwithstanding, it is important to determine whether such a Self-help Programme could really be useful and in what way such a Programme could benefit those experiencing sexual difficulties; and

vi) the assessment of the Premium Rate Service form of intervention with female orgasmic difficulty was unique in that it was the first Programme of its kind ever to be implemented and assessed (Davis, 1992; LoPiccolo 1992; Whipple, 1992a). Once the effectiveness of a Premium Rate Service form of intervention for female orgasmic dysfunction was determined, various other dysfunctions, for example, premature ejaculation, could then be assessed in a similar fashion.

2.4.6 The Self-Help Programme for Female Sexual Dysfunction

The following Premium Rate Service "Dr. Paul" sexual self-help topics were included in the Self-help Programme. These topics were researched, compiled and scripted and then recorded by the author of the present study to be used on the Premium Rate Service.
These topics formed the basis for the Sexual Self-help Programme for female orgasmic dysfunction:

REACHING A CLIMAX
1. Female orgasm: the facts
2. Genital and sexual self-exploration
3. Reaching a climax through self-stimulation
4. Reaching a climax with the help of your partner
5. Reaching a climax during sexual intercourse
6. Using a vibrator
7. The G-spot
8. Clitoral stimulation
9. Achieving better orgasms
10. Multiple orgasms
11. Non-genital pleasuring
12. Genital pleasuring

SEXUAL ENRICHMENT
13. Female sexual fantasies
14. Adventurous foreplay
15. Better sexual techniques for women
16. Erotic kissing
17. Erogenous zones
18. Oral sex
19. Lovemaking positions
20. Not interested in sex?

The rationale for choosing the above topics is as follows:— From a perusal of the research literature as well as from the popular self-help sex manuals available, most of these topics have been included as part of their programmes (McCarthy and McCarthy, 1991; Stoppard, 1991; Westheimer, 1991).

Similar subject matter has also been included in other reputable programmes treating female sexual dysfunction (Barbach, 1974; Barbach, 1980; Fischer, 1973; Graber and Klein-Graber, 1975; Heiman et al, 1976; Heiman and LoPiccolo, 1988; Masters and Johnson, 1970).
The Self-help Programme has been divided into two parts. The first part deals specifically with "reaching a climax" as well as improving orgasmic potential and satisfaction. The second half broadly deals with sexual enrichment and improving sexual technique. The study set out to assess not only changes in orgasmic response but also other variables such as sexual satisfaction, sexual experience, sexual knowledge, sexual drive, sexual fantasy and sexual pleasure.

2.4.7 Recruitment of Subjects

Details of the present study, termed "The Female Sexuality Research Project", were announced one month prior to the commencement of the Project. The announcement was made in August 1992, during one of "Dr. Paul’s" Sexually Speaking programmes on Radio 702.

During the announcement, the following details were given. The nature of the Project was outlined, i.e. that it would be a Self-help Programme, there would be no face to face consultations; the Self-help Programme would take place over a period of eight weeks, commencing in a month’s time; all tasks would be completed at home, either by the subject or together with the subject’s partner; only women who were married or involved in a committed relationship for the past six months would be included; various questionnaires would have to be completed during the duration of the Project; further details of the Project, together with an Initial Questionnaire would be sent to interested individuals and this would also be used for selection purposes; total confidentiality was assured and listeners were informed that "Dr. Paul" would be the only person conducting the research and having access to all this personal information.
Women who had never experienced orgasm through any means or who were currently experiencing difficulty in reaching orgasm as well as those who were unhappy with the frequency and method of reaching orgasm, i.e. experiencing either primary or secondary orgasmic dysfunction, would be selected. Listeners who were interested in participating in the Project were asked to call a specific number and were asked to leave their names and addresses. A computerised answering machine was used for this purpose. Listeners were informed that Project details would be sent to them within a week.

Following the initial announcement, 201 listeners left their names and addresses. All 201 respondents were sent an Introductory Letter, outlining details of the Project (see Appendix A) as well as an Initial Biographical Questionnaire (see Appendix B). Of the 201 initial respondents, 102 completed and returned the Initial Questionnaire.

The reasons for the 50% drop-out rate could be attributed to the fact that many individuals were uncertain as to what the project actually entailed, hence needing more information to describe the exact nature of the Project. Many probably felt that such a Programme, i.e. no therapist contact, was not suitable, and some probably found completing the questionnaire too threatening, as very personal and sensitive information was requested. Others may have responded initially out of mere curiosity. Nevertheless, the return rate can be considered as more than adequate (Fowler, 1988). Of the 102 who completed the questionnaire, 91 met the selection criteria and were included as part of the study. They were randomly assigned to one of the three Experimental groups, and the one Control group used in the study.
Following selection, subjects received the following:

Experimental Group 1 (PRS 1) and Experimental Group 3 (BIB): Each subject received a letter informing them that they had been selected to participate in the Project (see Appendix N). The test measures were then sent for completion by each subject. Each subject was informed that they would receive a Self-help Programme on receipt of their completed test measures. One subject in the PRS 1 group did not return the questionnaire and two subjects in the BIB Group did not return their questionnaires.

Experimental Group 2 (PRS 2): No initial test measures were sent to subjects in this group. This was to avoid "contaminating" the Self-help Programme in any way by introducing extraneous variables (Mann, 1975), and to duplicate the Premium Rate Service as closely as possible. To further minimise the effect of any extraneous variables that may have some bearing on the results, it was decided that minimal instructions were to be given, similar to that as outlined on the Premium Rate Service sexual self-help lines. Subjects in this group were sent the Self-help Programme together with a covering letter (see Appendix O).

The Waiting-list Control Group (CONTROL) were sent the test measures for completion and were informed that there would be an eight-week delay before they received the Self-help Programme (see Appendix P). Seven respondents in this group did not return their questionnaires. Possible reasons for this include: the fact that they did not want to be kept waiting and that the waiting period was too long; that they had lost interest - that they wanted help immediately and were not prepared to wait; and the questionnaires were lengthy and perhaps they became disillusioned not believing that they would ultimately receive a Self-help Programme.

A personal letter was sent to respondents who failed to meet the selection criteria, explaining the reasons for non-selection.
On receipt of the completed test measures, subjects received the following:

Experimental Group 1 (PRS 1):
Subjects received an audiocassette recording of the identical 20 Premium Rate Service sexual self-help topics making up the Self-help Programme. A covering letter (see Appendix Q); the Self-help Programme contents (see Appendix R); and the Self-help Programme guidelines (see Appendix S) were sent to all subjects in this group.

Experimental Group 3 (BIB):
Subjects were sent a transcript of the same 20 Premium Rate Service topics making up the Self-help Programme which was compiled into a manual form (see Appendix T). A covering letter (see Appendix Q); Self-Help Programme guidelines (see Appendix S); and the Self-help Programme contents (see Appendix U) were sent to all subjects in this group.

Waiting-List Control Group:
Eight weeks after subjects in the Control group had completed and returned the initial test measures they were once again requested to complete the test measures and were informed that they would be receiving the Self-help Programme within a week, irrespective of whether or not they returned their questionnaires (see Appendix V).

At the end of the eight-week period, allocated for completion of the Self-help Programme, the entire test battery, together with a covering letter (see Appendix W) and a Programme Evaluation Questionnaire (see Appendix X), was sent to all subjects in the three Experimental groups.

Table 6. below provides details of the composition of the three Experimental and one Control group, during the duration of the study.
Table 6.

Attrition rates in terms of Pre-test and Post-test Group Composition

<table>
<thead>
<tr>
<th>GROUP</th>
<th>INITIAL SELECTION</th>
<th>AFTER PRE-TESTING</th>
<th>COMPLETION OF INTERVENTION AND POST-TEST MEASURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREMIUM RATE SERVICE 1 (PRS 1)</td>
<td>23</td>
<td>22</td>
<td>14</td>
</tr>
<tr>
<td>PREMIUM RATE SERVICE 2 (PRS 2)</td>
<td>23</td>
<td>*</td>
<td>11</td>
</tr>
<tr>
<td>BIBLIOTHERAPY (BIB)</td>
<td>23</td>
<td>21</td>
<td>8</td>
</tr>
<tr>
<td>CONTROL</td>
<td>22</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td>TOTAL</td>
<td>91</td>
<td>42</td>
<td></td>
</tr>
</tbody>
</table>

*Not applicable as PRS 2 subjects were not required to complete the pre-test measures.

In addition, one letter was received from a subject in the PRS 1 group, one letter from a subject in the PRS 2 group and two letters from subjects in the BIB group, informing the author of the present study as to why they were unable to participate. Reasons included the following: the timing to complete the Self-help Programme was bad; their relationship had broken up; their partners were not prepared to cooperate; and the sort of intervention was not appropriate for them. Four subjects from the PRS 1 group and one subject from the BIB group returned their post-intervention questionnaires after the cut-off date had expired. In other words a "response" was received from 55% of the subjects, initially selected to participate in the Project.
2.4.8 Experimental Design and Analysis

In order to assess the effects of the Premium Rate Service and Bibliotherapy interventions on the dependant variables, a multivariate analysis of variance was conducted. Thereafter the dependant variables were assessed by a univariate analysis of variance. Following this, an analysis of covariance was used to assess significance of differences between the groups for the specific dependant variables while controlling for pre-test levels of that intervention.

In the event of the analysis of variance or the analysis of covariance being significant, a Sheffé post-hoc analysis would be used to test for significance of differences between individual means of the groups used in the study for a specific dependant variable.

Relationships between all of the dependant variables were then assessed by obtaining Pearson Product Moment Correlation Coefficients.
RESULTS

3.1 Introduction

The aim of the present study was firstly to establish a professional and clinically based Premium Rate Telephone Service (PRS) adult sexuality self-help programme. By monitoring calls to this service for the initial period of six months, the relative need could then be determined. Secondly, the effectiveness of such a service for female orgasmic dysfunction was then assessed.

The study sought to investigate whether the "Dr. Paul" PRS adult sexuality self-help service could be regarded as a valid and alternative form of self-help therapy for treating female orgasmic dysfunction.

Studies have shown that although numerous self-help programmes are in existence today (Quackenbush, 1991; Riordan and Wilson, 1991; Rosen, 1987; Starker, 1991), few have been scientifically and empirically validated (Dodge et al, 1982; Heiman et al, 1976; Heiman and LoPiccolo, 1988; Trudel and Proulx, 1987; Zeis, 1978; Zilbergeld, 1980).

Self-help treatment programmes for female sexual dysfunction are available in various forms, namely, do-it-yourself books and manuals; audiocassettes; videotapes and computer-based programmes (Binik et al, 1989; Heiman et al, 1976; Heiman and LoPiccolo, 1986; Jankovich and Miller, 1978).

A recent, innovative self-help medium is the Premium Rate Telephone Service. This study was carried out in accordance with the recommendations regarding the validation of self-help programmes made by the APA Task Force Report on Self-
Help Therapies (1978), i.e., to validate the PRS Self-help Programme in an empirical and scientific manner.

Numerous cognitive-behaviourally orientated techniques and formats have been used as part of "sex therapy packages" to treat female orgasmic dysfunction (Barbach, 1980; Heiman and LoPiccolo, 1988; LoPiccolo and Lobitz, 1972; Sollod, 1988).

This study sought to investigate how an innovative and alternate method, namely the telephone, could be used to treat female orgasmic dysfunction.

The hypotheses upon which the study was based and which are tested in this research are as follows:

1. A Premium Rate Service intervention would lead to a significant improvement in sexual arousability, sexual satisfaction and quality of sexual interaction for women with reported orgasmic dysfunction.

2. A Bibliotherapy intervention would lead to a significant improvement in sexual arousability, sexual satisfaction and quality of sexual interaction for women with reported orgasmic dysfunction.

3. A Waiting-list Control group would show no significant improvement in sexual arousability, sexual satisfaction and quality of sexual interaction for women with reported orgasmic dysfunction.

4. A Premium Rate Service intervention would lead to a greater degree of sexual arousability\(^1\) compared to a

\(^1\) As measured by the Sexual Arousability Inventory (SAI); the Derogatis Sexual Functioning Inventory (DSFI): Information, Sexual Drive and Sexual Fantasy sub-tests; and the Sexual Interaction Inventory (SII): Female-Pleasure sub-tests
Bibliotherapy intervention and a non-intervention Control group for women with reported orgasmic dysfunction.

5. A Premium Rate Service intervention would lead to a greater degree of sexual satisfaction\textsuperscript{2} compared to a Bibliotherapy intervention and a non-intervention Control group for women with reported orgasmic dysfunction.

6. A Premium Rate Service intervention would lead to a greater improvement in the quality of sexual interaction\textsuperscript{3} compared to a Bibliotherapy intervention and a non-intervention Control group for women with reported orgasmic dysfunction.

In order to test the hypotheses a battery of test measures was administered to each of the subjects prior to the intervention and eight weeks after the intervention, for the Experimental groups, and in the case of the Control group, at the end of the eight-week "waiting period". The battery of tests included the following:

1. Sexual Arousal was assessed by the SAI; the Sexual Drive, Sexual Information and Sexual Fantasy sub-tests of the DSFI; and the Female Pleasure sub-test of the SII.

2. Sexual Satisfaction was assessed by the Sexual Satisfaction and Global Sexual Satisfaction sub-tests of the DSFI and the Female Dissatisfaction and Female Self-Acceptance sub-tests of the SII.

\textsuperscript{2} As measured by the DSFI: Sexual Satisfaction and Global Sexual Satisfaction sub-tests; the SII: Female Dissatisfaction and Female Self-Acceptance sub-tests

\textsuperscript{3} As measured by the DSFI: Experience sub-test; the SII: Total Disagreement and Mate Acceptance - Female of Male sub-test
3. The Quality of Sexual Interaction was assessed by the Sexual Experience sub-test of the DSFI; the Total Disagreement and Mate Acceptance - Female of Male sub-tests of the SII.

Although a total number of 91 subjects were initially included in the study, 42 (i.e. 46%) completed the post-intervention measures (see Table 6, Page 142 for subject composition and attrition rates).

The results of the measures completed by the 42 subjects in the study were then statistically analysed.

In this chapter the results of the study will be presented as follows:

Firstly, the results of the needs analysis of the "Dr. Paul" adult sexual self-help service is presented, secondly the quantitative data obtained by the various measures used in the study will be presented and thirdly, the qualitative data obtained from the subjects' responses to the Project Evaluation Questionnaire will be presented.

3.2 The Establishment of the "Dr. Paul" Adult Sexuality Self-Help Lines run on the Premium Rate Telephone Service: Assessing the Response to the Service i.e. the Need

3.2.1 Introduction

The aim of the first part of this study was firstly to establish the "Dr. Paul" adult sexuality self-help lines to operate on the Premium Rate Telephone Service. The Service was widely advertised in both English and Afrikaans newspapers as well as in various popular magazines. (The Service was only offered in English).

Secondly, in order to determine the extent to which such a Service was used i.e. the response, all calls to the
Service were monitored over the initial period: 15th October 1991 - 15th April 1992.

In addition an analysis was made of the total number of minutes that callers listened to the information on the Service. This is referred to as "total call minutes". Calls to each specific topic were recorded as the length of time, in minutes, that the caller listened to the specific topic. This is termed the "average call holding time".

Once this data had been obtained an analysis of the 24 most popular topics was made i.e. the 24 topics receiving the highest number of calls.

3.2.2 The Response to the Premium Rate Service "Dr. Paul" Adult Sexuality Self-help Lines

The response to the Service over the initial period (15th October 1991 - 15th April 1992) was recorded. This data then formed the basis for the second part of the study i.e. assessing the effectiveness of such a Service for female sexual dysfunction.

Table 7 (see page 149) is a summary of the response to the Service.

From Table 7 it is evident that the total number of calls to the PRS "Dr. Paul" adult sexuality self-help lines, including calls to the Directory lines (which gave out a list of topics and relevant numbers to the caller), was 214,015. The total number of call minutes to the Service over the initial six-month period was 700,930. This reflects an average of 1,170 calls made daily to the Service.
The "Dr. Paul" Adult Sexuality Self-help lines:
Call Volume Data (15th October 1991 - 15th April 1992)

| Table 7. |
|---------------------------------|------------------|
| **NUMBER OF PREMIUM RATE SERVICE (PRS) ADULT SEXUALITY LINES** | **TOTAL** |
| **NUMBER OF CALLS RECEIVED** | 214,015 |
| **NUMBER OF CALL MINUTES** | 700,930 |
| **AVERAGE CALL HOLDING TIME** | 3.28 MINUTES |

* See Appendix X for a complete list of topics.

---

1. Number of call minutes refers to the cumulative amount of time, in minutes, that users of the PRS "Dr. Paul" adult sexuality self-help lines, actually listened to specific information and advice for all the topics.

2. Average call holding time refers to the average number of minutes that users of the PRS "Dr. Paul" adult sexuality self-help lines, listened to the information for a specific topic, before replacing his/her telephone receiver.
3.2.3 Assessing the "Dr. Paul" Sexual Self-help topics receiving the highest call volumes i.e. the most popular topics

In order to determine which topics were the most popular the call volume to each topic was examined.

The 24 most popular "Dr. Paul" sexual self-help topics are listed in Table 8 in order of popularity, together with the total number of calls received per topic, over the initial six-month period. (See page 151).

From Table 8 it can be seen that 33% of the most popular topics dealt specifically the "female orgasm" and a further 33% dealt with "female sexuality issues". In other words a total of 66% of the most popular topics dealt with one or other aspect of female sexuality.

Based on the response to the Service, as well as owing to the fact that 66% of the most popular topics dealt with female sexuality, it was then necessary to determine the effectiveness of such a self-help service for female sexual dysfunction.

Part 2 of the study, which assesses the effectiveness of the PRS Self-help Programme for female sexual dysfunction according to the specific hypotheses being tested, is presented in the following section.
TABLE 8.

The 24 most popular Premium Rate Service "Dr. Paul" sexual self-help topics and call volumes (15th October 1991 - 15th April 1992)

<table>
<thead>
<tr>
<th>RANK</th>
<th>TOPIC</th>
<th>CALL VOLUME</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Vibrator use</td>
<td>10,817</td>
</tr>
<tr>
<td>2.</td>
<td>Does penis size count?</td>
<td>10,578</td>
</tr>
<tr>
<td>3.</td>
<td>Masturbation (women)</td>
<td>10,309</td>
</tr>
<tr>
<td>4.</td>
<td>The G-Spot</td>
<td>9,434</td>
</tr>
<tr>
<td>5.</td>
<td>Masturbation (men)</td>
<td>9,254</td>
</tr>
<tr>
<td>6.</td>
<td>Genital-pleasuring</td>
<td>8,216</td>
</tr>
<tr>
<td>7.</td>
<td>Kissing techniques</td>
<td>7,248</td>
</tr>
<tr>
<td>8.</td>
<td>What turns women on?</td>
<td>6,842</td>
</tr>
<tr>
<td>9.</td>
<td>Sexual fantasies (women)</td>
<td>5,660</td>
</tr>
<tr>
<td>10.</td>
<td>Condoms</td>
<td>5,584</td>
</tr>
<tr>
<td>11.</td>
<td>What turns men on?</td>
<td>5,335</td>
</tr>
<tr>
<td>12.</td>
<td>Sexual fantasies (men)</td>
<td>5,243</td>
</tr>
<tr>
<td>13.</td>
<td>Self stimulation (reaching an orgasm)</td>
<td>5,069</td>
</tr>
<tr>
<td>14.</td>
<td>Foreplay</td>
<td>4,659</td>
</tr>
<tr>
<td>15.</td>
<td>Penis angle/curvature</td>
<td>4,520</td>
</tr>
<tr>
<td>16.</td>
<td>How to be a better lover (men)</td>
<td>4,124</td>
</tr>
<tr>
<td>17.</td>
<td>How to be a better lover (women)</td>
<td>3,767</td>
</tr>
<tr>
<td>18.</td>
<td>Reaching orgasm (during sexual intercourse)</td>
<td>3,656</td>
</tr>
<tr>
<td>19.</td>
<td>Importance of clitoral stimulation</td>
<td>3,596</td>
</tr>
<tr>
<td>20.</td>
<td>Better orgasms (strengthening the P.C. muscle)</td>
<td>3,509</td>
</tr>
<tr>
<td>21.</td>
<td>Morning erection, wet dreams</td>
<td>3,109</td>
</tr>
<tr>
<td>22.</td>
<td>Non-genital pleasuring</td>
<td>3,035</td>
</tr>
<tr>
<td>23.</td>
<td>Reaching orgasm (with partner's help)</td>
<td>2,843</td>
</tr>
<tr>
<td>24.</td>
<td>Coping with extra-marital affairs</td>
<td>2,837</td>
</tr>
</tbody>
</table>
3.3 The Effect of the Premium Rate Service (PRS) and Bibliotherapy (BIB) Interventions on Indices of Sexual Functioning and Interaction

3.3.1 Introduction

In order to assess the effect of the PRS and BIB interventions on indices of sexual functioning and interaction as measured by the Sexual Arousability Inventory (Sexual Arousability), the Derogatis Sexual Functioning Inventory (Information, Experience, Sexual Drive, Sexual Fantasy, Satisfaction, Global Sexual Satisfaction sub-tests) and the Sexual Interaction Inventory (Total Disagreement, Female Frequency Dissatisfaction, Female Self-Acceptance, Female Pleasure, Mate Acceptance - Female of Male sub-tests), dependant variable means were firstly cast in a multivariate analysis of variance.

Subsequent to that, individual dependant variables were subjected to univariate analysis of variance with Sheffé post-hoc analyses to test for significant differences between the groups comprising the independent variables. Following this an analysis of covariance with Sheffé post-hoc analysis to test for significant differences between the groups comprising the independent variables while controlling for pre-intervention levels of the respective variables, was conducted. Finally a Pearson Product Moment Correlation was conducted between the dependant variables.

3.3.2 Multivariate Analysis of Variance: The effect of the intervention on the combined dependant variables

In order to determine the effect of the Premium Rate Service intervention and the Bibliotherapy intervention on indices of sexual functioning and interaction as measured by the Sexual Arousability Inventory (Sexual Arousability) subscales of the Derogatis Sexual Functioning Inventory
(Information, Experience, Sexual Drive, Sexual Fantasy, Satisfaction, Global Sexual Satisfaction) and subscales of the Sexual Interaction Inventory (Total Disagreement, Female Frequency Dissatisfaction, Female Self-Acceptance, Female Pleasure and Mate Acceptance - Female of Male), a multivariate analysis of variance was conducted.

Table 9.

Multivariate analysis of variance: The effect of the intervention on the combined dependant variables.

<table>
<thead>
<tr>
<th>Statistic</th>
<th>Value</th>
<th>F</th>
<th>df (Num)</th>
<th>df (Den)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wilks' Lamda</td>
<td>0.355</td>
<td>0.9398</td>
<td>36</td>
<td>80.502</td>
<td>70.05</td>
</tr>
<tr>
<td>Pillai's Trace</td>
<td>0.837</td>
<td>0.9359</td>
<td>36</td>
<td>87</td>
<td>70.05</td>
</tr>
<tr>
<td>Hotelling - Lawley Trace</td>
<td>1.320</td>
<td>0.9412</td>
<td>36</td>
<td>77</td>
<td>70.05</td>
</tr>
<tr>
<td>Roy’s Greatest Root</td>
<td>0.829</td>
<td>2.0042</td>
<td>12</td>
<td>29</td>
<td>70.05</td>
</tr>
</tbody>
</table>

The multivariate analysis of variance for the grouped dependant variables revealed no significant effects due to the interventions (p>0.05) (see Table 9).

3.3.3 Analysis of Variance: The Effects of the Premium Rate Service intervention and Bibliotherapy intervention on individual measures of sexual functioning and interaction

The difference in means between the groups were analysed in terms of the dependant variables:- Sexual Arousalability; Information; Experience; Sexual Drive; Sexual Fantasy; Satisfaction; Global Sexual Satisfaction; Total Disagreement; Female Frequency Dissatisfaction; Female Self-Acceptance; Female Pleasure and Mate Acceptance - Female of Male (see Table of Means, Table 10, page 155).
3.3.3.1 Analysis of Variance: The Effect of the Premium Rate Service Intervention and the Bibliotherapy Intervention on the Dependant Variable Sexual Arousability as measured by the Sexual Arousability Inventory

In order to determine the differences between the groups for the dependant variable Sexual Arousability as measured by the Sexual Arousability Inventory, an analysis of variance was conducted.

### Table 11.

Analysis of variance for the dependant variable: Sexual Arousability, as measured by the Sexual Arousability Inventory.

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>3</td>
<td>549.702</td>
<td>183.234</td>
<td>0.28</td>
<td>p&gt;0.05</td>
</tr>
<tr>
<td>Error Variance</td>
<td>38</td>
<td>24719.367</td>
<td>650.510</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

An analysis of variance for the effect of the intervention for the dependant variable Arousability as measured by the Sexual Arousability Inventory revealed no significant difference (p>0.05) (see Table 11).
<table>
<thead>
<tr>
<th>DEPENDENT VARIABLES</th>
<th>GROUPS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PRS 1</td>
</tr>
<tr>
<td></td>
<td>PRE</td>
</tr>
<tr>
<td>SEXUAL AROUSABILITY</td>
<td>59.43</td>
</tr>
<tr>
<td>INFORMATION</td>
<td>20.57</td>
</tr>
<tr>
<td>EXPERIENCE</td>
<td>16.00</td>
</tr>
<tr>
<td>SEXUAL DRIVE</td>
<td>14.00</td>
</tr>
<tr>
<td>SEXUAL FANTASY</td>
<td>3.64</td>
</tr>
<tr>
<td>SATISFACTION</td>
<td>4.14</td>
</tr>
<tr>
<td>GLOBAL SEXUAL SATISFACTION</td>
<td>3.71</td>
</tr>
<tr>
<td>TOTAL DISAGREEMENT</td>
<td>113.50</td>
</tr>
<tr>
<td>FEMALE FREQUENCY DISSATISFACTION</td>
<td>23.07</td>
</tr>
<tr>
<td>FEMALE SELF-ACCEPTANCE</td>
<td>18.71</td>
</tr>
<tr>
<td>FEMALE PLEASURE</td>
<td>43.57</td>
</tr>
<tr>
<td>MATE ACCEPTANCE - FEMALE OF MALE</td>
<td>10.00</td>
</tr>
</tbody>
</table>

* No pre-testing was carried out
### Analysis of Variance: The Effect of the Premium Rate Service Intervention and the Bibliotherapy Intervention on the Dependant Variable Information as measured by the Derogatis Sexual Functioning Inventory

In order to determine the differences between the groups for the dependant variable Information as measured by the Derogatis Sexual Functioning Inventory, an analysis of variance was conducted.

#### Table 12.

Analysis of variance for the dependant variable: Information, as measured by the Derogatis Sexual Functioning Inventory.

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>3</td>
<td>20.410</td>
<td>6.820</td>
<td>0.98</td>
<td>p&gt;0.05</td>
</tr>
<tr>
<td>Error Variance</td>
<td>38</td>
<td>265.660</td>
<td>6.991</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

An analysis of variance for the effect of the intervention for the dependant variable Information as measured by the Derogatis Sexual Functioning Inventory revealed no significant difference (p>0.05) (see Table 12).
Analysis of Variance: The Effect of the Premium Rate Service Intervention and the Bibliotherapy Intervention on the Dependant Variable Experience as measured by the Derogatis Sexual Functioning Inventory

In order to determine the differences between the groups for the dependant variable Experience as measured by the Derogatis Sexual Functioning Inventory, an analysis of variance was conducted.

Table 13.

Analysis of variance for the dependant variable: Experience, as measured by the Derogatis Sexual Functioning Inventory.

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>3</td>
<td>46.455</td>
<td>15.485</td>
<td>0.66</td>
<td>p&gt;0.05</td>
</tr>
<tr>
<td>Error Variance</td>
<td>38</td>
<td>892.045</td>
<td>23.475</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

An analysis of variance for the effect of the intervention for the dependant variable Experience as measured by the Derogatis Sexual Functioning Inventory revealed no significant difference (p>0.05) (see Table 13).
3.3.3.4 Analysis of Variance: The Effect of the Premium Rate Service Intervention and the Bibliotherapy Intervention on the Dependant Variable Sexual Drive as measured by the Derogatis Sexual Functioning Inventory

In order to determine the differences between the groups for the dependant variable Sexual Drive as measured by the Derogatis Sexual Functioning Inventory, an analysis of variance was conducted.

Table 14.

Analysis of variance for the dependant variable: Sexual Drive as measured by the Derogatis Sexual Functioning Inventory.

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>3</td>
<td>94.480</td>
<td>31.494</td>
<td>1.15</td>
<td>p&gt;0.05</td>
</tr>
<tr>
<td>Error Variance</td>
<td>38</td>
<td>1044.495</td>
<td>27.487</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

An analysis of variance for the effect of the intervention for the dependant variable Sexual Drive as measured by the Derogatis Sexual Functioning Inventory revealed no significant difference (p>0.05) (see Table 14).
3.3.3.5 **Analysis of Variance: The Effect of the Premium Rate Service Intervention and the Bibliotherapy Intervention on the Dependant Variable Sexual Fantasy as measured by the Derogatis Sexual Functioning Inventory**

In order to determine the differences between the groups for the dependant variable Sexual Fantasy as measured by the Derogatis Sexual Functioning Inventory, an analysis of variance was conducted.

**Table 15.**

Analysis of variance for the dependant variable: Sexual Fantasy, as measured by the Derogatis Sexual Functioning Inventory.

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>3</td>
<td>25.088</td>
<td>8.363</td>
<td>0.78</td>
<td>p&gt;0.05</td>
</tr>
<tr>
<td>Error Variance</td>
<td>38</td>
<td>409.031</td>
<td>10.764</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

An analysis of variance for the effect of the intervention for the dependant variable Sexual Fantasy as measured by the Derogatis Sexual Functioning Inventory revealed no significant difference (p>0.05) (see Table 15).
3.3.3.6 Analysis of Variance: The Effect of the Premium Rate Service Intervention and the Bibliotherapy Intervention on the Dependant Variable Sexual Satisfaction as measured by the Derogatis Sexual Functioning Inventory

In order to determine the differences between the groups for the dependant variable Sexual Satisfaction as measured by the Derogatis Sexual Functioning Inventory, an analysis of variance was conducted.

Table 16.

Analysis of variance for the dependant variable: Satisfaction, as measured by the Derogatis Sexual Functioning Inventory.

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>3</td>
<td>9.957</td>
<td>3.319</td>
<td>0.54</td>
<td>p&gt;0.05</td>
</tr>
<tr>
<td>Error Variance</td>
<td>38</td>
<td>233.115</td>
<td>6.135</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

An analysis of variance for the effect of the intervention for the dependant variable Satisfaction as measured by the Derogatis Sexual Functioning Inventory revealed no significant difference (p>0.05) (see Table 16).
3.3.3.7 Analysis of Variance: The Effect of the Premium Rate Service Intervention and the Bibliotherapy Intervention on the Dependant Variable Global Sexual Satisfaction as measured by the Derogatis Sexual Functioning Inventory

In order to determine the differences between the groups for the dependant variable Global Sexual Satisfaction as measured by the Derogatis Sexual Functioning Inventory, an analysis of variance was conducted.

Table 17.

Analysis of variance for the dependant variable: Global Sexual Satisfaction, as measured by the Derogatis Sexual Functioning Inventory.

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>3</td>
<td>10.352</td>
<td>3.451</td>
<td>1.34</td>
<td>p &gt; 0.05</td>
</tr>
<tr>
<td>Error</td>
<td>38</td>
<td>97.766</td>
<td>2.573</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

An analysis of variance for the effect of the intervention for the dependant variable Global Sexual Satisfaction as measured by the Derogatis Sexual Functioning Inventory revealed no significant difference (p > 0.05) (see Table 17).
3.3.3.8 Analysis of Variance: The Effect of the Premium Rate Service Intervention and the Bibliotherapy Intervention on the Dependant Variable Total Disagreement as measured by the Sexual Interaction Inventory

In order to determine the differences between the groups for the dependant variable Total Disagreement as measured by the Sexual Interaction Inventory, an analysis of variance was conducted.

Table 18.

Analysis of variance for the dependant variable: Total Disagreement as measured by the Sexual Interaction Inventory.

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>3</td>
<td>12942.654</td>
<td>4314.218</td>
<td>0.94</td>
<td>p&gt;.05</td>
</tr>
<tr>
<td>Error Variance</td>
<td>38</td>
<td>174145.465</td>
<td>4582.775</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

An analysis of variance for the effect of the intervention for the dependant variable Total Disagreement as measured by the Sexual Interaction Inventory revealed no significant difference (p>0.05) (see Table 18).
3.3.3.9 Analysis of Variance: The Effect of the Premium Rate Service Intervention and the Bibliotherapy Intervention on the Dependant Variable Female Frequency Dissatisfaction as measured by the Sexual Interaction Inventory

In order to determine the differences between the groups for the dependant variable Female Frequency Dissatisfaction as measured by the Sexual Interaction Inventory, an analysis of variance was conducted.

Table 19.

Analysis of variance for the dependant variable: Female Frequency Dissatisfaction, as measured by the Sexual Interaction Inventory.

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>3</td>
<td>265.131</td>
<td>88.377</td>
<td>1.23</td>
<td>p&gt;0.05</td>
</tr>
<tr>
<td>Error Variance</td>
<td>38</td>
<td>2719.846</td>
<td>71.575</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

An analysis of variance for the effect of the intervention for the dependant variable Female Frequency Dissatisfaction as measured by the Sexual Interaction Inventory revealed no significant difference (p>0.05) (see Table 19).
In order to determine the differences between the groups for the dependent variable Female Self-Acceptance as measured by the Sexual Interaction Inventory, an analysis of variance was conducted.

**Table 20.**

Analysis of variance for the dependent variable: Female Self-Acceptance, as measured by the Sexual Interaction Inventory.

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>3</td>
<td>166.399</td>
<td>55.466</td>
<td>1.10</td>
<td>p&gt;0.05</td>
</tr>
<tr>
<td>Error Variance</td>
<td>38</td>
<td>1921.434</td>
<td>50.564</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

An analysis of variance for the effect of the intervention for the dependent variable Female Self-Acceptance as measured by the Sexual Interaction Inventory revealed no significant difference (p>0.05) (see Table 20).
3.3.3.11 Analysis of Variance: The Effect of the Premium Rate Service Intervention and the Bibliotherapy Intervention on the Dependant Variable Mate Acceptance - Female of Male as measured by the Sexual Interaction Inventory

In order to determine the differences between the groups for the dependant variable Mate Acceptance - Female of Male as measured by the Sexual Interaction Inventory, an analysis of variance was conducted.

Table 21.

Analysis of variance for the dependant variable: Mate Acceptance - Female of Male, as measured by the Sexual Interaction Inventory.

