Incorporating Mindfulness into an Internet-Based Intervention for Female Sexual Dysfunctions

by

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Abstract

This thesis explores the use of manualised treatments for female sexual dysfunctions (FSDs), with a particular focus on internet-based treatments. Due to the embarrassment that can surround FSDs, online interventions offer an anonymous and private treatment alternative. To date, only one previous controlled study has evaluated the effectiveness of an internet-based treatment for FSDs, and findings from this study offered preliminary support for this approach to FSD treatment. This thesis presents four articles focusing on the development, implementation and evaluation of a new online cognitive–behavioural therapy program for mixed FSDs - the PursuingPleasure (PP) program. The PP program consisted of sensate focus, communication exercises, and unlimited email contact with a therapist, and extended upon prior research by being the first online treatment for sexual dysfunctions to incorporate online chat-groups and mindfulness training. The first article reviews the importance of psychological treatments in the area of FSDs, and specifically explores the benefits and challenges of using manualised treatment programs for FSDs. The second and third articles present quantitative data on the effectiveness of the PP program for both sexual and relationship functioning. Lastly, the fourth article provides a qualitative exploration of the content and usefulness of the online chat-groups that were included in the PP program. Finally, this thesis presents a discussion of the quantitative and qualitative data collected over the implementation of PP, the challenges encountered while administering the online treatment, and implications for research and treatment in the area of FSDs. Limitations of the PP studies and recommendations for future research are also discussed.
Chapter 1

Classification, Prevalence and Etiology of Female Sexual Dysfunctions

Sexuality is an important aspect of women’s lives (Mimoun & Wylie, 2009). Female sexual problems, and the distress associated with them, can have a negative impact on women’s lives and the lives of their partners. In order to understand female sexual dysfunctions (FSDs) it is important to have an understanding of normative female sexual functioning, as well as the causal and maintaining factors involved in the development of FSDs. This chapter provides a conceptualisation of normative female sexual response and presents the current FSD classification system. The prevalence of FSDs are then considered, followed by an exploration of medical and psychological etiological factors.

Female Sexual Response

Models of female sexual response aim to provide a representation of normative sexual functioning, from which assessments of dysfunction may be based. The most influential model of female sexual response emerged from the work of Masters and Johnson (1966). Their model views the female sexual response as a linear process occurring over four distinct phases - arousal, plateau, orgasm and resolution – and does not include the desire phase of the sexual response cycle. However, in 1979, Kaplan established the triphasic model of female sexual response which includes a phase of sexual desire, as well as arousal and orgasm. Masters and Johnson’s model and Kaplan’s triphasic model form the basis upon which the Diagnostic and Statistical Manual of Mental Disorders-4th edition-Text Revised (DSM-IV-TR; APA, 2000) classifies sexual dysfunction.
Both of these models of female sexual response have been criticised for their linear structure, their focus on genital responses at the exclusion of other relevant aspects of sexual response, and their application of a male sexual response model to female sexuality (Basson, 2000; Leiblum, 1998; Tiefer, 1991). Both models also lack sufficient empirical support and validation (Basson, 2000; Giles & McCabe, 2009). To address these criticisms, Basson (2000) developed a circular/feedback sexual response model that incorporates a nonlinear structure, non-sexual motivational factors relevant to females, and both spontaneous and responsive sexual desire. Although this model has not been incorporated into the DSM-IV-TR classification system, preliminary evidence supports the use of a modified circular/feedback model of female sexual response for women with FSDs because of its inclusion of intimacy-based motivational factors (Giles & McCabe, 2009). A circular/feedback model also better explains the common observation of dysfunctions occurring over multiple phases of the sexual response (Jones & McCabe, 2011; McCabe, 2001).

As demonstrated by this brief history of female sexual response models, the conceptualisation of what constitutes sexual normality, and the way this is represented, changes over time. While these models represent theoretical pathways that are subject to cultural influence and bias, they are nonetheless utilised in the current classification, diagnosis and treatment of FSDs.

Classification and Diagnosis of FSDs

According to the DSM-IV-TR (APA, 2000), sexual dysfunctions are classified under four categories: desire, arousal, orgasm and pain. The dysfunctions listed under these categories consist of hypoactive sexual desire disorder (HSDD), sexual
aversion disorder, sexual arousal disorder, orgasmic disorder, dyspareunia and vaginismus (APA, 2000; Mimoun & Wylie, 2009). These can be further specified as being lifelong or acquired, and generalised or situation/partner specific. Although separate diagnoses are used for sexual dysfunctions occurring at different phases of the sexual response, many women present with mixed FSDs occurring at multiple phases of the sexual response cycle (Jones & McCabe, 2011; McCabe, 2001; Mimoun & Wylie, 2009).

Several criticisms of the DSM-IV-TR classification system have been cited, such as the use of conceptual models that lack empirical support (Basson, 2000), the overlap of diagnostic criteria (Segraves, 2007) and the inappropriate grouping of female and male sexual dysfunctions (MSDs), such as male and female HSDD (Basson, 2000; Jones, 2010). Criticisms also concern the use of FSD as a diagnosis altogether because this may encourage the pathologising of normal sexual variation and ignore the relational context of sexual dysfunctions (Bobele, 2004; Flemons & Green, 2004). Despite these criticisms, the classification of FSDs is still considered useful for communication between professionals, research purposes, treatment planning and insurance reimbursement (Mitchell & Graham, 2008).

A number of changes to the FSD classification system have been proposed for the new DSM-5 that is due to be released in 2013. The proposed changes include relocating sexual aversion disorder to the anxiety disorders (Brotto, 2010b); the addition of “reduced intensity of orgasmic sensations” to the definition of female orgasmic disorder (Derogatis et al., 2010; Graham, 2010a, p. 267); merging HSDD and sexual arousal disorders into a “sexual interest/arousal disorder” (Brotto, 2010a; Graham, 2010b, p. 252); and merging vaginismus and dyspareunia into a “genito-pelvic pain/penetration disorder” (Binik, 2010a; Binik, 2010b, p. 285). Much debate
currently surrounds these proposed changes (Brotto, Graham, Binik, Segraves, & Zucker, 2010; Derogatis et al., 2010).

**Prevalence of FSDs**

Prevalence estimates are an important tool for understanding the burden of FSDs among women and couples, and can help in the identification of risk factors for individuals and couples (Lewis et al., 2010). A number of prevalence studies have been conducted for FSDs, with estimates varying greatly due to differing definitions of FSDs, different measurement tools and sampling techniques, and age differences within studies (Lewis et al., 2004; Shifren, Monz, Russo, Segreti, & Johannes, 2008). In 2010, an international consultation of experts reviewed the prevalence data for sexual dysfunctions from 18 descriptive epidemiology studies across various countries. Based on their review, it was estimated that 40-45% of adult women have at least one manifest FSD occurring “rather often, often, nearly always or always” (Lewis et al., 2010, pp. 1600). This prevalence rate is consistent with an earlier review (Lewis et al., 2004).

The most common sexual complaint reported by women across a number of different countries is low sexual desire/interest, with prevalence rates ranging from 11-55% (Lewis et al., 2004; Lewis, 2010; Ventegodt, 1998). Other prevalence estimates across various population studies include those for lack of sexual pleasure (16-27%), orgasm difficulties (7-29%), arousal and lubrication problems (8-28%), vaginismus (6%) and dyspareunia (1-27%) (Lewis et al., 2004; Lewis, 2010; Richters, Brulich, de Visser, Smith, & Rissel, 2003; Shifren et al., 2008; Ventegodt, 1998). Prevalence estimates for women also indicate that some FSDs increase with
age, such as low sexual desire/interest and sexual arousal disorders (Lewis et al., 2010).

Prevalence rates for women with multiple FSDs were obtained in a study showing more than 20% of women to have more than one FSD (Najman, Dunne, Boyle, Cook, & Purdie, 2003). Another study, investigating a circular/feedback model of sexual response, found women to be more likely to experience dysfunctions in two or more domains of sexual response than one domain (Giles & McCabe, 2009).

It should be noted that female sexual problems are only defined as clinical dysfunctions if they meet the DSM-IV-TR criteria, which includes distress or interpersonal difficulties associated with the sexual problem (APA, 2000). Many epidemiologic studies of FSDs have neglected to measure associated distress or interpersonal difficulties (Shifren et al., 2008). In studies that have measured associated distress, it has been consistently found that only a proportion of women with sexual problems also have associated distress (e.g., Bancroft, Loftus, & Long, 2003; Shifren et al., 2008).

**Etiology of FSDs**

Women with sexual dysfunctions are a highly heterogeneous group (Burri, Greven, Leupin, Spector, & Rahman, 2012), with many factors influencing their sexual functioning, their sexual satisfaction, and associated distress. In order to gain a comprehensive understanding of the development of FSDs, it is important to utilise an etiological framework that addresses both biological and psychological factors. Etiological factors can further be categorised as predisposing, precipitating,
maintaining or contextual, and many factors may fit into more than one of these categories (Althof et al., 2010; Hawton & Catalan, 1986; McCabe et al., 2010).

**Biological factors.** Genetic traits and biological factors such as hormonal, neurological, vascular and anatomical characteristics may act as predisposing factors for FSDs (Althof et al., 2010; McCabe et al., 2010). Although the precise influence of genetics is unclear, a recent twin study of FSDs identified that there are at least two genetic factors involved in FSD, and that these factors could potentially play an organising role in the classification of FSD (Burri et al., 2012).

Certain medical illnesses related to hormonal, neurological and vascular functioning, such as multiple sclerosis and Parkinson’s disease, may act as both precipitating and maintaining factors that alter sexual functioning in women (e.g., Bronner, Royter, Korczyn, & Giladi, 2004; DasGupta & Fowler, 2003; McCabe, 2004). Substance abuse and many prescription and non-prescription medications have also been found to impact on female sexual functioning (Basson, 2001; Chedraui, Perez-Lopez, San Miguel, & Avila, 2009; Clayton, 2003; Wylie, Steward, Seivewright, Smith, & Walters, 2002), including commonly prescribed anti-depressant medications (Montejo, Llorca, Izquierdo, & Rico-Villademoros, 2001; Sidi, Asmidar, Hod, & Guan, 2012) and hormonal contraceptive pills (Burrows, Basha, & Goldstein, 2012). For these reasons, a full medical examination is highly recommended for women seeking treatment for FSDs (Davis, Guay, Shifren, & Mazer, 2006a; Hawton, 1985), and substance use and general medical conditions must be ruled out as exclusive causal factors (APA, 2000).