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>3</td>
<td>214.146</td>
<td>71.382</td>
<td>1.57</td>
<td>p&gt;0.05</td>
</tr>
<tr>
<td>Error Variance</td>
<td>38</td>
<td>1729.473</td>
<td>45.512</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

An analysis of variance for the effect of the intervention for the dependant variable Mate Acceptance - Female of Male as measured by the Sexual Interaction Inventory revealed no significant difference (p>0.05) (see Table 21).
3.3.4 Analysis of Covariance: The Effects of the Premium Rate Service intervention and Bibliotherapy intervention on individual measures of sexual functioning and interaction with pre-test levels of the same measures as the covariate

The difference in means between the groups were analysed in terms of the dependant variables:- Sexual Arousability; Information; Experience; Sexual Drive; Sexual Fantasy; Satisfaction; Global Sexual Satisfaction; Total Disagreement; Female Frequency Dissatisfaction; Female Self-Acceptance; Female Pleasure and Mate Acceptance - Female of Male, with pre-test levels of measures as covariates (see Table of Means, Table 10, page 155).

3.3.4.1 Analysis of Covariance: The Effect of the Intervention on the Dependant Variable Sexual Arousability as measured by the Sexual Arousability Inventory

In order to determine the effects of the intervention on the dependant variable Sexual Arousability as measured by the Sexual Arousability Inventory with pre-test levels of Sexual Arousability as the covariate, an analysis of covariance was conducted.
An analysis of covariance to determine the effect of the intervention on Sexual Arousability as measured by the Sexual Arousability Inventory with pre-test levels of Sexual Arousability as the covariate revealed a significant effect due to the interventions (p<.0001) (see Table 22). There was a significant effect due to the covariate pre-test levels (p<.0001) (see Table 22).

Owing to the difference between the intervention groups a Scheffé post-hoc analysis of significance of difference between individual groups was conducted.

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>3</td>
<td>10022.74</td>
<td>3340.91</td>
<td>9.96  ****</td>
</tr>
<tr>
<td>Error Variance</td>
<td>27</td>
<td>9055.26</td>
<td>335.38</td>
<td></td>
</tr>
<tr>
<td>Covariate</td>
<td>1</td>
<td>8948.10</td>
<td>8948.10</td>
<td>26.68 ****</td>
</tr>
</tbody>
</table>

* p<.05
** p<.01
*** p<.001
**** p<.0001

Table 22.

Analysis of covariance for the dependant variable: Sexual Arousability.
Scheffé post-hoc significance of differences for individual interventions for the dependant variable Sexual Arousalability.

<table>
<thead>
<tr>
<th></th>
<th>MEAN</th>
<th>PRS 1</th>
<th>BIB</th>
<th>CONTROL</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRS 1</td>
<td>82.71</td>
<td>-</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>BIB</td>
<td>82.13</td>
<td>NS</td>
<td>-</td>
<td>NS</td>
</tr>
<tr>
<td>CONTROL</td>
<td>77.33</td>
<td>NS</td>
<td>NS</td>
<td>-</td>
</tr>
</tbody>
</table>

NS: Not Significant

A Scheffé post-hoc analysis for significance of difference between means of Sexual Arousalability as measured by the Sexual Arousalability Inventory showed no significant effects (p>0.05) (see Table 23).

3.3.4.2 Analysis of Covariance: The Effect of the Intervention on the Dependant Variable Information as measured by the Derogatis Sexual Functioning Inventory

In order to determine the effects of the intervention on the dependant variable Information as measured by the Derogatis Sexual Functioning Inventory with pre-test levels of Information as the covariates, an analysis of covariance was conducted.
Analysis of covariance for the dependant variable: Information.

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>3</td>
<td>139.30</td>
<td>46.43</td>
<td>11.39 ****</td>
</tr>
<tr>
<td>Error</td>
<td>27</td>
<td>110.06</td>
<td>4.08</td>
<td></td>
</tr>
<tr>
<td>Covariate</td>
<td>1</td>
<td>138.62</td>
<td>138.62</td>
<td>34.01 ****</td>
</tr>
</tbody>
</table>

An analysis of covariance to determine the effect of the intervention on Information as measured by the Derogatis Sexual Functioning Inventory with pre-test levels of Information as the covariate revealed a significant effect due to the interventions (p<.0001) (see Table 24). There was a significant effect due to the covariate pre-test levels (p<0.0001) (see Table 24).

Scheffé post-hoc significance of differences for individual interventions for the dependant variable Information.

<table>
<thead>
<tr>
<th></th>
<th>MEAN</th>
<th>PRS 1</th>
<th>BIB</th>
<th>CONTROL</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRS 1</td>
<td>20.57</td>
<td>-</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>BIB</td>
<td>19.88</td>
<td>NS</td>
<td>-</td>
<td>NS</td>
</tr>
<tr>
<td>CONTROL</td>
<td>20.11</td>
<td>NS</td>
<td>NS</td>
<td>-</td>
</tr>
</tbody>
</table>

A Scheffé post-hoc analysis for significance of difference between means of Information as measured by the Derogatis Sexual Functioning Inventory showed no significant effects (p>0.05) (see Table 25).
3.3.4.3 Analysis of Covariance: The Effect of the Intervention on the Dependant Variable Experience as measured by the Derogatis Sexual Functioning Inventory

In order to determine the effects of the intervention on the dependant variable Experience as measured by the Derogatis Sexual Functioning Inventory with pre-test levels of Experience as the covariates, an analysis of covariance was conducted.

Table 26.

Analysis of covariance for the dependant variable: Experience.

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>3</td>
<td>200.08</td>
<td>66.69</td>
<td>3.45 *</td>
</tr>
<tr>
<td>Error Variance</td>
<td>27</td>
<td>522.63</td>
<td>19.36</td>
<td></td>
</tr>
<tr>
<td>Covariate</td>
<td>1</td>
<td>122.18</td>
<td>122.18</td>
<td>6.31 *</td>
</tr>
</tbody>
</table>

An analysis of covariance to determine the effect of the intervention on Experience as measured by the Derogatis Sexual Functioning Inventory with pre-test levels of Experience as the covariate revealed a significant effect due to the interventions (p<.05) (see Table 26). There was a significant effect due to the covariate pre-test levels (p<0.0001) (see Table 26).
A Scheffé post-hoc analysis for significance of difference between means of Experience as measured by the Derogatis Sexual Functioning Inventory showed no significant effects (p>0.05) (see Table 27).

3.3.4.4 Analysis of Covariance: The Effect of the Intervention on the Dependant Variable Sexual Drive as measured by the Derogatis Sexual Functioning Inventory

In order to determine the effects of the intervention on the dependant variable Sexual Drive as measured by the Derogatis Sexual Functioning Inventory with pre-test levels of Sexual Drive as the covariate, an analysis of covariance was conducted.
Table 28.

Analysis of covariance for the dependant variable: Sexual Drive.

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>3</td>
<td>383.88</td>
<td>127.96</td>
<td>11.39 ****</td>
</tr>
<tr>
<td>Error Variance</td>
<td>27</td>
<td>303.22</td>
<td>11.23</td>
<td></td>
</tr>
<tr>
<td>Covariate</td>
<td>1</td>
<td>362.43</td>
<td>362.43</td>
<td>32.27 ****</td>
</tr>
</tbody>
</table>

An analysis of covariance to determine the effect of the intervention on Sexual Drive as measured by the Derogatis Sexual Functioning Inventory with pre-test levels of Sexual Drive as the covariate revealed a significant effect due to the interventions (p<.0001) (see Table 28). There was a significant effect due to the covariate pre-test levels (p<0.0001) (see Table 28).

Table 29.

Scheffé post-hoc significance of differences for individual interventions for the dependant variable Sexual Drive.

<table>
<thead>
<tr>
<th></th>
<th>MEAN</th>
<th>PRS 1</th>
<th>BIB</th>
<th>CONTROL</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRS 1</td>
<td>15.57</td>
<td>-</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>BIB</td>
<td>17.38</td>
<td>NS</td>
<td>-</td>
<td>NS</td>
</tr>
<tr>
<td>CONTROL</td>
<td>14.22</td>
<td>NS</td>
<td>NS</td>
<td>-</td>
</tr>
</tbody>
</table>

A Scheffé post-hoc analysis for significance of difference between means of Sexual Drive as measured by the Derogatis Sexual Functioning Inventory showed no significant effects (p>0.05) (see Table 29).
3.3.4.5 **Analysis of Covariance: The Effect of the Intervention on the Dependant Variable Sexual Fantasy as measured by the Derogatis Sexual Functioning Inventory**

In order to determine the effects of the intervention on the dependant variable Sexual Fantasy as measured by the Derogatis Sexual Functioning Inventory with pre-test levels of Sexual Fantasy as the covariate, an analysis of covariance was conducted.

**Table 30.**

Analysis of covariance for the dependant variable: Sexual Fantasy.

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>3</td>
<td>171.210</td>
<td>57.07</td>
<td>16.09 ***</td>
</tr>
<tr>
<td>Error Variance</td>
<td>27</td>
<td>95.76</td>
<td>3.55</td>
<td></td>
</tr>
<tr>
<td>Covariate</td>
<td>1</td>
<td>166.06</td>
<td>166.06</td>
<td>46.82 ***</td>
</tr>
</tbody>
</table>

An analysis of covariance to determine the effect of the intervention on Sexual Fantasy as measured by the Derogatis Sexual Functioning Inventory with pre-test levels of Sexual Fantasy as the covariate revealed a significant effect due to the interventions (p<.0001) (see Table 30). There was a significant effect due to the covariate pre-test levels (p<0.0001) (see Table 30).
Table 31.

Scheffé post-hoc significance of differences for individual interventions for the dependant variable Sexual Fantasy.

<table>
<thead>
<tr>
<th></th>
<th>MEAN</th>
<th>PRS 1</th>
<th>BIB</th>
<th>CONTROL</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRS 1</td>
<td>4.57</td>
<td>-</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>BIB</td>
<td>3.88</td>
<td>NS</td>
<td>-</td>
<td>NS</td>
</tr>
<tr>
<td>CONTROL</td>
<td>3.33</td>
<td>NS</td>
<td>NS</td>
<td>-</td>
</tr>
</tbody>
</table>

A Scheffé post-hoc analysis for significance of difference between means of Sexual Fantasy as measured by the Derogatis Sexual Functioning Inventory showed no significant effects (p>0.05) (see Table 31).

3.3.4.6 **Analysis of Covariance: The Effect of the Intervention on the Dependant Variable Satisfaction as measured by the Derogatis Sexual Functioning Inventory**

In order to determine the effects of the intervention on the dependant variable Satisfaction as measured by the Derogatis Sexual Functioning Inventory with pre-test levels of Satisfaction as the covariate, an analysis of covariance was conducted.
Table 32.

Analysis of covariance for the dependent variable: Satisfaction.

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>3</td>
<td>71.89</td>
<td>23.96</td>
<td>5.32 *</td>
</tr>
<tr>
<td>Error</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Variance</td>
<td>27</td>
<td>121.53</td>
<td>4.50</td>
<td></td>
</tr>
<tr>
<td>Covariate</td>
<td>1</td>
<td>61.16</td>
<td>61.16</td>
<td>13.59 ***</td>
</tr>
</tbody>
</table>

An analysis of covariance to determine the effect of the intervention on Satisfaction as measured by the Derogatis Sexual Functioning Inventory with pre-test levels of Satisfaction as the covariate revealed a significant effect due to the interventions (p<.05) (see Table 32). There was a significant effect due to the covariate pre-test levels (p<0.0001) (see Table 32).

Table 33.

Scheffé post-hoc significance of differences for individual interventions for the dependent variable Satisfaction.

<table>
<thead>
<tr>
<th></th>
<th>MEAN</th>
<th>PRS 1</th>
<th>BIB</th>
<th>CONTROL</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRS 1</td>
<td>6.14</td>
<td>-</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>BIB</td>
<td>6.13</td>
<td>NS</td>
<td>-</td>
<td>NS</td>
</tr>
<tr>
<td>CONTROL</td>
<td>4.89</td>
<td>NS</td>
<td>NS</td>
<td>-</td>
</tr>
</tbody>
</table>

A Scheffé post-hoc analysis for significance of difference between means of Satisfaction as measured by the Derogatis Sexual Functioning Inventory showed no significant effects (p>0.05) (see Table 33).
3.3.4.7 Analysis of Covariance: The Effect of the Intervention on the Dependant Variable Global Sexual Satisfaction as measured by the Derogatis Sexual Functioning Inventory

In order to determine the effects of the intervention on the dependant variable Global Sexual Satisfaction as measured by the Derogatis Sexual Functioning Inventory with pre-test levels of Global Sexual Satisfaction as the covariate, an analysis of covariance was conducted.

Table 34.

Analysis of covariance for the dependant variable: Global Sexual Satisfaction.

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>3</td>
<td>39.69</td>
<td>13.23</td>
<td>8.50  ***</td>
</tr>
<tr>
<td>Error Variance</td>
<td>27</td>
<td>42.05</td>
<td>1.56</td>
<td></td>
</tr>
<tr>
<td>Covariate</td>
<td>1</td>
<td>38.71</td>
<td>38.71</td>
<td>24.86 ****</td>
</tr>
</tbody>
</table>

An analysis of covariance to determine the effect of the intervention on Global Sexual Satisfaction as measured by the Derogatis Sexual Functioning Inventory with pre-test levels of Global Sexual Satisfaction as the covariate revealed a significant effect due to the interventions (p<.001) (see Table 34). There was a significant effect due to the covariate pre-test levels (p<0.0001) (see Table 34).
A Scheffé post-hoc analysis for significance of difference between means of Global Sexual Satisfaction as measured by the Derogatis Sexual Functioning Inventory showed no significant effects (p>0.05) (see Table 35).

### 3.3.4.8 Analysis of Covariance: The Effect of the Intervention on the Dependant Variable Total Disagreement as measured by the Sexual Interaction Inventory

In order to determine the effects of the intervention on the dependant variable Total Disagreement as measured by the Sexual Interaction Inventory with pre-test levels of Total Disagreement as the covariate, an analysis of covariance was conducted.
Table 36.

Analysis of covariance for the dependant variable: Total Disagreement.

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>3</td>
<td>93759.25</td>
<td>31253.08</td>
<td>10.32 ****</td>
</tr>
<tr>
<td>Error</td>
<td>27</td>
<td>81775.52</td>
<td>3028.72</td>
<td></td>
</tr>
<tr>
<td>Covariate</td>
<td>1</td>
<td>92781.10</td>
<td>92781.10</td>
<td>30.63 ****</td>
</tr>
</tbody>
</table>

An analysis of covariance to determine the effect of the intervention on Total Disagreement as measured by the Sexual Interaction Inventory with pre-test levels of Total Disagreement as the covariate revealed a significant effect due to the interventions (p<.0001) (see Table 36). There was a significant effect due to the covariate pre-test levels (p<0.0001) (see Table 36).

Table 37.

Scheffé post-hoc significance of differences for individual interventions for the dependant variable: Total Disagreement.

<table>
<thead>
<tr>
<th></th>
<th>MEAN</th>
<th>PRS 1</th>
<th>BIB</th>
<th>CONTROL</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRS 1</td>
<td>90.50</td>
<td></td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>BIB</td>
<td>42.25</td>
<td>NS</td>
<td></td>
<td>NS</td>
</tr>
<tr>
<td>CONTROL</td>
<td>85.78</td>
<td>NS</td>
<td>NS</td>
<td></td>
</tr>
</tbody>
</table>

A Scheffé post-hoc analysis for significance of difference between means of Total Disagreement as measured by the Sexual Interaction Inventory showed no significant effects (p>0.05) (see Table 37).
Analysis of Covariance: The Effect of the Intervention on the Dependant Variable Female Frequency Dissatisfaction as measured by the Sexual Interaction Inventory

In order to determine the effects of the intervention on the dependant variable Female Frequency Dissatisfaction as measured by the Sexual Interaction Inventory with pre-test levels of Female Frequency Dissatisfaction as the covariate, an analysis of covariance was conducted.

Table 38.

Analysis of covariance for the dependant variable: Female Frequency Dissatisfaction.

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>3</td>
<td>482.98</td>
<td>160.99</td>
<td>2.46 (NS)</td>
</tr>
<tr>
<td>Error Variance</td>
<td>27</td>
<td>1767.02</td>
<td>65.45</td>
<td></td>
</tr>
<tr>
<td>Covariate</td>
<td>1</td>
<td>235.79</td>
<td>235.79</td>
<td>3.60 (NS)</td>
</tr>
</tbody>
</table>

1. NS = Not Significant

An analysis of covariance to determine the effect of the intervention on Female Frequency Dissatisfaction as measured by the Sexual Interaction Inventory with pre-test levels of Female Frequency Dissatisfaction as the covariate revealed no significant effect due to the interventions (p>.05) (see Table 38). There was no significant effect due to the covariate pretest levels (p>.05) (see Table 38).

Owing to the fact that no significant difference was found a Scheffé post-hoc analysis was not conducted.
Analysis of Covariance: The Effect of the Intervention on the Dependant Variable Female Self-Acceptance as measured by the Sexual Interaction Inventory

In order to determine the effects of the intervention on the dependant variable Female Self-Acceptance as measured by the Sexual Interaction Inventory with pre-test levels of Female Self Acceptance as the covariate, an analysis of covariance was conducted.

Table 39.

Analysis of covariance for the dependant variable: Female Self-Acceptance.

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>3</td>
<td>752.44</td>
<td>250.82</td>
<td>8.05  ***</td>
</tr>
<tr>
<td>Error</td>
<td>27</td>
<td>841.42</td>
<td>31.16</td>
<td></td>
</tr>
<tr>
<td>Covariate</td>
<td>1</td>
<td>681.73</td>
<td>681.73</td>
<td>21.88 ****</td>
</tr>
</tbody>
</table>

An analysis of covariance to determine the effect of the intervention on Female Self-Acceptance as measured by the Sexual Interaction Inventory with pre-test levels of Female Self-Acceptance as the covariate revealed a significant effect due to the interventions (p<.001) (see Table 39). There was a significant effect due to the covariate pre-test levels (p<0.0001) (see Table 39).
Scheffé post-hoc significance of differences for individual interventions for the dependant variable: Female Self-Acceptance.

<table>
<thead>
<tr>
<th></th>
<th>MEAN</th>
<th>PRS 1</th>
<th>BIB</th>
<th>CONTROL</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRS 1</td>
<td>15.00</td>
<td>-</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>BIB</td>
<td>11.50</td>
<td>NS</td>
<td>-</td>
<td>NS</td>
</tr>
<tr>
<td>CONTROL</td>
<td>14.89</td>
<td>NS</td>
<td>NS</td>
<td>-</td>
</tr>
</tbody>
</table>

A Scheffé post-hoc analysis for significance of difference between means of Female Self-Acceptance as measured by the Sexual Interaction Inventory showed no significant effects (p>0.05) (see Table 40).

3.3.4.11 Analysis of Covariance: The Effect of the Intervention on the Dependant Variable Female Pleasure as measured by the Sexual Interaction Inventory

In order to determine the effects of the intervention on the dependant variable Female Pleasure as measured by the Sexual Interaction Inventory with pre-test levels of Female Pleasure Mean as the covariate, an analysis of covariance was conducted.
Table 41.

Analysis of covariance for the dependant variable: Female Pleasure.

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>3</td>
<td>370.16</td>
<td>123.39</td>
<td>8.67 ***</td>
</tr>
<tr>
<td>Error Variance</td>
<td>27</td>
<td>384.03</td>
<td>14.22</td>
<td></td>
</tr>
<tr>
<td>Covariate</td>
<td>1</td>
<td>343.89</td>
<td>343.89</td>
<td>24.18 ****</td>
</tr>
</tbody>
</table>

An analysis of covariance to determine the effect of the intervention on Female Pleasure as measured by the Sexual Interaction Inventory with pre-test levels of Female Pleasure Mean as the covariate revealed a significant effect due to the interventions (p<.001) (see Table 41). There was a significant effect due to the covariate pre-test levels (p<0.0001) (see Table 41).

Table 42.

Scheffé post-hoc significance of differences for individual interventions for the dependant variable: Female Pleasure.

<table>
<thead>
<tr>
<th></th>
<th>MEAN</th>
<th>PRS 1</th>
<th>BIB</th>
<th>CONTROL</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRS 1</td>
<td>45.36</td>
<td>-</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>BIB</td>
<td>47.25</td>
<td>NS</td>
<td>-</td>
<td>NS</td>
</tr>
<tr>
<td>CONTROL</td>
<td>45.33</td>
<td>NS</td>
<td>NS</td>
<td>-</td>
</tr>
</tbody>
</table>

A Scheffé post-hoc analysis for significance of difference between means of Female Pleasure as measured by the Sexual Interaction Inventory showed no significant effects (p>0.05) (see Table 42).
3.3.4.12 **Analysis of Covariance: The Effect of the Intervention on the Dependant Variable Mate Acceptance - Female of Male as measured by the Sexual Interaction Inventory**

In order to determine the effects of the intervention on the dependant variable Mate Acceptance - Female of Male as measured by the Sexual Interaction Inventory with pre-test levels of Mate Acceptance - Female of Male as the covariate, an analysis of covariance was conducted.

**Table 43.**

Analysis of covariance for the dependant variable: Mate Acceptance - Female of Male.

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>3</td>
<td>496.84</td>
<td>165.61</td>
<td>6.65 *</td>
</tr>
<tr>
<td>Error Variance</td>
<td>27</td>
<td>672.64</td>
<td>24.91</td>
<td></td>
</tr>
<tr>
<td>Covariate</td>
<td>1</td>
<td>341.54</td>
<td>341.54</td>
<td>13.71 ***</td>
</tr>
</tbody>
</table>

An analysis of covariance to determine the effect of the intervention on Mate Acceptance - Female of Male as measured by the Sexual Interaction Inventory with pre-test levels of Mate Acceptance - Female of Male as the covariate revealed a significant effect due to the interventions (p<.05) (see Table 43). There was a significant effect due to the covariate pre-test levels (p<0.0001) (see Table 43).
A Scheffé post-hoc analysis for significance of difference between means of Mate Acceptance - Female of Male as measured by the Sexual Interaction Inventory showed significant differences between the PRS and BIB groups (p<0.05) (see Table 44).

Women in the BIB group saw their partners as significantly more responsive than women in the PRS groups.

3.3.5 Differences between the Pre-Intervention and Post-Intervention means on individual Dependant Variables

In order to determine the significance of differences between the pre-intervention and post-intervention scores, t-Tests were conducted for each of the dependant variables. The significant t-Test analysis for the respective dependant variables are listed below.
3.3.5.1 Differences between the Pre-test and Post-test scores for the Dependant Variable Sexual Arousability for the Premium Rate Service Group 1 (Experimental Group 1)

In order to determine the significance of differences between the pre-test and post-test scores for the dependant variable Sexual Arousability as measured by the Sexual Arousability Inventory, t-Tests were conducted.

Table 45.

PRS 1: Differences between the pre-test and post-test scores for the dependant variable Sexual Arousability.

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>MEAN</th>
<th>STANDARD DEVIATION</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEXUAL AROUSABILITY</td>
<td>23.2857</td>
<td>18.9226</td>
<td>4.6043 ***</td>
</tr>
</tbody>
</table>

* p<.05  ** p<.01  *** p<.001  **** p<.0001

t-Tests conducted to determine the significance of difference between pre-test and post-test levels of Sexual Arousability as measured by the Sexual Arousability Inventory showed a significant difference (p<.001) (see Table 45).

The PRS1 group showed significantly greater sexual arousability following the intervention than prior to it.
3.3.5.2 Differences between the Pre-test and Post-test scores for the Dependant Variable Satisfaction for the Premium Rate Service Group 1 (Experimental Group 1)

In order to determine the significance of differences between the pre-test and post-test scores for the dependent variable Satisfaction as measured by the Derogatis Sexual Functioning Inventory, t-Tests were conducted.

Table 46.

PRS 1: Differences between the pre-test and post-test scores for the dependent variable Satisfaction.

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>MEAN</th>
<th>STANDARD DEVIATION</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>SATISFACTION</td>
<td>2.0000</td>
<td>1.6641</td>
<td>4.4969 ***</td>
</tr>
</tbody>
</table>

t-Tests conducted to determine the significance of difference between pre-test and post-test levels of Satisfaction as measured by the Derogatis Sexual Functioning Inventory showed a significant difference (p<.001) (see Table 46).

The PRS1 group showed significantly greater sexual satisfaction following the intervention than prior to it.
3.3.5.3 Differences between the Pre-test and Post-test scores for the Dependant Variable Global Sexual Satisfaction for the Premium Rate Service Group 1 (Experimental Group 1)

In order to determine the significance of differences between the pre-test and post-test scores for the dependant variable Global Sexual Satisfaction as measured by the Derogatis Sexual Functioning Inventory, t-Tests were conducted.

Table 47.

PRS 1: Differences between the pre-test and post-test scores for the dependant variable Global Sexual Satisfaction.

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>MEAN</th>
<th>STANDARD DEVIATION</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>GLOBAL SEXUAL SATISFACTION</td>
<td>1.000</td>
<td>1.03772</td>
<td>3.6055 *</td>
</tr>
</tbody>
</table>

t-Tests conducted to determine the significance of difference between pre-test and post-test levels of Global Sexual Satisfaction as measured by the Derogatis Sexual Functioning Inventory showed a significant difference (p<.05) (see Table 47).

The PRS1 group showed a significantly higher degree of overall sexual satisfaction following the intervention than prior to it.
3.3.5.4 Differences between the Pre-test and Post-test scores for the Dependant Variable Female Frequency Dissatisfaction for the Premium Rate Service Group 1 (Experimental Group 1)

In order to determine the significance of differences between the pre-test and post-test scores for the dependant variable Female Frequency Dissatisfaction as measured by the Sexual Interaction Inventory, t-Tests were conducted.

Table 48.

PRS 1: Differences between the pre-test and post-test scores for the dependant variable Female Frequency Dissatisfaction.

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>MEAN</th>
<th>STANDARD DEVIATION</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEMALE FREQUENCY</td>
<td>-6.7142</td>
<td>6.0565</td>
<td>-4.1480 ***</td>
</tr>
</tbody>
</table>

T-Tests conducted to determine the significance of difference between pre-test and post-test levels of Female Frequency Dissatisfaction as measured by the Sexual Interaction Inventory showed a significant difference (p<.001) (see Table 48).

The PRS1 group showed a significantly lesser degree of dissatisfaction with the repertoire of sexual behaviours following the intervention than prior to it.
3.3.5.5 Differences between the Pre-test and Post-test scores for the Dependant Variable Female Self Acceptance for the Premium Rate Service Group 1 (Experimental Group 1)

In order to determine the significance of differences between the pre-test and post-test scores for the dependant variable Female Self Acceptance as measured by the Sexual Interaction Inventory, t-Tests were conducted.

Table 49.

PRS 1: Differences between the pre-test and post-test scores for the dependant variable Female Self-Acceptance

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>MEAN</th>
<th>STANDARD DEVIATION</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEMALE SELF ACCEPTANCE</td>
<td>-3.7142</td>
<td>6.1822</td>
<td>-2.2479*</td>
</tr>
</tbody>
</table>

t-Tests conducted to determine the significance of difference between pre-test and post-test levels of Female Self-Acceptance as measured by the Sexual Interaction Inventory showed a significant difference (p<.05) (see Table 49).

The PRS1 group showed a significantly greater degree of self-acceptance and sexual enjoyment following the intervention than prior to it.
3.3.5.6 Differences between the Pre-test and Post-test scores for the Dependant Variable Sexual Arousability for the Bibliotherapy Group (Experimental Group 3)

In order to determine the significance of differences between the pre-test and post-test scores for the dependant variable Sexual Arousability as measured by the Sexual Arousability Inventory, t-Tests were conducted.

Table 50.

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>MEAN</th>
<th>STANDARD DEVIATION</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEXUAL AROUSABILITY</td>
<td>19.8750</td>
<td>21.8006</td>
<td>2.579 *</td>
</tr>
</tbody>
</table>

t-Tests conducted to determine the significance of difference between pre-test and post-test levels of Sexual Arousability as measured by the Sexual Arousability Inventory showed a significant difference (p<.05) (see Table 50).

The BIB group showed significantly greater sexual arousability following the intervention than prior to it.
3.3.5.7 Differences between the Pre-test and Post-test scores for the Dependant Variable Sexual Drive for the Bibliotherapy Group (Experimental Group 3)

In order to determine the significance of differences between the pre-test and post-test scores for the dependant variable Sexual Drive as measured by the Derogatis Sexual Functioning Inventory, t-Tests were conducted.

Table 51.

BIB: Differences between the pre-test and post-test scores for the dependant variable Sexual Drive.

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>MEAN</th>
<th>STANDARD DEVIATION</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEXUAL DRIVE</td>
<td>2.2500</td>
<td>1.8322</td>
<td>3.473 **</td>
</tr>
</tbody>
</table>

t-Tests conducted to determine the significance of difference between pre-test and post-test levels of Sexual Drive as measured by the Derogatis Sexual Functioning Inventory showed a significant difference (p<.05) (see Table 51).

The BIB group showed a significantly higher level of sexual drive following the intervention than prior to it.
3.3.5.8 Differences between the Pre-test and Post-test scores for the Dependant Variable Female Frequency Dissatisfaction for the Bibliotherapy Group (Experimental Group 3)

In order to determine the significance of differences between the pre-test and post-test scores for the dependant variable Female Frequency Dissatisfaction as measured by the Sexual Interaction Inventory, t-Tests were conducted.

Table 52.

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>MEAN</th>
<th>STANDARD DEVIATION</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEMALE FREQUENCY DISSATISFACTION</td>
<td>-5.000</td>
<td>3.9279</td>
<td>-3.6000 **</td>
</tr>
</tbody>
</table>

t-Tests conducted to determine the significance of difference between pre-test and post-test levels of Female Frequency Dissatisfaction as measured by the Sexual Interaction Inventory showed a significant difference (p<.01) (see Table 52).

The BIB group showed a significantly lesser degree of dissatisfaction with the repertoire of sexual behaviours following the intervention than prior to it.

There were no other significant differences between the pre-test and post-test scores for the remaining dependant variables. t-Test analyses conducted for the dependant variables failed to reveal any significant differences between the pre-test and post-test scores for the Control group.
3.3.6 Intercorrelation of the Dependant Variables

The correlation between the dependant variables namely, Sexual Arousability; Information; Experience; Sexual Drive; Sexual Fantasy; Satisfaction; Global Sexual Satisfaction; Total Disagreement; Female Frequency Dissatisfaction; Female Self-Acceptance; Female Pleasure Mean; and Mate Acceptance - Female of Male were determined for the Groups by a Pearson Product Moment Correlation procedure. (see Table 53, Pages 195 and 196).

The dependant variable, Sexual Arousability, as assessed by the Pearson Product Moment Correlation, correlated significantly and positively with Sexual Drive ($r=0.5844; p<.0001$); significantly positively with Sexual Fantasy ($r=0.4580; p<.01$) and significantly and positively with Female Pleasure Mean ($r=0.4581; p<.01$) (see Table 53, Pages 195 and 196).

The dependant variable Information as assessed by the Pearson Product Moment Correlation, correlated significantly and positively with Experience ($r=0.4072; p<.01$) (See Table 53, Pages 195 and 196).

The dependant variable Sexual Drive as assessed by the Pearson Product Moment Correlation, correlated significantly and positively with Sexual Fantasy ($r=0.4563; p<.01$) (see Table 53, Pages 195,196) and significantly and positively with Sexual Arousability (see Table 53, Pages 195 and 196).

The dependant variable Satisfaction as assessed by the Pearson Product Moment Correlation, correlated significantly and positively with Global Sexual Satisfaction ($r=0.5767; p<.0001$) (see Table 53, Pages 195 and 196).

The dependant variable Female Pleasure as assessed by the Pearson Product Moment Correlation, correlated
significantly and negatively with Female Self-Acceptance ($r = -0.5725; p < .0001$) (see Table 53, Pages 195 and 196).

The dependent variable Total Disagreement as assessed by the Pearson Product Moment Correlation, correlated significantly and positively with Female Self-Acceptance ($r = 0.3531; p < .05$) (see Table 53, Pages 195 and 196).

The dependent variable Global Sexual Satisfaction as assessed by the Pearson Product Moment Correlation, correlated significantly and negatively with Mate Acceptance - Female of Male ($r = -0.3745; p < .05$) (see Table 53, Pages 195 and 196).

3.4 **Descriptive Statistics and Subjective Reports of the Effects of the Intervention on Indices of Sexual Functioning and Interaction**

3.4.1 **Introduction**

At the completion of the Self-help Programme of intervention, subjects in the three Experimental groups were requested to complete the Project Evaluation Questionnaire. (see Appendix X). Suggestions, attitudes, comments, progress and criticism of various aspects of the Self-help Programme of intervention are reported. The assessment which follows is based on an analysis of the thirty-two Project Evaluation Questionnaires that were completed.

3.4.2 **Descriptive Statistics**

The first section of this assessment is presented as follows. Tabulated responses to the questions in the Evaluation Questionnaire are presented, followed by comments describing the various observed trends that emerged. Examples of specific responses made by the subjects are also presented.
<table>
<thead>
<tr>
<th></th>
<th>SEXUAL AROUSABILITY</th>
<th>INFORMATION</th>
<th>EXPERIENCE</th>
<th>SEXUAL DRIVE</th>
<th>SEXUAL FANTASY</th>
<th>SATISFACTION</th>
<th>GLOBAL SEXUAL SATISFACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEXUAL AROUSABILITY</td>
<td>-</td>
<td>r = 0.0583</td>
<td>r = 0.1333</td>
<td>r = 0.5844</td>
<td>r = 0.4580</td>
<td>r = 0.2960</td>
<td>r = 0.2140</td>
</tr>
<tr>
<td>INFORMATION</td>
<td>r = -0.0583</td>
<td>-</td>
<td>**</td>
<td>r = 0.4072</td>
<td>r = -0.9522</td>
<td>r = -0.0909</td>
<td>r = -0.2050</td>
</tr>
<tr>
<td>EXPERIENCE</td>
<td>r = 0.1333</td>
<td>**</td>
<td>-</td>
<td>r = -0.1125</td>
<td>r = 0.2083</td>
<td>r = 0.2380</td>
<td>r = 0.1071</td>
</tr>
<tr>
<td>SEXUAL DRIVE</td>
<td>r = 0.5844</td>
<td>r = 0.0952</td>
<td>r = -0.1125</td>
<td></td>
<td>r = 0.4563</td>
<td>r = -0.1255</td>
<td>r = -0.0809</td>
</tr>
<tr>
<td>SEXUAL FANTASY</td>
<td>**</td>
<td>r = 0.4580</td>
<td>r = -0.0908</td>
<td>r = 0.2082</td>
<td>**</td>
<td>r = 0.0687</td>
<td>r = -0.2413</td>
</tr>
<tr>
<td>SATISFACTION</td>
<td>r = 0.2959</td>
<td>r = 0.2050</td>
<td>r = 0.2389</td>
<td>r = -0.1255</td>
<td>r = 0.0687</td>
<td>-</td>
<td>****</td>
</tr>
<tr>
<td>GLOBAL SEXUAL SATISFACTION</td>
<td>r = 0.2140</td>
<td>r = -0.1769</td>
<td>r = 0.1071</td>
<td>r = 0.0809</td>
<td>r = 0.2413</td>
<td>r = 0.5767</td>
<td>-</td>
</tr>
<tr>
<td>TOTAL DISAGREEMENT</td>
<td>r = 0.1750</td>
<td>r = -0.0754</td>
<td>r = -0.1580</td>
<td>r = -0.1809</td>
<td>r = -0.0952</td>
<td>r = 0.0803</td>
<td>r = -0.0949</td>
</tr>
<tr>
<td>FEMALE FREQUENCY DISSATISFACTION</td>
<td>r = 0.0138</td>
<td>r = -0.1451</td>
<td>r = 0.0179</td>
<td>r = 0.0908</td>
<td>r = 0.2026</td>
<td>r = -0.1483</td>
<td>r = -0.1765</td>
</tr>
<tr>
<td>FEMALE SELF-ACCEPTANCE</td>
<td>r = -0.2645</td>
<td>r = -0.2386</td>
<td>r = -0.1587</td>
<td>r = -0.0223</td>
<td>r = 0.1360</td>
<td>r = 0.00264</td>
<td>r = -0.3108</td>
</tr>
<tr>
<td>FEMALE PLEASURE</td>
<td>**</td>
<td>r = 0.4580</td>
<td>r = 0.2237</td>
<td>r = 0.1863</td>
<td>r = 0.2105</td>
<td>r = 0.1390</td>
<td>r = 0.1655</td>
</tr>
<tr>
<td>MATE ACCEPTANCE - FEMALE OF MALE</td>
<td>r = 0.0155</td>
<td>r = 0.2174</td>
<td>r = 0.0000</td>
<td>r = 0.0377</td>
<td>r = -0.0577</td>
<td>r = -0.2766</td>
<td>r = -0.3745</td>
</tr>
</tbody>
</table>
### Table 53.

Intercorrelation Matrix for the Dependent Variables (continued)

<table>
<thead>
<tr>
<th></th>
<th>Total Disagreement</th>
<th>Female Frequency Dissatisfaction</th>
<th>Female Self-Acceptance</th>
<th>Female Pleasure</th>
<th>MATE Acceptance - Female of Male</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sexual Arousalability</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$r = 0.1750$</td>
<td>$r = 0.0138$</td>
<td>$r = -0.2645$</td>
<td>$r = 0.4581$</td>
<td>$r = 0.0155$</td>
</tr>
<tr>
<td><strong>Information</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$r = 0.0754$</td>
<td>$r = -0.1451$</td>
<td>$r = -0.2386$</td>
<td>$r = 0.2237$</td>
<td>$r = 0.2174$</td>
</tr>
<tr>
<td><strong>Experience</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$r = -0.1580$</td>
<td>$r = 0.0179$</td>
<td>$r = -0.1587$</td>
<td>$r = 0.1864$</td>
<td>$r = 0.0000$</td>
</tr>
<tr>
<td><strong>Sexual Drive</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$r = 0.1809$</td>
<td>$r = 0.0908$</td>
<td>$r = -0.0223$</td>
<td>$r = 0.2106$</td>
<td>$r = -0.0377$</td>
</tr>
<tr>
<td><strong>Sexual Fantasy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$r = -0.0952$</td>
<td>$r = 0.2026$</td>
<td>$r = 0.1361$</td>
<td>$r = 0.1390$</td>
<td>$r = -0.0501$</td>
</tr>
<tr>
<td><strong>Satisfaction</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$r = 0.0803$</td>
<td>$r = -0.1483$</td>
<td>$r = -0.0264$</td>
<td>$r = 0.1655$</td>
<td>$r = -0.2766$</td>
</tr>
<tr>
<td><strong>Global Sexual Satisfaction</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$r = -0.0949$</td>
<td>$r = -0.1765$</td>
<td>$r = -0.3108$</td>
<td>$r = 0.2321$</td>
<td>$r = -0.3745$</td>
</tr>
<tr>
<td><strong>Total Disagreement</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$r = 0.2213$</td>
<td>$r = -0.2750$</td>
<td>$r = 0.3531$</td>
<td>$r = 0.0549$</td>
<td></td>
</tr>
<tr>
<td><strong>Female Frequency Dissatisfaction</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$r = 0.2213$</td>
<td></td>
<td>$r = 0.0018$</td>
<td>$r = 0.0126$</td>
<td>$r = -0.2428$</td>
</tr>
<tr>
<td><strong>Female Self-Acceptance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>*</td>
<td></td>
<td>$r = 0.3531$</td>
<td>$r = 0.2651$</td>
<td></td>
</tr>
<tr>
<td><strong>Female Pleasure</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$r = -0.2750$</td>
<td></td>
<td>$r = 0.0126$</td>
<td>$r = -0.5725$</td>
<td>$r = 0.2651$</td>
</tr>
<tr>
<td><strong>Mate Acceptance - Female of Male</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$r = 0.0547$</td>
<td></td>
<td>$r = 0.2428$</td>
<td>$r = -0.0444$</td>
<td></td>
</tr>
</tbody>
</table>
3.4.2.1 Analysis of responses regarding the time period of the Self-help Programme

Table 54 and Table 55 presented below reflect the total time spent by subjects in the three Experimental groups, as well as the adequacy of the eight-week time period allocated for completion of the Self-help Programme.

**Table 54.**

Total time spent participating in the Self-help Programme.

<table>
<thead>
<tr>
<th>EXPERIMENTAL GROUP</th>
<th>PRS 1 * (N=14)</th>
<th>PRS 2 ** (N=10)</th>
<th>BIB *** (N=8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AVERAGE NUMBER OF HOURS</td>
<td>27</td>
<td>40</td>
<td>21</td>
</tr>
</tbody>
</table>

* Experimental Group 1: Premium Rate Service 1  
** Experimental Group 2: Premium Rate Service 2  
*** Experimental Group 3: Bibliotherapy

Table 54 indicates a breakdown of the average number of hours each Experimental group spent on the Self-help Programme. Subjects in the PRS 2 group spent the greatest number of hours participating in the Self-help Programme followed by the PRS 1 group and the BIB group.
Adequacy of the eight-week time period for the Self-help Programme.

<table>
<thead>
<tr>
<th>EXPERIMENTAL GROUP</th>
<th>PRS 1 (N=14)</th>
<th>PRS 2 (N=10)</th>
<th>BIB (N=8)</th>
<th>TOTAL (N=32)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENOUGH TIME</td>
<td>5</td>
<td>6</td>
<td>5</td>
<td>16 (50%)</td>
</tr>
<tr>
<td>NOT ENOUGH TIME</td>
<td>9</td>
<td>4</td>
<td>3</td>
<td>16 (50%)</td>
</tr>
</tbody>
</table>

From Table 55 it can be seen that 50% of the woman reported that the time allocated was sufficient to carry out the Self-help Programme. For the other 50% this appeared to be one of the drawbacks of the Programme.

Nevertheless, many subjects said they would continue with the Self-help Programme in the months ahead and felt that the Self-help Programme was "just a start".

Other responses included the following: "Owing to the time pressure I've been under, I have not adequately followed the Programme"; "For my needs - more time required"; "After 20 years of conditioning, one needs more time to undo and change"; "With little kids running around the house - often it's not easy"; "I will continue working at the Programme on a regular basis".

3.4.2.2 Analysis of responses regarding change in orgasmic responsivity following the Self-help Programme

Table 56 and Table 57 presented below reflect subjects' positive changes regarding both frequency and satisfaction with their orgasmic response, following the Self-help Programme.
intercourse"; "Not much has changed as we have not been able to participate fully and have not kept to a schedule".

Table 57.

Satisfaction with orgasmic responsivity following the Self-help Programme.

<table>
<thead>
<tr>
<th>EXPERIMENTAL GROUP</th>
<th>PRS 1 (N=14)</th>
<th>PRS 2 (N=10)</th>
<th>BIB (N=8)</th>
<th>TOTAL (N=32)</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>10</td>
<td>8</td>
<td>5</td>
<td>23 (72%)</td>
</tr>
<tr>
<td>NO</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>9 (28%)</td>
</tr>
</tbody>
</table>

From Table 57 it can be seen that 72% of women reported increased satisfaction with their orgasmic responsivity following the Self-help Programme. Some of the trends noted that contributed to this feeling of satisfaction included the following: Orgasms were more frequent, more intense and more satisfying.

Many women reported being able to reach an orgasm far more quickly than before whilst several others were now experiencing multiple orgasm for the first time. Many women felt that the improvement in foreplay had made a tremendous difference to their satisfaction with orgasmic response. In turn many implied feeling more responsive and were experiencing increased sexual desire.

Specific comments included the following: "Deeper orgasms are experienced as the PC exercises created deep sensations"; "I've learned the best positions during sexual intercourse for orgasm to take place"; "My satisfaction is complete - our sexual relationship and orgasm is very intense - I try different methods and I've learned a lot"; "Before I could only reach a climax during self-stimulation, and now with partner stimulation. I will
practice having sexual intercourse and clitoral stimulation at the same time"; "Vibrator stimulation has certainly helped"; "I enjoy the sex act more fully and I don’t want to get it over with as soon as possible - I am satisfied through self and partner stimulation" and "G-Spot stimulation has helped me reach a climax".

Less favourable comments included: "I get to the brink with enormous intensity, but no climax. However, I have so much satisfaction that I do not feel physically frustrated"; "There’s not enough time to participate fully".

3.4.2.3 Analysis of responses regarding improvement in sexual satisfaction following the Self-help Programme

Table 58 presented below reflects the changes that subjects in the three Experimental groups reported, regarding improvement in their general sexual satisfaction following the Self-help Programme.

Table 58.

<table>
<thead>
<tr>
<th>EXPERIMENTAL GROUP</th>
<th>PRS 1 (N=14)</th>
<th>PRS 2 (N=10)</th>
<th>BIB (N=8)</th>
<th>TOTAL (N=32)</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>13</td>
<td>10</td>
<td>7</td>
<td>30 (94%)</td>
</tr>
<tr>
<td>NO</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2 (6%)</td>
</tr>
</tbody>
</table>

From Table 58 it is evident that the majority of women indicated that they were far happier with their general level of sexual satisfaction following the Self-help Programme.
Generally responses ranged from "Beginning to enjoy sex more" and "Only slightly satisfied" to "Feeling more relaxed and less inhibited and as a result enjoying sex more". Many stated that once again it was the better foreplay that led to this improvement. Others stated that as a result of their feeling more relaxed and at ease, and closer to their partners, this had led to an improvement in overall sexual satisfaction.

Specific comments included the following: "I am now climaxing regularly during sexual intercourse - and enjoy the whole sexual experience"; "We are now much more open and making more effort to please each other"; "I am more willing to have sex more often and feel happier and satisfied"; "I feel more fulfilled during sexual intercourse - this is a feeling I have never felt before"; "I'm enjoying sex more, great improvement but I still am not reaching a climax"; "Things are a lot better - it feels so good"; "G-Spot stimulation is very exciting"; "Due to knowledge of our bodies, we're now more satisfied"; "I am satisfied with the progress made - I know it will become even better"; "The problem with our relationship prevented greater sexual satisfaction".

3.4.2.4 Analysis of responses regarding changes in lovemaking techniques and communication following the Self-help Programme

Table 59, Table 60 and Table 61 presented below reflect positive changes in general lovemaking, in specific lovemaking techniques and in general and sexual communication following the Self-help Programme.
Positive changes in general lovemaking following the Self-help Programme.

<table>
<thead>
<tr>
<th>EXPERIMENTAL GROUP</th>
<th>PRS 1 (N=14)</th>
<th>PRS 2 (N=10)</th>
<th>BIB (N=8)</th>
<th>TOTAL (N=32)</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>12</td>
<td>10</td>
<td>7</td>
<td>29 (91%)</td>
</tr>
<tr>
<td>NO</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>3 (9%)</td>
</tr>
</tbody>
</table>

From Table 59 it can be seen that 91% of subjects reported at least some positive change in their general lovemaking. Subjects attributed this improvement to feeling less inhibited, more eager to get involved sexually and to take the initiative. Others stated that the lovemaking was now more creative and fun. A common response throughout was the fact that they were making more time for their lovemaking and this had led to greater experimentation and greater use of imagination.

Specific comments were as follows: "I take the initiative more than before"; "We discuss different ways of being stimulated"; "I am more aware and accepting of my husband's sexual needs"; "We spend more time and experiment with different sexual positions"; "There is more touching now". Less positive comments included: "I am still not satisfied with our lovemaking"; "We still need to work on our lovemaking".
Table 60.

Positive changes in general and sexual communication following the Self-help Programme:

<table>
<thead>
<tr>
<th>EXPERIMENTAL GROUP</th>
<th>PRS 1 (N=14)</th>
<th>PRS 2 (N=10)</th>
<th>BIB (N=8)</th>
<th>TOTAL (N=32)</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>12</td>
<td>8</td>
<td>6</td>
<td>26 (81%)</td>
</tr>
<tr>
<td>NO</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>6 (19%)</td>
</tr>
</tbody>
</table>

From Table 60 it can be seen that 82% of subjects reported at least some improvement in their general and sexual communication.

Responses ranged from "No real improvement" and "Slightly better" to "Much better" and "Very good". Subjects reported that their communication was now more open and honest, they were able to talk about their sexual likes and dislikes more freely than before.

Specific comments included: "Our communication is now more exciting and interesting"; "We are now more aware of each others sexual needs - no more ‘microwave’ sex"; "The Self-help Programme has definitely taught us to communicate better"; "My husband is more open to my suggestions and I am now able to say what pleases me". Less positive comments included: "My husband finds it difficult to communicate"; "There still could be improvement".
Table 61.

Positive change in specific sexual techniques following the Self-help Programme.

<table>
<thead>
<tr>
<th>EXPERIMENTAL GROUP</th>
<th>PRS 1 (N=14)</th>
<th>PRS 2 (N=10)</th>
<th>BIB (N=8)</th>
<th>TOTAL (N=32)</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>12</td>
<td>10</td>
<td>7</td>
<td>29 (91%)</td>
</tr>
<tr>
<td>NO</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>3 (9%)</td>
</tr>
</tbody>
</table>

As can be seen from Table 61, the majority of subjects reported positive improvements regarding their specific sexual techniques. Furthermore, from their responses, common factors contributing towards this improvement could be attributed to the following: Couples were now making more time available for their lovemaking and this in turn led to an increased period for foreplay, which in turn became more meaningful. Another trend noted was that couples were experimenting more, for example, trying new positions, and that couples were feeling more relaxed regarding their lovemaking.

Specific comments included the following: "I am now more outgoing and less shy"; "My husband now understands the importance of foreplay"; "I love my husband watching me masturbate"; "Dressing up in sexy underwear is a great turn-on"; "We now have a great variety of foreplay techniques and combine intercourse with deep kissing"; "Oral stimulation - before I could never relax while he did it, now it's great"; "I am more positive - there's more variety and it's more exciting"; "Foreplay does not only focus on genitals". Negative comments included: "I am still quite tense about kissing and foreplay leading up to lovemaking".
3.4.2.5 Analysis of responses regarding changes in sexual fantasies and attitudes towards self-stimulation following the Self-help Programme

Table 62 and Table 63 presented below reflect positive changes in sexual fantasies and in attitude towards self-stimulation following the Self-help Programme.

Table 62.

Positive changes in sexual fantasies following the Self-help Programme.

<table>
<thead>
<tr>
<th>EXPERIMENTAL GROUP</th>
<th>PRS 1 (N=14)</th>
<th>PRS 2 (N=10)</th>
<th>BIB (N=8)</th>
<th>TOTAL (N=32)</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>18 (56%)</td>
</tr>
<tr>
<td>NO</td>
<td>7</td>
<td>4</td>
<td>3</td>
<td>14 (44%)</td>
</tr>
</tbody>
</table>

From Table 62 it can be seen that there were two distinct responses. Fifty-six percent of the women reported positive changes and improvements regarding their sexual fantasies, whilst the other 44% did not experience such positive changes.

Responses ranged from still experiencing no fantasy to there being a great improvement in sexual fantasy. Generally speaking, those showing no improvement indicated that they did not find fantasising easy and some said that they did not believe in fantasising at all. Those experiencing improvements stated that they were now fantasising more often and were more willing to try fantasy as part of their lovemaking. Many fantasised about having sex more often.

Specific responses included the following: "I got new ideas and these occurred more frequently - I feel less guilty"
about my fantasies"; "I feel more comfortable with the idea of fantasising and have a wider spectrum of fantasies"; "I enjoy fantasising - it really helps to get turned on this way"; "I use fantasies to help me get aroused"; "I don't believe in fantasising".

**Table 63.**

Positive change in attitude towards self-stimulation following the Self-help Programme.

<table>
<thead>
<tr>
<th>EXPERIMENTAL GROUP</th>
<th>PRS 1 (N=13)</th>
<th>PRS 2 (N=11)</th>
<th>BIB (N=8)</th>
<th>TOTAL (N=31)</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>7</td>
<td>7</td>
<td>5</td>
<td>19 (59%)</td>
</tr>
<tr>
<td>NO</td>
<td>7</td>
<td>3</td>
<td>3</td>
<td>13 (41%)</td>
</tr>
</tbody>
</table>

From Table 63 it can be seen that there was a wide variation in responses regarding this particular sexual practice. Some women found the topics on self-stimulation to be most beneficial whilst others found them to be distressing. In general, the responses to this question ranged from extremely positive to a completely negative reaction. This is indicative of the fact that this is a difficult subject for many. Some women felt uncomfortable with the topic and the exercises that were suggested, while others found this to be a great learning experience and a tremendous way of finding sexual release. Some women reported that they enjoyed the self-stimulation exercises. Several of the women reported that their attitude towards masturbation had changed and that they were now masturbating more frequently, and as a result were feeling more sexually satisfied.

Some of the specific positive comments concerning masturbation, were as follows: "Much less scary now - doing it more freely now"; "It's o.k. in private"; "I thought it
was sinful but now I see it is part of my life”; "It’s even better now – far more intense and pleasurable as I feel less inhibited”; "I never knew how pleasurable it could be”; "I feel less guilty now – there has been an improvement in my attitude”.

Some of the negative responses indicated the following: "Still cannot bring myself to do it"; "Can’t stimulate myself in front of my husband"; "Uneasy about masturbation"; "I worked at it but found it distasteful"; "I do not enjoy touching myself"; "Disinterested in masturbation – sexual satisfaction is togetherness"; "No improvement – still cannot accept it morally"; "I tried it but it did not help"; "I need a lot of time with this – alone" and "I just don’t feel it is right".

3.4.2.6 Analysis of responses regarding changes in self-understanding following the Self-help Programme

Table 64 presented below reflects changes that subjects reported in their general sexual self-understanding following the Self-help Programme.

Table 64.

Positive changes in general sexual self-understanding following the Self-help Programme.

<table>
<thead>
<tr>
<th>EXPERIMENTAL GROUP</th>
<th>PRS 1 (N=14)</th>
<th>PRS 2 (N=10)</th>
<th>BIB (N=8)</th>
<th>TOTAL (N=32)</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>11</td>
<td>10</td>
<td>8</td>
<td>29 (91%)</td>
</tr>
<tr>
<td>NO</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>3 (9%)</td>
</tr>
</tbody>
</table>

From Table 64 it is evident that following the Self-help Programme there was an improvement in general sexual self-understanding. Common trends highlighted the fact that
women were now more sexually aware and as a result were understanding their sexual needs better. There was also a feeling of "understanding my body better" and of "feeling more sexual in general". Many attributed these changes to specific exercises suggested, for example "genital and self-exploration" and "achieving better orgasms" and "non-genital pleasuring". With increased experimentation and lessening of inhibitions, women began to get more in touch with their sexuality and sexual self-understanding improved.

Three women felt that they had not made that much progress and that there was still lots of room for improvement.

Specific comments included the following: "I now understand the functioning of my body much better"; "I now don't feel inadequate as a woman"; "I became even more aware of my desire for improvement and need for sexual fulfilment"; "I experience more relaxed feelings within myself during sexual intercourse"; "I never realised I could affect my husband in the way I did - all learnt from the Self-help Programme"; "I have rights and don't hold back any more"; "I realise reaching a climax is my responsibility"; "I am more comfortable with my body but still feel there is lots of room for improvement"; "I am less inhibited and more in touch with my body".

3.4.2.7 Analysis of responses regarding partners' cooperation and involvement in the Self-help Programme

Table 65 presented below reflects subjects' perceptions regarding their partners' involvement and cooperation in the Self-help Programme.
Table 65.

Partners' cooperation and involvement in the Self-help Programme.

<table>
<thead>
<tr>
<th>EXPERIMENTAL GROUP</th>
<th>PRS 1 (N=13)</th>
<th>PRS 2 (N=10)</th>
<th>BIB (N=8)</th>
<th>TOTAL (N=32)</th>
</tr>
</thead>
<tbody>
<tr>
<td>VERY INVOLVED</td>
<td>10</td>
<td>8</td>
<td>5</td>
<td>23 (72%)</td>
</tr>
<tr>
<td>NOT INVOLVED</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>9 (28%)</td>
</tr>
</tbody>
</table>

From Table 65 it can be seen that the majority of husbands were involved and cooperative regarding the completion of the Self-help Programme. One subject did not tell her husband that she was participating in the Self-help Programme. Other subjects stated that their partners were reluctant to participate whilst others reported that their partners were not involved at all. On the positive side, many women reported that their partners were willing to help them to try and bring about change - offering support and assistance wherever possible.

Several women reported that their partners enjoyed the sex but were not really interested in getting involved in the non-sexual exercises.

Other comments as reported by the subjects regarding their partners' participation are as follows: "He's in love again"; "He was delighted with the more responsive and loving, willing and adventurous me"; "He likes me taking the initiative"; "He's more content"; "He's happier that I am more satisfied"; "He says times are much better for us - less inhibited"; "My husband is more willing and interested to try different things"; "My husband can't believe my sex drive has increased from once per three months to once per week!"; "I feel he is threatened by a vibrator"; "He says I am more positive about sex - also commented on my tighter
vagina, because of the PC exercises"; "My increased enjoyment has increased his".

3.4.3 Evaluation Questionnaire: Subjective Responses

The second part of this assessment is presented as follows. Firstly, the specific question asked in the Evaluation Questionnaire is presented. Where applicable, categories of questions have been presented together. This is followed by an analysis of the general trends observed, based on the subjects' elicited responses. Where appropriate specific comments are quoted.

3.4.3.1 Analysis of responses regarding aspects of the Self-help Programme that subjects found to be most beneficial

WHAT DID YOU FIND MOST BENEFICIAL ABOUT THE SELF HELP PROGRAMME?

The most common response was that subjects indicated that they now had the opportunity of discovering different ways of reaching orgasm. Several subjects reported that, for the first time, they now had learnt how to become orgasmic. Another common response was that owing to the self-exploration exercises, some women had gained a greater understanding and learnt more about their bodies and sexual organs. Others reported that their partners likewise were now more in touch with their sexual needs. The Programme had opened up better communication with their partners, and the fact that the Programme could be carried out in the privacy of their own homes was extremely advantageous. As a result of the Programme, many women reported feeling better about their sexuality, closer to their partners, and indicated that they now could be more adventurous and experimental in their lovemaking. In addition they were more relaxed and found the new ideas learnt "refreshing".
Specific comments regarding the Programme benefits included the following:
"I learnt that sex is natural and not dirty"; "I now feel more positive about sex and more in touch with my sexual feelings"; "The practical down-to-earth advice and getting the facts straight were beneficial"; "The discovery that I'm not unusual"; "Learning to touch without always being sexual"; "The Self-help Programme was an eye opener - most interesting, enlightening and educational"; "Realising there is an opportunity for improving my situation"; "I feel more relaxed and I understand more about my sexuality and orgasm"; "It's o.k. to want variety".

3.4.3.2 Analysis of responses regarding aspects of the Self-help Programme that subjects found to be least beneficial

WHAT WAS LEAST BENEFICIAL ABOUT THE SELF-HELP PROGRAMME?

Fifty percent of the subjects responded that the time allocated for completion of the Self-help Programme was not adequate, for example "I find my inhibitions don't break down very quickly" and "It's going to take more than these few weeks to become more responsive". Several subjects indicated that although they had enough time, they would still continue with the Self-help Programme. Two subjects experienced dissatisfaction in the fact that they still had not become orgasmic. Several subjects reported great difficulty carrying out the masturbation exercises suggested, and one subject expressed concern that using a vibrator could lead to "vibrator dependency". One woman stated "The fact that I kept the Self-help Programme a secret from my husband was most distressing for me". Several subjects reported that they could not masturbate in front of their partners as they found this distasteful, whilst others felt that masturbation per se made them feel guilty and they had difficulty in carrying out these suggested exercises.
Regarding masturbation, one woman commented as follows: "At first my attitude towards masturbation caused me distress, however, I learnt that it can be pleasurable". Another woman commented on the fact that she found it "difficult to explore my own body, let alone masturbate". Whilst another woman stated that she was "still scared of oral sex and masturbate in front of my husband", which created distress for her.

3.4.3.3 Analysis of responses regarding topics that subjects found to be most beneficial and enjoyable

WHICH TOPICS DID YOU FIND MOST BENEFICIAL/ENJOYABLE?

A wide range of responses was reported. In fact, all of the 20 Self-help topics were mentioned on several occasions as being beneficial/enjoyable. Several subjects reported finding all the topics beneficial, in some way. The 10 most beneficial and enjoyable topics, in order of popularity, were as follows:-

1. Achieving better orgasms (strengthening your PC muscles);
2. Non-genital pleasuring;
3. Vibrator use;
4. G-Spot stimulation;
5. Adventurous foreplay;
6. Better sexual techniques;
7. Reaching a climax through self-stimulation;
8. Clitoral stimulation;
9. Genital and sexual self-exploration;
10. Reaching a climax with the help of your partner.

As can be seen from the above, the most popular topics focused both on "becoming orgasmic" aspects as well as "improving sexual technique and enjoyment".
3.4.3.4 Analysis of responses regarding topics that subjects found to be least beneficial and enjoyable

WHICH TOPICS DID YOU FIND LEAST BENEFICIAL/ENJOYABLE?

The topics listed as being the least helpful/enjoyable were as follows:-

1. Vibrator use;
2. Reaching a climax through self-stimulation;
3. Genital and sexual self-exploration;
4. Sexual fantasies;
5. Oral sex;
6. Sexual positions;
7. Multiple orgasm;
8. Erotic kissing.

It is interesting to note that these "most unpopular" topics for some women proved to be the "most popular" for others. This, once again, highlights important individual differences regarding sexual functioning. The topics were interesting enough to afford subjects the opportunity to enjoy and gain benefit from at least some of them.

3.4.3.5 Analysis of responses regarding general orgasmic response

GENERAL COMMENTS REGARDING ORGASMIC RESPONSE

Several subjects reported finding a vibrator to be extremely useful, in particular when they wanted a quicker orgasmic response. Others felt that they sometimes needed "a long period of time to reach a climax". However, the more relaxed they felt, the easier they would "let it happen". Several women stated that they were now enjoying sexual intercourse far more than ever before. They were having more intense orgasms and sometimes were experiencing
multiple orgasm which was very satisfying. Several commented that although they were orgasmic during self or partner stimulation, they still wanted to reach a climax during sexual intercourse alone.

Specific comments included the following: "I feel more feminine and creative"; "I can now climax through oral sex"; "Reaching a climax more regularly has made me feel more sexy"; "By spending more time with foreplay and by being more responsible for my own pleasure, I climax more regularly"; "Clitoral stimulation and PC muscle exercises has helped me - I'm two seconds from reaching a climax"; "Self-stimulation and PC exercises made me more sensitive although I have not reached an orgasm yet".

3.4.3.6 Analysis of responses regarding faking orgasm

IF YOU FAKE ORGASM BEFORE, HAS THIS CHANGED?

Responses elicited from the Initial Biographical Questionnaire revealed that 14 women in the study faked orgasm. Three women in the Control group faked orgasm. The 11 women in the Experimental groups, faked orgasm on a regular basis. Following the Self-help Programme, only three women in the Experimental groups were still faking orgasm, for the following reasons: "I still fake it as I can't reach a climax fast enough"; "Occasionally I fake orgasm if I feel my husband has not put some effort into the lovemaking"; "Occasionally when I'm tired I fake it to get it over with quickly".

Other reasons that contributed to women no longer needing to fake orgasm included: "There is more honest communication"; "Don't need to any more"; "I don't fake orgasm - I just tell my husband that I did not climax"; "Faking now can never be the same again - my husband knows
the difference now"; "Climaxing is my responsibility - so I no longer fake"; "No, I'd rather be honest".

3.4.3.7 Analysis of responses regarding the most important thing learnt and the biggest advantage of the Self-help Programme

WHAT IS THE MOST IMPORTANT THING YOU HAVE LEARNT FROM THE SELF-HELP PROGRAMME?

Significant trends revealed the following: The importance of being more open and honest and expressing one’s feelings as well as taking the initiative in order to get one’s sexual needs met. A significant number of women stated that they realised that they were "normal" and this feeling in turn led to the realisation that they could continue enjoying themselves sexually.

Several women stated that they now realised that women can, and do, enjoy sex as much as men. Other common trends noted was the realisation of the importance of foreplay and making more time for sex which in turn was more fun and enjoyable.

Specific responses included the following: "I do not have to have an orgasm each time we make love"; "Not to be embarrassed with your body and to express sexual feelings more openly"; "I learnt how to reach a climax"; "It's o.k. to have orgasm through self or partner stimulation only"; "That it is possible to have an orgasm!"; "Acceptance of my own sexuality - that it differs from others"; "That I was more inhibited about sex than I thought"; "That my sex life is worse than I realise"; "To experiment and keep things exciting".
WHAT IS THE BIGGEST ADVANTAGE OF SUCH A SELF-HELP PROGRAMME?

Two important themes emerged from the subjects' responses. Firstly that the Self-help Programme could be carried out in the privacy of one's home which enabled one to work at one's own pace. "One can find a solution to your problems at home - without anyone having to know your business".

Secondly, the Self-help Programme provided a great opportunity to learn more about one's sexuality.

Several subjects thought that the Self-help Programme was excellent for shy people who did not want to discuss their problems person to person. "Those too shy to seek professional help can be helped by such a Programme".

Other comments included the following: "Everything was advantageous - even though I am 61, I was very ignorant and it taught me a great deal"; "Being exposed to all of the different techniques in lovemaking helps to understand one's body and to analyse one's feelings"; "Brings one's problems out into the open and encourages a greater sense of self and sexuality"; "The lifting of taboos and restrictions and self-exploration".

3.4.3.8 Analysis of responses regarding the biggest disappointment and drawback of the self-help Programme

WHAT IS YOUR BIGGEST DISAPPOINTMENT REGARDING THE SELF-HELP PROGRAMME?

Five women were disappointed with the fact that they were still unable to reach a climax specifically during sexual intercourse - which was an expectation they had of the Programme. Two women expressed disappointment as they had
not yet reached a climax. Others were disappointed in not having spent as much time as they would have liked to on the Self-help Programme, whilst others were unable to complete the entire Self-help Programme.

Specific responses included the following: "Have not approached the Programme in a systematic way and I was not able to discuss it with my husband"; "I was hoping to find the G-Spot - still trying"; "I was hoping I'd be more orgasmic during sexual intercourse but realise this takes time"; "My partner did not have enough time to do the programme properly"; "I would have liked my partner to be involved"; "I was not able to participate fully owing to time constraints" and "It hasn't changed much at all".

WHAT IS THE BIGGEST DRAWBACK OF SUCH A SELF-HELP PROGRAMME?

The most common drawback experienced by subjects was that they felt that they would have liked to have had someone to talk to, i.e. personal contact to discuss certain matters and to clarify issues and questions that arose during the course of the Programme. Being completely on their own was difficult at times. For many it would have been advantageous to discuss problems, progress, and to ask advice when needed (i.e. minimal therapist contact). Many also felt that the time factor, i.e. eight weeks, was problematic. They needed more time. Nevertheless, many did indicate that they intended to continue with the Programme on their own.

Other comments regarding the drawback of the Programme included the following: "You need to be very disciplined"; "Finding the time and privacy in a busy household"; "Getting the cooperation of one's partner"; "Nothing as helpful as the Programme could be a drawback"; "That things have not changed as hoped for".
3.4.3.9 Analysis of responses regarding the Programme format, topics in general and other topics that should have been included

COMMENTS ON THE TOPICS IN GENERAL

Generally, subjects found the topics to be very good, comprehensive, sensitively handled, user-friendly, interesting, informative and educational. Several responded that the topics were well researched, very enlightening, extremely helpful and educational, whilst others felt that the information was presented in a succinct way and was easy to understand. Two women felt that they would have liked the topics to have been longer whilst one woman felt that some of the topics needed to be shorter.

Specific comments included the following: "I learnt something from each topic"; "Could listen to topics without feeling embarrassment about an intimate subject"; "The length was just right"; "Very good, all absolutely excellent"; "I found all the topics informative, well presented and just the right length to keep me absorbed and interested".

WHAT OTHER SPECIFIC TOPICS SHOULD HAVE BEEN INCLUDED IN THIS SELF-HELP PROGRAMME?

Generally speaking, most subjects were happy with the topics stating that "everything was well covered". Others suggested that the following topics be included: Sex and the older person; coping with previous sexual abuse; how to handle lovemaking with teenage children at home; overcoming inhibitions and controlling premature ejaculation. Generally, most were happy with the topics stating that everything was well covered and all topics were helpful.
COMMENTS REGARDING PROGRAMME FORMAT

Premium Rate Service Group 1 and Group 2:
Most subjects in these two Experimental groups were happy with the audio presentation. They reported that a "voice" made the Programme more personal and that a manual would have been too impersonal. Several subjects did suggest that a manual could be included as an adjunct to the audio presentation.

Bibliotherapy Group:
Six subjects in this group requested an audiocassette presentation in addition to the manual. The other two subjects in the group felt that a manual gave one the time needed to go through the Programme thoroughly. One subject suggested a video presentation in addition to the manual.