Aging and particular life stages, such as pregnancy, childbirth and menopause, may act as precipitating factors for FSDs (Althof et al., 2010; Katz,
For example, an increase in lubrication problems with age has been well documented (e.g., Bancroft et al., 2003; Laumann, Paik, & Rosen, 1999).

**Psychological factors.** A range of sexual and nonsexual psychological factors influence women’s sexual motivation and sexual response (Althof et al., 2010; Basson, 2000; Carvalheira, Brotto, & Leal, 2010; Meana, 2010; McCabe et al., 2010). It is useful to divide these psychological factors into intergenerational, individual and relationship factors, and it is common for a combination of different psychological factors to interact in the development and maintenance of FSDs (Althof et al., 2010; McCabe, 1991; McCabe et al., 2010).

**Intergenerational factors.** Intergenerational factors may predispose a woman to FSD, and these factors include attitudes, rules and beliefs passed down from the family of origin, and the way in which love and affection were expressed within the family (McCabe et al., 2010; McCabe, 1991). Restrictive upbringing, inadequate sex education and negative messages (both overt and covert) about sex from the family of origin are among the intergenerational factors that can have a significant impact on female sexual functioning (Clayton, 2003; McCabe, 2001; McCabe & Cobain, 1998). Common consequences of these factors include the development of guilt about sex (Kelly, Strassberg, & Kircher, 1990; Morokoff, 1985), endorsement of sexual myths (Rathus, Nevid, & Fichner-Rathus, 2005), and unfamiliarity with sexual anatomy and response (Clayton, 2003).

Childhood and adolescent sexual abuse, as well as other forms of carer-related abuse and trauma, are frequently associated with a variety of sexual problems in women (Althof et al., 2010; McCabe et al., 2010; McCabe & Cobain, 1998;
Meston, Rellini, & Heiman, 2006). In studies of female victim/survivors of childhood sexual abuse, it has consistently been found that this group of women experience higher rates of sexual dysfunction than non-abused women (Bartoi & Kinder, 1998; Rellini, Ing, & Meston, 2011).

**Individual factors.** Individual psychological factors may also play a role in the development and maintenance of FSDs (Althof et al., 2010; McCabe, 1991; McCabe et al., 2010). These factors include a woman’s current attitudes and beliefs about herself, sex and masturbation (Hawton, 1985; Nobre & Pinto-Gouveia, 2006; McCabe, 2005), her past sexual experiences, including first intercourse (Woo & Brotto, 2008), and her current mental health (McCabe et al., 2010; Wylie et al., 2002).

An individual’s sexual self-schema, or how they view themselves as a sexual being, has been associated with women’s sexual adjustment and sexual response (Anderson & Cyranowski, 1994; Kuffel & Heiman, 2006; Nobre & Pinto-Gouveia, 2008; Reissing, Laliberté, & Davis, 2005). Negative sexual self-schemas, such as those related to inadequacy and incompetence, are influenced by past sexual experiences, lack of sexual confidence and low sexual self-efficacy (Reissing et al., 2005). These negative schemas may be activated during a sexual encounter, and are accompanied by automatic negative thoughts about sex and the sexual self (Nobre & Pinto-Gouveia, 2008). These thoughts may act as a distressing and distracting presence during sexual activity, eliciting negative emotions such as sadness and guilt, and prevent women from focussing on pleasurable or erotic sensations (Nobre & Pinto-Gouveia, 2008).

There are many types of automatic negative thoughts that may influence a woman’s sexual functioning. Negative believes and thoughts related to poor body
image have been identified as a factor that may predispose, precipitate and maintain sexual difficulties and low sexual satisfaction, and may lead to distraction during sexual activity and increase sexual avoidance (Althof et al., 2010; Pujols, Meston, & Seal, 2010; Reissing et al., 2005). Additionally, negative attitudes towards genitals, including appearance, smell and taste, may also influence sexual avoidance and facilitate sexual shame (Herbenick, 2009; Karasz & Anderson, 2003; Zielinski, Kane-Low, Miller, & Sampsel, 2012).

The thoughts and beliefs surrounding performance anxiety and sexual incompetency have been identified as predictive factors in FSD (Nobre & Pinto-Gouveia, 2008), and this was the primary focus of Master and Johnson’s (1970) behavioural sex therapy. An individual’s level of general anxiety has been associated with FSD (Burri & Spector, 2011), as well as depression and stress, and comorbid anxiety and mood disorders are not uncommon alongside FSD (Burri & Spector, 2011; Campillo, Bravo, Carmona, Perales, & Calderón, 1999; Laurent & Simons, 2009; McCabe et al., 2010).

**Relationship factors.** Relationship factors have been consistently identified as contributing to the precipitation and maintenance of FSDs (Basson, 2005; Hawton, Catalan, & Fagg, 1991; McCabe & Goldhammer, 2012), although this association may be bi-directional in nature (Basson, 2000). Such factors include relationship quality and duration (Burri & Spector, 2011; Kelly, Strassberg, & Turner, 2006; McCabe & Goldhammer, 2012; Witting et al., 2008), with longer duration and lower relationship satisfaction being related to higher rates of FSD (Burri & Spector, 2011; McCabe & Goldhammer, 2012). The interrelationship between partner sexual functioning has been consistently demonstrated within the literature, with a sexual dysfunction in one partner often precipitating a sexual
dysfunction in the other (Chevret-Méasson et al., 2009; McCabe & Goldhammer, 2012). The converse relationship has also been demonstrated, where alleviation of sexual dysfunction in one partner is associated with increased sexual functioning in the other (Heiman et al., 2007).

Power dynamics within the relationship have been hypothesised as a relationship factor that may impact on sexual functioning via its influence on relationship satisfaction (Brezsnyak & Whisman, 2004). Although research on this topic is limited, anecdotal evidence suggests that it is common for partners in a relationship with a power imbalance to use sexual restriction as a means of redistributing power and control (Brezsnyak & Whisman, 2004; Metz & Epstein, 2002). Communication difficulties and low levels of intimacy between partners can also play a central role in the development and maintenance of FSDs (Kelly et al., 2006; McCabe, 1991; McCabe, 1997; McCabe & Goldhammer, 2012).

Lastly, contextual factors such as environmental constraints, mood, degree of privacy, energy levels, fatigue, and current life stressors can disrupt a couple’s attempt to maintain a sexually satisfying relationship (Althof et al., 2010; McCabe et al., 2010).
Chapter 2

Treatment Approaches for Female Sexual Dysfunctions

This chapter discusses the medical and psychological treatment methods for FSDs. The discussion begins with an overview of the issues involved in assessing the effectiveness of FSD interventions. This is followed by an exploration of the effectiveness of available medical and psychological interventions. Factors commonly associated with positive treatment outcomes are then reviewed.

Issues in Assessing the Effectiveness of FSD Treatments

Although a range of treatment methods are used for FSDs, there are some areas of controversy and complexity in the evaluation of both medical and psychological treatments (Clayton et al., 2010; McCabe et al., 2010). Difficulties in this area stem from differing views on: 1) The appropriate definition of FSD; 2) The inclusion and exclusion criteria deemed appropriate; 3) The appropriate outcome goals; and 4) The outcome measurement tools used (Clayton et al., 2010; Kingsberg & Althof, 2011; McCabe et al., 2010). Particular areas of concern in the study of medical interventions for FSDs include the use of outcome measures that do not address the DSM-IV defined symptomatology of FSDs, the use of unreliable measurement tools (e.g., daily diaries for sexual desire), the study design and duration, the availability of long-term safety data, and the generalisability of data in the context of the exclusion criteria (Clayton et al., 2010; Kingsberg & Althof, 2011; McCabe et al., 2010).

Research into the psychological treatment of FSDs has been criticised for a range of methodological problems such as small sample sizes, a lack of controlled
studies, a lack of long-term follow-up data, high attrition rates, and inadequate descriptions of treatment methods utilised (Althof, 2010; Spence, 1991). Similar to medical interventions, research into psychological treatments for FSDs has also been criticised for unclear definitions of FSDs and treatment outcome goals (McCabe et al., 2010; Spence, 1991), and for the assessment tools used (Althof et al., 2010; Barsky, Friedman, & Rosen, 2006; Segraves & Althof, 1998).

**Medical Treatments for FSDs**

Since the approval of sildenafil for male erectile dysfunction (ED), research into FSD treatment has been increasingly pharmacologically based (Shames, Monroe, Davis, & Soule, 2007). To date, the results of the search for the “pink Viagra” (Cacchioni, 2011, pp. 1) are mixed and inconclusive, and currently there is only one drug for FSD approved in the European Union and none approved within Australia or the U.S. (Clayton et al., 2010; Foster, Mears, & Goldmeier, 2009). Research into medical interventions for FSDs are guided by the U.S Food and Drug Administration guidelines for standards of clinical trials. There have been various criticisms of these guidelines (Clayton et al., 2010; Kingsberg & Althof, 2011) and it has been suggested by some that the lack of approved drugs for FSDs has more to do with inadequate guidelines than the efficacy of the drugs themselves (Clayton et al., 2010).

**Hormone treatments.** Female sexual functioning involves the sex hormones oestrogen, progesterone and testosterone (Wierman, 2007; Wylie & Malik, 2009). Hormone treatments for FSDs have focussed on the delivery of oestrogen and testosterone, both of which play key roles in female sexual response (Wylie &
Malik, 2009). Oestrogen therapy is commonly used for sexual dysfunctions in women undergoing hormonal changes due to menopause, and target symptoms such as diminished levels of lubrication and decreased vulvar sensation (Wierman, 2007; Wylie & Malik, 2009). To date, there is no specific evidence that oestrogen therapy is efficacious for FSDs (Davis et al., 2006a), and the side effects of oestrogen therapy can include increased risk of endometrial cancer, gallbladder disease and venous thromboembolic events (Wylie & Malik, 2009).