3.4.3.10 Analysis of responses regarding completing the Questionnaires

COMMENTS REGARDING COMPLETING THE QUESTIONNAIRES:

Regarding the completion of the questionnaires throughout the Project, some women felt that it was difficult to complete such intimate questionnaires, that the questionnaires were lengthy, whilst others felt that they did not mind completing them. Some women stated that they even enjoyed completing the questionnaires.

The following responses were elicited: "Direct - makes a person really think"; "Never before did I have to express my needs, desires, fantasies..."; "It's the first time I have been open about my problems - it helps to write it down"; "Very valuable, because it consolidates what you have learnt"; "Tedious, but necessary"; "Very intense"; "Needed more time to answer the questions in the allocated time".
3.4.3.11 Analysis of responses regarding going for therapy

IF YOUR DIFFICULTY HAS NOT BEEN SUFFICIENTLY HELPED, WOULD YOU NOW CONSIDER GOING FOR THERAPY?

The consensus was evenly split - 50% of the subjects felt that they would now go for professional help if the need arose. The other 50% indicated that they would not go for help, largely owing to the fact that they were now happy with their sexual response and therapy was not necessary.

3.4.4 Subjective Reports: Unsolicited Comments

The final part of this assessment consists of unsolicited comments obtained under the heading "Further Comments". A wide variety of spontaneous comments were elicited regarding the Self-help Programme, orgasmic response and lovemaking in general.

The specific responses that subjects reported under the description "Further Comments" are as follows:-

"My relationship with my husband improved a thousand fold. His attitude towards my sexual satisfaction has changed dramatically. I reach orgasm regularly. For years I have taken for granted that men know everything about sex when in fact, they know very little. From this Programme I am slowly learning to relax and change my attitude towards sex - I have always been far too inhibited and shy. We have always had a good relationship and now it's even better."

"For me, it is a long term process. I can now accept more than I could eight years ago. It is o.k. for me to climax with my partner stimulating. I need more than eight weeks to improve my sex life."
"I feel more open minded than in the beginning - I will definitely continue the programme."

"Orgasm and sex has improved but our relationship could still improve - this needs more communication and spending time with each other."

"The programme is valid and useful as a starting point but further counselling is probably a good idea if problems are not resolved."

"I think the programme is very good for people whose relationship is better than ours."

"Our sexual relationship can only improve."

"'Dr. Paul' thank you for the time you have taken to draw up this unique project. Thank you for all the help you have given so many like me."

"'Dr. Paul' - thank you so much for the Programme, I will carry on working at it because I would like to enjoy a full sex life."

"Thank you for the opportunity of participating in this Programme. I have learnt a great deal and I thoroughly enjoyed it. Keep up the great work, 'Dr. Paul'."

"We have both become more aware of each other as sexual beings - more sensitive to each others' needs, desires, etc. Thank you!"

"It would be great if more people had access to your Programme."
"I still desperately want to improve my feelings about lovemaking and hopefully reach an orgasm and improve that side of my relationship. Thank you for your good work and for the Programme."

"We are about to be married this week and I just cannot thank you enough for allowing me to participate in this Programme. I have enjoyed it very much."

"Our relationship has improved with the experience, thank you very much. I have great respect and trust in 'Dr. Paul’s' advice."

"Thank you so much for your information and caring 'Dr. Paul'. The Programme has helped my sexual relationship - what used to be just an exercise now has more meaning. My husband realised and admits to ignorances - we were unaware of before."

"It's a great Programme. Thank you for what I have learned. I think you are doing a wonderful job."

"I am sure this Programme will also be a great help to lots of people. It certainly was to me. Thank you and Good Luck for the rest of your work."

"Thank you for opening new avenues and adventures for us!"

"'Dr. Paul' - I can't thank you enough for including me in your Project, you have changed my life - Thank You!"
DISCUSSION

4.1 Introduction

In South Africa the Premium Rate Telephone Service has recently been introduced. Together with this new service there has been an emergence of numerous so-called "sexual advice lines", none of which have been validated. Many of these services have offered advice by so-called "experts" making great claims as to what can be achieved by using their services. However, there is no scientific evidence available to date, to back up any of these claims. Hence, as with all self-help programmes there exists a need to assess the effectiveness of such PRS self-help programmes. This validation needs to be carried out in a scientific and empirical manner in order to determine the actual benefits, possibilities and scope of such a service.

The aim of the present study was to firstly investigate whether a need existed for an adult sexuality self-help service to be run on a Premium Rate Telephone System.

Once this need had been established it was then necessary to investigate whether such a PRS service could be effective in treating female sexual dysfunction. This investigation has not been carried out previously (LoPiccolo, 1992).

Already back in 1978 the American Psychological Association Task Force on Self-Help Therapies had set out guidelines for self-help therapies including principles and procedures that needed to be carried out to evaluate such programmes. Owing to the fact that the "Dr. Paul" Premium Rate Service Self-help Programme used in the present study can be regarded as a form of self-help therapy, the present study was carried out in accordance with the principles and

As with previous studies (Zeis, 1978) a cognitive-behaviourally orientated approach was employed i.e. a brief intervention with no therapist contact with the focus on homework exercises, sexual skills training and directive masturbation training.

Rosen (1976) and Glasgow and Rosen (1987) maintained that self-help programmes need to be validated. Hence, it is both logical and imperative for this innovative "Dr. Paul" Premium Rate Service Self-help Programme to be evaluated.

Furthermore, owing to the fact that numerous PRS sexual advice services are available today, the necessity for this validation becomes a matter of urgency - in order to determine which are truly effective.

Once such a PRS Self-help Programme for sexual dysfunction had been successfully validated it would then be available to the public as a useful, cost-effective, convenient, scientifically validated and effective form of "sex therapy".

The specific hypotheses upon which the study was based and which are tested in order to determine the efficacy of the "Dr. Paul" Self-help Programme are as follows:

1. A Premium Rate Service intervention would lead to a significant improvement in sexual arousability, sexual satisfaction and quality of sexual interaction for women with reported orgasmic dysfunction.

2. A Bibliotherapy intervention would lead to a significant improvement in sexual arousability, sexual satisfaction and quality of sexual interaction for women with reported orgasmic dysfunction.
3. A Waiting-list Control group would show no significant improvement in sexual arousability, sexual satisfaction and quality of sexual interaction for women with reported orgasmic dysfunction.

4. A Premium Rate Service intervention would lead to a greater degree of sexual arousability\(^1\) compared to a Bibliotherapy intervention and a non-intervention Control group for women with reported orgasmic dysfunction.

5. A Premium Rate Service intervention would lead to a greater degree of sexual satisfaction\(^2\) compared to a Bibliotherapy intervention and a non-intervention Control group for women with reported orgasmic dysfunction.

6. A Premium Rate Service intervention would lead to a greater improvement in the quality of sexual interaction\(^3\) compared to a Bibliotherapy intervention and a non-intervention Control group for women with reported orgasmic dysfunction.

The results of the present study will now be described in three phases:

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\(^1\) As measured by the Sexual Arousability Inventory (SAI); the Derogatis Sexual Functioning Inventory (DSFI): Information, Sexual Drive and Sexual Fantasy sub-tests; and the Sexual Interaction Inventory (SII): Female-Pleasure sub-tests

\(^2\) As measured by the DSFI: Sexual Satisfaction and Global Sexual Satisfaction sub-tests; the SII: Female Dissatisfaction and Female Self-Acceptance sub-tests

\(^3\) As measured by the DSFI: Experience sub-test; the SII: Total Disagreement and Mate Acceptance - Female of Male sub-tests
Firstly, the need and the relative use of the "Dr. Paul" Premium Rate Service sexual help lines will be discussed in order to establish whether a need for such a service indeed exists.

In the second phase, the inferential statistical analysis will be presented in terms of the quantitative data analysis of the relative effectiveness of the Premium Rate intervention in comparison to a Bibliotherapy intervention and a Waiting-list Control group.

Lastly, a qualitative analysis of the responses will be undertaken as sexual functioning is an area of human behaviour that is of such sensitivity that it cannot always be measured effectively by means of quantitative methodology.

4.2 The Need and Relative Frequency of Use of the "Dr. Paul" Adult Sexuality Self-help Lines run on the Premium Rate Telephone System

Before the effectiveness of a Premium Rate Service intervention as compared to a Bibliotherapy intervention and a Waiting-list Control can be discussed, it would be important to discuss some of the descriptive statistics related to the "Dr. Paul" adult sexuality self-help lines — in order to establish whether a service of this nature was used significantly to warrant an evaluation of its possible success in terms of reducing sexual dysfunction and improving sexual functioning.

The "Dr. Paul" adult sexuality self-help service was introduced in October 1991 with a total of 64 adult sexuality topics. During the initial period being assessed, namely, 15 October 1991 to 15 April 1992 (182 days), over 214 000 calls were received. Callers listened to the information given out on specific topics for an average of approximately 3.28 minutes. This translates into a total number of call minutes of close on 800 000, for the initial
period. This means that the average daily call volume received was approximately 1 100 calls.

In terms of the overall usage of the Service it could be considered to be substantial. Furthermore, in terms of the response elicited, it could be regarded as a relevant and important service for the South African population, in need of information concerning their sexuality and help in overcoming specific, commonly experienced sexual difficulties.

From an examination of the 24 most popular topics (see Table 8, Page 151), it is evident that 33% deal specifically with "reaching a climax", whilst a further 33% deal with general "female sexuality" issues. Several reasons are offered for this finding:

1. Women generally more readily seek help for marital and sexual difficulties (Barbach, 1974; Kitzinger, 1983).

2. Female orgasmic dysfunction is typically cited as the most common sexual difficulty presented to practitioners (Burnap and Golden, 1967; Derogatis et al, 1986; Kaplan, 1974). In sex therapy clinics the frequency of female orgasmic dysfunction as the primary presenting problem ranges from 18% (Bancroft and Coles, 1976) to 76% (Frank et al, 1976). Renshaw (1988) reports primary orgasmic dysfunction rates at 32% and secondary orgasmic dysfunction rates of 37% in her sex clinic sample.

3. Owing to the extensive media coverage, for example, radio and television talk shows, namely, Sexuality Speaking and Sex Talk with "Dr. Paul" as well as numerous articles written in popular magazines on the topic of female sexuality, many women, and men, now want accurate information and are keen to learn more about their sexuality - regarded as taboo years ago.
4. The Feminist movement too, has contributed positively to this greater awareness and openness regarding female sexuality and the sexual needs of women (Boston Women's Health Collective, 1984). It would appear that today, an increasing number of women are interested in understanding the facts regarding their sexuality and in particular learning how to achieve greater sexual satisfaction for themselves including improving their orgasmic responsivity, either alone or within their particular relationships (Darling et al, 1991b; De Bruijn, 1982; Kitzinger, 1983; Stoppard, 1991).

5. It is probable too, that both men and women called into the "female sexuality" topics. This may have been as a result of mere curiosity but, for many, it may also have served as an important learning experience. In other words, having the opportunity to learn more about their own and their partner's sexuality so that they could increase the quality of their sexual interaction within their particular relationships.

Contrary to what was expected in the area of male sexuality, topics dealing with premature ejaculation and erectile difficulties were not amongst the 24 most popular. Hawton (1985), Renshaw (1988) and Leiblum and Rosen (1989) have reported these to be amongst the most widely presenting problems at sex clinics. Reinisch and Beasley (1990) report that the most frequently asked questions by men at the world famous Kinsey Institute in America are concerns and problems with getting and keeping erections.

Reinisch and Beasley (1990) report that at the Kinsey Institute problems with penis size, shape and appearance are the second most frequently asked questions by men. Masters et al (1988) also report that concerns with penis size are common in males of all ages. Delvin (1974) states, "To the average man, his penis is, consciously or subconsciously, the most important thing in the whole world" (p.21).
Similarly, in the present study, the topics dealing with the penis were popular and received a high percentage of the calls.

It is apparent too that women and men want to lead more pleasurable and satisfying lives and avoid a great deal of unnecessary suffering and frustration (Barbach, 1984; Boston Women’s Health Collective, 1984; Kitzinger, 1983; Ladas et al, 1982). For this reason, it would appear that topics dealing with sexual pleasure and sexual technique received a high percentage of the calls.

Topics generally regarded as taboo and highly controversial, for example, vibrator use, masturbation, the G-spot, sexual fantasies, and what turns men and women on, received some of the highest call volumes. Masturbation, the sexual practice engaged in by a high percentage of the population, both male and female (Delvin, 1974; Kinsey et al, 1953; Masters and Johnson, 1970; Stoppard, 1991) is one that is least spoken about. This sexual practice is often clouded in numerous myths and veiled in secrecy. This probably contributed to the high call volumes for this particular topic, including both male and female masturbation. Many individuals sought clarification about this practice.

From an analysis of the most popular topics, it is evident that there was a great interest shown concerning vibrator use. Many individuals have come to understand that using a vibrator can provide pleasure and satisfaction and can be used as an alternative to sexual intercourse or as an adjunct to their lovemaking—often being used merely as a sex aid (Reinisch and Beasley, 1990; Stanaway, 1991).
Similarly, the G-spot and sexual fantasy topics, both often controversial and shrouded in mystery, recorded a high call volume. For many, these subjects and practices are not spoken about and for many still remain taboo (Stanaway, 1992; Whipple, 1992).

It is interesting to note that the topic dealing with condoms was one of the most popular. Taking into account the high incidence of sexually transmitted diseases, concerns with AIDS, and the emerging awareness of safer sex practices, could all have contributed to this topic being popular.

On a more general level, a possible reason for the high call volume to the "Dr. Paul" service was the fact that this service, which was available 24 hours a day, assured one of complete confidentiality. Calls to this service could not be traced and individuals may have felt more comfortable to get this important information via the PRS system, as opposed to initially consulting a professional.

Although it is likely that the high call volume may have reflected an initial curiosity value, particularly in the early stages of the service being introduced, the average call holding time was approximately three and a half minutes. It is likely that individuals experiencing sexual difficulties and various sexual concerns and who were more "serious" about receiving professional information, probably listened to the advice for a longer period.

It is also feasible that certain individuals who needed various sexual myths and other sexual issues to be clarified called the service, something they may otherwise never have done. Furthermore the fact that this sexual information was obtainable so conveniently, a "mere telephone call away" may also have contributed to the high call volume. Moreover from a review of all the "PRS sexual
advice" services on offer in South Africa at the time, the "Dr. Paul" sexual self-help service was the most comprehensive and was the only PRS service offering a systematic self-help programme for common sexual dysfunctions.

Finally, the diverse South African cultural background must be taken into account. Sexuality in general has been a taboo topic for so many years. People have been denied access to sexual facts and information. With the advent of the "Dr. Paul" adult sexuality self-help lines, this important sexual information, presented both clinically and professionally could be obtained a mere phone call away.

Hence, for all the above reasons it is likely that the "Dr. Paul" adult sexuality self-help lines received such a high call volume and created such an impact in the South African community at large.

4.3 The Effects of the Premium Rate Service Intervention and the Bibliotherapy Intervention on the Dependant Variables

For the purpose of the quantitative analysis of the data obtained in this study, the pre-intervention and post-intervention scores were assessed for significance of degree of difference and a comparison was made on the final scores for the groups. On the whole the data obtained from this information supported the hypotheses for the study.

It was found that a significant number of the measures improved from the pre- to post-intervention phase for the PRS group while fewer measures showed a similar improvement with the BIB group and no changes were observed in the Waiting-list Control group.
This would seem to indicate that the PRS and BIB interventions would show a degree of effectiveness as indicated by means of the quantitative measures of sexual functioning. However, when the groups were compared on post-test measures there were no significant differences found -indicating that other variability factors were implied. One such factor was the small group size which would increase the intra-group variability compared to the inter-group variability. When specific measures are addressed the following significant pre- to post-test intervention dependant variables showed significant changes.

As regards the construct sexual satisfaction, the positive findings of the present study are in keeping with the reported changes observed in other outcome studies, in both orgasmic responsivity and other variables of sexual satisfaction. For example, employing a systematic desensitisation programme Husted (1975); Jones and Park (1972) and Sotile and Kilmann (1978) report significant improvements in orgasmic responsivity and sexual satisfaction. Using a directed masturbation treatment approach, significant changes in orgasmic responsivity and sexual satisfaction were reported by Lobitz and LoPiccolo (1972); LoPiccolo and Lobitz (1972); McGovern et al (1975) and Reisinger (1974).

Using a group therapy format, Barbach and Flaherty (1980); Heinrich (1976); Kuriansky et al (1982); Schneidman and McGuire (1976) and Wallace and Barbach (1974) also reported similar changes in orgasmic responsivity and sexual satisfaction together with a greater feeling of self-acceptance for the female subjects participating in their studies.

Although the PRS intervention had never been evaluated previously (LoPiccolo, 1992; Whipple, 1992a) the changes brought about by the interventions within the Experimental
groups are in accordance with the numerous other research findings using various cognitive-behaviourally orientated treatment techniques and formats. Furthermore, in spite of the fact that the PRS and BIB interventions were completely self-administered, certain of the post-intervention changes observed in sexual functioning as measured by the dependent variables are similar to those changes in sexual functioning reported by studies conducted on a face to face basis - using different therapeutic formats.

As regards the quality of sexual interaction construct the findings in the present study also lend support to other studies, whereby not only was there an increase in frequency of orgasmic responsivity, but also an improvement in general interaction with partner and in particular as regards an improvement in sexual communication. Studies using different interventions and formats, reflecting these positive changes regarding improvement in sexual interaction include those of Husted (1975); Kilmann (1978); McGovern et al (1975); McMullen and Rosen (1979); Snyder and Berg (1983) and Sotile and Kilman (1977). Once again it must be pointed out that the PRS and BIB interventions were completely self-administered.

Similarly as regards the sexual arousability construct, following the Self-help Programme, the subjects reported an improvement in their level of sexual arousability. These findings, once again, are comparable with the results of face to face therapeutic formats, for example, Hoon and Hoon (1982); Hoon et al (1976) and Trudel and Saint-Laurent (1983). These significant improvements as measured by the quantitative measures were likewise supported by the subjective reports of the subjects. The findings of the subjective reports will be discussed in the next section.

It would now be important to look at some of the possible factors that may have contributed to the significant pre-
to post-intervention improvements in sexual functioning. Both interventions used in the present study are cognitive-behaviourally orientated, essentially providing a brief therapeutic programme with instructions to learn to carry out the therapeutic procedures, whilst offering relevant information in an attempt to increase the subjects' knowledge and understanding of their sexual functioning. One of the aims of the interventions was to alter etiological factors that may have been causing or maintaining the dysfunction for example, sexual ignorance, anxiety, and ineffective sexual techniques as well as negative sexual attitudes.

By informing the subjects as to what might be helpful in terms of improving communication, by helping to correct deficits in knowledge and sexual skill, and by guiding them in a systematic way through the Self-help Programme, an improvement in sexual functioning was brought about.

These principles are in accordance with the theoretical and clinical formulations of Barbach (1980); Heiman and LoPiccolo (1988) and Masters and Johnson’s (1970).

Although the PRS and BIB interventions were completely self-administered they are nevertheless similar to those employed by other cognitive-behaviourally orientated "face to face" treatment approaches, for example, systematic desensitisation (Husted, 1975; Sotile and Kilman, 1977), directed masturbation (Lobitz and LoPiccolo, 1972; LoPiccolo and Lobitz, 1972) and group therapy (Barbach, 1974; Barbach and Flaherty, 1980; Wallace and Barbach, 1974).

A review of the literature reveals that numerous studies covering female orgasmic functioning have concentrated primarily on improving orgasmic responsivity as the sole criteria for success. In the present study, other important
variables were additionally examined, for example, sexual arousability, sexual drive, sexual fantasy, quality of sexual interaction and sexual satisfaction.

The findings of the present study are also comparable with the numerous other outcome studies treating female orgasmic dysfunction (Andersen, 1982; Blakeny et al., 1976; Delaney and McCabe, 1988; LoPiccolo, 1986).

Further reasons that may have contributed to the significant changes include the fact that the interventions were structured and task-orientated. This lent support to the findings of Zilbergeld and Kilman (1984), who stated that directly working on a problem by doing tasks may be more effective than just talking about the complaint.

The significant improvements in sexual arousability and sexual satisfaction in the present study lent credence to the Darling (1991b) findings in which women who became more adventurous and more explorative were able to enhance their orgasmic responsivity and many went on to become multiply orgasmic. The subjective reports in the present study similarly add support to these findings, regarding improvement in sexual arousability.

Further reasons that may have contributed to the significant changes in the dependent variables include the fact that once the subjects received the Self-help Programme and started working through them, they probably felt less alone, stigmatised and helpless. Furthermore, their understanding as to why their particular problem had developed, may have become clearer - gaining insight into the nature of their problems may have been helpful, learning more about their sexual functioning and potential, including ways of enhancing their sexual self-awareness and learning more about the particular needs of their partners, and ways of improving their self-understanding all led to
significant improvements. Althof and Kingsburg (1992) recorded similar findings when examining the reasons why people request self-help books and the benefits thereof.

In addition the programmes of intervention provided relevant information helping subjects to set reasonable expectations, reduce levels of anxiety and as a result increase levels of arousability. This in turn led subjects to take the initiative more often, to explore, experiment and enjoy their sexuality, hence leading to significant improvements in their overall sexual arousability and sexual satisfaction. These findings are comparable to those of Barbach (1980) and Barbach and Flaherty (1980).

Recent studies have been conducted assessing the effectiveness of minimal-contact bibliotherapy interventions on sexual functioning. In the present study several significant pre- to post-test intervention changes for the Bibliotherapy group were noted. These findings indicated that following a bibliotherapy intervention subjects experienced a greater degree of sexual arousability, sexual drive and more satisfaction with the repertoire of sexual practices they engaged in with their partners, as measured by the quantitative analysis. These findings were also supported by the subjective reports, which will be discussed later. Moreover, these findings offer further support to the reported outcome studies of Dodge et al (1982); Libman et al (1982) and McMullen and Rosen (1979), where similar improvements in sexual functioning were recorded - using a minimal-contact therapist bibliotherapy format. It is interesting to note that Libman et al (1984) found no difference between a group format and a minimal-contact bibliotherapy intervention in improving sexual satisfaction and orgasmic response.

Trudel and Saint-Laurent (1983) also found a bibliotherapy procedure combined with minimal therapist contact to be
useful in increasing sexual arousability and sexual satisfaction for a group of women.

Morokoff and LoPiccolo (1986) using the Becoming Orgasmic book and film as the basis for their self-help intervention showed that a minimal therapist format as well as a therapist-administered sex therapy could be equally effective in bringing about changes in sexual functioning.

Heinrich (1976) showed that both a therapist run group as well as a self-administered bibliotherapy intervention both led to improvements in sexual functioning. However, the therapist led intervention was shown to be more effective.

The findings in the present study lent support to the above mentioned studies, in particular, the fact that a self-administered self-help intervention has shown to be effective. The PRS intervention is merely an extension of the Bibliotherapy format containing the exact same information but delivered through a different medium i.e. the telephone.

Hence, from the above it can be seen that the hypotheses were supported to an acceptable degree when considering pre- to post-test significant changes for the Experimental groups.

However, when the outcome measures for the groups were assessed for differences across the groups it was found that without controlling for pre-intervention baseline data there was no significant difference. However, when pre-intervention baselines were controlled for by means of an analysis of covariance, significances were obtained on 11 out of the 12 dependant variables. This leant further support to the hypotheses being investigated that PRS and BIB interventions would bring about pre- to post-test changes in sexual functioning and interaction.
Unfortunately, the significant differences with the F-test were not supported by subsequent Sheffé post-hoc analysis. This can be explained on the basis that the Sheffé post-hoc analysis is a very stringent and conservative test when compared to the F-test used in the analysis of covariance.

Only large differences given a significant intra-group variance could be reflected as significant by the Sheffé post-hoc test. Unfortunately the low rate of return and attrition of the sample, in particular that of the Bibliotherapy group, caused intra-group variance to be so large that differences which can be observed in terms of means could not be afforded statistical significance.

However, if the means are analysed visually subsequent to the significances found in the analysis of covariance procedure, important trends are noted (see Table 10, Page 155):

The PRS group revealed a tendency for greater improvements compared to the BIB group for the following dependant variables: sexual arousability, sexual fantasy, female frequency dissatisfaction, female self-acceptance and female pleasure compared to the BIB group. Taking into account these trends as well as the greater number of dependant variables showing significant pre- to post-test intervention changes it would appear that the PRS intervention is superior to a BIB intervention and a non-intervention Control.

The only significant difference was for the superiority of the BIB group compared to the PRS group for the dependant variable Mate Acceptance - Female of Male. This could be attributed to the fact that more effort was required to read through the manual compared to just listening to the PRS intervention. It must also be noted that for the BIB group, pre- to post-intervention significance for Sexual
Drive was also significant. Perhaps women in this group became more assertive and expected greater participation from their partners. Furthermore, the fact that partners had to read the manual could have indicated a greater degree of involvement from the partners and hence perhaps these women perceived their partners' sex responses as more ideal when compared to the other group.

Leiblum (1990) points out that the whole field of sex therapy is changing - this PRS intervention can be regarded as an innovative approach to treating sexual problems. The PRS Self-help Programme is available to women regardless of their relationship status.

This is in keeping with Barbach's (1974) formulation that successful treatment outcome can be achieved when a woman is involved in treatment without a partner. In Barbach's approach to treatment, group procedures were employed. In the present study one of the selection criteria was that subjects be involved in a stable sexual relationship. Nevertheless, the focus of the Intervention was directed to the women herself, whilst her partner played an important role, his participation was not crucial.

George Miller stated, "Give psychology away" (Miller, 1969, p.29). The PRS intervention certainly is a means of bringing psychology to the people. Self-help therapies are increasingly playing a significant role in the practice of psychotherapy (Riordan and Wilson, 1989) whereby patients are taking greater responsibility for treatment progress (Lenkowsky, 1987; Pardeck, 1986).

Studies assessing the treatment effectiveness of other sexual dysfunctions have found similar positive results. Using a minimal-therapist contact format, Lowe and Mikulas (1978); Trudel and Proulx (1987) and Zeiss (1978) treating premature ejaculation found significant improvements.
In Zeis' study, contrary to what was found in the present study, a no-therapist, Bibliotherapy intervention proved to be totally ineffective.

Psychotherapists recommend books to patients for help with their particular sexual or marital problem for which they seek help (Althof and Kingsburg, 1992). The PRS intervention could be recommended in a similar way.

Mode of therapy delivery, whether the directive sex therapy takes place with individuals, with couples, in groups or in a non-contact bibliotherapy format, have shown to be effective in treating female orgasmic dysfunction - whether time limited or whether the goals have been realised. In the present study, the PRS intervention has been shown to be as effective, in certain respects, as the other cognitive-behaviourally orientated interventions.

One further issue that deserves mention concerns the relationship variable, particularly owing to the fact that by its very nature the PRS intervention could not deal directly with these interactional issues, other than by suggesting various tasks to be completed together.

Hawton (1985) claims that it is uncommon to find no relationship problems in people with sexual dysfunction whilst Hartman et al (1983) do not believe that this is inevitably so. They believe that sex problems can be treated in isolation by a directive approach and still achieve good results. It would appear unlikely that the PRS intervention would be ideally suited for treating female sexual dysfunction in instances where there is severe marital discord and more complex personal pathology. Barbach (1984) disagrees with Hawton et al's contention - in particular as regards orgasmic dysfunction, which she claims is mostly a learnt response. However, LoPiccolo and Hogan (1979) and Zeeman (1987) point out that failure to
resolve relationship issues can result in the failure of sex therapy.

Significant correlations were found to exist in the present study between the dependant variables sexual arousability and sexual drive, sexual fantasy and female sexual pleasure. This would seem to indicate that subjects who regularly used fantasy, either as a "sexual stimulant" to get things going sexually and during lovemaking would experience a greater degree of sexual arousal, which in turn would increase their "sexual energy" or sexual drive (Whipple, 1992). This in turn would lead to a greater degree of pleasure derived from the sexual experience as a whole. This finding is consistent with the findings of Heiman and LoPiccolo (1986); LoPiccolo and Lobitz (1972) and Stanaway (1991).

Furthermore, a significant correlation was found to exist between information and sexual experience. This is once again consistent with the research findings of Derogatis et al (1986); Derogatis and Melisaratos (1979), whereby it has been shown that women who have the necessary information regarding sexual functioning are better equipped to enjoy and participate in a greater variety of sexual experiences.

Another positive correlation found to exist between the dependant variables in the present study was that of sexual satisfaction and global sexual satisfaction. This indicates that women who were satisfied with various specific sexual activities, for example, frequency of sexual intercourse, petting, masturbation and kissing, reported a greater level of overall sexual satisfaction and experienced greater satisfaction with their general sexual relationship. This is in line with the findings of Barbach (1984); Davidson and Darling (1989) and Delaney and McCabe (1988).
The positive correlations lent further support to the significant findings in the present study.

Regarding the negative correlation found between the dependant variables of global sexual satisfaction and the subjects being accepting of their male partners — this would seem to indicate that although women may in fact have been accepting in a general way of their partners, it did not necessarily translate into an overall feeling of sexual satisfaction, once again indicating the complexity of human sexual functioning.

A further negative correlation was found to exist for women who experienced some sexual pleasure and yet were still not necessarily accepting of themselves. It was possible to experience some degree of sexual satisfaction and reach a climax but still experience feelings of self-doubt and not being entirely satisfied with the general nature of the sexual relationship. i.e. they had still not attained their desired level of sexual satisfaction.

4.4 Analysis of the Subjective Reports of the Effectiveness of The Interventions on the Indices of Sexual Functioning and Interaction

Significant trends noted in the subjective reports include the following:
Owing to the information and advice obtained, together with completing the various exercises as outlined in the Self-help Programme, subjects reported feeling more relaxed within themselves, and were making more time for their lovemaking. This led to an improvement in the quality of their foreplay, sexual technique and general communication. As a result they were enjoying the sexual interaction more and were experiencing an improvement in orgasmic responsivity. Women reported that they were now experimenting more, they were trying new sexual positions, enjoying oral sex, and kissing more than ever before.
This change could also be attributed to the fact that the sexual and general communication within their relationships had largely improved.

Regarding specific changes in orgasmic responsivity, the majority of women reported experiencing orgasm more frequently, some for the first time ever, whilst some experienced orgasm for the first time in many years. Orgasms were reported to be more intense and pleasurable. Many attributed this change to the directed masturbation exercises, increase in sexual fantasies and the longer time spent on genital stimulation, in particular manual stimulation of the clitoris and G-spot. This reported increase in sexual satisfaction supports the pre- to post-intervention findings of the quantitative data. The reported changes in this study are also comparable to those outcome studies of Barbach (1974); Barbach and Flaherty (1980); Heinrich (1976) and LoPiccolo et al (1985).

According to the findings of Barbach (1980); Darling et al (1991b); Fisher (1975) and Masters and Johnson (1970), difficulty in experiencing orgasm can often largely be attributed to lack of adequate sexual information and misinformation as well as negative attitudes. The PRS and BIB interventions gave subjects the necessary information and advice, together with guidelines and therapeutic procedures to bring about the significant changes that were recorded.

A further trend that emerged was that women who were still not coitally orgasmic reported wanting to be able to reach a climax during sexual intercourse alone. This trend is in accordance with Hite (1976) who reported that only 30% of women experience coital orgasm. The women who fall into the other 70% category often feel abnormal. Perhaps the goal for most women of being coitally orgasmic can be regarded as unrealistic (Kaplan, 1974).
Another trend noted was that women who were now regularly reaching a climax, whether through manual clitoral stimulation, oral stimulation or through G-spot stimulation felt "good and o.k." about this, i.e. coital orgasm was not so important for them.

As regards attitudes towards sexual fantasy and self-stimulation, several interesting trends emerged. On the positive side women reported that their sexual drive had increased owing to an increase in sexual fantasy and practicing self-stimulation more frequently. Furthermore the self-stimulation exercises were reported to be an important learning experience and also enjoyable. These findings support the research of Barbach and Flaherty (1976); Heinrich et al (1988) and LoPiccolo and Lobitz (1972) as well as the positive correlations between certain of the dependant variables found in the present study.

On the negative side, the trend that emerged was that both self-stimulation and sexual fantasy were too "distasteful". These practices for certain women were still regarded as taboo. This further supports the reasons why these controversial topics proved to be so popular i.e. receiving high call volumes as assessed in the first part of this study.

It is interesting to note that 30% of the subjects in the present study faked orgasm prior to the commencement of the Intervention. Following the Intervention only three women in the Experimental groups still reported faking orgasm. These findings support the results of De Bruijn (1982) and Darling et al (1991a).

The unsolicited comments obtained in the present study lend further support to the benefit of the Self-help Programme in bringing about improvement in sexual satisfaction, sexual arousal, and improving the quality of sexual interaction.
From the above it is evident that the subjective reports reflect the significant changes obtained from the quantitative measures.

4.5 Conclusion

The need for a "Dr. Paul" sexual self-help service has been shown to exist. The quantitative analysis indicated that the PRS intervention as well as the BIB intervention, to a lesser extent, is effective when viewed in conjunction with the qualitative analysis. There would appear to be sufficient support for the usefulness and effectiveness of the Self-help interventions. Owing to the reportedly high incidence of female sexual dysfunction (Bankcroft and Coles, 1976; Burnap and Golden, 1967; Derogatis et al, 1986; Frank et al, 1976; Renshaw, 1988), self-help programmes and in particular the PRS intervention has shown to be effective in improving female sexual dysfunction.

This innovative intervention can now be added to the currently available treatment modalities for treating female sexual dysfunction.

Sex therapy for many is still unacceptable. The PRS intervention is an ideal way of obtaining relevant information - a mere phone call away. Furthermore, it is ideal for individuals who are too shy or who refuse to see a therapist, on personal, religious or moral grounds. These individuals would be ideally suited to participate in such an intervention.

One of the greatest advantages of such a service is that it is available a mere phone call away. The phone is one of the most convenient ways of obtaining instant information and is cost-effective as well.

Levay (1973) indicates that perhaps only 20% of the current patient population may be ideally suited to a directive Masters and Johnson's type of sex therapy. If a similar
percentage could be effectively helped by a PRS intervention many individuals would be able to receive help that previously was unobtainable. Those individuals who are not experiencing major marital or relationship problems would be ideally suited to participate in this Self-help Programme. Women without regular partners would also be able to participate in such an intervention leading to improved orgasmic responsivity and sexual functioning.

Despite the positive findings, the PRS intervention cannot be regarded as a panacea for all female orgasmic difficulties. As was noted in the study, not all subjects reported positive changes in their orgasmic response and sexual satisfaction. However, for a large percentage of subjects participating, the Self-help Programme brought about specific positive changes to their level of sexual arousability, sexual satisfaction and quality of sexual interaction.