The most promising hormone therapy results are from the use of transdermal testosterone patches (TTPs) for postmenopausal female sexual desire (Foster et al., 2009). Efficacy trials for TTPs have found an increase in the frequency of sexually satisfying events and sexual desire in postmenopausal women with HSDD (Braunstein et al., 2005; Buster et al., 2005; Davis et al., 2006b; Davis et al., 2008; Panay et al., 2010; Shifren et al., 2000; Shifren et al., 2006; Simon et al., 2005). Although these results are positive, there are concerns over adverse side-effects, such as increased hair growth and acne, as well as the safety of long-term use, such as the drugs impact on cardiovascular disease and breast cancer risk (Brown, Blagg, & Reynolds, 2007; Davis & Braunstein, 2012; Panay et al., 2010). Therefore, further clinical trials are recommended (David et al., 2006a; Wylie & Malik, 2009). Despite the inconclusive data, the use of off-label testosterone for FSDs is widespread (Davis & Braunstein, 2012), and TTPs have been approved in the European Union for the treatment of HSDD in oopherectomised women (Jordan, Hallam, Molinoff, & Spana, 2011).

**Peripherally and centrally acting agents.** Various agents acting peripherally on the female sexual response (e.g., phosphodiesterase inhibitor type 5
– PDE5i) have been investigated as interventions for FSD (Basson & Brotto, 2003; Berman, Berman, Toler, Gill, & Haughie, 2003; Caruso, Intelisano, Farina, Di Mari, & Agnello, 2003; Caruso, Intelisano, Lupo, & Agnello, 2001; Chivers & Rosen, 2010; Laan et al., 2002). In a review of the studies investigating PDE5i treatment for female sexual arousal (Chivers & Rosen, 2010), it was found that physiological aspects of sexual arousal (genital vasocongestion) were consistently and significantly improved, but that this did not generally lead to improvements in self-reported measures of female sexual functioning. It was suggested that these results are consistent with the demonstrated discordance between objective genital arousal and subjective sexual response in women, and that pharmacological treatments are therefore unlikely to be successful as standalone treatments (Chivers & Rosen, 2010; Jordan et al., 2011). Side effects of PDE5i treatments for FSD include headache, flushing, and nausea (Wylie & Malik, 2009).

Centrally acting agents, which take effect on neurotransmitter sites, have been proposed as a more appropriate medical intervention for FSDs (Brown et al., 2007). Buproprion, a dopamine agonist, has been investigated as a treatment for premenopausal women with HSDD (Segraves, Clayton, Croft, Wolf, & Warnock, 2004; Segraves et al., 2001). While results showed small increases in sexual arousal, orgasm and satisfaction, no effect on sexual desire has been observed, and side effects include nervousness, insomnia, and nausea. Flibanserin, a 5-HT1A agonist/5-HT1A antagonist, has also been gaining attention as a potential treatment for HSDD in premenopausal women (Brown et al., 2007; Stahl, Sommer, & Allers, 2010). In two recent studies (DeRogatis et al., 2012; Thorp et al., 2012), a once-daily dose of flibanserin was associated with modest improvements in “satisfying sexual events” and sexual distress, and statistically significant improvements in one (out of two)
measures of sexual desire. To date, flibanserin has been rejected for approval for FSD treatment due to concerns over adverse side effects, such as dizziness, nausea, fatigue, and sedation, as well as limited efficacy regarding sexual desire outcomes (Jordan et al., 2011).

In summary, pharmacotherapy for FSDs has demonstrated limited benefits thus far (Foster et al., 2009). These interventions appear to target relevant objective aspects of female sexual functioning, but may have little effect on subjective aspects of sexual functioning (Chivers & Rosen, 2010; Jordan et al., 2011). It is also important to note that the various side-effects of the differing pharmacological treatments for FSD, such as sedation, fatigue, dizziness, nausea, headaches, increased hair growth and acne, do not appear to be conducive of positive sexual experiences or positive body-image, and this aspect of the side effects of medical interventions for FSD is in need of further research attention.

**Psychological Treatments for FSDs**

Psychological intervention has been the main treatment method for FSDs since the development of Masters and Johnson’s (1970) behavioural sex therapy. As part of the evidence-based practice (EBP) movement, manualised psychological treatments have become an integral part of most efficacy research (Nathan, Stuart, & Dolan, 2000). Manualised treatments in FSD research provide an operationalised description of treatment methods and timelines, and can help to improve research rigor through the use of standardised procedures (Chambless & Ollendick, 2001; Luborsky & DeRubeis, 1984). Despite this, sufficient efficacy data on psychological treatments for FSDs are still lacking, and a host of methodological flaws still occur
in the research literature (Basson, Wierman, van Lankveld, & Brotto, 2010; McCabe, 2001; Spence, 1991).

**Face-to-face psychological treatment.** Face-to-face psychological interventions for sexual dysfunctions became widely accepted after the highly influential behavioural techniques of Masters and Johnson (1970), which focussed on performance anxiety as the main etiological factor involved in sexual dysfunction. Masters and Johnson’s techniques included psychoeducation, communication exercises and sensate focus (graded mutual touch exercises). Although these techniques initially showed very positive results, further applications demonstrated a need for a broader etiological approach (Clayton, 2003; Hawton et al., 1986; Kelly et al., 2006; Wiederman, 1998).

**Cognitive-behavioural therapy interventions.** Whilst continuing to capitalise on behavioural techniques, more recent approaches to FSDs tend to utilise cognitive-behavioural therapy (CBT) techniques. The CBT model for sexual dysfunction proposes that sexual functioning is influenced by thoughts, feelings, attitudes and behaviours, and the interactions that occur between them (Barlow, 1986; Basson et al., 2010). Cognitive techniques aim to modify attitudes, beliefs and expectations underlying the sexual dysfunction (Barlow, 1986; Basson et al., 2010; Ellis, 1975) and have been applied to a range of FSDs (e.g., Brotto, Basson, & Luria, 2008a; McCabe, 2001; ter Kuile et al., 2007; Trudel et al., 2001). For example, Trudel and colleagues compared a CBT group intervention to a control condition for HSDD, with outcome measures showing 74% of the intervention group no longer meeting HSDD criteria at post-test.
As well as the use of general techniques such as behavioural and cognitive strategies, some studies targeting particular FSDs have found specific techniques to be useful for some disorders. For example, alongside general CBT techniques, directed masturbation is the most efficacious treatment for lifelong/generalised orgasmic problems, and the use of vaginal dilators is indicated for vaginismus (Basson et al., 2010; Heiman & Meston, 1997). Group therapy techniques have also been used in many of the studies evaluating psychological treatments for FSDs (e.g., Brotto et al., 2008a, 2008b; Smith, Beadle, & Shuster, 2008). Group processes that have been found to be helpful in the treatment of FSDs include self-disclosure, normalisation, validation, social support, learning from other’s experiences, and offering guidance and support to others (Gehring & Chan, 2001; Mills & Kilmann, 1982).

**Mindfulness-based interventions.** A recent and promising addition to the CBT approach for HSDD and sexual arousal disorders involves the inclusion of mindfulness - a Buddhist meditation practice (Althof, 2010; Brotto et al., 2008a, 2008b; Brotto et al., 2012b, 2012c; Hahn, 1975). Mindfulness techniques facilitate nonjudgmental observation and present-moment awareness, and in the context of FSD, help to decrease cognitive and affective distractions and performance anxiety during sexual activity, and increase women’s attention and awareness of pleasurable sensations (Brotto & Heiman, 2007; Brotto, Krychman, & Jacobson, 2008c). To demonstrate the impact of mindfulness on women’s sexual response, a recent randomized, controlled study explored the effects of mindfulness training on women’s awareness of physiological responses to sexual stimuli (Silverstein, Brown, Roth, & Britton, 2011). It was found that the mindfulness training group became significantly faster at registering physiological responses to sexual stimuli as
compared to the control group. It was also found that the mindfulness training group observed significant improvements in attention, self-judgement and anxiety, three factors that have been proposed as psychological barriers to healthy sexual functioning (De Jong, 2009; Silverstein et al., 2011).

To date, four studies have evaluated the incorporation of mindfulness training into group interventions for women with FSDs. In the first study (Brotto et al., 2008a), a mindfulness-based CBT intervention was delivered to a group of 26 women seeking treatment for acquired sexual desire and/or arousal difficulties. This treatment group reported significant improvements in sexual desire and sexual distress at post-test, as well as improvements in perception of genital arousal despite a lack of change in objective sexual arousal. The second study (Brotto et al., 2008b) involved the delivery of a mindfulness-based CBT intervention to a group of 22 women with early-stage gynaecological cancer seeking treatment for acquired sexual arousal difficulties. This treatment group reported significant improvements in sexual desire, arousal, orgasm, satisfaction, and sexual distress. Trends towards improvement were also reported for both objective and perceived genital arousal, and women reported a significant improvement in overall well-being.

The third study (Brotto et al., 2012b) evaluated the effectiveness of a mindfulness-based CBT intervention for a group of 31 female survivors of endometrial or cervical cancer who reported sexual desire and/or sexual arousal difficulties. This study involved a waitlist control group, and results demonstrated that the women in the treatment group reported significant improvements in all areas of sexual response, as well as a trend towards improvement on scores of sexual distress, as compared to the control group. Women’s ability to perceive genital arousal during an erotic film also increased significantly in the treatment group,
despite no change in objective sexual arousal, and improvements were maintained at 6-month follow-up (Brotto et al., 2012b).

Upon further inspection of Brotto and colleagues (2008a) results from the mindfulness-based CBT intervention, it was found that women with a history of sexual abuse had greater levels of improvement on various measures of sexual function and distress as compared to those without a history of sexual abuse. To further explore these results, the fourth study (Brotto et al., 2012c) compared the effectiveness of a mindfulness-based intervention to a CBT intervention for 22 partnered women with sexual difficulties, associated distress, and a history of childhood sexual abuse. Results suggested that women in the mindfulness-based treatment group reported significantly greater levels of subjective sexual arousal at post-test as compared to the CBT group, and that both treatment groups experienced significant decreases in sexual distress (Brotto et al., 2012c).