Many individuals in South Africa are not reached by regular psychological services. The majority do not have easy access to sex therapists. The PRS intervention is an ideal form of treatment which may be suited to them.

The PRS intervention is essentially non-intrusive and certainly may be able to serve an important mental health need. From the subjective reports it would appear that participation in the Self-help Programme did not cause distress, nor was it harmful in any way. This is a concern that was expressed by Rosen (1977; 1984) but refuted by Barbach (1980) and Barbach and Flaherty (1980) as well as by the studies undertaken by Starker (1991a; 1991b). Self-help Programmes in various formats are here to stay (Starker, 1991a). It would appear that the PRS intervention can play an important role in this regard, providing such services are well implemented and comply with professional standards in order to be regarded by the population as being a credible service.
A further advantage of the Self-help Programme is that in addition to offering a specific programme to improve orgasmic response, it can provide sexual information on a variety of sexually related topics. Hence, the PRS intervention has great potential for helping large numbers of individuals in a cost-effective and convenient way. Furthermore, the PRS intervention enables individuals to maintain their autonomy and individuality (Starker, 1991), and can be regarded in many ways as serving a preventative and educational function — in accordance with the principles and guidelines of the American Psychological Association Task Force on Self-Help Therapies (1978).

From the subjective reports it would appear that the eight-week intervention period, for many, was too short. This may have been a factor in not enabling several subjects to report more positive changes regarding orgasmic response. Many subjects however, did indicate that they intended continuing with the Programme.

It would also appear that a need existed for some therapist contact (i.e. for a minimal therapist contact format) whereby women would have been able to discuss various aspects of the Programme. This is in line with the studies of Dodge et al (1982) and Libman et al (1984). This suggestion was mentioned by several of the respondents. Another possible drawback of the Programme could have been the lengthy questionnaires. Partners, in particular, appeared to be reluctant to complete all the requested questionnaires.

The small sample size was also a limitation of the present study — largely due to the attrition rate of the subjects. This is indicative of the tremendous commitment and self-discipline required to carry out all the steps of the Self-help Programme (Kass and Strauss, 1975).
4.6 Implications for Application and Future Research

The short term benefits of the Self-help Programme has been shown. Future research should focus on whether the short term improvements would be maintained over a longer period of time. D’Amicis et al (1985), Hawton (1986) and Kilman et al (1980) completed studies showing that the long term effectiveness of various sex therapy programmes is not always so favourable. Similarly the long term effectiveness of the PRS intervention needs to be assessed.

Individuals who do not have easy access to therapists would be ideally suited to participate in similar self-help programmes. Partially sighted and blind individuals too would be ideally suited to participate in the PRS intervention with minor modifications. Individuals who are not sufficiently mobile to see a therapist on a regular basis could also benefit and in such instances perhaps a minimal therapist format would be ideal.

The PRS Self-help Programme could also be extended to other population groups and could include other languages for specific cultural groups.

The PRS Self-help Programme could also be run by the Department of Health providing a service on a toll-free number - owing to the shortage of sex therapists and the popularity of the "Dr. Paul" adult sexuality lines, hence making such a service more affordable for many individuals. There are different ways of being able to offer the service in terms of toll-free or minimal cost phone calls.

Other sexual dysfunctions also need to be assessed, using the PRS format, for example, premature ejaculation. Future studies concerning PRS interventions should also examine whether the same treatment format provided in different time frames have differential effects.
Future studies should also evaluate larger samples of both primary and secondary non-orgasmic women. This would enable a comparison of the relative effectiveness of the PRS intervention on these two specific groups and would thus enable one to determine which groups would be ideally suited for such an intervention.

Certain minimal guidelines need to be established regarding Premium Rate Service "sexual advice" services, in particular those offering "sexual therapy". This is the first study of this nature and it is hoped that all other services will likewise be evaluated in order to prevent the abuse of such services as was seen in South Africa i.e. preventing "sleaze lines" and non-professional sex lines from operating.

The scope and possibilities of the PRS intervention are enormous and exciting and from the present investigation it would appear that the PRS intervention could become an integral part of our Mental Health Service.

It would behoove all other Premium Rate Service "sexual advice" operators to assess the effectiveness of their particular services, in accordance with the recommendations of the APA Task Force on Self-Help Therapies (1978) and in accordance with the scientific and empirical validation carried out in the present study.
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BIBLIOGRAPHY


Derogatis, L.R., Meyer, J.K., & Dupkin, C.N. (1976). Discrimination of organic versus psychogenic impotence with the DSFI. Journal of Sex and Marital Therapy, 2, 229-239.


TELEPHONIC SERVICE INTERVENTION FOR FEMALE SEXUAL DYSFUNCTION

APPENDICES
Thank you for your interest. The aim of the Research is to assess the effectiveness of various Self-help Programmes for women experiencing sexual difficulties, in particular, the inability to regularly reach a climax and experience sexual satisfaction.

Here are some other important aspects of the Research Project.

1. Owing to the overwhelming response thus far, selection for participation will be based on the first respondents meeting the specific selection criteria. I suggest you reply promptly.

2. There will be no cost for the Self-help Programme, other than your commitment to participate in the Project.

3. Selection will be based on those women experiencing difficulty in climaxing, i.e., either rarely or seldomly; those women who have never reached a climax through any form of stimulation; and women who are generally dissatisfied with their overall level of sexual functioning. Several other personal factors will have to be taken into account in order to meet the requirements of a Research Project.

4. The Self-help Programme will be sent to participants who meet the selection criteria. You will be required to carry out various self help "homework" assignments in the privacy of your own home. A minimum of 4 - 6 hours is required per week. Guidelines will be given for optimal benefit. Working through the Self-help Programme should assist you to achieve an improved level of sexual functioning and sexual satisfaction.

5. There are no face to face i.e. personal therapist consultations as in standard sex therapy. You work through the Self-help Programme at your own pace, over a period of 8 weeks.

6. You will be required to complete several questionnaires throughout the duration of the study - this is the only way progress can be assessed.
7. The questionnaires and other information are all of a highly personal and sensitive nature. I assure you of TOTAL CONFIDENTIALITY. I am the only one who will have access to the information, used for research purposes only. Names will only be used for mailing purposes.

8. The Confidential Questionnaire must be completed so I can assess whether you meet the necessary selection criteria.

Please complete the Confidential Questionnaire as well as the Consent Form and return it in the enclosed self addressed, stamped envelope within 48 hours, i.e., within 2 days.

Once again I thank you for your interest. I will contact you shortly after receiving your Questionnaire.

Kindest regards.

Yours sincerely,

"DR. PAUL"
APPENDIX B.

INITIAL BIOGRAPHICAL QUESTIONNAIRE

CONFIDENTIAL QUESTIONNAIRE

NAME (MRS, MISS) ____________________________________________

AGE ________________________________________________________

OCCUPATION ________________________________________________

IF MARRIED OR LIVING TOGETHER HUSBAND/PARTNER'S OCCUPATION ___

____________________________________________________________

HIGHEST EDUCATION LEVEL (SELF) ________________________________

(PARTNER) __________________________________________________

MARITAL STATUS

SINGLE _____ MARRIED _____ DIVORCED _____ WIDOWED _____

LIVING TOGETHER _____

LENGTH OF MARRIAGE/CURRENT SEXUAL RELATIONSHIP

______________________________

STEADY SEX PARTNER? ____ YES/NO? LENGTH? ______________________

CHILDREN? NUMBER & AGES _____________________________________

PRIMARY SEX ORIENTATION

HETEROSEXUAL _____ BISEXUAL _____ LESBIAN _____

MEDICAL/PHYSICAL PROBLEMS DURING PAST 5 YEARS, INCLUDING CURRENT

PROBLEMS (OPERATIONS, ILLNESSES, HOSPITALISATIONS, ETC.)

________________________________________________________________

________________________________________________________________

MEDICATION / DRUGS TAKEN DURING PAST 5 YEARS

________________________________________________________________

________________________________________________________________

DURING PAST 5 YEARS HAVE YOU RECEIVED TREATMENT BY A

PSYCHIATRIST, PSYCHOLOGIST OR A COUNSELLOR?

IF YES, ELABORATE ___________________________________________

________________________________________________________________

IN WHAT WAY ARE ANY MEDICAL/PHYSICAL PROBLEMS AFFECTING YOUR

SEXUAL FUNCTIONING? ___________________________________________
ETHNIC GROUP
WHITE _____ BLACK _____ ASIAN _____ COLOURED _____ OTHER _____

RELIGIOUS AFFILIATION (IF ANY) ____________________________________________

HOME LANGUAGE: ENGLISH _____ AFRIKAANS _____ OTHER _____

HOW OFTEN HAVE YOU LISTENED TO RADIO 702'S "SEXUALLY SPEAKING" TALK SHOW OVER THE PAST 4 YEARS? ____________________________________________

COMMENTS: ____________________________________________________________

________________________________________________________________________

________________________________________________________________________

HAVE YOU EVER PHONED THE 087 SEXUAL SELF-HELP LINES BEFORE? _____
IF SO, WHICH ONES? ______________________________________________________

COMMENTS: ____________________________________________________________

________________________________________________________________________

WHAT ARE YOUR PRESENT SEXUAL DIFFICULTIES? (WHEN STARTED, POSSIBLE REASONS, ETC.) ________________________________________________________

________________________________________________________________________

________________________________________________________________________

DO YOU HAVE OTHER RELATIONSHIP PROBLEMS? IF YES, ELABORATE:
________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

HAVE YOU EVER REACHED A CLIMAX/ORGASM? _______________________________

IF YES, WHEN LAST AND BY WHAT MEANS (EG. DURING SEXUAL INTERCOURSE, ORAL SEX, SELF STIMULATION, SEXUAL INTERCOURSE PLUS MANUAL STIMULATION, VIBRATOR, OTHER •••.) ____________________________________

________________________________________________________________________

________________________________________________________________________

HOW OFTEN DO YOU USUALLY REACH A CLIMAX? IF YOU DON'T USUALLY REACH A CLIMAX WHAT IS THE MAIN REASON FOR THIS? ____________________________

________________________________________________________________________

________________________________________________________________________

HOW OFTEN WOULD YOU LIKE TO REACH A CLIMAX? ___________________________

FREQUENCY OF SEXUAL INTERCOURSE? _______________________________________

________________________________________________________________________

________________________________________________________________________
DOES YOUR PARTNER EXPERIENCE ANY SEXUAL PROBLEMS? _____ YES/NO?

IF YES, ELABORATE ________________________________________________________

__________________________

__________________________

HAVE YOU EVER BEEN FOR HELP FOR YOUR SEXUAL PROBLEM? ___ YES/NO?

IF YES, ELABORATE ________________________________________________________

__________________________

__________________________

IF NO, WHY DO YOU WANT HELP NOW? ________________________________________

__________________________

__________________________

YOUR EXPECTATIONS OF THE SELF-HELP PROGRAMME? ____________________________

__________________________

__________________________

DESCRIBE YOUR PRESENT LEVEL OF SEXUAL SATISFACTION/FULFILMENT ________________

__________________________

__________________________

DO YOU EVER EXPERIENCE PAIN DURING OR AFTER SEXUAL INTERCOURSE? ELABORATE:

______________________________________________________________

__________________________

__________________________

DO YOU EVER FAKE ORGASM? _____ YES/NO?

HAVE YOU EVER BEEN SEXUALLY ABUSED?

IF YES, ELABORATE ________________________________________________________

__________________________

__________________________

DO YOU OR YOUR PARTNER USE ANY FORM OF CONTRACEPTION? IF YES, WHICH METHOD?

______________________________________________________________

__________________________

__________________________

ARE YOU PREGNANT? ________________________________________________________

__________________________

__________________________

DO YOU HAVE ACCESS TO A TAPE RECORDER THAT USES A STANDARD CASSETTE? _____ YES/NO?

Please return this questionnaire in the enclosed stamped, self addressed envelope within 48 hours.

Your co-operation is greatly appreciated.

[FURTHER COMMENTS CAN BE WRITTEN ON THE BACK OF THIS PAGE]
APPENDIX C.

INFORMED CONSENT

I, the undersigned, agree to participate in the Female Sexuality Research being carried out by "Dr. Paul" at R.A.U., provided that all information given is treated with confidentiality and is to be used for research purposes only.

I have read the covering letter (detailing aspects of the Research Project) and understand the nature of the study and have no objections to participating.

"Dr Paul" cannot be held accountable should I not progress as desired.

SIGNED:

NAME (BLOCK LETTERS):

DATE:
### APPENDIX D.

#### THE SEXUAL AROUSABILITY INVENTORY

**Instructions:** The experiences described below may or may not be sexually arousing to you. There are no right or wrong answers. Read each item carefully, and then circle the number which indicates how sexually aroused you feel when you have the described experience or how sexually aroused you think you would feel if you actually experienced it. *Be sure to answer every item.* If you aren’t about an item, circle the number that seems about right. The meaning of the numbers is given in the table below:

- **adversely affects arousal:** unthinkable, repulsive, distracting
- **doesn’t affect sexual arousal**
- **possibly causes sexual arousal**
- **sometimes causes sexual arousal; slightly arousing**
- **usually causes sexual arousal; moderately arousing**
- **almost always sexually arousing; very arousing**
- **always causes sexual arousal; extremely arousing**

#### Every Item

<table>
<thead>
<tr>
<th>Item</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>When a loved one stimulates your genitals with mouth and tongue</td>
<td>-1</td>
</tr>
<tr>
<td>When a loved one fondles your breasts with his/her hands</td>
<td>-1</td>
</tr>
<tr>
<td>When you see a loved one nude</td>
<td>-1</td>
</tr>
<tr>
<td>When a loved one caresses you with his/her eyes</td>
<td>-1</td>
</tr>
<tr>
<td>When a loved one stimulates your genitals with his/her finger</td>
<td>-1</td>
</tr>
<tr>
<td>When you are touched or kissed on the inner thighs by a loved one</td>
<td>-1</td>
</tr>
<tr>
<td>When you caress a loved one's genitals with your fingers</td>
<td>-1</td>
</tr>
<tr>
<td>When you read a pornographic or &quot;dirty&quot; story</td>
<td>-1</td>
</tr>
<tr>
<td>When a loved one undresses you</td>
<td>-1</td>
</tr>
<tr>
<td>When you dance with a loved one</td>
<td>-1</td>
</tr>
<tr>
<td>When you have intercourse with a loved one</td>
<td>-1</td>
</tr>
<tr>
<td>When a loved one touches or kisses your nipples</td>
<td>-1</td>
</tr>
<tr>
<td>When you caress a loved one (other than genitals)</td>
<td>-1</td>
</tr>
<tr>
<td>When you see pornographic pictures or slides</td>
<td>-1</td>
</tr>
<tr>
<td>When you lie in bed with a loved one</td>
<td>-1</td>
</tr>
<tr>
<td>When a loved one kisses you passionately</td>
<td>-1</td>
</tr>
<tr>
<td>When you hear sounds of pleasure during sex</td>
<td>-1</td>
</tr>
<tr>
<td>When a loved one kisses you with an exploring tongue</td>
<td>-1</td>
</tr>
<tr>
<td>When you read suggestive or pornographic poetry</td>
<td>-1</td>
</tr>
<tr>
<td>When you see a strip show</td>
<td>-1</td>
</tr>
<tr>
<td>When you stimulate your partner's genitals with your mouth and tongue</td>
<td>-1</td>
</tr>
<tr>
<td>When a loved one caresses you (other than genitals)</td>
<td>-1</td>
</tr>
<tr>
<td>When you see a pornographic movie (blue movie)</td>
<td>-1</td>
</tr>
<tr>
<td>When you undress a loved one</td>
<td>-1</td>
</tr>
<tr>
<td>When a loved one fondles your breasts with mouth and tongue</td>
<td>-1</td>
</tr>
<tr>
<td>When you make love in a new or unusual place</td>
<td>-1</td>
</tr>
<tr>
<td>When you masturbate</td>
<td>-1</td>
</tr>
<tr>
<td>When your partner has an orgasm</td>
<td>-1</td>
</tr>
</tbody>
</table>
SEXUAL INTERACTION INVENTORY ITEM LIST

1. The male seeing the female when she is nude.
2. The female seeing the male when he is nude.
3. The male and female kissing for one minute continuously.
4. The male giving the female a body massage, not touching her breasts or genitals.
5. The female giving the male a body massage, not touching his genitals.
6. The male caressing the female’s breasts with his hands.
7. The male caressing the female’s breasts with his mouth (lips or tongue).
8. The male caressing the female’s genitals with his hands.
9. The male caressing the female’s genitals with his hands until she reaches orgasm (climax).
10. The female caressing the male’s genitals with her hands.
11. The female caressing the male’s genitals with her hands until he ejaculates (has a climax).
12. The male caressing the female’s genitals with his mouth (lips or tongue).
13. The male caressing the female’s genitals with his mouth until she reaches orgasm (climax).
14. The female caressing the male’s genitals with her mouth (lips or tongue).
15. The female caressing the male’s genitals with her mouth until he ejaculates (has a climax).
16. The male and female having intercourse.
17. The male and female having intercourse with both of them having an orgasm (climax).
APPENDIX F.

SAMPLE PAGE OF THE SEXUAL INTERACTION INVENTORY

**Item:** The male caressing the female's breasts with his mouth (lips or tongue).

When you and your mate engage in sexual behaviour, does this particular activity usually occur? How often would you like this activity to occur?

1. Currently occurs:  
   1. Never  
   2. Rarely (10% of the time)  
   3. Occasionally (25% of the time)  
   4. Fairly often (50% of the time)  
   5. Usually (75% of the time)  
   6. Always

2. I would like it to occur:  
   1. Never  
   2. Rarely (10% of the time)  
   3. Occasionally (25% of the time)  
   4. Fairly often (50% of the time)  
   5. Usually (75% of the time)  
   6. Always

How pleasant do you currently find this activity to be? How pleasant do you think your mate finds this activity to be?

3. I find this activity:  
   1. Extremely unpleasant  
   2. Moderately unpleasant  
   3. Slightly unpleasant  
   4. Slightly pleasant  
   5. Moderately pleasant  
   6. Extremely pleasant

4. I think my mate finds this activity:  
   1. Extremely unpleasant  
   2. Moderately unpleasant  
   3. Slightly unpleasant  
   4. Slightly pleasant  
   5. Moderately pleasant  
   6. Extremely pleasant

How would you like to respond to this activity? How would you like your mate to respond? (In other words, how pleasant do you think this activity ideally should be, for you and for your mate?)

5. I would like to find this activity:  
   1. Extremely unpleasant  
   2. Moderately unpleasant  
   3. Slightly unpleasant  
   4. Slightly pleasant  
   5. Moderately pleasant  
   6. Extremely pleasant

6. I would like my mate to find this activity:  
   1. Extremely unpleasant  
   2. Moderately unpleasant  
   3. Slightly unpleasant  
   4. Slightly pleasant  
   5. Moderately pleasant  
   6. Extremely pleasant
APPENDIX G.

THE "DR. PAUL" SEXUAL SELF-HELP LINES

UNDERSTANDING ADULT SEXUALITY

TOPICS

1. How to use the Sexual Self-help Lines

PREMATURE/RAPID EJACULATION:

2. Overview - Part 1
3. Overview - Part 2
4. Further Questions
5. Partner’s role in Rapid Ejaculation
6. Coping with Self Stimulation
7. Coping with the help of a Partner
8. Coping through Sexual Intercourse
9. Advanced techniques to control

DELAYED EJACULATION:

10. Description
11. Coping with

FEMALE ORGASM:

12. Facts & Myths
13. Failure to reach Orgasm (Anorgasmia)
14. Further Questions
15. Self Exploration and Enhancement (Genital)

REACHING ORGASM:

16. Self Stimulation
17. With the help of your partner
18. During sexual intercourse
19. Using a vibrator
20. Improving Sexual Response (Vaginal Muscle Exercises)
21. The G-Spot
22. The importance of Clitoral Stimulation
23. Vaginismus - (Difficulty in penetrating/pain) - Overview
24. Vaginismus - Coping with
ERECTILE PROBLEMS (IMPOTENCE):
25. Overview
26. Psychological causes
27. Physical causes
28. The role of Alcohol/Drugs
29. Coping at home - Self Stimulation
30. Coping at home - Self Stimulation with partner's help
31. Coping at home - Sexual Intercourse

PENIS:
32. Does size count?
33. Angle and curvature
34. Erections: Early morning/evening. Wet dreams

SEXUAL DESIRE:
35. Overview
36. Lack of desire: Men
37. Lack of desire: Women
38. Coping with problems of excessive and incompatible sex drives

PLEASURING:
39. Non Genital
40. Genital

GENERAL:
41. Pregnancy - Sex during first three months
42. Pregnancy - Sex during six to nine months
43. Extra Marital Affairs
44. The Seven Year Itch
45. Empty nest syndrome
46. Condoms and Use of Condoms
47. What turns men on
48. What turns women on
49. Erotic Kissing
50. Romance and Sexual Enrichment
51. How to be a better lover - Men
52. How to be a better lover - Women
53. Sexual Fantasies - Men
54. Sexual Fantasies - Women
55. Adventurous Foreplay
56. Contraception
57. Abusive Relationships
58. Sexually Transmitted Diseases
59. AIDS
60. Abortion
61. Hysterectomy
62. Masturbation - Men
63. Masturbation - Women
64. Sex after Childbirth (Part 1)
65. Sex after Childbirth (Part 2)
APPENDIX H.

THE "DR. PAUL" SEXUAL SELF-HELP LINES

UNDERSTANDING CHILDHOOD SEXUALITY

A GUIDE FOR PARENTS

TOPICS

1. The necessity of parental sex education
2. Parental attitudes to sex
3. Physical contact between parent and child
4. Responding to the subject of sex
5. Communication about sex
6. Toilet training and sexuality
7. Earliest sex questions
8. Later sex questions
9. Masturbation
10. Sexual development of girls
11. Sexual development of boys
12. Older children's sex concerns
13. The link between sex and self esteem
14. Parental concerns/dilemmas
15. Love
16. Sex education, morals, beliefs and religion
17. Contraception
18. Sexual molestation
19. Lessening the chance of sexual abuse
20. What to do if your child has been sexually molested
21. The effects of exposure to sex on TV/Movies
22. Sexually transmitted diseases
23. Sex role identity
24. The single parent and childhood sexuality
25. Lessening the risk of early sexual activity
APPENDIX I.

THE "DR. PAUL" SEXUAL SELF-HELP LINES

UNDERSTANDING ADOLESCENT SEXUALITY

A GUIDE FOR PARENTS & TEENAGERS

TOPICS

1. The Physical Development of Boys
2. The Physical Development of Girls
3. Male Sex Organs
4. Female Sex Organs
5. Masturbation
6. Coping with Menstruation
7. Is it OK to be a virgin?
8. Love/Crush... What's the difference?
9. Should I have sex or not?
10. I'm not interested in the opposite sex
11. What are the risks of having sex?
12. Am I pregnant? What do I do?
13. Sexually transmitted diseases
14. AIDS - how easy is it to get?
15. Contraception
16. What is safer sex?
17. Religion/Morals and sex
18. There is no one to talk to about sex!
19. Parental attitudes towards their teenagers sexuality
20. Saying "No" to sex (Peer Group Pressure)
21. How special should/can sex be?
22. Self-image and sex
23. Sexual Abuse (Date Rape)
24. Dealing with teenage pregnancy - parents
APPENDIX J.

THE "DR. PAUL" SEXUAL SELF-HELP LINES

AIDS INFORMATION LINE

TOPICS

1. AIDS: The basic and essential information
2. How to prevent yourself from getting AIDS
3. Should you have an HIV test?
4. The HIV Blood Test
5. Some considerations before having an HIV test
6. What do I do if I test HIV positive?
7. How AIDS is spread
8. Being HIV positive
9. Living with AIDS
10. Safer Sex
11. AIDS in the workplace
12. AIDS in the home
13. Condoms and condom use
14. Commonly asked questions about AIDS: Spread of AIDS
15. Commonly asked questions about AIDS: Sexual practices
16. Commonly asked questions about AIDS: General
17. Where to get help
18. Casual sex in the 90's
19. AIDS Myths/Fears and misconceptions
20. AIDS & sexually transmitted diseases
21. AIDS & pregnancy
22. Children/Infants & AIDS
23. AIDS & healthcare workers
24. Ethical issues concerning AIDS
APPENDIX K.

THE "DR. PAUL" SEXUAL SELF-HELP LINES

UNDERSTANDING MARRIAGE AND RELATIONSHIPS

TOPICS

1. The pro's and con's of living together
2. Choosing a Partner
3. What is Love?
4. Preparing yourself for Marriage
5. Becoming a Parent
6. Jealousy in Marriage
7. Coping with In-Laws
8. Enriching your Marriage
9. Coping with Marital Breakdown
10. Coping with Divorce - Emotional Aspects
11. Coping with Divorce - Legal Aspects
12. Life after Divorce
13. Helping children cope with divorce
14. Coping with Extra-marital affairs
15. Violence in Marriage
16. Alcohol/Drug abuse and Marriage
17. Retirement and Marriage
18. Loneliness in Marriage
19. Ageing in Marriage
20. Unemployment and Marriage
21. Coping with Infertility
22. Mid-Life Crisis - Men
23. Mid-Life Crises - Women
24. Coping with the Death of a Spouse
25. Coping as a Single Parent
26. Step Parenting - Remarriage
27. Coping with your Step-Children
28. Resolving conflict in relationships
29. Communication in Marriage
30. Emigration concerns
31. Adult Survivors of Sexual Abuse
APPENDIX L.

RADIO 702 SEXUALLY SPEAKING TOPICS

1. Introduction to Human Sexuality
2. Female Sexual Problems
3. Stress and Sexual Functioning
4. Honeymoon Sex
5. Sex and your heart
6. Adolescent Sexuality
7. Gynaecological Problems & Sexuality
8. Living together arrangements
9. Celibate Marriages
10. Male Sexual Problems
11. Desire Problems
12. Sex and the Disabled
13. Sex and Sport
14. Romance
15. Impotence: Psychological Aspects
16. Surgery & Sexuality
17. Sex & Infertility / Miscarriage
18. Sexual Needs of Women
19. Understanding Adult Sexuality
20. Sexual Fantasies & Secrets
21. Common Sexual Problems
22. Affairs and Sexuality
23. Religion & Sexuality
24. Cross Cultural Sexuality
25. Sexual Expectations
26. Divorce and Sexuality
27. Sex and The Law
28. Age-discrepant Relationships
29. Good Sexual Relationships
30. Sexually Transmitted Diseases
31. Adolescent Relationships: "It’s okay to say no"
32. Sex Education in the Schools
33. Abusive Husbands
34. Unconsummated Marriages
35. Sexual Needs of Men
36. Sex Quiz
37. Casual Sex
38. Compulsive Sexual Behaviour
39. "Not Tonight Darling"
40. Unusual Sexual Behaviour
41. Pregnancy & Sexuality
42. Good Sex
43. Holidays & Sex
44. Sexual Abuse
45. Sexual Chemistry
46. Sexual Aftermath of Affairs
47. Sexual Boredom
48. Pre marital Sex & Post Marital Sexual Adjustment
49. Sexual Myths & Hangups
50. Childhood Sexuality
51. Adolescent Sexuality : Peer Pressure
52. The Seven Year Itch
53. Sexual Communication
54. Sexual Harassment
55. Sex & The Over 50’s
56. Virginity
57. Contraception
58. How Important is Sex in Marriage?
59. Stress, Fatigue, Burnout & Sexual Functioning
60. Sex Aids
61. Non Verbal Communication
62. Alcohol/Drugs & Sex
63. First Sexual Experience
64. Psychiatric Illness & Sex
65. Does Sex Improve/Deteriorate With Time?
66. Neurological Conditions & Sexual Functioning
67. Pregnancy & Post Partum Sexuality
68. The Importance of Foreplay/Afterplay
69. Sexology & Virology
70. Burning Vulva Syndrome / Pain & Intercourse
71. Is Sex a Wife’s Duty - Husband’s Right?
72. Sexual Problems & General Family Practice
73. Marital Failure
74. Sex & Menopause
75. Intimacy & Communication
76. AIDS Counselling
77. Midlife Sexual Crisis
78. Male Sexuality & Fertility
79. AIDS, Herpes, Hepatitis, Genital Warts
80. Casual Sex and Sexually Transmitted Diseases
81. Condoms
82. Safer Sex Practices
83. Marriage / Love / Jealousy
84. Hypnosis and Sex Therapy
85. Hysterectomy & Sex
86. Homosexuality / Bisexuality
87. Is There Sex After Marriage?
88. Sex on Campus
89. It’s okay to say "no" to Sex / Date Rape
90. Sexual Paraphilia
91. Does Sex Get Better As One Gets Older?
92. AIDS In The Workplace
93. Problems With Orgasm (Male & Female)
94. Vasectomy & Sexuality
95. Charming Men Abusive Lovers
96. Erectile Dysfunction
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98. Excessive Sexual Desire
99. Engagements
100. Body Image and Sexuality
101. Responsible Teenage Sexuality
102. Sex & Ethics
103. Talking to Children About Sex
104. Sex And The Media
105. Female Sexuality
106. Faking Orgasm
107. Lesbian Relationships
108. Erotica
109. Is Size Important?
110. The G-Spot
111. Becoming Orgasmic
112. Masturbation
113. The Role Of Sexual Fantasy
114. Sexual Attitudes
115. Sex & Disability
116. Marital/Sexual Failure
117. Sexual Intimacy
118. Vaginismus
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120. Petting
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123. The Art Of Kissing
124. Sexual Coma
125. Sensual Secrets of the Orient
126. Post Divorce Sexuality
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SEX TALK WITH "DR. PAUL"

TOPICS
1. Childhood sexuality
2. Sex during and after pregnancy
3. Stress and sex
4. Abusive relationships
5. Virginity today
6. Casual sex and sexually transmitted diseases
7. AIDS: The facts
8. Honeymoon sexuality
9. Prime time sex
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APPENDIX N.

LETTER OF SELECTION SENT TO PRS 1 AND BIB GROUPS

"DR PAUL"

FEMALE SEXUALITY RESEARCH PROJECT

P O BOX 1347
HIGHLANDS NORTH
2037

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You have been selected to participate in the Self-help Programme. Hopefully the Programme will be able to meet some of your expectations.

In order to assess what changes may take place as a result of the Self-help Programme I need you to assist me: Please complete the enclosed QUESTIONNAIRE - without this information the whole project cannot be scientifically and clinically evaluated.

Although the Project is designed primarily for women, there is one separate (enclosed) QUESTIONNAIRE that I would like your Husband/Partner to complete – please encourage him to do so. If not, you will still be able to participate.

Before you begin the Self-help Programme it is essential that I have the completed Questionnaires from you, and hopefully from your Husband/Partner.

I am sure that you will find the QUESTIONNAIRE both informative and interesting.

Please return the completed Questionnaires in the enclosed, stamped, self addressed envelope within 48 hours.

As soon as I receive the Questionnaires I will send you the Self-help Programme, together with specific guidelines.

As mentioned in the first letter, you will not be required to pay for the Self-help Programme – all that is required is for you to complete several Questionnaires throughout the duration of the Project, and to work through the Self-help Programme.

Your participation and co-operation in this Project is much appreciated. Thank you!

Kindest Regards

"DR PAUL"
You have been selected to participate in the Research Project. The Self-help Programme and Guidelines are enclosed.

Owing to the nature of the Project you will be required to complete a final questionnaire in approximately 8 weeks time.

Good luck with the Self-help Programme.

Regards

"DR. PAUL"
Part 1 of the Self-help Programme broadly deals with Becoming Orgasmic and improving your orgasmic potential and satisfaction.

Part 2 of the Self-help Programme broadly deals with sexual enrichment and improving your sexual techniques.

Use the Self-help Programme in whatever way that works best for you. More detailed guidelines and various exercises are outlined in each topic. I suggest that you work through the Self-help Programme in a systematic way - later on you can skip topics/exercises or go back to specific ones - this will help you to progress optimally.

Most of the exercises require that you spend time alone. I suggest setting aside at least one hour, 4 - 6 times a week for the next 8 weeks (more if possible).

Become familiar with what you will do over the next 8 weeks - draw up your own Self-help Programme Schedule.

You can get your partner involved to the extent that both of you feel comfortable and willing to work on this Self-help Programme together.

If you have not had a gynaecological examination in the past year, I suggest you do this - to rule out any possible physical problems that may be contributing to your present difficulties.
LETTER OF SELECTION SENT TO CONTROL GROUP

"DR PAUL"
P O BOX 1347
HIGHLANDS NORTH
2037

FEMALE SEXUALITY RESEARCH PROJECT

You have been selected to participate in the Self-help Programme.

However, owing to the overwhelming response - there is a backlog. More of the Self-help materials are being copied. I expect there to be a delay of about 6 - 8 weeks. However, as soon as the material is ready you will receive a Self-help Programme together with guidelines.

In the meantime please complete the enclosed QUESTIONNAIRE. Owing to the fact that this is a Research Project I need this information to make an adequate clinical and scientific assessment.

Although the Project is primarily designed for women there is one enclosed QUESTIONNAIRE for your Husband/Partner to complete - please encourage him to do so. Even if he does not complete it, you will still receive the Self-help Programme.

I do appreciate that completing the various Questionnaires is time consuming but this is the only way to carry out a Research Project of this nature. Nevertheless I am sure you will find completing the Questionnaires both interesting and informative.

Please return the completed Questionnaires in the enclosed stamped, self addressed envelope within 48 hours. As soon as I receive the Questionnaire you will be placed on the mailing list for the Self-help Programme to be sent to you.

I appreciate your patience and co-operation. Thank you!

Kindest Regards

"DR. PAUL"
APPENDIX O.

COVERING LETTER SENT TO PRS 1 AND BIB GROUPS

"DR PAUL"
PO BOX 1347
HIGHLANDS NORTH
2037

FEMALE SEXUALITY RESEARCH PROJECT

Dear

Thank you for completing the QUESTIONNAIRE. Enclosed herewith is your SELF-HELP PROGRAMME together with suggested Guidelines:

**Part 1** of the Self-help Programme broadly deals with Becoming Orgasmic and improving your orgasmic potential and satisfaction.

**Part 2** of the Self-help Programme broadly deals with sexual enrichment and improving your sexual techniques.

Use the Self-help Programme in whatever way that works best for you. More detailed guidelines and various exercises are outlined in each topic. I suggest that you work through the Self-help Programme in a systematic way - later on you can skip topics/exercises or go back to specific ones - this will help you to progress optimally.

Most of the exercises require that you spend time alone. I suggest setting aside at least one hour, 4 - 6 times a week (more if possible) for the next 8 weeks.

Become familiar with what you will do over the next 8 weeks - draw up your own Self-help Programme Schedule.

The very nature of a Self-help Programme means that you have to rely on your own resources. Of course some individuals/couples must have personalised counselling. No relationship can survive without communication and if this has broken down completely only an experienced counsellor can help you restore it.

If you are already orgasmic, I suggest that you still go through all the topics and try the exercises, step by step - you may be pleasantly surprised how easy it is to communicate and discover even greater sexual fun and contentment.

As regards your partner: if he is willing to co-operate - go through the topics together with him - so that he can also become familiar with the Self-help Programme.
Although the participation of your partner is preferable it is not crucial - there are many aspects of the Self-help Programme that you can go through alone.

I would suggest that you try and avoid having sexual intercourse, or any unpleasant sexual activities, for the first couple of weeks as you begin the Self-help Programme. (You may satisfy your partner in other ways during this time).

As you begin to become familiar with the Self-help Programme and as you carry out the various exercises and suggestions you will begin to feel more relaxed and enjoy making progress. Give yourself ample time and opportunity to go through the Self-help Programme.

If you have not had a gynaecological examination in the past year I suggest you do this - to rule out any possible physical causes contributing to your difficulty.

Best Wishes,

"DR. PAUL"
## APPENDIX R.

### SELF-HELP PROGRAMME

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You and your partner may go through these topics as often as you wish. The above will help you locate specific topics. You are advised to make notes of certain suggestions and exercises before you actually begin the Self-help Programme.
APPENDIX S.

GUIDELINES SENT TO PRS 1 AND BIB GROUPS

SELF-HELP PROGRAMME SCHEDULE

(This is only an example of what you could plan – remember you need to set up your own schedule – depending on your particular difficulties and needs – working at your own pace and being able to modify the schedule as you progress – the schedule is only a guideline for the proposed activities – be creative as you draw up your own).

**Week 1/2**
- Familiarise yourself with all aspects of the Self-help Programme (make notes of the various exercises outlined in the topics).
  - Begin Self Exploration exercises
  - Begin Self Stimulation exercises
  - Begin PC Muscle exercises

(Continue with these three exercises over the next 6 - 8 weeks).

Don’t forget about the importance of Clitoral Stimulation.
  - Begin Non-Genital Pleasuring exercises (continue with these throughout the Programme).
  - **No sexual intercourse for at least 2 weeks (try if possible).**

**Week 2/3**
- Introduce a vibrator (try with Self Stimulation).
  - Begin Genital Pleasuring exercises with your partner.
  - Get partner involved with Genital Exploration and Stimulation.
  - Self Stimulation With Partner (if OK).
  - Locate G-Spot – stimulation first by self and then by partner.
  - Talk about what you and your partner enjoy.

**Week 3/4**
- Continue with PC Exercises, and Self Stimulation, etc.
  - Improve foreplay techniques.
  - Sexual intercourse using female superior position only. Plenty of clitoral stimulation (by yourself or by partner).
  - Introduce Oral Sex (if OK?).
  - Talk about Sexual Fantasies.
  - Talk about what turns you on.

**Week 4/5**
- Exploration of other Erogenous Zones (take time – slow down the pace).
  - Prolonged sensual massage (full body – both partners).
  - Vary sex positions – still with clitoral stimulation.
- Continue using vibrator if necessary - contracting of PC muscles often - during sexual intercourse - with different movements.
- Improve knowledge of Kissing Techniques and Adventurous Foreplay.
- Introduce Sexual Fantasies - if not done before.

**Week 5/6**
- Continue with different positions/variations of sexual intercourse.
- PC muscle exercises during sexual intercourse.
- Taper off clitoral stimulation during sexual intercourse.
- Experiment with G-Spot Stimulation.
- Introduce some "Erotic Surprises" (Adventurous Foreplay).
- Spend time discussing likes/dislikes and progress thus far.

**Week 6-8**
- Continue with specific exercises that you have enjoyed doing in the previous weeks.
- Work on specific aspects that still need attention.
- Try being more adventurous and less inhibited - be more creative as regards your lovemaking.
- Set lots of time aside for long sessions of pleasuring (Non-Genital as well as Genital...).
- Try some dressing up games - sexy lingerie, etc. Whatever will turn you and your partner on ... Experiment and Enjoy!

Remember - only you can draw up a schedule - the above is merely a basic guideline to assist you in getting started - you must draw up your own schedule and try to get your partner involved.

The more effort you put into this Self-help Programme the more you will get out of it. Make a real commitment for the next 8 weeks.

If there are certain suggestions/exercises that you don’t feel comfortable doing - try others that feel more comfortable - but remember give yourself the opportunity to experiment and enjoy.

It is important to communicate your needs, likes and dislikes, throughout the Self-help Programme.
APPENDIX T.

MANUAL

THE SELF-HELP PROGRAMME

(Transcript of the "Dr. Paul" Premium Rate Service Self-help Programme for Female Orgasmic Dysfunction.)

1. FEMALE ORGASM: THE FACTS
2. GENITAL AND SEXUAL SELF EXPLORATION
3. REACHING A CLIMAX THROUGH SELF STIMULATION
4. REACHING A CLIMAX WITH THE HELP OF YOUR PARTNER
5. REACHING A CLIMAX DURING SEXUAL INTERCOURSE
6. USING A VIBRATOR
7. THE G-SPOT
8. CLITORAL STIMULATION
9. ACHIEVING BETTER ORGASMS - STRENGTHENING YOUR PC MUSCLES
10. MULTIPLE ORGASMS
11. NON-GENITAL PLEASURING
12. GENITAL PLEASURING
13. FEMALE SEXUAL FANTASIES
14. ADVENTUROUS FOREPLAY
15. BETTER SEXUAL TECHNIQUES FOR WOMEN
16. EROTIC KISSING
17. EROGENOUS ZONES
18. ORAL SEX
19. LOVEMAKING POSITIONS
20. NOT INTERESTED IN SEX?
When you ask women what they feel like when they are having an orgasm you are likely to get very different responses. Some women describe increasing heat and pleasure focused in the genitals followed by a burst of shuddering sensations beginning in the clitoris and spreading through the whole groin. Others speak of waves of sweet sensations radiating out from the clitoris to deep inside the vagina. Some describe good feelings that diffuse all over the body while others say that they reach such an intensity that they feel they are going to faint. And then of course there are many, many women who say they don’t know what an orgasm feels like because they have never had one.

However much descriptions of orgasm may vary, the famous sex researchers, Masters and Johnson have shown us that there is a sequence of events that always occurs when a woman has an orgasm. They divided this sequence into four phases, the excitement phase, the plateau phase, climax, and resolution. Let’s take these stages one at a time so that you can learn exactly what an orgasm entails.

During the excitement phase a woman’s breathing increases, her nipples harden and become erect, her chest becomes flushed, and soon her vagina becomes lubricated. The walls of the vagina open like a tent, and the outer vaginal lips draw apart.

In the plateau phase the woman is close to orgasm. The breasts and nipples become larger and her body becomes more flushed. She may make shuddering or jerking movements and her breathing gets faster. The inner vaginal lips become engorged to a scarlet colour and the entrance to the vagina swells and becomes puffy. The hood of the clitoris swells and sometimes disappears from view.

Clear physiological events occur during the actual climax. While the skin becomes even more flushed, and the breasts and nipples more erect, a series of muscular contractions occurs involuntarily in the pelvic floor. These are rhythmical and very fast. The muscles around the rectum and also the abdomen contract too and the whole area clasps and unclasps in rapid squeezing movements.
Unlike a man, women may also have several climaxes if further stimulation occurs. Sometimes these multiple orgasms increase in intensity and pleasure.

During the resolution phase the clitoris goes back to its usual position, the colour of the vaginal lips fades, blood pressure and heart rate subside, and breathing returns to normal.

Generally speaking, the source of the orgasm is clitoral but a woman may feel sensations all over her body. This is why a clitoris that is directly stimulated gives an orgasm that feels different from one that occurs through vaginal penetration. The one is sharp and incredibly intense - the other is diffused, with the sensations spreading throughout the body. This is also why some women say they do not have orgasms while they are making love but only when they masturbate. An orgasm with penile thrusting may not feel like an orgasm if you are used to masturbating the clitoris, because it is sometimes less intense. And then, again, no two orgasms are alike. They vary in intensity and in pleasure - some are ordinary, some are dramatic - some are so low key that a woman may not even realize that she has had one except that she feels sleepy and relaxed afterwards.

Orgasms are related to feelings. If you are feeling relaxed and refreshed you will have an entirely different kind of orgasm from when you are stressed or exhausted. A woman who feels emotionally bonded to a man may not need the experience of orgasm every time she makes love - she may just enjoy the feeling of being close to him. However, there are many women who feel bitter and depressed because they do not have frequent orgasms and there are some women who never reach a climax. These women often feel as if they have failed themselves and their partners, and that they have missed out on something precious.

It is first of all important to stress that not all orgasms are like those you can see in an erotic movie or read about in a steamy novel, where the woman screams and faints or falls off the bed in ecstasy.
It is crucial that each woman be allowed to define her own sexuality and she should have the courage to state what it is that gives her and her alone pleasure.

It is also very limiting to regard the sexual experience as a goal-directed game in which orgasm is the end-point. Lovemaking is a total experience in which closeness, emotional bonding, affection and pleasure are inter-related to form a total experience.

We are often influenced by common myths propagated by the media and if we pay too much attention to these myths, we are bound to be disappointed in our expectations. This applies particularly to the sexual experience in general and to orgasm in particular. One of the myths most often spread around is the myth of simultaneous orgasm. Certainly these do occur but they are not necessarily the best type of orgasm. Many couples who strive for simultaneous orgasm find that the effort involved in trying to hold back or hurry up is not worth the result, while others find that it makes them so self-conscious that they forget to enjoy themselves. Simultaneous orgasm is the exception rather than the rule, and it is not always the most pleasurable type of orgasm you can experience.

Another myth is that the multi-orgasmic woman has a better time than the women who has only one orgasm and, even more ridiculous, that a woman who has only one orgasm has a problem. Quality is more important than quantity.

The next myth is that as women get older they need fewer orgasms. This is by no means a general rule. While it is true that a woman in her eighties has fewer sexual outlets than a woman in her twenties, some women stay sexually active all their lives and continue to be orgasmic.

Related to this idea is the myth that a post-menopausal woman will stop having orgasms. This is also not true. A woman who is post-menopausal will be more relaxed about sex because the fear of unwanted pregnancy has been removed.
There is a myth that orgasm is essential if a couple are to remain sexually fulfilled. This is a particularly harmful idea because there are millions of women who do not reach a climax during intercourse and yet have rewarding sexual relationships. More often than not women need extra clitoral stimulation during sexual intercourse to help them achieve orgasm.

Failure to reach orgasm on a regular basis or failure to reach climax at all can be a problem for some women, causing great distress and unhappiness. This is a condition known as anorgasmia and it can have many causes.

There has been so much attention given to orgasm in recent years that it has become the subject of countless articles and books. This has been a good and a bad thing. First it has taught women that they are entitled to sexual happiness and sexual fulfilment and that sexual gratification is not for men only. But it has also put undue emphasis on the necessity for a woman to be orgasmic, giving her the idea that if she is not she should regard herself as a failure.

The inability to have an orgasm during intercourse may not necessarily be the woman’s failure. Rather it may be due to the man’s lack of expertise or his lack of knowledge of the way a woman’s body functions during intercourse. If a man is too hurried or if his sole aim is penetration and quick orgasm for himself, or if he regards foreplay as an irritating routine to be got through hurriedly, then the woman may never be sufficiently aroused to experience orgasm during lovemaking. Generally speaking, women require a much longer period for sexual stimulation. Some women need well over half an hour to forty minutes of direct clitoral stimulation before they can have an orgasm and this is why so many women find it easier to reach a climax when they masturbate than when they have sexual intercourse.

Failure to reach orgasm can also be due to a woman’s upbringing or a lack of sexual information or to traumatic sexual experiences such as rape, incest or abuse.
Many women find that they do not reach orgasm just after they have given birth or during post-partum depression. Sexual inhibition may be due to religious or moral values or to a poor self concept.

If you have orgasms when you masturbate, you are probably capable of reaching a climax when having intercourse. It may be just a matter of changing the tempo or trying a different position or avoiding doing things which cause you discomfort. The most important step if you wish to become orgasmic is learning how to get in touch with your body and your sexual responsiveness.

Finally, I would like to point out that only $\pm 30\%$ of women reach a climax during sexual intercourse, without any other form of stimulation - this is due to anatomy. It is because of the inadequate penile contact with the clitoris during thrusting and during penetration - hence most women need extra other kinds of stimulation before, during and perhaps even after sexual intercourse. It's also useful during sexual intercourse to assume the female on top, the female superior position and vary one's movements which all can help you to become orgasmic.
BECOMING ORGASMIC

.2. GENITAL AND SEXUAL SELF-EXPLORATION

Generally speaking before a woman can become orgasmic, she must learn to be comfortable with her body and tuned into her sensual and sexual reactions. While you read this topic, you will learn how to discover, explore and learn more about and enjoy your body to a greater degree. It is important to remember as you go through these exercises that there are no right or wrong responses to them.

The first thing to do is to make the time to have a long, leisurely, warm bath using your favourite bath oil. Make sure that you are alone and will not be interrupted. Stretch out and soap your body, enjoying the sensation of your hands touching your calves, thighs and arms. Spend time on your feet and toes, massaging them until you are completely relaxed. Move up your legs, caressing your ankles, feeling the softness behind your knees and stroking your thighs. Slide your hands all over your body so that you become responsive to its curves and textures. When you are ready, dry yourself slowly, caressing yourself as you do so.

Now go on to your bedroom and lie on your bed, preferably without clothes on. Again, I must stress that you should be alone and in no danger of being interrupted. Cover yourself with a sheet or duvet if you are cold, and put some music on if that helps you to relax. Now make yourself comfortable, close your eyes, and relax. Get rid of any tension in your body by tensing and relaxing each muscle group in turn, beginning with your toes and ending with your forehead. Take at least five to ten minutes to do that. Now you should be completely relaxed.

To learn more about your genital anatomy you should look at your genitals using a small mirror. Be comfortable with the sight and feel of your genitals while you explore them. First look at the genitals before you begin to touch them.
When looking at yourself in a mirror, the first thing you will see is the layer of fat over the pubic bone. This is called the mons and it is covered with hair - some women have more hair than others. Next you will see the labia majora, that's the larger lips of the vagina. Notice how they are formed irregularly and look like the lips of a tropical flower, not at all neat and tidy like the drawings in many anatomy books show. The labia majora may also be covered in hair. Separate the outer lips or labia majora of the vagina and you will see the labia minora or smaller lips which consist of sensitive red tissue which becomes slightly erect when a woman is excited. These lips are smooth and silky and glisten with moisture, especially if you are sexually aroused.

Now try to find the clitoris under its hood. This is the most sensitive and responsive part of the female genitals. When it is stimulated, it becomes slightly enlarged and erect, and for most women it is the centre of response during orgasm. Notice how the smaller lips, the labia minora, surround the vaginal opening. Spread the vaginal opening with two fingers and notice the colour and texture of the interior. Feel the warmth, softness and dampness.

You may like to insert a finger into the vagina while you watch in the mirror. What happens? How does it feel? Keep touching that whole area and, without the mirror, imagine what it looks like in there. You know your own face so well because you look at it every day in a mirror. Why is it different to look at your vagina in a mirror and to get to know it as well as you know your face?

Look again. Beneath the inner lips or labia minora is the clitoris itself which lies at the upper end of the vagina, between the folds of the labia. The smooth, curved tip of the glans, projects out and there is often a thin fold of skin, like a hood, over the clitoris so that you might not be able to see it without pulling the inside lips aside with your fingers.
If you slip your finger a little further down the entrance of the vagina and press it inwards, you will be able to feel the root of the clitoris lying behind the glans, the part that you can see. If you squeeze it repeatedly you will notice that the glans pumps up in response to the stimulation.

Now slide your finger in further still and press forward and you will feel a pad of thick spongy tissue between your pubic bone and your urethra.

The urinary opening is located between the clitoris and the vaginal opening. Urine is released by the bladder and passes through the urethra and out through the urethral opening. The vagina itself is situated between the bladder and the rectum, and it is about four or five inches long. Normally, the elastic walls touch each other but stretch considerably during intercourse and more so during childbirth. The vagina is lubricated by a mucous secretion which pours out of the vaginal wall when a woman becomes sexually excited. Usually the outer third of the vagina is more sensitive than the rest, but sensitivity varies with different women.

Try squeezing your pelvic floor, tensing and relaxing the whole pelvic area and feeling the contractions of the vagina. These are very important muscles which you can use while making love and it is also just as well to get to know them while you are on your own. Do this contraction while your finger is inside your vagina and feel the pressure of the vaginal walls against your finger. I describe how to do this in greater detail in another topic called 'Better Orgasms - Strengthening Your PC Muscle'.

Now you have explored your genitals tactually and visually. If at any stage you feel uncomfortable or anxious about looking at your vagina or feeling it, stop, relax and then start again. The point of this exercise is not necessarily to become sexually aroused, although there is nothing wrong with that, but simply to get used to looking at your genitals and to get used to the pleasure that you may derive from touching and feeling yourself.
Many women feel extremely shy or reluctant to give themselves pleasure believing that it is somehow wrong. If you give yourself time to relax and get used to the idea that it is good to touch yourself lovingly, you will benefit enormously from your knowledge about your own body and you will be able to communicate this knowledge to your partner.
.3. REACHING A CLIMAX THROUGH SELF-STIMULATION

Before you begin these self-stimulation exercises, it is important to find a place where you will not be disturbed and where there will be no distractions. These exercises require absolute relaxation and you will not be able to relax if there is the slightest possibility that you will be disturbed. If you are tense or fatigued, have a relaxing bath. (It would be helpful if you read the topic on Genital and Sexual Self Exploration so that you are familiar with the techniques of getting to know your body). Finally, allowing yourself to be experimental - use your imagination. If, after reading this topic, you would like to know about using a vibrator for self-stimulation, I suggest that you then read that particular topic i.e. Vibrator Use.

Using some lubricant on your hand, begin exploring your breasts. Caress them in a slow, firm movement from the outer area towards the middle. Touch the nipples lightly in a teasing manner. Alternate between breast and nipple stimulation gradually increasing the pressure directly on the nipple. Some women like to massage the whole breast including the nipple quite strongly. Find out what suits you best.

Now begin touching the outer lips of the vagina and the clitoris. Do this slowly and exploratively at first and again do whatever feels comfortable for you. The clitoris, like the breasts, can be stimulated in a number of ways using the thumb, forefinger and two or three fingers together. You could use one finger on each hand, both thumbs, the palm and so on. You can move up and down, from side to side, or in a circular fashion. Try out different strokes to see which are most effective. Learn the movements which increase the feeling of pleasure, then learn how to decrease it by altering the touch. Touch and play with yourself, you can play with your whole body in fact. And while you are playing you are also learning what gives you most pleasure.

At this stage, do not try to reach an orgasm. The goal in this part of the exercise is not to reach orgasm but to feel comfortable while exploring all your bodily sensations.
I would suggest that you continue with this first phase for about twenty minutes, four or five times a week. When you can explore your breasts and vaginal area without feeling uncomfortable, anxious or guilty, you can consider this step complete. If, after some days you notice no difference in sensation, then use a suitable lubricant, which will reduce the friction and increase sensation. The more sensations you feel the closer you are to orgasm.

Another idea is to fantasise. Although this is not essential most women report that this helps them when doing these exercises. Fantasise about whatever turns you on - this is not something I can tell you how to do as fantasies are the most private thoughts an individual can have.

You could also use erotic literature or erotic movies to get you in the mood. A lot of women get turned on by reading about sex or watching other people doing it in the movies. In fact many women cannot achieve orgasm by themselves without some form of accompanied erotica or fantasy.

Another suggestion is to insert a finger or two into the vagina while you are stimulating yourself and feel the gripping and releasing movements that result from the rhythmic contractions of the muscles. Repeated contractions of these muscles will increase the blood flow to the lower third of the vagina and clitoris, thereby increasing their sensitivity. (You should also read the topic on How To Strengthen Your Vaginal Muscles).

Even if it takes you a few weeks to achieve your first masturbatory orgasm, every session of training exercises will lead you in the direction of greater sexual maturity. You are learning about your sexual responses all the time. You may need forty-five minutes of sustained clitoral stimulation, or combined breast and clitoral stroking or vaginal stimulation before you achieve your first masturbatory orgasm.
There may be times when you feel that you are on the brink but cannot reach the final peak. If you try too hard you may block the final letting go, but as your confidence grows and you begin to understand exactly which sensations you respond best to, you will achieve an important breakthrough. From that point it becomes easier and you approach each arousal with an expectation of success rather than of failure.

You will also find that reaching orgasm takes less and less time until you will be capable of attaining orgasm in a couple of minutes and you will be ready to respond to your partner’s caresses.

When you find yourself on the brink of orgasm don’t stop. Don’t stop the stimulation until you feel a series of vaginal contractions, or waves of feeling. Continue the stimulation until the contractions or waves have stopped. Remember that stimulation needs to be continuous to reach an orgasm especially around the clitoral area. There are many women who experience warm and tingling sensations which flood the pelvis and other parts of the body and then they stop stimulating. This point, known as the pre-orgasmic stage, is just prior to orgasm, and if you continue touching yourself you will feel the actual orgasm. If you stop, the orgasm will stop.

Remember that you cannot force an orgasm. It is far more important to enjoy all your bodily sensations, indulge in sexual fantasies and relax. Orgasm should not be hard work.

The final stage of these exercises is also the key to relaxing sexually. Take deep breaths letting them slowly out making a sighing sound. Take a deep breath in, hold it, and then let it out with a deep sigh. While you are doing this you can imagine a beautiful landscape or have a sexual fantasy. Next you should speed up the breathing and make the sighing a full-blown noise. The sound should be loud and don’t force it, just let it flow out easily. Imagine the sound is starting way down in your pelvis and travelling up your wind-pipe.
Whenever you do this have sexual thoughts so that you connect breathing in this way with making a noise and having a sexual fantasy.

Give yourself ample opportunity to carry out these exercises for them to be optimally beneficial. You may also incorporate using a vibrator as part of these exercises.
.4. REACHING A CLIMAX WITH THE HELP OF YOUR PARTNER

If you have gone through the exploratory exercises teaching you about your own erotic responses in the previous topics you may or may not have reached a climax through self-stimulation. Even if you have not yet experienced an orgasm there is no harm if you involve your partner at this point. What I am going to tell you is how to become comfortable with your partner watching you stimulate yourself, and after that how to teach your partner to stimulate you.

Before you begin this particular exercise I would suggest that you discuss with your partner what you have done thus far, and ascertain whether he is willing to participate in the following exercises.

You and your partner should get into the right frame of mind before you begin. Perhaps have a glass of wine, share a bath together, then when you are completely relaxed and ready for each other, lie on the bed. (Of course, it need not be on a bed - it can be anywhere where you are relaxed, comfortable and alone that will be suitable).

Now the point of this exercise is to communicate with your partner and to show him how you pleasure yourself. This may be very difficult for you to imagine yourself doing without embarrassment or shyness. You may have grown up with the idea that masturbation is something that you do to yourself. It is a private and secret act. Likewise your partner may have reservations about watching you masturbate - he may not like the idea that you masturbate at all. So all these things need discussion. Talk about your feelings and ask your partner to share his views with you. If you both decide that this is not for you, then ignore this part of the Self Help Programme and concentrate on the more acceptable aspects.

If you are ready, you can carry on. Remember that you are not performing for your partner - you are teaching him. First of all, set the mood with soft music, a warm room and candlelight if you wish.
Do whatever you find suitable to create a loving environment. Both of you should be nude but if you find that this makes you shy or that you are cold, then wear something loose or transparent. Your partner should be able to see what you are doing to yourself.

Begin by holding each other, hugging and kissing. When you are ready, get yourself into a position that is comfortable. You can lie between your partner’s legs or you can lie side by side with your partner bending over you so that he can stroke your breasts. You may not want your partner to touch you while you are stimulating yourself or you may want to keep close to him. Do whatever feels right for you. When you have shown your partner how you touch yourself and what gives you most pleasure, he may want to stimulate himself so that you can learn from him. End this session with some closeness, hugging and kissing and talk about what has happened. Tell each other what you felt and experienced during this time.

After you have gone through this exercise for several sessions, with or without orgasm, you may be ready for your partner to stimulate you. Again, get yourselves comfortable and in the mood for communicating with each other. You may lie as before or facing your partner, with your legs bent in a comfortable manner. Your partner should have easy access to your breasts and genitals but at this stage the focus should not be on the genitals but on the entire body.

As you become aroused and lubricated you can insert two fingers into your vagina and spread the vaginal lubrication throughout the entire genital region, particularly around the clitoris and the clitoral shaft. If you have not lubricated naturally, then have some lubricating jelly ready and do the same with that.

At this stage there should not be penile insertion. In other words, no sexual intercourse. What you can do is let your partner explore the outer genitals and then gently guide his finger or fingers into your vagina showing him exactly how it is you enjoy being stimulated.
You will probably find that you want your partner to explore your whole body and not just focus on your genitals.

Enjoy the vaginal stimulation but remember to tell your partner to stop whenever you have had enough or when you feel so aroused that you would like him to move on to clitoral stimulation. You can combine clitoral stimulation with touching the breasts, and you can also include oral stimulation if you wish. In fact, kissing the whole body and exploring with the mouth is a good idea at this stage. Many women find it highly pleasurable when their partners orally bring them to orgasm. You may find it more arousing when your partner gives you oral stimulation on your clitoris or gently around the vaginal lips. Again this is a personal preference but you may want to try it. A separate topic deals with Oral Stimulation which you can listen to.

What is important is that you let your partner know what actions arouse you. Also let him be the active one - the pleasure giver.

Now you will probably find that you are highly aroused. Take your partner’s hand and guide it in the way that gives you the most satisfaction. Perhaps you need more vigorous stimulation of the clitoris. Perhaps you require a circular movement that just misses the clitoris or perhaps you want him to put a finger or two in your vagina for deep penetration. Whatever will bring you to a climax is what you should be focusing on.

There are several ways of going about this. You can put your hand on top of your partner’s hand and perform the movements together. Or you can do the last stage on your own with your partner right next to you. Or you can tell him what to do as you are getting closer to orgasm.

Let me sum up the procedure once again. First begin with non-demanding pleasuring of the whole body. Do not focus on the genitals and do not make orgasm your goal. Enjoy the sensations and guide your partner to what suits you best. Then slowly move on to specific genital pleasuring, once again communicating to your partner exactly what it is that gives you the most pleasure.
Bring yourself to the point of orgasm and then show your partner, either with your hand or verbally, how to bring you to orgasm. If after you have reached a climax, and you want to go on to reach another one, tell your partner what you need to do. On the other hand, this may be the moment for your partner to have his own orgasm. You will either be the spectator or the active participant in this.

Once you have completed this set of exercises you will be in a position to move on to the next stage which is reaching an orgasm through sexual intercourse. Read the topics on Using A Vibrator and G-Spot Stimulation as well as The Importance Of Clitoral Stimulation, as part of the next step in the Self Help Programme.
To achieve the best results with this Self Help Programme, it is advisable to once again read the topics on Self-Exploration and on Reaching A Climax Through Self-Stimulation. You will also need the co-operation of your partner so it is better if you are involved in a committed, trusting and caring relationship as opposed to a casual one. Your partner needs to be receptive to your level of sexual responsiveness; he needs to be concerned for your well-being and emotionally supportive. He needs to be loving and encouraging and above all willing to let you take responsibility for your own progress.

Achieving an orgasm while having intercourse with your partner is somewhat more complex than achieving an orgasm on your own. You will always have some concern for your partner and what he thinks about your progress or lack of it which can easily become distracting.

It is important to proceed very, very slowly before penetration takes place. You should dictate the pace and you should indicate when you want penetration to take place. The best position for this purpose is for you to be on top of your partner. When you are aroused after a period of foreplay and loveplay and you are ready for penetration, that is after a long period of foreplay, with or without self or partner stimulation of your genitals and when you feel that you are sufficiently lubricated, guide the penis slowly into the vagina.

Now contract your vagina by squeezing the vaginal muscles together each time the penis goes in or out of the vagina.
Do this regularly and rhythmically, holding the squeeze until the penis starts in the other direction, then resting until it starts back in the direction in which you squeeze it. (If you need further help on this particular exercise, refer to the topic that deals with Strengthening The Vaginal Muscles, also called Better Orgasms). Every time you have intercourse you should get into the habit of using these muscles because the increased blood flow to the muscles will enhance vaginal stimulation and as a result of this enhanced vaginal stimulation, will increase your pleasure.

The next step is to start various types of movements during penetration. The action of the penis going in and out of the vagina does very little by itself to stimulate the nerve endings in the vaginal muscles. Now the easiest way of getting this stimulation is by moving your hips in a rotating motion while at the same time contracting the vaginal muscles. This will cause the penis to rub against the muscles giving you greatly increased sensations. The key here is to rotate your pelvis to achieve the greatest amount of pleasuring.

Remember that you are on top and that you are controlling the pace and movement. The extent to which you move and don’t move your body during intercourse will determine how much sensation you will feel, and the bonus is that your partner will enjoy this as much as you do.

While you are moving your pelvis and contracting your vaginal muscles, begin to stimulate the clitoris. You can do this by manoeuvring yourself into a position where the clitoris is in direct contact with your partner, or you and your partner can do this manually.

It may take a little practice before you can co-ordinate all three procedures and certainly don’t try to achieve an orgasm the first time you try do this. However, remember that these three movements, that’s the pelvic rotation, contracting the muscles and clitoral stimulation are almost a duplication of the stimulation you received during masturbation.
By practising, you can recreate the same feelings during intercourse, thus eventually reaching an orgasm. You will probably have realized by now that although you need the co-operation of an understanding partner, you are actively seeking and working for your own orgasm.

As I have said, you need to take time over this stage. However, when you feel confident you can begin the process of tapering off the clitoral stimulation during intercourse, but I must stress that you should try this only if you are successfully achieving orgasm with clitoral stimulation. This is how you do it.

During sexual intercourse, squeeze your vaginal muscles and move your pelvis as before, and also use clitoral stimulation. However, when you feel your orgasm beginning, stop the clitoral stimulation. If you lose the orgasm completely, resume the clitoral stimulation immediately and again stop as the orgasm begins. Do this up to 3 or 4 times during one lovemaking session. If you are unable to complete your orgasm without clitoral stimulation, you may have one orgasm with clitoral stimulation. You will with practice eventually be able to reach a climax without direct clitoral stimulation and when this happens you can try moving the moment of stopping the clitoral stimulation further and further from the point of orgasm. Eventually you will reach the point where you just begin intercourse with clitoral stimulation, to where you may not need stimulation at all or perhaps for only a brief time before actual penetration.

I must stress however that there is nothing wrong with having an orgasm with clitoral stimulation, in fact, many women find this a preferable way to have an orgasm. Remember that for most, the most intense sensations come from the clitoris and therefore stimulating this part of you is bound to produce the most pleasurable sensations.
Finally, I must say that a number of perfectly normal and emotionally happy women do not experience orgasm or do not experience orgasm during sexual intercourse; that's with penile penetration. The absence of orgasmic response does not mean that there is anything wrong. A woman can be a perfectly satisfactory sexual partner without being orgasmic or without being orgasmic all the time. She can be warm, loving, responsive, sensitive and interesting without ever having had an orgasm and she can also be deeply loved and accepted by her partner if she is non-orgasmic.
6. **USING A VIBRATOR**

If you have read the topics on Self-Exploration and Self-Stimulation you will by now have a basic knowledge of how your body works and how best you can arouse yourself to the point where you can achieve orgasm. The use of a vibrator is simply an extension of these experiences. Its' purpose is to increase and enhance the feelings of stimulation. In fact, a vibrator can be used to help you attain your first orgasm by providing a more sustained and efficient stimulus particularly to the clitoris.

Some women have reservations about using a vibrator. You may be one of those who feel that there is something wrong about using a "machine" to achieve arousal. Some women believe that if they continually use a vibrator, they will become dependant on it and will not be able to have orgasms any other way. This is not so. Anything that can enhance your sexual pleasure is a good idea and will increase your chances of becoming orgasmic with your partner. Perhaps the best way to think of the vibrator is that it is a useful means of increasing your sexual response and of learning about the sensations of the orgasmic response. Research has shown that for many women a vibrator is a good first step towards orgasm by self-stimulation which can be followed by partner stimulation and lastly by sexual intercourse.

There are many kinds of vibrators on the market but the best types are electric, two-speed, hand held, self-contained units with several kinds of rubber attachments. They are also sold in large retailers or pharmacies as body or scalp massagers. There are also types of vibrators which are shaped like a penis and which are sold as a facial massage vibrator. Use whichever you feel more comfortable with. You may also need to buy a sterile lubricant jelly to use with your vibrator to prevent soreness and chaffing.

To begin, you may want to take a relaxing bath and then lie down on your bed feeling comfortable. (Remember never to use an electrical vibrator near water). Focus your thoughts on sensual feelings. Get in touch with your bodily feelings by touching yourself lightly with your hands.
Now turn on your vibrator and press it gently onto your body directing it towards those parts of your body that you have found most pleasurable. Don't try too hard to get a sexual response in the beginning - just allow yourself to be relaxed and comfortable.

When you have explored the non-genital parts of your body, spread your knees and, beginning at the centre of your thighs, move the vibrator slowly up your leg, until it's resting against the outer lips of the vagina. Then, spreading the outer lips with your fingertips, gently lower the vibrator next to the clitoris.

Relax and enjoy the flow of feelings. Know that these feelings are natural and a healthy part of you, so stay with them and enhance them. If at any time you become uneasy or anxious or these new feelings become frightening, relax and use the vibrator on other parts of the body which you feel safer with. After a time, move the vibrator back to the clitoral region and stay relatively passive while the vibrator provides stimulation.

Stay relaxed and passive for as long as it feels comfortable, but try to hold it for at least a few minutes, lengthening the time you use the vibrator every day, up to 30 minutes if possible and if necessary. If it helps to fantasise, try switching on to sexual fantasies. Think about your partner or someone you have seen or whatever erotic thoughts you find exciting. Your favourite music might provide a sensual atmosphere. Don't be afraid to use your imagination and whatever else it takes to create a sensual atmosphere. Now focus your vibrator on the most sensual areas of your genital region.

For most women this will be the area immediately around the clitoris. Hold the vibrator on this area, massaging in slow, gentle movements and then more rapidly. Use the vibrator imaginatively in ways that suit you best. Try anything that will enhance your sexuality. If at this stage you have a climax lie back and enjoy the feelings this gives you. This is a natural culmination of the pleasuring process.
If you chose, you can re-stimulate yourself with the vibrator in a similar or in a different position and you can reach another climax. Once you have learnt how to be responsive and orgasmic using the vibrator, your next step is to share this information with your partner and to begin working towards a mutually enjoyable sexual relationship.