Lastly, it has also been theorised that mindfulness training may benefit women with sexual pain disorders (Basson, 2012; Brotto, Basson, Carlson, & Zhu, 2012a). There is currently no quantitative data to support this hypothesis, but qualitative findings from a pilot study assessing the use of mindfulness-based approaches for women with provoked vestibulodynia (a chronic pelvic pain condition) suggests that participants benefitted from the intervention and experienced a greater sense of control over pain management (Brotto et al., 2012a).

**Other considerations.** Although most studies of psychological interventions have targeted a specific FSD, a number of research findings report positive results for sexual symptoms other than those specifically targeted (e.g., Brotto et al., 2008b; Hurlbert, White, Powell, & Apt, 1993; McCabe, 2001; Trudel et al., 2001). Also, while some specific techniques are indicated for particular disorders, the therapeutic
techniques used for different FSDs tend to overlap considerably. For example, 
sensate focus and psychoeducation have been found to be useful for multiple FSDs 
(Brotto et al., 2008b; McCabe, 2001; van Lankveld, Everaerd, & Grotjohann, 2001). 
These results, and the fact that many women present with multiple FSDs, support 
the use of psychological treatment programs aimed at mixed FSDs. Studies 
investigating interventions for mixed FSDs have found positive results (Brotto et al., 
2008b; Jones & McCabe, 2011; McCabe, 2001).

**Self-help interventions.** Self-help methods for FSDs include bibliotherapy 
and video-therapy and can be completely self-administered or involve therapist 
assistance in varying degrees (Hubin, De Sutter, & Reynaert, 2011; van Lankveld, 
2009). The benefits of using this treatment format include convenience, increased 
self-efficacy, and reduced problems associated with generalisation from the therapy 
setting to the home setting (van Lankveld, 2009). These methods may be especially 
suited to women who do not want to seek face-to-face treatment for sexual problems 
for various reasons such as embarrassment, shame or anxiety. It has also been 
suggested that self-help sex therapy may be more suited to women with a capacity 
for self-management and self-reflection, as well as the appropriate reading ability 
(Hubin et al., 2011). Although the content of written materials and videos used for 
treating FSDs varies considerably, all share a focus on behavioural techniques and, 
more recently, include CBT techniques (van Lankveld, 2009). In a review of self-
help treatments for sexual dysfunctions, it was concluded that bibliotherapy differed 
minimally from face-to-face sex therapy, although some gains were lost at follow-up 
(van Lankveld, 2009). It was also found that bibliotherapy with therapist assistance 
was superior to completely self-administered bibliotherapy. The literature on video
therapy is more limited than that of bibliotherapy, though preliminary results suggest that neither self-help format may be superior to the other (Hahn, 1981).

**Internet-based interventions.** Internet-based interventions are the most recent approach for treating FSDs and have been applied to a range of MSDs and FSDs, with preliminary evidence supporting its use for both (Hall, 2004; Jones & McCabe, 2011; McCabe & Price, 2008; van Lankveld, Leusink, Diest, Gijs, & Slob, 2009). A more thorough discussion of the use of internet-based interventions for FSDs will be presented in Chapter 3.

It should be noted that the majority of interventions assessed for FSDs have been designed for heterosexual women in a relationship. Both conceptual models and treatment outcome literature are lacking for single women with FSDs and women in same-sex relationships (Catalan, Hawton, & Day, 1991; Kaplan, 2009; Stravynski et al., 2007). It should also be noted that no study to date has assessed the combination of medical and psychological treatments for FSDs.

**Factors Related to FSD Treatment Outcomes**

The literature on FSDs has identified various factors that are related to treatment outcome. While the nature of the sexual dysfunction itself is a factor that may affect prognosis, other factors related to the individual, the partner and the relationship may also be predictive of treatment success and treatment drop-out.

**Characteristics of the dysfunction.** Some FSDs have been found to be more difficult to treat than others, and this is likely to influence treatment success. HSDD is generally the most difficult to treat and has the poorest treatment outcomes
(Kaplan, 1979; McCabe, 2001). The number of difficulties experienced by the woman over the sexual response cycle may also be related to treatment success. Interestingly, in one study, women who experienced multiple FSDs were more likely to complete therapy than those with only one FSD (McCabe, 2001). In response, the author suggested that having more sexual problems may act as a motivating factor in treatment. The duration of the FSD has also been identified as a predictor of treatment success, with longer-standing, pervasive dysfunctions being more resistant to change (Hawton et al., 1991; McCabe, 2001), although mixed findings have been reported on this recently (Jones & McCabe, 2011).

**Motivation to change.** An individual’s motivation to change has been consistently related to successful FSD treatment (Hawton, 1985; Hawton et al., 1991; Hawton et al., 1986; McCabe, 2001). Motivation levels may influence the degree of engagement achieved in therapy, the amount of homework completed and the individual’s expectations of treatment. These findings are consistent with the literature regarding readiness for treatment, and emphasise the need to tailor interventions to differing levels of readiness for treatment (Miller, Donahey, & Hubble, 2004).

The male partner’s motivation and involvement in treatment has also been associated with treatment success (Hawton, 1985; Hawton et al., 1991; Hawton et al., 1986; Jones & McCabe, 2011; LoPiccolo & Stock, 1986; McCabe, 2001). For this reason, various authors have suggested that male partners be engaged in the treatment process to increase positive treatment outcomes and decrease drop-out rates (Brotto et al., 2008a; Brotto & Heiman, 2007)
Compliance. Treatment compliance has been consistently associated with positive treatment outcomes. Compliance has been measured in a range of ways including completion of homework assignments (Brotto et al., 2008a; Hawton et al., 1991), time spent doing homework tasks (Sarwer & Durlak, 1997; van Lankveld, 2009) and the degree of effort put towards sexual problem-solving (van Lankveld et al., 2001). A factor potentially related to compliance, that has been positively associated with treatment outcome, is the amount of progress made in the early stages of treatment (Hawton, 1985; Hawton & Catalan, 1986; Hawton et al., 1991), although this may be a consequence of other factors such as motivation.

Partner characteristics. As well as partner motivation and involvement in treatment being associated with better prognosis for FSDs (eg. LoPiccolo & Stock, 1986), characteristics of the male partner’s sexual functioning have been related to female sexual functioning (Çayan, Bozlu, Canpolat, & Akbay, 2004; Heiman et al., 2007). Studies investigating the interdependence of sexual functioning between partners suggest that improvement in one partner tends to be positively related to improvement in the other. For example, Çayan and colleagues (2004) reported significant improvements in women’s arousal, satisfaction, lubrication and pain after successful treatment of the male partner’s ED. These findings highlight the importance of evaluating the sexual functioning of both partners prior to treatment.

Relationship quality. Whilst characteristics of each individual in a relationship influence the treatment prognosis of FSD, characteristics of the relationship itself play an important role in treatment outcome. Relationship quality, intimacy, communication, attraction, satisfaction and conflict have all been
associated with FSD treatment outcomes (Hawton, 1985; Hawton & Catalan, 1986; Jones & McCabe, 2011; LoPiccolo & Stock, 1986). In a recent study of the effects of a CBT treatment for mixed FSDs, analyses revealed that women who dropped out of treatment had lower levels of couple intimacy and relationship satisfaction as compared to the women who completed treatment (Jones & McCabe, 2011). These findings emphasise the importance of assessing and treating FSDs in the context of the relationship in which they exist, and targeting relevant relationship issues within therapy.
Chapter 3

Internet-Based Interventions for Female Sexual Dysfunctions

The internet is becoming a widespread and popular database for mental health information (Tate & Zabinski, 2004). This chapter discusses the variety of internet-based psychotherapy approaches used to treat mental health issues, the advantages and disadvantages of using internet technology as a psychotherapeutic tool, and ethical considerations specific to online psychological services. A discussion of how internet-based interventions have been applied to the treatment of MSDs and FSDs will follow. Particular attention will be paid to the most recent internet-based intervention for mixed FSDs – the Revive program (Jones & McCabe, 2011) – and future directions for the treatment of FSDs over the internet.

Internet-Based Approaches to Mental Health

Internet-based interventions have been successfully used for a variety of mental health problems such as eating disorders (Zabinski, Wilfley, Calfas, Winzelberg, & Taylor, 2004), substance abuse and other addictions (Alemi et al., 2007; Gainsbury & Blaszczynski, 2011), anxiety disorders (Aydos, Titov, & Andrews, 2009; Cuijpers et al., 2009; Hedman et al., 2011), and depression (Moritz, Schilling, Hauschildt, Schröder, & Treszl, 2012; Spek et al., 2007). As well as demonstrating post-treatment gains, various studies have also demonstrated the long term benefits that internet-based therapies can achieve (e.g., Carlbring, Nordgren, Furmark, & Andersson, 2009; Hedman et al., 2011; Ljotsson et al., 2011).

Internet-based interventions vary substantially in the formats adopted, the therapeutic techniques utilised and the degree of interactivity offered. Although
many health-related websites, online support groups and general counselling websites exist, this discussion will be limited to internet-based manualised treatment programs, which are defined as those that include a structured, replicable treatment program and online therapist involvement (Abbott, Klein, & Ciechomski, 2008).

**Synchronous and asynchronous methods.** Internet-based interventions utilising asynchronous methods involve communications between therapist and client that are not in real-time and can include email therapy and electronic communication boards (Tate & Zabinski, 2004). Asynchronous methods increase convenience because no specific timing of communication is necessary, but this can have the disadvantage of creating a time-lag in communication (Jones & Stokes, 2009). Synchronous interventions involve real-time communication between therapist and client and can include internet relay chat for individual counselling or online chat-rooms for group discussion forums and group therapy sessions. While both synchronous and asynchronous methods can be effective, it has been suggested that synchronous methods increase client engagement (Alemi et al., 2007; Jones & McCabe, 2011; Zabinski et al., 2004) and better mimic face-to-face therapy (Tate & Zabinski, 2004; Zabinski et al., 2004). A combination of synchronous and asynchronous methods may also be utilised to gain the advantages of both methods (Tate & Zabinski, 2004; Zabinski et al., 2004).