Some women become quickly orgasmic and more responsive with their partners after they have used the vibrator to pleasure themselves. Others take longer to adjust to the new feelings and sensations the vibrator brings. The fact remains that however you achieve orgasm, you have taken a major step in accepting yourself as a sexual person and have learnt to become orgasmic.
.7. THE G-SPOT

Although most women reach a climax through clitoral stimulation, the clitoris is not the only source of female pleasure. Research has confirmed that there is a small area of erogenous tissue inside the front wall of the vagina that responds to stimulation. This appears to be a small cluster of nerve endings, glands, ducts and blood vessels around the bladder and the urethra, that is the urinary passage, running in front of the vaginal wall. This area cannot normally be felt when it is unaroused, and only becomes distinguishable as a specific area during deep vaginal stimulation.

If this area is properly stimulated for long enough, it can result in intensely satisfying orgasms which when they occur, produce a small ejaculation of clear fluid in some women.

Many women have known that they have been aroused without clitoral stimulation if the front wall of their vagina is stimulated, without realizing that this area is called the G-spot. Once there is stimulation to this area, the G-spot transformation takes place very quickly. As stimulation continues, it begins to swell, sometimes very rapidly, and a small mass with a distinct edge, stands out from the vaginal wall. In fact there are some women who only have pleasurable intercourse in positions in which the penis stimulates the front wall of the vagina.

Now you are probably wondering where your G-spot is. Perhaps you would like to discover it. But remember that it is not the easiest part of the female anatomy to be found as it has to be stimulated first.

If you want to discover where your G-spot is it is best if you sit down because gravity tends to pull the internal organs away from the vaginal entrance, so I recommend a sitting or squatting position. See that your vagina is well lubricated using a lubricant if necessary, and insert one or two fingers into the vagina using a firm upward pressure to the front of the inside vaginal wall.
Sometimes it helps to use the other hand to press firmly down on the outside of your tummy while you experiment with stimulating the upper front wall of the vagina.

After you have stimulated it for a while, that G-spot area will begin to swell and will feel like a small lump between the fingers on the inside of the vagina. The size of the lump varies from woman to woman, but it usually feels like a small bean when it is swollen. It may measure a couple of centimetres across. You may feel as if you want to urinate but this will pass.

Try finding the G-spot and stimulating it while squatting with your knees apart on the floor or on the bed. After you are thoroughly familiar with your G-spot position and you are used to stimulating it, you may like to get your partner involved in G-spot stimulation.

Your partner also needs to use some lubricating jelly on his fingers. Then he can insert one or two fingers inside the vagina and gently stroke the front vaginal wall. If you move your pelvis you will help him to locate the spot and at the same time you will discover the most enjoyable stimulation. Remember that the initial sensations which may feel like the desire to urinate will pass and are simply the sensations that will lead to orgasm.

You can also lie naked with your partner face to face and guide his index finger into your vagina making sure that it's well lubricated; you could even use saliva. With his palm facing upwards towards you, let him gently push around in the area of the outer third of the vagina’s top region.

At first, don’t expect any orgasm. Just experience the sensations which you may or may not find pleasant. The feelings alter at different times and vary from one woman to another. Sometimes you may find the sensation very pleasurable, whilst at other times uncomfortable. If your partner pushes firmly up with his index finger you may experience the urge to urinate.
If you or your partner continue to stroke the G-spot, you will probably notice some pleasurable contractions in your uterus and this may be the beginning of orgasm. Remember that the sensations will be felt deeper inside than when you stimulate the clitoris.

At a later stage your partner can insert his penis into your vagina and stimulate the G-spot in this way as he did when his fingers were pressing on the front wall of the vagina. Move your pelvis to help him locate the correct spot. Incidentally it is worth remembering that if you use a diaphragm as a means of contraception you may not be able to find the G-spot as it cannot be adequately stimulated through the diaphragm. The preferred position for optimal G-spot stimulation is the rear-entry position.

In conclusion, I would like to say - don’t become overly concerned with finding your G-spot and don’t become obsessed by the idea that G-spot orgasms are superior to any other type. Many women are unable to locate and stimulate the G-spot. If you find that G-spot stimulation can enhance your sexual pleasure, that’s fine. If not, leave it and enjoy your sexuality in other ways.
8. CLITORAL STIMULATION

How important is clitoral stimulation for the sexually active woman? To put it simply, for most women, clitoral stimulation is the necessary forerunner to orgasm and it is also the basic trigger for the entire orgasmic process. Clitoral stimulation for the woman has the same function that penile stimulation has for the man, in fact, the clitoris is sometimes known as the little penis.

In a sense, pleasure is more focused in the clitoris than it is in the penis although there are portions of the vagina and the labia that are also sexually sensitive, and there is also recent evidence to suggest that a small area of the vaginal wall called the G-spot may serve as a trigger for female orgasm. (You may like to read the topic on the G-spot later). But for most women, sexual intensity starts in the clitoris and never leaves it, even though orgasm itself consists of involuntary contractions surrounding the vagina. In fact, the reason why so many women do not achieve orgasm is because they do not understand that clitoral stimulation is an essential component to produce orgasms, and neither do their partners. As a result of insufficient clitoral stimulation, anorgasmia (that's the failure to reach orgasm) and other related sexual and relationship problems may develop.

The clitoris is not ideally located for stimulation by penile thrusting. It is covered by what is called the clitoral hood which is connected to the labia minora, or smaller lips of the vagina. Penile thrusting moves the labia back and forth, which provides for stimulation of the clitoris. This friction, which is twice removed, does not usually provide adequate stimulation to provide orgasm in the majority of women. Therefore more direct stimulation is almost always needed in addition to foreplay and even during intercourse itself.

Assuming that your partner is willing to provide manual stimulation during foreplay, he may not know how to find the clitoris.
It's one thing being able to identify the organ in a manual, but it's something else knowing what it feels like to the touch, and many men are embarrassed to ask their partners where in fact the clitoris is. There are also many women who either do not know where it is themselves, or who are too embarrassed to talk about it, or who do not wish to hurt their partner's feelings by pointing out his ignorance. The result of all of this is insufficient clitoral stimulation and very often, lack of orgasm.

If you do not know where your clitoris is, you can find out by using a small hand-held mirror. Or you can read the topic on Self-Exploration, or, when you next visit your gynaecologist or doctor, you can ask to be shown where it is.

Clitoral stimulation should usually be very gentle. The clitoris is an extremely sensitive organ, and for most women, a very light pressure is adequate. Some women, in fact, find extremely gentle pressure irritating and prefer indirect stimulation as opposed to direct stimulation. There are others who prefer direct, more forceful stimulation, so you can see how important it is for you to get to know your own body and how it responds and to make your preferences known to your partner.

Not nearly enough time is devoted to clitoral stimulation. On average, a woman requires anything from ten to twenty minutes of clitoral stimulation to reach orgasm. Some women need up to 45 minutes. Most men do not know this, and many women do not tell them because they have been conditioned to feel that mentioning this requirement is an imposition on their partner. This is a pity because most men like to think of themselves as good lovers, and if it takes half an hour or more in foreplay, caressing and stimulating the clitoral area to help the woman come to an orgasm most men will certainly not object.

What if he does? Well there are other ways, there are other alternatives. The woman can stimulate herself to the point at which her partner's stimulation plus thrusting may lead to orgasm, or she may use a vibrator with her partners' help if need be.
(I would suggest you read the topic on Using A Vibrator). Self-stimulation can be provided by the woman herself in just about any position that leaves one of her hands free, but manual stimulation of the woman by the man is most satisfactory when the woman is on top, that is in the female superior position. This leaves the man's hands free for clitoral stimulation and also gives the woman freedom to manoeuvre and to direct the thrusting activity to provide herself the greatest amount of stimulation.

It might be helpful to know that once you have achieved orgasm by whatever means, it becomes easier to have another one the next time. So a woman should not feel bad about asking her partner to spend time on helping her to orgasm because regular and frequent orgasms will increase the likelihood that they will become easier, and that the partner will subsequently have to spend less time with clitoral stimulation.

I should also say that clitoral stimulation is only part of love play - it does not have to be the most important part. Human beings are not machines needing the correct buttons to be pushed in order to perform. Just so, knowing how to stimulate the clitoris does not necessarily ensure imaginative or erotic lovemaking. You and your partner's attitude to each other is crucial for your mutual arousal and satisfaction. Provided you both understand this, it is safe to say that adequate clitoral stimulation is one of the most important guarantees of complete orgasmic satisfaction.
Muscles that most affect feeling and sensation in the vagina are known as the PC muscles, called the pubococcygeus muscles. Because that’s a rather fancy word, I refer to these muscles as the PC muscles.

Doing PC exercises tones up the vaginal muscles and makes the vaginal walls firmer. Your genital muscles need exercise like any other muscle in your body and again like other muscles in your body they will lose tone if you do not consciously try to strengthen them. By tightening and exercising the PC muscles, you can pull the walls of your vagina together, moving the nerve bundles into their most sensitive position to be stimulated and responsive during intercourse.

It is a good idea to consult your gynaecologist to determine the physical condition of your vaginal muscles. If the muscle has poor strength, your gynaecologist may recommend another procedure. So, particularly if you have had a recent operation, it would be wise if you consulted your gynaecologist before beginning this programme of exercises.

As I have said, exercising the PC muscle is helpful in increasing sexual feeling and gaining an awareness of the muscle as a sexual organ. The importance of the vaginal muscles has been acknowledged for a long time but primarily as a means of giving pleasure to the male. Nowadays it is recognised that it can be very important to the woman’s enjoyment of sexual intercourse. When you use the PC muscles during intercourse, it grips the penis and greatly enhances both your and your partner’s pleasure - this action will also increase your orgasmic potential.

When you first try to isolate the vaginal muscles you may find it difficult. I suggest that as a preliminary exercise you lie on the bed and practice isolating and contracting different sets of muscles in turn. For example, contract your calf muscles, then your tummy muscles, then your upper arm muscles. Now try to isolate and contract the vaginal muscles.
This may be difficult for you because they are so closely connected to the urinary and rectal areas and often you find yourself tightening these and the tummy muscles as well. Don’t worry if you can’t do this lying down. The easiest way to locate your PC muscles is to stop the flow of urine when you are on the toilet. The muscle that you use to stop the flow is the PC muscle.

If you have a difficult time in stopping the flow this would suggest that the PC muscle is weak. If you still have trouble in identifying the muscle simply sit on the toilet with your legs far apart and lift your body a little off the toilet seat. This should make it easier for you to stop the flow. Start and stop the flow several times to identify the muscle correctly.

The second step in identifying the PC muscle is to try contracting it in a fast flicking movement. Although these fast flicks will do little to gain control of the muscle, they are helpful in assisting you to identify it quickly and to begin learning how to move it.

Now for the actual exercises. These should be done with nothing inserted in the vagina and in any position, lying, sitting or standing. At first it may be easier for you to lie completely relaxed on your bed, but you may find that a sitting position is best.

Visualize the two sides of your vagina. Now try to bring these two sides together in a slow, steady squeeze as if you were trying to stop urinating. Concentrate on the vagina not the rectum, although the rectum will contract on its own. Try also not to contract your tummy muscles. It is helpful to place a hand on your tummy at first to remind you not to use these muscles.

Doing these exercises requires a great deal of concentration, so it’s important that you are relaxed. Don’t talk, don’t read, don’t watch T.V. Just relax and focus on your vaginal muscles.
Do the following contraction to the count of six. Each number represents one second.

One       - Contract your vagina slowly and steadily
Two       - Hold this contraction steady
Three     - Continue to hold it
Four      - Hold it some more
Five      - Give one extra squeeze as hard as you can using your abdominal muscle to give you extra strength; and
Six       - Relax.

When you do this on your own, take a deep breath in as you contract, count up to five seconds, squeeze extra hard and relax on six. Do this for five minutes, three times a day or use any other combination that equals fifteen minutes a day.

You may start getting a mild sexual feeling, then you know that you are making good sexual progress. You may also notice a full warm feeling in your genitals as you are doing these exercises. This is probably due to the flow of blood to this area and may or may not give you pleasurable feelings.

Continue doing these exercises as part of your daily programme for the rest of your life. If you don’t the muscle will lose tone and vaginal responsivity will decrease with time. The purpose of these exercises is to build tone in the vaginal area and so increase sexual feeling. By being more aware of your sensations in these areas, you can better integrate them into your feelings about yourself as a sensual and sexual person.

Remember that each woman is different in the way her body responds to these exercises. The important thing is for you to relax and get as much enjoyment as possible by doing them. You will certainly benefit from the strengthening of these muscles and you will have better control over the way you function as a sexual woman.
10. **MULTIPLE ORGASMS**

Given enough stimulation, most women are capable of having more than one orgasm. Research has shown that in most cases a woman was capable of having a second, third, fourth or even fifth and sixth orgasm before she is finally satisfied.

Many women have multiple orgasms than is generally realised, but the vast majority do not have them from intercourse alone. It is this that makes many men think that their partner is not multiply-orgasmic, when in fact she is.

Most women have multiple orgasms only when masturbating and this is because they can control the situation and maintain stimulation for longer periods than is possible during sexual intercourse.

Sex researchers have found that the largest number of orgasms occurred when women used vibrators.

Probably about 1 in 3 women are totally satisfied with a single climax, in the same way that a man is and many women say that stimulation after orgasm is painful and unpleasant and it really detracts from any further pleasure for them.

Many women also say that because direct clitoral stimulation very often produces the best orgasm for them, it does not follow that subsequent orgasms should also be brought about through clitoral stimulation, because very often the clitoris, after orgasm, is highly sensitive and direct stimulation may in fact feel uncomfortable, even painful.

Use other methods of stimulating the clitoris indirectly. This may include caressing the whole vulva area, away from the clitoris, sexual intercourse itself and stimulating some other part of your partner’s body altogether.
That is why it is so common for a woman who has climaxed before intercourse, let's say by direct clitoral stimulation, to reach a climax again when they are having sexual intercourse, when the clitoris is stimulated indirectly.

Women, unlike men, have been endowed with the capability and the capacity to climax time and time again, and some until they are physically exhausted.

Now not all women have repeated climaxes every time they have sex or masturbate. Some women are multiply orgasmic every time they masturbate or have sexual intercourse, but for the vast majority, the mood needs to be right, and they need to have plenty of stimulation and foreplay, as well as prolonged stimulation of the right areas of their bodies.

For the woman who feels that she may be multiply orgasmic or wants to be, here are some suggestions.

You may start experimenting on your own during masturbation. Next time you feel especially sexy, perhaps around period time, allow yourself to get very aroused and once you have had one orgasm, experiment with another way of stimulating yourself until you have another. If you usually climax with your fingers, stimulating your clitoris, perhaps you could try a vibrator around the area until you reach a climax again.

If the clitoris is tender after reaching the first climax, don't continue to stimulate it, find other ways of doing it indirectly. Perhaps try a vibrator. Naturally you may find, as many women do, that simply repeating what you did to get your first orgasm, may in fact produce several further orgasms.

Don't forget, what's important is to use your favourite fantasy during these early stages of arousal and once you have learnt to have several orgasms, then you are ready to perhaps involve your partner.
Now, when you are feeling very sexy, encourage your partner to stimulate your clitoris possibly even orally, and give you a really enjoyable first orgasm. Then you need to tell him how to help you reach a second orgasm and this will depend on how you have learnt to do this during masturbation.

Tell him what you would like him to do most for you and don’t expect him to be able to keep an erection for as long as you need, perhaps you also need to encourage him to use a vibrator on or inside you as well.

When you feel you have had nearly enough, perhaps you could have sexual intercourse again. You may discover how quickly you can become multiply orgasmic with less and less stimulation. If you then only have one orgasm on a particular occasion, don’t worry about it because perhaps your newly learnt pattern may then resume.

Don’t forget the G-Spot. Women who enjoy the front wall of their vagina being stimulated to orgasm, say that the sensation is totally different from that produced during a clitorally induced orgasm.

A few women are able to go from one orgasm to the next almost without a break and for a small minority of women, orgasm keeps coming one after the other, until the woman is very often, physically exhausted. For many multiply orgasmic women, a short waiting period between orgasms of a minute or so, is the norm.

Whether multiple orgasms are worth the effort spent by the woman or a partner, really can only be determined by the woman herself, although some men will receive great pleasure simply from the knowledge that their partners are multiply orgasmic and enjoying this.

Some men say they most enjoy sexual intercourse with their partners who reach a climax once, like themselves and if a partner has to have repeated stimulation, this can sometimes be more of a hassle.
As regards men, some men are able to be multiply orgasmic. It is not just a female phenomenon but men can have several orgasms a day, perhaps in fairly quick succession, yet not ejaculate at all, or may simply do this on the last occasion.

Few Western men ever come to this particular situation because they have no training in these techniques. A lot of men don’t realise that such self control can be achieved, and that dry orgasm is even possible.

Many men under the age of 25 can have repeated orgasms, rather in a way that a woman can, but as males age, he needs longer and longer to recover to re-erect physiologically from his climaxes and cannot, say by middle age, ejaculate again and again in quick succession.

Multiple orgasms are uncommon in all but young men, but if the setting is right, the mood exciting and the partner arousing, quite a few, even middle aged men, can have more than one orgasm.

It is not unusual to find that a single orgasm woman becomes multiply orgasmic in middle or even older age, as her partner gains greater ejaculatory control.

Any such women would have been multiply orgasmic years before, were it not for their partner’s perhaps being a little selfish or experiencing rapid ejaculation.

So, if it’s multiple orgasms that you want, a programme to help you achieve this, certainly can be interesting, exciting and rewarding.
11. NON-GENITAL PLEASURING

The self-help programme is aimed at helping you overcome specific sexual problems as well as improving your sexual knowledge and skills, and promote a level of communication that will enable you to share the responsibility for creating a more satisfying sexual relationship. A truly rewarding sexual relationship doesn't come easily. It has to be worked at constantly.

The first stage consists of non-genital pleasuring. The first thing to do is to create a sensual, relaxed atmosphere in the bedroom or wherever you decide to be. You may decide to use candles or merely to have the lights down low but don't choose to be in darkness because it's important to see each other's nakedness. If you don't feel comfortable with the lights on by all means have the lights off - perhaps at a later stage you will feel more confident about your body. If it's cold use heaters to warm the room up and, if you wish, have a glass of wine, but don't get intoxicated.

Perhaps part of the preparation for this self-pleasuring could be taking a bath or shower together. After you have your bath have a jar of body lotion or baby oil handy. Take the phone off the hook and take off all your clothes. Now you're ready to begin the non-genital pleasuring exercises.

For the first 15 to 20 minutes one of you will assume the role of pleasurer. Let's say it's the male partner who begins. Using a large amount of body oil, start to caress, fondle and massage your partner, trying to give her the nicest possible feelings. Take it nice and slowly but at no time should you touch her breasts or her genitals. Stay away from the breasts, nipples, and the whole genital area. All these areas are strictly out of bounds. You are not trying to arouse your partner sexually but only to share with her a leisurely exploration of the non-sexual areas of her body.

I'm taking about sensual as opposed to sexual focus. You may touch and kiss her neck, ears, arms, stomach, toes, legs, back, rubbing oil into all these areas.
Your partner should be indicating to you which touches she likes most and which areas of her body she wants you to touch. Very often a foot or hand massage is relaxing and enjoyable. Experiment with different things. The task of the pleasurer is to do all kinds of things to give the partner sensual as opposed to sexual pleasure. Enjoy this giving experience.

It’s important to talk to each other while this is happening since communication lies at the heart of all satisfying sexual relationships. Comment on the smoothness of her skin and talk about the different parts of her body in a positive way. Make her feel good about herself, as you give her pleasure. Tell her about your feelings as the pleasurer.

It’s important to use "I" language with each other. "I love it when you touch me here", "I prefer it here rather than there". "I" language lets your partner know exactly what it is that you are feeling.

Don’t be put off by the mess of the oil. If necessary, put a towel on the bed. The oil lessens the friction and adds to the sensuality of the experience. Experiment, be spontaneous and be creative.

After 15 to 20 minutes switch roles. Now it’s the woman’s turn to be the pleasurer. Remember that your partner’s genitals, that is his penis, scrotum, testicles and perineum are out of bounds. As you caress him, your partner should describe the nice feelings he is receiving from you or his pleasure at seeing your breasts and your body. No matter how much he wants or desires more intimate touching of his genitals, do not allow it at this stage. This is very important if you want to get the most out of the experience.

The emphasis is on relaxed enjoyment. If you find yourself becoming aroused don’t worry. Just get in touch with parts of the body that you might not have thought of before. Cuddle and enjoy the closeness. The pressure is off all sexual contact.
Now perhaps you are both covered in oil and maybe you are both feeling strong sexual urges. Avoid sexual intercourse at all costs, for the next 7 - 10 days. In fact, this stage of the non-genital pleasuring should be conducted over a minimum of 7 to 10 sessions with no genital touching at any time. Vary the routine some nights by switching who starts first. You may be tempted to break the rules and say "let’s have intercourse tonight, we can continue this tomorrow". I would suggest you try to avoid immediate gratification now because later you will be the losers.

If you want to try to improve your closeness and your awareness of each other (and I guess that’s why you are reading this topic), you should do your best to follow the rules.

There may be nights when both of you are irritable. At these times try talking about your irritation before starting these exercises. After going through the procedure for the allocated time period, you should be more aware of each other’s pleasure zones and much more in touch with each other’s bodies. Now you will be ready to move on to the Genital Pleasuring which is described in a separate topic.
12. GENITAL PLEASURING

Having gone through the exercises outlined on the previous topic Non-Genital Pleasuring, you have now established the base of slow, gentle, rhythmic touching and you may now proceed to the genital touching. However, don’t confine all your interactions to the genital areas. Remember the pleasure you both gained by giving and receiving pleasure from non-genital touching, and include the whole body in your exploration. In fact genital touching should always be preceded by non-genital touching and should be integrated with non-genital touching. They should compliment each other.

Begin by taking a relaxing bath or shower together as part of your shared love play then focus on the relaxing and sensuous kinds of non-genital touching that your partner appreciates most. If the man is beginning the pleasuring, he may now begin to examine and caress the woman’s breasts very gently. Starting with the nipples you can explore together the ways in which the nicest feelings can be obtained. Press them gently between your fingers, roll them in your palms, kissing, licking, sucking, first gently then firmly, relying on your partner to guide you with verbalizations such as "that’s too hard", or "that’s too gentle, I can hardly feel it" and so on. For some women nipple caresses can be very erotic, while others gain little pleasure. If your partner gets no feeling but nipple caressing gives you erotic feelings then it’s important for both of you to know that it’s only exciting for you and not for her.

The next area to move onto is the genital area. Here you can run your fingers through your partner’s pubic hair, caress her stomach up to her waist, then return to her pubic hair and place both cupped hands over most of her pubic hairs, spreading your hands rhythmically in small circles. Spread the labia majora, that’s the larger lips, with your fingers and explore the genital area. The goal is to feel comfortable with the sight and feel of your partner’s genitals rather than worrying about sexual arousal. Find the clitoris and the clitoral shaft and look carefully at the vaginal lips. Spread the vaginal opening with your fingers and notice the colour and texture of the vagina.
Feel the warmth and dampness and gently insert one finger into the vagina and notice how it feels. As you touch this whole area ask your partner how it feels and tell her how you feel.

If you’re using body oil or lotion spread this all over the genital area to enhance the sensitivity. Now caress the clitoris. Proceed very carefully and gently using your partner’s guidance to show you exactly where to touch. The clitoris is especially sensitive so rather than stimulate it directly, you should run your fingers next to it. As your partner becomes aroused, the clitoris becomes larger and withdraws under the clitoral hood. Direct clitoral stimulation can sometimes cause pain so massage the clitoral shaft thereby indirectly massaging the clitoris. If your partner becomes lubricated and sexually aroused just enjoy these feelings but do not attempt intercourse at this stage.

When it is the woman’s turn to do the pleasuring, use the same technique of beginning with non-genital pleasuring then proceed to the genital area, touching the penis, scrotum, testicles, anus and perineum. You can also rub oil into the sensitive genital skin and with your partners’ guidance learn where the penis is most sensitive and which caresses are most sensual. Your partner should tell you exactly which touching suits him best such as "it’s too dry, use some more oil" or "that’s great when you stroke me there", and so on. It’s important to communicate in this way.

If the penis is flaccid, that’s non-erect, gently and in a non-demanding way, massage and caress it until it becomes erect. Keep your hand on your partner’s penis and enjoy feeling it become erect. Place your hands in a cup-like curve and hold them over the scrotum noticing how the scrotum changes as the penis becomes erect. Let the penis subside by continuing with non-genital touching so that you tease it a little. Be aware of your partner’s feelings as the erection subsides.
Often men become anxious at this point, yet in reality there is nothing to be worried about because an erection can decrease and can be regained without making demands on yourself. Use as much oil as you wish to explore the genital area slowly and thoroughly.

After this exercise, spend time talking with each other about the experience. Talk about your heightened levels of arousal. It is important that you both feel comfortable with non-genital and genital stimulation before you attempt to move on to "Oral Sex" which is in fact outlined in a separate topic.
FEMALE SEXUAL FANTASIES

It would be true to say that, in general, women have a strong fantasy life and indulge in sexual fantasies to a greater extent than men, although few women are willing to admit to this. The fantasy world is the only place where one can be free from inhibitions and one's sexual fantasies can help one understand oneself and one's sexual natures in a way that can be beneficial and constructive both for oneself and for one's relationships.

Fantasy is a way in which we daydream about sexual matters either on our own or when making love. These fantasies can occur in a wide variety of settings and circumstances and can serve to enliven a boring sexual experience or to provide a sense of sexual excitement.

Fantasy starts in the early pre-teen years even though at this stage the content of these fantasies is usually romantic. Many of these early fantasies involve unavailable men such as older boys, film stars and TV heroes. At their height of puberty, most girls will start masturbating accompanied by various kinds of fantasies to enhance their arousal. Some women will find themselves fantasizing quite openly.

Although a fantasy might be thought of as a piece of fiction as opposed to what might actually happen in reality, this is not always so. In some cases a sexual fantasy expresses sexual desire while in others it provokes sexual desire.

In other words, a fantasy doesn't necessarily require acting upon or acting out for fulfilment. Many people regard their fantasies as private and like to keep them to themselves. However, sharing one's fantasy with one's partner can sometimes encourage understanding and intimacy of each other's sexuality.

You might feel fearful of discussing your fantasies with your partner, thinking that he might think you're being cheap or tarty or worried that he might be embarrassed or offended or unwilling to participate.
It is important that one has to be cautious because some fantasies can be offensive and one has to use one’s discretion. It’s obvious that the better one knows one’s partner the better able one will be able to judge whether or not to share the fantasy.

Your partner may in fact react in a jealous way if you tell him that you often fantasize. He may feel threatened by knowing what the content of your fantasy is. He might ask you why you indulge in such activities when you have the so-called real thing in himself and hence he may feel very threatened.

The ultimate goal in sharing your fantasies is to improve your sexual relationship, so if you feel that one of your fantasies may cause negative reactions of jealousy or feelings of being threatened, rather keep that particular fantasy to yourself. Most important is to introduce fantasies carefully and sensitively and stop at any signs of distress. Remember that sharing sexual fantasies must be a mutual decision and that way both you and your partner can achieve the maximum form of heightened sexual pleasure without anyone being offended.

On the other hand, you don’t have to have your fantasies acted out in reality with your partner. You might find that after telling your partner about your fantasy and/or enacting it with him, the value of the fantasy fades. This is a very common occurrence and sometimes it is better to just keep the fantasy to yourself and use it to heighten the sexual arousal as opposed to sharing it.

For some the use of fantasy provides an initial boost to get things under way. Others use fantasy to move from the leisurely low-key sexual level to a more passionate state. Some men and women report that they are unable to be orgasmic unless they use fantasy. Sexual fantasies can enhance both the psychological and physiological sides of sexual response in many ways.
It can counteract boredom, it can focus thoughts and feelings, thus avoiding distractions and pressures, it can boost ones’ self-image, and in ones’ fantasies one can assume ones’ desired physical attributes and need not worry about breast size, body weight and so on. One can also imagine an ideal partner who suits all of ones’ needs.

Sexual fantasies also provide a safe, protective environment for engaging the imagination and letting our sexual feelings roam. Some women fantasize about being tied up and having sex with several men at once while others have fantasies about being taken rather forcibly. These are the kinds of fantasies that the woman would not like enacted in real life. They are the kind of fantasies that absolve her from sexual responsibility and occur in women who feel ambivalent about taking the lead in sexual activity.

The range of ones’ erotic imagination is virtually limitless. The fantasies may be explicit and detailed or sometimes rather vague. One popular type of fantasy is to imagine experiences that you’ve never tried in real life, starring in an erotic movie, or making love in different exotic or public places and so on. Very often, it’s the thrill of the forbidden or of being discovered in the act which is the powerful switch on and many find such fantasies intensely erotic.

Imagining having sex with different people is one of the most common varieties of sexual fantasies for women. If you view such a fantasy as a sign of infidelity, don’t continue with the fantasy. But replacing an established partner with another person is so common that the chances are high that you and your partner have both fantasized in this way. However, it is not always necessary to share this type of fantasy because sometimes it can damage your relationship.

Some women are turned on by the thought of making love with someone of the same sex. That does not necessarily mean that you are a lesbian if you have these fantasies. It’s merely that you might find something erotic or forbidden in this fantasy.
You probably wouldn't be excited by the reality of it. The element of power is a significant element in many sexual fantasies of women. Some women like to imagine themselves perhaps as a schoolteacher or seducing the boss, or a salesman, and so on.

The other side of this conquest fantasy is the idea of being conquered and of being dominated, commanded or being forced to give in to someone else's sexual advances. You might imagine yourself to be a virginal innocent girl seduced by an older man or woman and unable to resist, but becoming extremely excited at the same time. Perhaps you become aroused by thoughts in which you are watching others engaging in sex and in your fantasy you might never join in the action.

Of course there are other fantasies with overtones of romance, tranquillity, in other words, idyllic encounters. You might find they involve meeting a stranger under near perfect conditions, for example, a deserted secluded beach, with just the right ingredients for romance, the sexual attraction may ignite between the two of you and then an ecstatic interlude could follow.

In fact, some women fantasize and hope that their partners might be just a little more romantic and go with them for a nice candle lit dinner or just do something more romantic. The fantasy doesn't have to be more elaborate than that. The most enjoyable element in all this is escapism through which one can lose oneself in another world in one's mind.

Most women do fantasize. Some women fantasize and find this enhances the sexual relationship. Some women who do not fantasize - they report having a wonderful relationship. The bottom line is that you need only do that which feels good and appropriate for you.
14. ADVENTUOUS FOREPLAY

For most couples there are times when intercourse can become routine and predictable. Using imaginative, adventurous foreplay can open up some exciting variations and possibilities.

In fact in adventurous sex, foreplay can often take over from the actual sexual intercourse as the main source of excitement.

Many couples enjoy sharing a meal, or dancing together in the nude as part of foreplay. Many couples enjoy erotic kissing, that is deep kissing with varying intensities and building up to extreme passion.

Many things can be used to stimulate the skin sensually. Some people have specialised tastes for rubber and leather. Most people enjoy the warmth and stimulating effects of fur and feathers.

A stimulating session on a fur rug in the winter months in front of a fire, can be a fantasy come true and a fur brushed lightly over the surface of the skin, can be extremely sensual as can a fur glove used to stroke your partner.

Feathers can be used to stimulate the nipples, the palms of the hands, the soles of the feet and the surface of the skin rather than the genitals directly.

Anticipation is one of the most powerful sexual stimulants. The idea that you are going to become excited or sexually aroused is exciting in itself.

Another type of foreplay is using a light, almost tickling massage, using only the lightest touch of the tips of the fingers and with the eyes closed, the person receiving has to concentrate and appreciate that they are not being touched at all.

The aim is not actually to touch the skin, but to touch the hairs above it and this can be an extremely erotic experience.
Sex is usually concerned with warm things, but for some, the thrilling cold of ice has a special place in foreplay and can have a stimulating affect for many people.

One has to be careful not to use ice directly from the deep freezer. Normal ice, which is on a point of melting, leaves deliciously cool, damp trails across the skin and it is advisable to test the ice on your tongue before you begin.

Ice will certainly stimulate the nipples and many woman prefer to place ice on various other parts of their body, as well as their partner’s body, which can be sexually so exciting.

Blowing on wet skin, automatically produces goose pimples and the resulting tightening of the skin can often be highly arousing.

A tongue massage, or a tongue bath often as it’s called, is another type of foreplay. You can lick your partner’s body all over with your tongue and if you are adventurous, you can go into unexplored nooks and crannies.

One has to be very careful about blowing around the ears when stimulating the earlobes, breathe in instead of out. Slow, self stimulation and mutual stimulation is one of the specialised lovemaking techniques that benefits from one partner being totally passive.

Another fantastic technique is that of teasing. You touch your partner, caress them, excite them to the limit and then withdraw, teasing, until they sort of beg for more, then once again you raise the sexual excitement until it is almost unbearable and then just stop short of the gratification, and then continue.

The female partner can take this further, coming close to her partner and really teasing him, almost offering her body to him and then withdrawing.
Now once the male partner is sufficiently aroused, the female partner could start caressing his body lightly, and blow on him, touch him lightly with her fingertips, or nipples, or brush him with her hair, always moving towards the genitals, but never actually touching and when finally arriving at the genitals, one has to approach with caution because he is probably ready to ejaculate.

Direct genital kisses can also be given, only for a few seconds stopping, then alternating between using hands and mouth in a teasing fashion. Obviously bringing him close to the point of orgasm and then stopping.

Trailing your hair across his body can also be exciting, as can be when you use your tongue, your lips, your hands, breasts, nipples and vulva to keep him well aroused as part of this adventurous foreplay.

When it’s his time to excite his female partner, the important thing is to concentrate on the mouth, the breasts, especially the nipples and the clitoris, but of course using a variety of touching and teasing procedures.

The woman’s mouth and breasts should receive attention first before moving on to the genitals.

Most men enjoy oral sex, and there are plenty of adventurous and advanced ways that this can be done.

Some men like the contrast between hot and cold, that can be given by being stimulated by a woman with ice cubes in her mouth. Others find ice cubes too hard and prefer a woman’s mouth filled with something else, you just need to be creative.

Many woman find that they can use food in very creative, exciting and erotic ways.
Adventurous couples very often dress up especially for their private lovemaking sessions. Again you can relive a favourite holiday event or fantasy. The variations are really endless.

Sensual massage, taking a lot of time, using oil and maybe using furs, leather, feathers, ice and so on can really be exciting.