**Therapeutic techniques.** A range of therapeutic techniques can be used over the internet, most of which are adapted from face-to-face therapy techniques. A large proportion of internet-based interventions for mental health problems utilise structured CBT programs or psychoeducation interventions (e.g., Heinicke, Paxton,
McLean, & Wertheim, 2007; Jones & McCabe, 2011; McCabe, Price, Piterman, & Lording, 2008; Zabinski et al., 2004), and it has been suggested that CBT techniques are especially well suited to online delivery (Robinson, 2009).

Because of the written format of internet-based interventions, reflective writing tasks, text role-plays, and dialogue activities can be integrated into online interventions (Abbott et al., 2008; Jones, 2010). These techniques may be especially helpful for challenging maladaptive cognitions and attitudes, cognitive restructuring and behaviour rehearsal. Group therapy techniques, such as brainstorming and perspective taking, can also be utilised in online chat-groups, and may help to develop social support and enable validation and normalisation of mental health problems (Alemi et al., 2007; Heinicke et al., 2007; Tate & Zabinski, 2004; Zabinski et al., 2004). This may be especially helpful for clients in remote areas or those dealing with sensitive problems, such as sexual dysfunctions (Jones & McCabe, 2011; Tate & Zabinski, 2004).

**Interactivity and usability.** Features of online treatment programs that increase general interactivity include web-links, self-monitoring systems, online diaries, and videos or audio clips, while interactivity with a therapist can be increased by the use of email, message boards and chat-groups. A survey of preferences of online users suggested that interactivity is valued in online programs and may be useful in increasing usability and engagement (Ferney & Marshall, 2006). Adopting a user-centred design process that focuses on a specific audience and enables appealing and user-friendly web-pages has been recommended (Corry, Frick, & Hansen, 1997; Ferney & Marshall, 2006).
Advantages of Internet-Based Interventions

Internet-based therapies decrease some of the barriers to receiving treatment such as inconvenience, time constraints, physical disability, travel costs and geography (Jones & Stokes, 2009; Tate & Zabinski, 2004). Online therapies also offer a sense of anonymity and invisibility which cannot be achieved in face-to-face therapy, and has been linked to reduced social desirability and self-consciousness, and increased information disclosure (Cook & Doyle, 2002; Skarderud, 2003; Tate & Zabinski, 2004). It has been suggested that anonymity may be especially helpful for clients with sensitive and embarrassing problems, such as sexual dysfunctions (Barak & Fisher, 2003; Hall, 2004; Jones & McCabe, 2011; Skarderud, 2003).

Other advantages of internet-based interventions, which stem from their unique format, include the possibility of more cost-effective methods of treatment (Abbott et al., 2008; Alemi et al., 2007; Tate & Zabinski, 2004) and instant written records of client interactions, which can be useful for reflection, treatment planning, evaluation, and supervision (Tate & Zabinski, 2004). In addition, online interventions with social components, such as chat-groups and public message boards, allow for the establishment of social support from a safe distance. Internet-based interventions can therefore be interactive and draw together a community of people who may have previously been unable to interact, whilst simultaneously maintaining their anonymity (Jones & McCabe, 2011; Leusink & Aarts, 2006; McCabe & Price, 2008; Tate & Zabinski, 2004).

Disadvantages of Internet-Based Interventions

One potential disadvantage of internet-based therapy is the lack of face-to-face contact with a therapist (Jones & Stokes, 2009; van Lankveld, 2009). While this is a
valid concern, evidence suggests that clients can form a trusting, open and comfortable relationship with online therapists, comparable to face-to-face therapy (Cook & Doyle, 2002; van Lankveld, 2009), and reach a similar level of emotional engagement as occurs in face-to-face interactions (Alemi et al., 2007; Rotondi, Sinkule, & Spring, 2005).

The use of text instead of spoken language has the potential to create misunderstandings and inadequately convey meaning and empathy (Heinicke et al., 2007). To address this concern, it has been recommended that therapists and clients utilise computerised text features in order to express themselves more accurately, such as varying text fonts and styles (e.g., I guess I’m just feeling blue...), utilising upper and lower case text (e.g., You sound ANGRY!), and using emoticons (e.g., 😊 😒) for visual representations of emotions and affect (Heinicke et al., 2007; Jones & Stokes, 2009).

Another potential disadvantage is that a client’s speed of typing and reading ability may become an issue when utilising online interventions (Jones & Stokes, 2009; Tate & Zabinski, 2004). Other technological issues that may be encountered include delays in online communication and internet connection problems (Tate & Zabinski, 2004).

**Ethical Considerations and Suitability of Clients**

Internet-based interventions introduce new ethical issues to the practice of psychotherapy, especially those surrounding confidentiality and informed consent (Abbott et al., 2008; APS, 2004; Jones & Stokes, 2009; Tate & Zabinski, 2004). Although no therapy medium is free of risk, the nature of online materials increases the risk of confidential information being viewed by unauthorised parties (APS,
It is therefore the responsibility of the therapist to communicate confidentiality limits to clients and take appropriate measures to ensure optimal confidentiality, such as using encryption and password-protected websites, email accounts, and chat-rooms (Abbott et al., 2008; APS, 2004; Robinson, 2009).

Informed consent for online psychotherapy involves providing the clients with sufficient information about the service being offered, such as what treatment is available and what the treatment involves, the credentials of the service provider, the limits of confidentiality and the potential benefits and risks of the service (Abbott et al., 2008; APS, 2004; Robinson, 2009). Information regarding frequency of contact, protocols for technological problems, and the computer literacy and reading skills necessary for treatment should also be relayed prior to therapy commencement (Abbott et al., 2008; APS, 2004).

The suitability of clients for internet-based psychotherapy should be assessed before commencing therapy. Certain groups have been identified as being less suitable for this medium of treatment, including people experiencing distortions of reality or suicidal ideation and those who are currently victims of sexual and/or physical abuse (Abbott et al., 2008; APS, 2004).

**Internet-Based Interventions for Sexual Dysfunctions**

The application of internet-based interventions for people with sexual dysfunctions has been advocated for some years (e.g. Cooper & McLoughlin, 2001; Leiblum, 2001). The anonymity and privacy inherent in internet-based treatments has been regarded as especially helpful for the sensitive and embarrassing nature of sexual dysfunctions (Jones & McCabe, 2011; Leusink & Aarts, 2006; McCabe & Price,
Research into the use of online treatments for sexual dysfunctions is currently limited and a discussion of the findings to date for both MSDs and FSDs will follow.

**Male sexual dysfunctions.** Although research is limited, internet-based interventions have recently been used for MSDs with positive results. Hall (2004) conducted a pilot study evaluating the use of an internet-based treatment for eight participants (six males and two females) with a range of sexual dysfunctions. Participants were delivered an online treatment plan specific to their sexual problem, as well as undertaking a sexual self-awareness and self-focus program, and engaged in emails or real-time chat with the therapist. Although no psychometrically valid questionnaires were utilised, post-treatment evaluation forms indicated that seven out of the eight participants experienced an increase in sexual functioning.

While this study has many limitations, including a small sample and no control group, it does suggest that internet-based interventions can be beneficial to some people experiencing sexual dysfunctions (Hall, 2004). Hall described several benefits of the use of internet-based interventions for sexual dysfunction such as anonymity, reflective email therapy and therapist idealisation through the lack of visual/auditory contact. Hall also noted some difficulties in achieving good emotional engagement with some participants, and stressed the importance of giving specific instructions and clarifying the client’s understanding of therapeutic tasks.

Leusink and Aarts (2006) evaluated the effectiveness of an online consultation website for 219 men with ED, which provided psychoeducation, prescriptions for a medical intervention, basic behavioural exercises and psychotherapy referrals. The usefulness of the website was evaluated using a standardised questionnaire for erectile function (EF), finding that 81% of
participants had improved EF scores at completion. This study did not include a control group and no follow-up data were collected.

A pilot study investigating the use of an online psychological intervention for 39 men with a range of sexual dysfunctions was conducted by van Diest and colleagues (2007). Therapy was conducted over email for a period of 3 months and, of the men who completed the online therapy, 67% reported an improvement in sexual functioning and 47% reported sustained improvements at a one-month follow-up. van Diest and colleagues noted that confidential relationships were established with all participants, although some participants stated that the treatment seemed impersonal and distant. This study did not include a control group, making it difficult to draw conclusions about the efficacy of the intervention.

McCabe and Price (2008) conducted the only trial to date comparing internet-based psychological treatment alone with a combination of oral medication and internet-based psychological treatment for 12 men with ED. The online CBT treatment included sensate focus, communication exercises and email contact with a therapist, and the oral medication was a phosphodiesterase inhibitor. A no-treatment control group was also included. Both treatment groups improved significantly on scores of EF compared to the no treatment control, and neither treatment group was found to be superior to the other. McCabe and Price also reported that significant improvements in relationship satisfaction were found for both treatment groups as compared to the control group.

Another study was conducted to compare the same internet-based CBT treatment (from McCabe & Price, 2008) for men with ED to a no treatment control group (McCabe et al., 2008). EF scores were found to significantly improve in the treatment group as compared to the control group, as well as sexual relationship
satisfaction and sexual relationship quality. Improvements were maintained over the 3-month follow-up, with some participants experiencing further gains. Although these results were positive for these men, McCabe and colleagues suggested that internet-based interventions may not be suitable for men with more severe or prolonged sexual dysfunctions or high relationship discord. The authors also commented on the high attrition rate observed in their study, which was consistent with the general trend of higher attrition rates in internet-based treatments compared to face-to-face treatments (Emmelkamp, 2005; McCabe et al., 2008; van Diest et al., 2007).