As mentioned earlier, tongue massage is another type of foreplay. But also use parts of your body that you would never normally think of, for example, your feet and thighs, or a woman can use her breasts and so on.

Many people like to have their genital area stimulated with a vibrator, including men. Some women like their partner to use a dildo as part of foreplay and a woman’s pleasure from a dildo usually varies. Some enjoy it being used as a penis, others enjoy it in a different way.

Experiment with what you both enjoy, that’s the most important thing.

Fingers can play a vital part in adventurous pleasuring, as the hands are a sensitive part of the body, especially the fingertips.

Kissing and massaging the hands tenderly, as well as the palms with a little oil, can be very exciting.

Many women enjoy their partner’s fingers inside their vagina as part of foreplay as well.

Also stimulating the G-Spot, which is the sensitive area found in the front wall of the vagina, can often bring a woman to a climax very rapidly.

As part of the adventurous foreplay, oral sex can be extremely exciting and one has to be pretty varied about this.
Now, how far you can take this mouth play towards orgasm is up to you, but the idea of such adventurous foreplay is to raise the sexual excitement so that both of you want each other so much and cannot wait to make love, but yet if you do wait, certainly for the multiply orgasmic woman, this level of foreplay gives her a chance to reach a climax, perhaps several times before actual intercourse, and then the lovemaking certainly can be even more passionate and exciting.

So, stop, start, and the very nature of adventurous foreplay, makes it last, and distinguishes it from the routine, boring sort of activity that is the forerunner to sexual intercourse for so many people.

Verbal sexual fantasising is a great turn on for most couples. Learn about each others fantasies, take turns to talk to each other when pleasuring each other prior to sexual intercourse.

Many people know just how to bring their partner to climax by just telling them the right story in the right way.

So, this sort of adventurous foreplay really enhances the lovemaking between couples and such adventurous foreplay takes time and effort to practice and certainly is worthwhile.
.15. **BETTER SEXUAL TECHNIQUES FOR WOMEN**

Whether you are in an existing long term relationship or involved with someone new, most women want to be better lovers but juggling a career with being a wife and/or mother and dealing constantly with domestic issues can put a huge strain on your sex life.

Trying to be a better lover and keeping the spark alive therefore has to be constantly worked at, and you have to plan your love life as you do other aspects of your life, to make time for sex. The minute you become complacent, because your partner says your sex life is fine or great, the relationship is at risk.

Try and get away from predictable sexual patterns and habits of behaviour especially if you are married or have been together with someone for a long time.

Too many women expect the man to lead the way, to initiate sex each time. Most men find it incredibly exciting if their partners make sexual advances from time to time.

The build up or expectation of sex is a great turn on. You could try a seductive phone call to your partner at his office. Tell him he is on your mind and how much you want him, that you can hardly wait until he gets home.

Carry on the so-called 'teasing' at home. Prepare a romantic dinner for him, making prior arrangements to see to it that you will not be interrupted. Put on some romantic background music. Dim the lights, you can even use candles, wear sexy underwear or leave the underwear off and suggest to your partner that you are naked underneath you dress. Remember also, that touch is a powerful aphrodisiac as is eye contact. You might even find that he can't wait until after dinner.

Some men say that they enjoy their partner's doing a strip for them. If you feel comfortable doing this, it can be the most erotic thing you've ever done.
Undress very slowly, perhaps leaving stockings and suspenders on, then brush your body lightly over his. Continue to tease, to seduce, make it last, even if he begs you to go faster.

Remember it's the surprise element that seldom fails to excite a man. You know men are more visually orientated which is obvious from the dozens of girlie magazines available for them to look at.

You could be his very own centrefold, and always make sex fun and exciting. Many men enjoy watching erotic movies and videos. Watching them together can be highly erotic if this is okay for you.

Men also enjoy seeing their partner getting sexually aroused, and a lot of men get turned on by watching their partner stimulate themselves. You might also want to show him that you are getting sexually aroused when it is appropriate, and, if you feel confident about masturbating in front of him, do so. He might learn something about the way you like to be touched.

As regards oral sex, most men enjoy this form of loveplay, so try to overcome your inhibitions about performing fellatio. Men love having their penises sucked and licked and can become helpless when a woman does this for an extended time.

Treating your partner to an all over body massage, using natural scented oils, can be a most pleasurable and intimate experience for both of you.

Men love being spoilt by their partners. They like to feel loved and adored, it also may increase their sense of masculinity.

Perhaps run a bath for him, wash him all over, teasing and soaping him all over, really spoil him from time to time. Then you can take him to the bedroom for a sensual massage. Rubbing the oil in your hands and mapping out the contours of his body with your hands.
Alternate kneading him firmly and stroking him gently. Towards the end, you can slide your own body up and down over his. This can be highly arousing.

Massage is a wonderful way to prolong foreplay and to reach maximum arousal for both of you before lovemaking. Extend the genital stimulation as part of the sensual and erotic massage. It can be highly exciting.

Sex in different places can also be exciting. Or you might enjoy quickie sex from time to time, providing it’s not really part of a regular pattern.

It’s also very important that during sexual intercourse, that you move, that you are more active. There is one thing that men do not always like and that is for their partners just to lie there and to be passive.

So it’s important for you to move your pelvis rhythmically, that is sure to excite your partner and also something very important is to learn how to tighten your vaginal muscles. This is very important, because it certainly can contribute to heightened sexual pleasure for both of you.

Like everything else in life, you have to work at making your sex life more exciting and perhaps even magical. Merely thinking of different ways to really excite your partner will help your own sensual arousal and if you are aroused, your partner is sure to sense it and respond to it accordingly.

Do things that are different, that are exciting. Spring erotic surprises on your partner, be imaginative and creative.
16. **EROTIC KISSING**

The mouth is highly responsive, second only to the genitals on the sensitivity scale. With all the potential enjoyment and excitement to be derived from oral contact, kissing techniques are clearly of great importance in lovemaking.

Kissing should not be restricted to mouth to mouth contact. The mouth is perfectly equipped to feel and taste every crease and crevice of the body.

Kissing your partner’s erogenous zones is the most intimate and stimulating act of foreplay.

You may start perhaps with the feet by kissing both of them all over. Give sexy soft kisses to the sensitive arch of the instep, and on the toes, in fact sucking the toes can be extremely erotic for many.

Caressing, massaging, licking and sucking the fingers and the palm of the hand can also be highly erotic. A responsive area is also to be found behind the knees. Here you can have more forceful kisses.

Continue kissing up the inside of the thighs and enjoying the rapid kisses all over the inner thigh certainly is going to excite both of you.

Kissing the buttocks with sharp, strong kisses, and tracing the spine with your tongue, as well as the shoulders and neck, will certainly increase the desire. Alternate soft and firm kisses on the back of the neck and also nuzzling the ear lobes, can be very exciting.

Some women’s breasts respond far more to oral caresses than to any other. Some women enjoy their partner’s taking as much of their breasts into their mouths as possible, then taking the nipples gently between their partner’s teeth and flicking the tongue back and forth across its hardened tip.
The ancient Chinese, Japanese and Indian love manuals go into great descriptions of kissing, for example, the neck, or nape kiss, here the woman covers her partner's eyes with her hand and then closing her eyes, thrusts her tongue into his mouth in a series of deep, slow, rhythmic movements, which are intended to simulate the act of intercourse itself.

Then there is the upper lip kiss, where she takes his lower lip between her teeth, then chews and bites it gently. He does the same with her upper lip.

Then there's the awakening kiss, here one of the couple, on finding the other fast asleep, presses their lips to them and gradually increases the pressure until they awake.

It is important to tell your partner when you find something particularly exciting or sensitive.

There are other areas that are equally and sometimes more acutely erotic, like kissing the back of the neck, the ears, the sensitive groin, not just the vulva and the clitoris, but the back of the knees, and the toes as well.

Encourage your partner to explore your body and to vary the way in which he or she uses his or her mouth, so that the most powerful sensations are created.

A man's nipples can be as sensitive and as erectile as a woman's. Many men may be surprised by the new sensations aroused by oral stimulation on their navel, inner thigh, scrotum and perineum.

Take time to kiss each other deeply and this will certainly help keep the relationship caring and passionate.
Run the tip of your tongue around your partner’s lips, inside and out and then over and around his or her tongue. Gently kiss the corners of your partner’s lips, keep going from one side of the mouth to the other, until your partner demands you go further. Many little kisses planted on your partner’s parted lips, can be really exciting.

Push your tongue hard into all the furthest parts of your partner’s mouth. Finally, with your mouth held over your partner’s, thrust in and out with a strong sort of stabbing movement. Many couples find this extremely exciting, especially when accompanying sexual intercourse.

Ancient writings on love making skills, emphasise the importance of deep, erotic kissing, so long as both the man and the woman enjoy it, they should kiss deeply as often as possible.

To carry out successful oral sex, a woman must learn to relax her mouth. If she is tense or stiff, she will not be able to use her lips to shield her teeth and may hurt the penis.

As regards Cunnilingus, the man performing oral sex, by kissing, sucking, licking the female genitals, it’s important to vary the pressure.

The advantages of erotic kissing, and learning to know how to kiss all the parts of the body properly, is a relatively simple but important matter, simply because there are no obstacles to overcome in kissing, such as premature ejaculation, impotence or lack of lubrication.

A passionate kiss can be even more gratifying than routine sexual intercourse. It is therefore important to understand how to use your lips and mouth for mutual pleasure and benefit.

To improve erotic kissing, firstly the facial muscles should be relaxed. Relaxation of the mouth and the tongue, makes erotic kissing possible because only then can you enter into a rich, pleasurable contact with your partner’s lips and tongue.
A tired, tense mouth loses a great deal of sensitivity, and when this happens, much of its sensuality is in fact lost, because of the poor contact and empty space it creates. Remember the less empty space there is in your mouth when you are kissing deeply, the more enjoyable the pleasure will be.

Pay special attention before making love, to seeing to it that you are both perfectly clean and do not have bad breath.

Finally as regards the teeth, they also have a part to play in erotic kissing. From time to time you can nip your partner’s lip or tongue, always very lightly so as not to hurt. Biting or nipping is really most effective on the ears, neck and shoulders and many men and women find this highly exciting, especially during intercourse.
17. EROGENOUS ZONES

The many special erogenous zones your partner has, and that you have, can take a lot of finding, but becoming aware of them will definitely turn your lovemaking into something really exciting and special.

Firstly I will just outline the basic erotic areas before talking about the more highly charged erotic areas.

There are many parts of the body, that can be extremely erotic. Stimulating various parts can also lead to orgasm in both men and women.

Some of the areas include the mouth, the lips, the tongue, which have high erotic potential. The buttocks, the inside of the thighs, behind the knees, for some the eyelids, the neck, the earlobes, the fingers and the toes. All respond differently for each individual to blowing, sucking, stroking, massaging, kissing, touching and various other types of caressing and touching.

What you would need to do is to experiment with various types of caressing, stroking and so on, on these various bodily parts.

Now there are some erogenous zones that are universal in their appeal for men.

The most obvious area is the penis. On the underside there is a little ridge of tissue that almost runs the whole length of the head from the rim to the tip. In uncircumcised men, it will be necessary to pull back the foreskin to reveal this. The area is also called the Frenulum and is highly erotic when stimulated. During intercourse, the woman's vaginal muscles caresses this part when it lies deep in her pelvis. Most men find that stimulation of this spot gives them an erection very quickly, especially if the area is made moist by vaginal juices. Your partner can use her tongue or a very wet finger to flick the ridge from side to side.
Another area that is highly erogenous is the scrotum, in other words, the skin bag housing the testicles. Along the mid-line there is a dark coloured ridge. If you run your finger tips or even finger nails very gently, along this ridge your partner will be delighted with the sensations.

Another area is that between the root of the penis and the anus and this is called the perineum. Many men like this area being gently massaged. It is a far richer source of pleasure than most men actually realise.

Men also get great pleasure from using a vibrator on these particular areas.

Further around is the anus, which when stimulated gently, can be highly arousing for many men. See to it that it is clean and fresh and try various methods of stimulation.

Let's look at the erogenous zones in women now.

Much has been written about the G-Spot and many women worry that they have failed to find it. It is situated in the front wall of the vagina.

Stimulating the G-Spot can produce sensations of wanting to pass urine, so see to it that you go to the toilet first before stimulation, and once your bladder is empty, you will know that this cannot be the reason for the sensations that you are experiencing. Once you become used to the sensation of caressing your G-Spot, you will enjoy it without the feeling of wanting to urinate.

You can insert 2 fingers and stroke up the wall. It can be quite high up the vagina, but obviously it varies from person to person. Generally speaking, it's about 5 to 6 cm's up. Practice with deep, firm pressure until you find what feels best.
Once you have mastered finding it, ask your partner to do so. Sensations vary a lot when the G-Spot is massaged. For some women it produces a very powerful orgasm and for others, very little sensation is experienced at all.

While you are exploring the vagina it is worth feeling around for other pleasurable spots. As you are moving the fingers, try massaging the opening of the vagina. Rub the areas gently but firmly, apply pressure or you can even use a vibrator, do whatever gives you the best sensations.

The main centre of sexual pleasure for most woman is the clitoris. Once located, remember it changes as your arousal cycle progresses. Most women find they get the best orgasms from clitoral stimulation. Many women use direct clitoral stimulation and others use a more indirect type of stimulation.

Also, do not forget the anus, because as in the case with men, there is a lot of sensual pleasure that can be derived from stimulation there. Make sure it is clean.

Do take care not to insert anything from the anus into the vagina as infections certainly could occur.

It is also important not to ignore the nipples. For most women these are one of the most erotic spots and for a few, nipple stimulation is enough to bring them to orgasm, but most need genital caresses as well. Some men as well, really get highly aroused from nipple stimulation.

Some women like the whole breast being sucked into the mouth, whilst others only like oral stimulation to the nipple. Do what you enjoy most.

No two bodies are the same and everyone likes to be touched in a different way, so it is important to learn what your partner likes and to teach each other where and how you like to be caressed.
18. **ORAL SEX**

Oral genital sexual expression is one of the most intimate, pleasurable and satisfying ways of being sexual. As with any sexual experience, you will have individual differences and preferences in oral genital sex.

Fellatio is the proper term for the woman orally stimulating the man and Cunnilingus for the man orally stimulating the woman.

Simultaneous performing of Fellatio and Cunnilingus by 2 people to each other is known as "69", representing 2 people lying head to toe.

Oral sex can be used as a complete sexual experience in itself, with either or both partners being brought to orgasm. More often it is used as a part of foreplay before genital intercourse takes place.

For many women, Cunnilingus is more exciting than intercourse, lubrication is more readily provided by the mouth and the vagina and the man has more control over his mouth than his genitals.

For a man Fellatio is particularly exciting because it is so different from conventional intercourse. It is also an extremely effective way of restarting a man for a second round of lovemaking.

Problems can arise in a relationship when one partner wants oral sex and the other refuses. Whether it is through embarrassment, fear or ignorance, this can put real pressure on a relationship, even though in every other way it may be very good.

What a couple decide to do in bed is a matter of personal preference and what feels right for both, not just one of them, at the time.
Oral sex, apart from providing pleasure, can on certain occasions be the most practical way to make love. For example when vaginal penetration is inadvisable, and it can also be helpful if the man ejaculates too soon and wants to bring his partner to orgasm.

Oral sex can help solve certain sexual problems.

Women who were thought of as being unorgasmic have enjoyed multiple orgasms from oral sex.

Men with erectile problems are able to satisfy their partner with Cunnilingus and some have been helped by Fellatio to overcome their sexual problems.

Although it is often thought that a woman kisses and sucks a man’s penis because it is so pleasant for him, many women do it because it gives them such intense sensations. In fact a few women find it so arousing that it gives them, as well as their partner, an orgasm.

The only preparation necessary for Fellatio and Cunnilingus, is to make sure that both your genitals are clean.

One needs to practice Fellatio in a comfortable way, as the penis goes in and out of the mouth and obviously the secret is to keep the teeth well out of the way at all times, alternating between the penis and the mouth and running the tongue up and down the length of the penis can also be very exciting.

You need to be creative in terms of how you will lick, and suck the penis and also be guided by your partner as to how much he is enjoying and what it is that he is enjoying.

If you have decided not to take semen into your mouth, you will soon learn to tell when he is about to ejaculate and hence take the penis out of your mouth.
Many couples do not take Fellatio to the extent of ejaculation but use it to one stage short of this, as a form of foreplay, which would then be followed by sexual intercourse.

As a re-arousal technique, Fellatio is also very useful, even the most reluctant, or fatigued penis can be brought back to life within a couple of minutes of tender and skilful oral caressing.

Performing Cunnilingus is often much more difficult than performing Fellatio. Almost all men will become erect and will ejaculate quickly with adequate oral stimulation.

For women things can be very different and this is largely due to the fact that women’s sexual responses are more variable.

You may work your way around the whole vulva area, kissing that area, from the larger lips to the inner lips. You need to be creative, in terms of using your tongue and lips, in general and in particular, around the clitoris.

Some women do not like the actual clitoris itself being licked or sucked, while others enjoy very firm sucking and tonguing motions as they near their climax.

Some women also enjoy a couple of fingers being inserted into the vagina as arousal increases and as orgasm becomes inevitable.

Check out with your partner what it is that she enjoys. Many women greatly enjoy fondling their partner’s genitals as they are being kissed in this way. See to it that you are in a position in which all of this can happen.

With some couples where the woman has difficulty in having an orgasm in every other way, oral sex may give the man the pleasure of seeing his partner being aroused and orgasmic if all else has not worked, and this can be really enjoyable to both.
One needs to get into a comfortable position. Put a pillow under your partner’s buttocks to raise them, caress her a lot before moving to the genitals, kiss all around the area and slowly get closer to the clitoris. Don’t make a dive right for it, right at the beginning.

Never bend the penis too far downwards. This can be very painful. You need to stoke the whole area gently.

Understanding more about oral sex can help couples to relax and fully enjoy the experience more. For many the culmination of sensual mouth play is mouth to genital contact.

But the idea of oral sex is still surrounded by taboos and embarrassment for many. Oral sex includes licking, nibbling, kissing and teasing with the lips and teeth. If the woman is nervous she need not take any more of the penis into her mouth than suits her. It’s also worth experimenting with positions where the woman is most in control of the angle and depth of entry. Unlike intercourse, he does not have to concern himself with thrusting to increase the woman’s pleasure, he allows his excitement to build up gently.

If the woman is taking her partner’s penis as fully as possible into her mouth, she can either cover her teeth with her lips or keep her mouth open as wide as she can. If one partner is nervous about the teeth problem, it is best for the woman to use her mouth in other ways to stimulate the penis.

As a form of lovemaking, it offers 2 distinctly different pleasures, one to the giver and one to the receiver. Using your mouth to discover your partner’s body is a unique sensation as you experience the way the skin’s texture changes.

Every couple develops their own style of giving pleasure with oral sex. Always be really clean before giving or receiving oral sex. Wash your genital area every day, especially before making love.
The following are considered to be the most favourite and basic sexual positions. There are numerous others, often variations on these positions which I will now outline.

Firstly, the missionary position.

Without a doubt the most pleasurable position for most women, according to surveys, is the missionary position. The woman lies on her back with her legs apart, either flat on the bed or drawn back upwards, towards her chest and the man lies between them and penetrates her, taking his weight on his hands or elbows, on the bed on either side of her.

Women say that this is pleasurable for many reasons. It is relatively tame, so that it also is romantic, because the couple face each other and it's also good for kissing.

The man has control of thrusting, which is good, if one is still a bit uncertain, fearing that ejaculation might happen too soon.

It also helps the man who needs a lot of thrusting to maintain his erection and it's a position that invites imaginative variations.

Women on top positions are preferred by the woman who likes to take the initiative and the man who likes to watch his partner during lovemaking.

The man lies flat on his back and the woman kneels with her knees either side of his hips. She then lowers herself onto his erect penis and he can caress her breasts, her thighs, her buttocks and at any time she can lean forward to kiss his face, lips or chest.

The advantage of this position is that the woman can be in control, and many men find this highly arousing. One of the nicest things from the woman's point of view is that she can angle her body so as to get her partner's penis exactly where she likes it.
Often the woman whose front vaginal wall is sexually sensitive, can experience an orgasm during intercourse, only when she is on top. The front vaginal wall is where the sensitive G-Spot is to be found.

Another advantage of this position is that it leaves the woman's hands free to stimulate herself if she wants by leaning back while sitting on the penis, she can even play with her breasts and nipples or even caress her clitoris to bring herself to an orgasm.

For the women who finds deep penetration painful, this position can be ideal because she can control the penetration and the speed of thrusting.

Many couples enjoy the rear entry position. The most common is where the woman kneels on all fours and the man enters her from behind. The advantage for the woman is that she is in the position where she can experience the maximum depth of penetration and very often, excellent G-Spot stimulation.

Another variation of this position is with the couple lying on their sides, like spoons.

A woman can turn her head so that she can kiss her partner and he can caress her breasts with one hand and her clitoris with the other.

In this position, the couple get the added enjoyment of a large area of their bodies being in contact.

Side entry positions can also be stimulating with the woman lying on her back and putting one or both legs over the man's hips. Here he has one hand free to caress her breasts or her clitoris and she can twist towards him to kiss and hug.

Both partners are free to move around and get maximum genital stimulation.
So these are a few of the basic styles. People have different and favourite love positions but if sex is not to become boring, it is important to experiment a little.

The majority of couples stay with their 2 or 3 favourite positions for most of their married life together and there are endless variations in the search for better sex.

There are many different ways in which a man can penetrate his partner and how he does so will vary from partner to partner and within the same relationship, according to the woman’s weight, height, and whether she is pregnant, her level of arousal, and the time of the month and so on.

Movement is the second most important feature of sexual intercourse. Women can move in all kinds of ways during sex, including thrusting, rotating the pelvis, teasing the penis by allowing it only to enter a little at the entrance and so on.

A woman can contract her vaginal muscles and her deep pelvic muscles to increase excitement and this can be achieved in almost any position. This is a very important exercise. It is in fact exercising the "Love Muscles".

As couples become more adventurous they can find other ways of positioning themselves to produce new sensations.

The adventurous couple need never be bored and can go on creating new lovemaking positions, year after year.
.20. NOT INTERESTED IN SEX?

Inhibited sexual desire is a lack of interest in sex or an inability to feel sexual or to get sexually aroused. There may also be differences in desire between two people in a relationship which can result in dramatic personal or relationship conflicts. Inhibited sexual desire may not be a serious problem, indeed, most of us have suffered at one time or another from periods when we felt little or no sexual desire. However, it can become a serious problem when prolonged periods of not being interested in sex lead to feelings of anxiety, guilt and stress within a relationship.

People who suffer from inhibited desire, whether temporary or prolonged, find that their ability to get sexually aroused diminishes or disappears altogether. Although they may occasionally engage in sexual activity, they have sex less often than they once did and find it less pleasurable, more mechanical, and more like hard work than play.

What are your concerns? You may be feeling anxious about your lack of interest in sex. You may be avoiding sex as well as any physical contact or emotional interchange you think might lead to sex. You might be arguing with your partner and feeling inadequate or guilty for not being an enthusiastic sexual partner. Alternatively, your partner may not be as interested in sex as he or she was in the past, and you feel the need for some reassurance and some way which you can understand the reasons for this reluctance.

Most people with inhibited sexual desire fall into at least one of the following categories. See which apply to you or to your relationship:

1. Couples with different levels of desire, for example a woman who would gladly have sex once a day, or a man who is more than satisfied with sex once a month or vice versa. These sort of couples get trapped in seemingly endless cycles of invitations and refusals, seductions and rejections.
Conflicts about when or whether or not to have sex spill over into their relationship outside the bedroom. Feeling frustrated and inadequate, the individual with greater desire may become preoccupied, even obsessed, trying to seduce the partner with less desire into bed. Feeling pressured, misunderstood and angry, the partner with the lower drive finds that desire decreases even further.

2. Couples experiencing significant relationship conflict in general. In this situation feelings of anger, emotional pain and disappointment, along with the tense atmosphere that is generated when unproductive fighting occurs, make it difficult for partners to draw close to each other and establish emotional or physical intimacy.

3. Couples with inhibiting lifestyles. Upwardly mobile individuals with high-pressured careers and high personal standards, are particularly susceptible to inhibited sexual desire. This is in fact a common occurrence today. Couples are too exhausted, under too much stress and too preoccupied with other matters to develop an interest in sex and to find the time or energy for it. When they realise that the frequency and quality of sex as well as their interest in it have dramatically decreased, they often panic and, because of their high expectations and drive to succeed at all they do, they try everything they can to try and solve the problem, creating additional stress and anxiety, which only further dampens sexual desire and satisfaction.

4. Men and women suffering from depression which, along with the general apathetic attitude to once enjoyable activities, leads to a loss of sexual appetite. This would include divorced or recently widowed people of all ages who are still grieving over their loss, and who fear that getting close will once again lead to rejection and pain.
5. Single men and women who have difficulty in finding suitable partners and who fear the possibility of sexually transmitted diseases. These people often learn to block out their desire for sex and often distract themselves with work, food, shopping, watching T.V., exercise and other non-sexual pursuits.

6. Men and women who feel pressured to perform sexually and who fear that they will not perform well enough because of a failure to perform in the past. As a result they avoid sexual situations and social situations which can lead to sexual ones.

7. Men and women who fear intimacy and try to avoid becoming vulnerable, making a commitment, or risking rejection by repressing sexual desire altogether or acting upon it only in casual, impersonal sex encounters.

8. Lastly, young married couples from strict, religious backgrounds, who have no experience with sex and very little information about it.

In general there are two categories of people who display inhibited sexual desire: those who have never felt like sex and can't be bothered with it now, and those who used to be interested in sex, but no longer feel the same level of desire. By far the majority of people belong in the second category, so perhaps I should discuss this in more detail.

Why do some people find that they are no longer interested in sex and what can they do about it?

For many people, common life events can have a detrimental effect on sexual desire. The birth of a child and the stress caused by having growing children in the family. Financial problems and the consequent worry of making ends meet. Prolonged sickness or a stressful job. All these can lead to decreased sexual desire.
Then there may be more personal problems, such as, boredom with the same sexual routine, an ongoing argument which is an indication of something wrong with the relationship, bad breath or unwashed bodies, or a lack of communication between partners.

It is important to realize that what is happening in your life directly affects your sexuality. Once you have recognised what is wrong it is time to take steps to do something about it. As a couple you need to be realistic about the need to plan sex and to make time for it. Just as you plan your busy work schedule and arrange your children’s activities, so you should make the time to be together as a couple and to plan for sex. Too many people are of the opinion that sex should be a spontaneous affair which needs no preparation. This is an unrealistic idea. Just think about when you most often make love. Isn’t it late at night, when the children are in bed and you are both drained and exhausted? Arguably, this time of night is the worst time for making love unless it is carefully planned and prepared for by creating the right atmosphere and ensuring that both of you are relaxed and in the right mood.

The other factor in addressing the problem of low sexual desire is communication. Too many couples do not tell each other what they like and don’t like. Don’t be afraid to talk to your partner about what turns you on. You may try to watch an erotic movie together and discuss which parts that you both found most arousing. Women respond differently at different times. Don’t be shy to tell your partner that perhaps tonight you want your breasts stroked in this way, or that you find this irritating and would rather have a back massage, and so on - be specific.

Finally, check on your current state of health and fitness. It is important that you get plenty of exercise to help you cope with stress (providing of course that you have your doctor’s permission first). Watch your diet and avoid those foods that are unhealthy. Try not to combat your stress by drinking and smoking too much. Take the time to be alone with your partner, when just the two of you can be together, and don’t allow boredom and monotony to enter your relationship.
Don’t make sex goal-related. There are many ways of having sexual interaction which include slow massage, bathing together, having a candlelit dinner, getting to know each other’s bodies, and many more erotic and sensual activities you can enjoy together. Try having some fun - perhaps even doing something different and out of the ordinary.

As you can now understand, inhibited sexual desire is a complex and varied condition experienced by many people in different ways, to different degrees and for different reasons.

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APPENDIX U.

SELF-HELP PROGRAMME

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<td>15. BETTER SEXUAL TECHNIQUES FOR WOMEN</td>
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<td>16. EROTIC KISSING</td>
<td>56 - 59</td>
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<td>17. EROGENOUS ZONES</td>
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<td>18. ORAL SEX</td>
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<tr>
<td>19. LOVEMAKING POSITIONS</td>
<td>67 - 69</td>
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<td>20. NOT INTERESTED IN SEX?</td>
<td>70 - 74</td>
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</tbody>
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You and your partner may go through these topics as often as you wish. The above will help you locate specific topics. You are advised to make notes of certain suggestions and exercises before you actually begin the Self-help Programme.
APPENDIX V.

CONTROL GROUP FOLLOW-UP LETTER

"DR PAUL"
P O BOX 1347
HIGHLANDS NORTH
2037

DEAR "DR PAUL",

The Self-help Programme is now available and will be sent to you within the next week. Thank you for your patience.

Owing to the fact that nearly two months have elapsed since you first completed the Questionnaire, I am appealing to you, to assist me by completing the Questionnaire, once again.

This may be a hassle but as this is a Research Project assessing the effectiveness of a Self-help Programme - it is important for the Questionnaire to be completed just prior to you commencing the Self-help Programme.

The Self-help Programme together with guidelines will definitely be sent to you within one week. PLEASE would you kindly complete the enclosed Questionnaire and return it to me in the enclosed, stamped self-addressed envelope within 2 days - it is important that I receive this completed Questionnaire before you receive the Self-help Programme, which should reach you within a week.

I hope that you will find working through the Self-help Programme both interesting and beneficial.

Thank you for your kind cooperation.

Kind regards.

Your sincerely,

"DR. PAUL"
APPENDIX W.

POST-INTERVENTION LETTER SENT TO THE THREE EXPERIMENTAL GROUPS

"DR PAUL"  
FEMALE SEXUALITY RESEARCH PROJECT  
P O BOX 1347  
HIGHLANDS NORTH  
2037

Dear

In order to assess the effectiveness of the Self-help Programme, I am once again appealing to you to complete the QUESTIONNAIRE. There is an additional PROJECT EVALUATION QUESTIONNAIRE which I would also appreciate you completing.

Your comments and criticism (both positive and negative) are crucial to the completion of this entire Project.

I sincerely hope that you have enjoyed participating in the Self-help Project and that you have benefitted, in some way.

Please would you kindly complete the QUESTIONNAIRES as soon as possible i.e. within two days and return it to me. It is most important for me to evaluate this Project scientifically. Your prompt response will enable me to do this before the school holidays.

I thank you for your willingness to participate in this unique Project.

I would like to wish you and your dear ones SEASONS GREETINGS and a HEALTHY, CONTENT and PEACEFUL NEW YEAR.

Kind Regards,

"DR. PAUL"
The following evaluation has been designed to gather important information regarding the Self-help Project. Your responses are most important. Please take some time to answer all the questions honestly and frankly.

Your cooperation is greatly appreciated. Thank you.

1. What three things did you find most beneficial about the Self-help Programme?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

2. What three things did you find least beneficial about the Self-help Programme?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

3. Did any aspect of the Self-help Programme cause you any distress? YES/NO Elaborate:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

4. Did any aspect of the Self-help Programme cause your partner any distress? YES/NO Elaborate:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

5. How involved and cooperative was your partner? _______

________________________________________________________________________
________________________________________________________________________

6. Which topics did you enjoy most?

________________________________________________________________________
________________________________________________________________________

7. Which topics did you enjoy least?

________________________________________________________________________
________________________________________________________________________

8. Which topics were most helpful?

________________________________________________________________________
________________________________________________________________________

9. Which topics were least helpful?

________________________________________________________________________
10. How did you go about doing the Self-help Programme? (eg. setting up a schedule ...) _______________________

                                                                                                           

11. How much time did you spend on the Self-help Programme during the past 6 - 8 weeks?

Time per week (approximate): _______________________
Total time: _____________________________________

12. What specific exercises/suggestions did you go through?

                                                                                                           

13. What specific exercises/suggestions did you and your partner go through? ____________________________

                                                                                                           

14. Following the Self-help Programme has there been an improvement in the following:

(i) Your lovemaking in general? (More creative, less inhibited ...) YES/NO Elaborate: ___________________

(ii) Your general and sexual communication? YES/NO Elaborate: ____________________________________

(iii) Your attitude towards masturbation/self stimulation? YES/NO Elaborate: _________________________

(iv) Your specific sexual techniques? (eg. kissing, foreplay ...) YES/NO Elaborate: __________________

(v) Your general understanding of your sexuality? YES/NO Elaborate: _________________________________

ORGASM/REACHING A CLIMAX

Following the Self-help Programme:

15. If you never or rarely reached a climax are you now able to reach a climax? YES/NO Elaborate: ________________
16. By what means are you now able to reach a climax? (Tick)
   (a) Sexual Intercourse
   (b) Sexual Intercourse and Clitoral Stimulation
   (c) Through Self Stimulation
   (d) Partner Stimulation
   (e) Oral Sex
   (f) Other means (specify): ___________________________

17. If you previously had difficulties in reaching a climax on a regular basis, or were unhappy with the way in which you reached a climax, has this now changed? YES/NO Elaborate:

18. Are you reaching a climax more regularly than before? YES/NO Explain: ______________________________________

19. Further comments regarding aspects of your orgasmic response (eg. satisfaction, method, frequency, intensity, difficulties .......

20. Have you discovered other ways of reaching a climax? YES/NO Explain: ________________________________

21. Has your present level of general sexual satisfaction changed? YES/NO Elaborate: _______________________

22. Following the Self-help Programme has there been any change in your sexual fantasies? (eg. frequency, content....) YES/NO Elaborate: ___________________________

23. If you faked orgasm before, has this changed? YES/NO Elaborate: ________________________________

24. What is your biggest disappointment (if any) regarding the Self-help Programme? ______________________
25. What is the most important thing you have learnt from the Self-help Programme? ____________________________

26. Please comment on the topics in general (content, length, presentation, etc. ....) ____________________________

27. What is the biggest drawback of such a Self-help Programme?

28. What is the biggest advantage of such a Self-help Programme? ____________________________

29. If your difficulty has not been sufficiently helped, would you now consider going for sex therapy? YES/NO _____

30. What other specific topics should have been included in this Self-help Programme? ____________________________

31. Was the time allocated to carry out the Self-help Programme adequate? YES/NO Elaborate: ____________________________

32. Your thoughts, comments and feelings as regards completing the QUESTIONNAIRES: ____________________________

33. Would you have preferred the Self-help Programme to have been presented differently? eg. a WRITTEN MANUAL ____________________________

34. Has your partner commented on any changes as regards your sexual relationship? YES/NO Elaborate: ____________________________

35. Further Comments: ____________________________

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________