The most recent study on internet-based interventions for MSDs was conducted by van Lankveld and colleagues (2009) and involved an online CBT treatment and a wait-list control group for men with ED and premature ejaculation (PE). Participants with ED significantly improved on scores of EF and overall sexual satisfaction, with gains remaining stable at follow-up, whilst results for PE were not superior to the control group. Outcome measures were obtained using self-reported improvements. Although further research is necessary, these studies provide preliminary support for the use of internet-based interventions for MSDs as an alternative to traditional face-to-face treatment, with the added benefit of anonymity and privacy for clients.

**Female sexual dysfunctions.** Because of the embarrassment and shame that can surround FSDs, many women avoid addressing sexual problems for prolonged periods of time (Jones & McCabe, 2011; McCabe, 2001). It has been suggested that internet-based interventions can offer the anonymity needed to make women feel
more comfortable undergoing treatment for their sexual problems (Hall, 2004; Jones & McCabe, 2011).

Only two studies to date have evaluated the use of internet-based interventions for FSDs. Two females (as well as six males) participated in the Hall (2004) study described previously; one with anorgasmia and the other with vaginismus. Although the authors did not distinguish between the male and female participants in their results, seven out of the eight participants reported improvements in their sexual functioning at treatment completion. As described previously, the limitations of this study included a small sample, no control group for comparisons, and the lack of any psychometric evaluation of outcomes.

Jones and McCabe (2011) conducted a study evaluating the effectiveness of an internet-based CBT program, called *Revive*, for women experiencing mixed FSDs within a heterosexual relationship. A total of 39 women participated in the study (17 in the treatment group and 19 in the control group). *Revive* consisted of sensate focus, communication exercises and unlimited email contact with a therapist. The main aim of the email contact was to address maladaptive cognitions as well as individual and relationship problems impacting sexual functioning (Jones, 2010; Jones & McCabe, 2011). The program consisted of five modules, with each module expected to take approximately two weeks to complete. Partners were expected to participate in the sensate focus and communication exercises.

Female sexual functioning and relationship functioning were assessed pre-test, post-test and at a 3-month follow-up using the Female Sexual Function Index (Rosen et al., 2000), the Sexual Function Scale (McCabe, 1998), and the Personal Assessment of Intimacy in Relationship Scale (Schaefer & Olson, 1981). It was found that the women who completed the *Revive* program improved significantly on
measures of sexual desire, arousal, lubrication, orgasm, sexual satisfaction and pain compared to those in the control group, although 33% of participants were still experiencing sexual problems more than 50% of the time after treatment completion (Jones & McCabe, 2011). The treatment group also reported significantly greater improvements in sexual intimacy, emotional intimacy and communication, but not for overall relationship satisfaction. Gains remained stable over the 3-month follow-up period and some participants reported further gains in sexual functioning. These results provide preliminary support for the use of internet-based psychological therapy for mixed FSDs as an alternative to face-to-face sex therapy. Although these results are positive, various limitations of the study and the Revive program require discussion.

**Attrition.** Of the 26 women who began treatment, 17 women completed the Revive program. Therefore, the overall attrition rate of Revive was 34.6% (Jones & McCabe, 2011). Although high, the authors commented that this rate is similar to those reported for some face-to-face treatments for sexual dysfunctions (Hawton, et al., 1986; McCabe, 2001; Sarwer & Durlak, 1996), and lower than some rates reported for internet-based treatments for MSDs (McCabe et al., 2008). Nevertheless, the patterns of participant drop-out revealed important information about the Revive program and the population involved.

Firstly, it was found that the women who failed to complete Revive reported significantly less relationship satisfaction and intimacy at pre-test (Jones & McCabe, 2011). Based on these results, the authors suggested that major relationship problems and low levels of intimacy may be a barrier to the use of internet-based interventions for FSDs. This is consistent with findings from the use of internet-
based therapy for MSDs (McCabe et al., 2008), and suggests that couples with significant relationship problems may need more intensive intervention.

Secondly, it was found that the majority of participant drop-outs occurred within the first module of Revive (Jones, 2010). Although many factors may have contributed to this attrition, a review of the content of the first module suggests that the program did not accommodate for the large majority of participants being in the ‘contemplation’ stage of change (Jones, 2010). While face-to-face psychological interventions would usually take time to complete a comprehensive assessment of the couple, provide appropriate psychoeducation and discuss touch exercises before implementing sensate focus (Hawton, 1985; Weeks & Gambrescia, 2008), the first module of Revive contained sensate focus exercises to be completed from the very beginning of treatment. Although the initial sensate focus exercises involved non-sexual touching, these exercises may have been intimidating for participants in pre-action stages of readiness for treatment and influenced the high drop-out. Accommodating to a client’s readiness for change, instead of rushing into action, has been associated with the formation of a strong therapeutic alliance as well as better treatment outcomes (Donahey & Miller, 2000; Miller et al., 2004).

While accommodating to a clients’ readiness for treatment is important, manualised online treatment programs like Revive necessitate a less individualised structure than face-to-face therapy, with pre-determined modules dictating the intervention structure. Therefore, in order to utilise a manualised treatment approach while also accommodating for a range of motivation levels, a balance needs to be struck between easing clients into therapy and moving them into action. The addition of a non-touch module at the beginning of treatment, oriented to reconnecting partners and contemplating change, may help to establish this balance.
Lastly, the high attrition rate of Revive led to a small sample size in the treatment condition which lowered statistical power and potentially resulted in a biased sample of highly motivated women (Jones & McCabe, 2011). As a consequence, the results from the Revive study must be interpreted with caution and may not be generalised to a wider female population. It would be useful to replicate the results from Revive with a larger sample of sexually dysfunctional women.

**Cognitive therapy.** Revive was intended to provide an intervention that utilised both cognitive and behavioural techniques (Jones & McCabe, 2011). The behavioural components were delivered through the sensate focus and couple communication exercises in each online module. Meanwhile, the cognitive components, such as identifying and challenging maladaptive beliefs, were intended to occur mainly through the email contact with the therapist. Unfortunately, the authors reported that there were significant problems in engaging participants over email and therefore very little cognitive therapy was achieved throughout the program (Jones, 2010; Jones & McCabe, 2011). From a biopsychosocial etiological framework, this suggests that many important individual, intergenerational and relationship factors involved in FSDs may not have been addressed during Revive (Jones & McCabe, 2011). Addressing these cognitive factors in future internet-based interventions for FSDs is likely to increase treatment success.

In order to target maladaptive cognitions, affects and attitudes, Jones (2010) suggested that future internet-based interventions for FSDs incorporate self-help cognitive strategies such as the written exercises used by Bach, Barlow, and Wincze (2004). The authors also encouraged the addition of online chat-groups to supplement the email exchanges (Jones, 2010; Jones & McCabe, 2011). By providing an opportunity for participants and therapist to interact in real-time,
participants may have the opportunity to explore maladaptive cognitions and attitudes, and associated affect. The chat-groups may also help to increase engagement in the program, increase motivation and enable social support among participants. The use of synchronous chat would also have the benefit of allowing for group therapy techniques to be incorporated (Abbott et al., 2008; Tate & Zabinsky, 2004).

A combination of both synchronous and asynchronous methods, as has been suggested by Jones and McCabe (2011), was recently used in an intervention for women with body-image concerns (Zabinski et al., 2004). Participants reported high satisfaction with the program format and high compliance rates were observed (Zabinski et al., 2004). A similar format could be utilised for future online treatments of FSD.

**Psychoeducation.** Revive (Jones, 2010; Jones & McCabe, 2011) lacked much of the psychoeducation commonly recommended for the successful treatment of FSDs (Basson et al., 2010; Hawton, 1985; LoPiccolo, 1978; Wincze, 2009). Some educational areas that were neglected in the program include etiological factors, common sexual myths, a thorough description of the female and male sexual response cycle, common sexual changes related to life stages, and realistic sexual expectations (Basson et al., 2010; Hawton, 1985; LoPiccoloc & Stock, 1986). While the inclusion of such information may not necessarily lead to symptom change, it has been suggested that the absence of such psychoeducation may lead to low success rates in the treatment of sexual dysfunction (LoPiccolo, 1978). The inclusion of comprehensive psychoeducation in internet-based interventions for FSDs may help to alleviate performance anxiety, to normalise sexual experiences and to expose unhelpful beliefs and attitudes that may be addressed through
cognitive therapy. Education and training in the use of sexual fantasy, sexual aids and sexual skills to expand a couple’s sexual repertoire have also been used in interventions for FSDs and may be helpful for some women (Brotto et al., 2008a, 2008b; Carvalheira et al., 2010; Heiman & LoPiccolo, 1988).

**Mindfulness training.** Due to recent research into the benefits of incorporating mindfulness training into treatments for FSDs (Brotto et al., 2008a, 2008b; Brotto et al., 2012a, 2012b, 2012c; Silverstein et al., 2011), the authors of *Revive* suggested that future internet-based interventions for FSDs may be enhanced by the addition of mindfulness techniques (Jones & McCabe, 2011). The potential benefits of this addition include reduced cognitive and affective distraction and performance anxiety during sexual activity, and increased awareness of pleasurable sensations (Brotto et al., 2008c; Silverstein et al., 2011). Mindfulness has been incorporated into CBT treatments for female sexual arousal and desire disorders by firstly developing non-sexual mindfulness skills through the practice of daily mindfulness exercises, and then transferring these skills into sensual and sexual activities (Brotto et al., 2008a, 2008b). Mindfulness has already been utilised in internet-based interventions for other disorders such as anxiety disorders (Houghton, 2008) and irritable bowel syndrome (Ljótsson et al., 2010), with positive results, and many other resources offer mindfulness training in a self-help format (e.g., Harris, 2008; Kabat-Zinn, 2006). Future internet-based treatments for FSDs could draw upon these methods to incorporate mindfulness techniques.

**Partner involvement.** Various authors have suggested that male partners should be engaged in the process of FSD treatment to increase treatment outcomes and decrease drop-out rates (Brotto et al., 2008a, 2008b; LoPiccolo, & Stock, 1986) due to the consistent association between partner involvement and FSD treatment.
success (Hawton, 1985; Hawton, et al., 1991; Hawton, et al., 1986; LoPiccolo & Stock, 1986; McCabe, 2001). Despite these recommendations, previously reported FSD treatment programs often do not engage male partners directly (e.g., Brotto et al., 2008a, 2008b; Jones & McCabe, 2011; Smith et al., 2008). Although partners were required to participate in the sensate focus and communication exercises in *Revive*, they were never directly contacted by the therapist and they received no psychoeducation about FSDs or the treatment (Jones & McCabe, 2011). Future internet-based interventions for FSDs need to target partner engagement and involvement more directly. One suggestion for achieving this is the preparation of educational handouts to be printed off for partners (Brotto et al., 2008a).

To increase partner engagement, it may also be beneficial to acknowledge any discomfort, anxiety and resistance experienced by the partner as a consequence of the woman undertaking treatment (LoPiccolo & Stock, 1986; Schneidman & McGuire, 1976). Partners may feel anxious about their private affairs being discussed with a third party, feel blamed for sexual and relationship problems, and feel worried about how the treatment will influence their relationship. They may also feel excluded and threatened by the new therapeutic relationship (LoPiccolo, & Stock, 1986). By communicating about these common experiences during FSD treatment, it is possible that a stronger partner alliance may form and potentially lead to lower attrition rates among the women, and better treatment outcomes.

The authors of *Revive* also suggested that internet-based interventions gather baseline and post-test data from male partners (Jones & McCabe, 2011). A thorough online assessment of male partners may help to increase partner involvement and develop couple alliance in the treatment process, and enable the evaluation of any benefits the intervention has on MSDs.
Summary

In summary, preliminary evidence supports the use of internet-based interventions for both MSD and FSD treatment. A review of the Revive program for mixed FSDs (Jones, 2010; Jones & McCabe, 2011) reveals several areas that could be addressed in order to improve internet-based interventions for FSDs: 1) Readiness for treatment needs to be taken into consideration; 2) Cognitive therapy needs to be directly incorporated into treatment; 3) Online chat-groups could be included to enhance cognitive therapy; 4) Comprehensive psychoeducation needs to be incorporated into treatment; 5) Mindfulness training could be included in treatment; and 6) Partner acknowledgement and involvement needs to be increased.
Chapter 4

Description of Publications

In order to address the limitations of prior internet-based interventions for FSDs (Hall, 2004; Jones & McCabe, 2011), a new internet-based intervention for FSDs was designed, implemented and evaluated. During this process, four publications were written on the topic of FSD treatment and the effectiveness of internet-based interventions. This chapter will describe a new internet-based treatment program for mixed FSDs - the PursuingPleasure (PP) program - and how it addressed the limitations of previous research. This will be followed by a description of the four articles written in the process of designing, implementing and evaluating the PP program.

The PursuingPleasure Program

PP was an online CBT intervention for women with mixed FSDs, including dysfunctions of sexual desire, arousal, orgasm and pain. The PP program was based on the structure of the Revive program (Jones & McCabe, 2011), but significantly modified in order to address several limitations: lack of accommodation for varying levels of readiness for treatment, lack of comprehensive psychoeducation, insufficient delivery of cognitive therapy, lack of mindfulness exercises, and insufficient attempts to engage male partners. The PP program addressed mixed FSDs, rather than one specific dysfunction, due to the large overlap in treatment methods for specific FSDs, and because many women experience more than one FSD (Giles & McCabe, 2009; McCabe, 2001; Jones & McCabe, 2011).
The PP treatment consisted of six progressive online modules, all of which were accessible from a password-protected website. Each module lasted approximately two weeks, although women were given flexibility to complete the program in their own timing. The content of the program included psychoeducation, communication exercises for couples, mindfulness exercises and sensate focus.

In order to address the limitations of previous online interventions for FSD, the following modifications were made within the PP program:

1) To accommodate for varying levels of readiness for treatment, a non-touch module was introduced at the beginning of treatment. This module included psychoeducation, communication exercises and mindfulness exercises, and instructed couples to abstain from any sexual activity. The aim of this module was to allow couples to reconnect and prepare for sensual and sexual touch in later modules;

2) To provide a platform for cognitive therapy, PP included online chat-groups every two weeks, as well as unlimited email contact with a therapist. Written CBT exercises that addressed maladaptive beliefs and attitudes were also included in each module;

3) Comprehensive psychoeducation was presented in each module, covering topics such as common sexual myths, female and male sexual anatomy, etiological factors and realistic sexual expectations;

4) Mindfulness exercises were incorporated into each module, beginning with non-sexual mindfulness exercises and then incorporating mindfulness into sensate focus in later modules;
5) To engage male partners, psychoeducation handouts were provided to partners in each module, and partners were also included in the assessment process at pre-test, post-test, and 3-month follow-up.

Further details of the PP program and the assessment process are presented within articles 2, 3 and 4, and appendices 6 and 7 include a Word document version of the full PP program and partner handouts.

**Article 1: Manualised Treatment Programs for Female Sexual Dysfunction: Research Challenges and Recommendations** (Alice Hucker & Marita McCabe, Published in the Journal of Sexual Medicine, 2012, Volume 9, Pages 350-360.)

In the initial planning and design phase of the PP program, a review of published manualised treatments for FSDs was conducted. In response to the evidence-based practice movement, manualised psychotherapy treatments have become an integral part of efficacy research (Nathan et al., 2000). The use of manualised treatments in research is advocated for a range of reasons related to research rigor and integrity, but this rigid treatment format also raises a range of research challenges in the area of psychological treatment. This article presents a detailed review of the manualised FSD treatments published between 1970 and 2011, including the recent treatment innovations of mindfulness-based interventions for FSD (Brotto et al., 2008a, 2008b) and Jones and McCabe’s (2011) internet-based treatment program, Revive. This review also identifies a range of methodological issues apparent in the manualised FSD treatments, such as small sample sizes and variability in inclusion and exclusion criteria. This is followed by a discussion of the benefits of manualised treatments for FSD research, as well as the research challenges inherent in the manualised treatment approach. This discussion is particularly focussed on the
degree of rigidity or flexibility built into the manualised treatment, and the impact that this has on the participants, the research validity and reliability (Eifert, Schulte, Zvolensky, Lejuez, & Lau, 1997), and the clinical utility of the treatment (Clarke, 1995). The article concludes with recommendations regarding manualised treatments for FSDs, with a focus on maximising internal validity and replicability while also providing enough flexibility for participants’ individual needs and readiness for treatment.

Article 2: Effectiveness of Cognitive Behavioral Therapy Incorporating Mindfulness Training in the Online Treatment of Female Sexual Dysfunction (Alice Hucker & Marita McCabe, Re-Submitted After Reviews for Publication in the Journal of Sexual Medicine)

Women with a range of sexual difficulties were recruited to participate in the PP studies. Study 1 involved a randomised controlled trial, with women being assigned to either the PP treatment group or the waitlist control group. After completing the waitlist period, women from the control group were offered treatment, and this data is presented in study 2. In both studies, participants and their partners completed online assessments at pre-test, post-test and 3-month follow-up. This article presents a rationale for the PP studies, a description of the studies, and the quantitative results from both treatment groups. While a range of outcomes were measured during the assessment phases of the program, this article focuses on changes in female sexual functioning and associated distress, as well as partner sexual functioning. A discussion of the implications of the results from both studies are presented, as well as a review of the limitations of the studies and recommendations.
for future research. This article also discusses the usefulness of online chat-groups and mindfulness training in the online treatment of mixed FSDs.

**Article 3: An Online, Mindfulness-Based, Cognitive-Behavioral Therapy for Female Sexual Dysfunction: Impact on Relationship Functioning (Alice Hucker & Marita McCabe, Re-Submitted After Reviews for Publication in the Journal of Sex & Marital Therapy)**

While article 2 focuses on changes in sexual functioning, article 3 presents data from the implementation of the *PP* program, but with a focus on relationship functioning. Previous research has demonstrated that relationship factors can play a large precipitating and perpetuating role in FSDs (Basson, 2000; Hawton et al., 1991) and various manualised treatments for sexual dysfunction have observed changes in relationship functioning as well as sexual functioning (Giles & McCabe, 2009; Jones & McCabe, 2011; Leusink & Aarts, 2006; McCabe & Price, 2008; McCabe et al., 2008; van Diest et al., 2007). The relationship factors assessed in this article were: sexual intimacy, emotional intimacy, communication and overall relationship satisfaction. Study 1 involved a randomised controlled trial, with women being assigned to either the *PP* treatment group or the waitlist control group. After completing the waitlist period, women from the control group were offered the *PP* treatment, and these data are presented in study 2. Both studies include comparisons of pre-test and post-test data, as well as an examination of the maintenance of treatment gains at 3-month follow. This article discusses the implications of the results from each study, and reviews the limitations of the studies and the limitations of the program with regards to relationship factors.
Article 4: A Qualitative Evaluation of Online Chat-Groups for Women Completing a Psychological Intervention for Female Sexual Dysfunction (Alice Hucker & Marita McCabe, Accepted for Publication in the Journal of Sex & Marital Therapy)

In order to provide a platform for cognitive therapy, Jones and McCabe (2011) suggested that future online interventions for FSD include online chat-groups to supplement the email exchanges. The PP program was the first online treatment for sexual dysfunction to incorporate online chat-groups, which women participated in every two weeks over the program. As well as providing women with a space for cognitive therapy in order to address and overcome challenges as they progressed through PP, the chat-groups also aimed to provide women with social support and to provide the therapist with a means to address misunderstandings throughout the program, monitor changes over time, and receive ongoing feedback from participants. This article presents a qualitative analysis of the chat-group content (based on transcripts from the chat-groups) in order to assess the degree to which the chat-groups fulfilled their intended functions. This article discusses how the use of online chat-groups in the internet-based treatment of FSDs is a useful addition to internet-based treatment, and presents feedback from participants about the use of online chat-groups in FSD treatment.
Manualized Treatment Programs for FSD: Research Challenges and Recommendations

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ABSTRACT

Introduction. The use of manualized treatment programs offers a useful research framework for assessing psychotherapeutic interventions for female sexual dysfunctions (FSDs), but it does not address all issues related to methodological rigor and replication, and raises new research issues in need of discussion.

Aims. The goals of this manuscript are to review the literature on treatment trials utilizing manualized psychotherapy treatments for FSD and to explore the benefits and research issues associated with the flexible use of treatment manuals.

Methods. The method used was the review of the relevant literature.

Results. While the use of manualized treatments for FSDs can address certain methodological issues inherent in psychotherapy research, flexibility in manual administration is necessary in order to allow tailoring for individual needs that can be beneficial to both the participant and the research. The flexible use of manuals, as opposed to strict manual adherence, may also be more relevant for clinical utility.

Conclusions. In order to administer manualized treatments for FSDs with appropriate flexibility, while also maximizing internal validity and replicability, the
authors recommend that predetermined decision rules be utilized to guide
directive tailoring, that potential gaps in the manual be identified and addressed,
and that differing levels of motivation and readiness for treatment be taken into
consideration in the treatment protocol. Hucker A and McCabe MP. Manualized
treatment programs for FSD: Research challenges and recommendations. J

**Key Words.** FSD; Psychological Treatments; Manualized Treatment Programs;
Research Methodology

**Introduction**
Past research has demonstrated the effectiveness of medical interventions alone [1, 2], and combined medical and psychological strategies [3, 4], in the
treatment of male sexual dysfunctions. However, the use of medical interventions for female sexual dysfunctions (FSDs) is not as well
established [5, 6], and currently there are no FDA approved medications for
the treatment of FSDs. A limited amount of research has focussed on the
use of combined medical and psychological treatments for FSDs.

Given the nature of FSDs, and the clear role of the relationship and other
psychosocial factors involved in female sexual functioning [4, 7], it has been
suggested that psychological treatments alone or a combination of medical and
psychological treatments may be the most effective interventions for FSDs
[4, 8]. For this reason, psychological researchers have been urged to
continue research into the effectiveness of psychological treatments for FSDs
[9, 10].

Research into psychological interventions for FSDs has been
criticised for a range of methodological problems, such as a lack of controlled studies, unclear definitions of outcomes, and the use of small samples
[8]. While many of these concerns are valid, there has been a lack of
recognition of the innovations of recent sex therapy research and increasing
rigorous research standards [8].

As part of the evidence-based practice (EBP) movement, manualised psychotherapy treatments have become an integral part of most efficacy research [11]. The use of manualized treatments in research is advocated in
order to provide an operationalized description of treatment methods, to
improve research rigor through the use of standardised procedures, and to aid
the objective comparison of treatments [13-16]. The use of the phrase ‘manualized treatment’ in this article will refer to psychotherapy treatments only.
While the use of manualized treatments in FSD research has the benefit of providing solutions for some of the methodological problems documented in much of the FSD research, it also raises new challenges for researchers. Designing a manualized treatment requires researchers to provide a clear description of their treatment protocol and method of delivery [11], usually with a specified timeline. While this may be relatively straightforward in medical research, psychological research is more difficult to describe and administer in such a standardized fashion. For example, while a daily 8am dose of a certain medication may be easy to describe and replicate, it may be more difficult to write a protocol regarding the amount and type of erotica that a woman should use in a homework task. For this reason, treatment manuals may end up being written in vague descriptions, or alternatively, written in a way that is too prescriptive and overly rigid. In response to this issue, the use of manualized treatments has at times been referred to as taking the “art” out of psychotherapy [11].

One of the major issues that is raised regarding the use of manualized treatments is the acceptable level of manual adherence and flexibility [14]. While there is no clear cut-off for the degree of flexibility that is appropriate, current literature on the transfer of efficacy research to effectiveness research and clinical dissemination, do suggest that an overly rigid manual may not transition well into clinical practice [15]. This article reviews the relevant literature on FSD manualized treatment trials and discusses the variability in treatment design and manual flexibility. Research challenges that arise from the use of flexible treatment manuals are then discussed. Lastly, research recommendations are provided, with a focus on specific strategies for incorporating appropriate flexibility into manualized treatments for FSDs.

**Manualized treatments for FSDs**

Research studies into the use of manualized treatments for women with sexual dysfunctions are outlined in Table 1 [17-52]. The studies show variability in many characteristics, and these will be discussed in more detail after a brief discussion of the history of manualized treatment for FSDs.

**Manualized treatments**

Masters and Johnson [31] were the first to describe a comprehensive sex therapy program for couples, which included psychoeducation, sensate focus and communication exercises to address a range of sexual difficulties within a relationship. Although their treatment program initially showed very positive results, further applications demonstrated a need for a broader etiological approach [53-55].

Since Masters and Johnson’s [31] behavioral sex therapy, the majority of manualized treatments developed and tested for FSDs have utilized cognitive-behavioral therapy approaches. For example, Trudel et al. [47] compared a CBT group program for female hypoactive sexual desire disorder (HSDD) to a waitlist control condition, with outcome measures showing 74% of the treatment group
### Table 1: Summary of studies evaluating manualized treatments for FSDs

<table>
<thead>
<tr>
<th>Study</th>
<th>Participants</th>
<th>Sample size</th>
<th>Intervention</th>
<th>Manual timing and flexibility</th>
<th>Main outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anderson, 1981</td>
<td>Women with primary orgasmic dysfunction.</td>
<td>30</td>
<td>Systematic desensitization (SD) group was compared to a directed masturbation (DM) group and a wait-list control.</td>
<td>Both treatment groups followed a 5-week (10 sessions) format. No information given on manual flexibility or individual tailoring.</td>
<td>Both treatment groups observed improvements in sexual pleasure and self-acceptance as compared to the control group; improvements maintained by the SD group at follow-up.</td>
</tr>
<tr>
<td>Barbach, 1974</td>
<td>Women with orgasmic dysfunction.</td>
<td>83</td>
<td>Group therapy program including masturbation exercises and discussion groups. No control group.</td>
<td>The treatment program followed a 5-week (10 sessions) manual. In later stages of program, homework exercises were individualized.</td>
<td>91.6% experienced orgasm through masturbation at post-treatment.</td>
</tr>
<tr>
<td>Bergeron et al., 2001</td>
<td>Women with dyspareunia.</td>
<td>78</td>
<td>A group CBT program was compared to surface electromyographic biofeedback and vestibulectomy.</td>
<td>The group CBT followed a 12 week (8 sessions) manual. The manual was adhered to 89.6% of the time (based on recordings of sessions).</td>
<td>All treatment groups showed improvements in sexual functioning; improvements maintained at 6-month follow-up.</td>
</tr>
<tr>
<td>Brotto et al., 2008</td>
<td>Women with sexual arousal disorder and/or HSDD.</td>
<td>26</td>
<td>A mindfulness-based group psychoeducational program. No control group.</td>
<td>The intervention followed a 3-session manual. No information given on manual flexibility or individual tailoring.</td>
<td>Improvements in desire, distress and self-assessed arousal; no significant changes in objective/physical arousal.</td>
</tr>
<tr>
<td>Brotto et al., 2008</td>
<td>Women with gynaecologic cancer.</td>
<td>22</td>
<td>3-session mindfulness-based group psychoeducational program. No control group.</td>
<td>The intervention followed a 3-session manual. No information given on manual flexibility or individual tailoring.</td>
<td>Improvements in desire, arousal, orgasm, satisfaction, distress, depression and overall wellbeing.</td>
</tr>
<tr>
<td>Dodge et al., 1982</td>
<td>Women with orgasmic dysfunction.</td>
<td>13</td>
<td>A minimal-contact DM manual was compared to a control group.</td>
<td>The intervention followed a 7-week bibliotherapy manual, with 3 therapist assisted sessions. No information given on manual flexibility or individual tailoring.</td>
<td>The treatment group observed greater improvements in sexual functioning as compared to the control group; improvements maintained at 6-week follow-up.</td>
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<tr>
<td>Study</td>
<td>Participants</td>
<td>Sample size</td>
<td>Intervention</td>
<td>Manual timing and flexibility</td>
<td>Main outcomes</td>
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<tr>
<td>Hurlbert, 1993</td>
<td>Women with HSDD.</td>
<td>39</td>
<td>A group intervention including orgasm training was compared to a standard group intervention.</td>
<td>The intervention followed an 8-session manual (sessions were longer in length for the orgasm training group). Progress was monitored but no information given on individual tailoring. Both treatment groups showed significant improvements in sexual desire and arousal; the orgasm training group reported greater improvements.</td>
<td></td>
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<tr>
<td>Hurlbert et al., 1993</td>
<td>Women with HSDD.</td>
<td>57</td>
<td>A women only orgasm training group was compared to a couple-only orgasm training group and a wait-list control.</td>
<td>Both groups were supervised to ensure adherence to manual. No information given on the timing of the intervention. Both treatment groups showed improvements on some sexual behaviour measures as compared to the control group; the couples-only group showed superior improvements at 6-month follow-up.</td>
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<tr>
<td>Jones &amp; McCabe, in press</td>
<td>Women with mixed sexual dysfunctions.</td>
<td>36</td>
<td>An internet-based CBT program was compared to a wait-list control group.</td>
<td>The intervention followed a flexibly timed 5-module manual, with a minimum of 10-weeks to complete. Unlimited email contact was offered to monitor progress and address challenges that arose over the program. The treatment group observed improvements in sexual and relationship functioning as compared to the control group; improvements maintained at 10-week follow-up.</td>
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<tr>
<td>Kilmann et al., 1986</td>
<td>Women with secondary orgasmic dysfunction.</td>
<td>55</td>
<td>Randomly assigned to a communication skills group, a sexual skills group, one of two combination group, or one of 2 control groups.</td>
<td>All women attended 2 sexual re-education sessions, and were then allocated to a treatment groups. All interventions followed an 8-session format. Some individual tailoring is described by the authors. 26% of the treatment groups observed improvements in sexual functioning as compared to the control groups; no significant difference between treatment formats; results not maintained at 6-month follow-up.</td>
<td></td>
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<tr>
<td>Kuriansky et al., 1982</td>
<td>Women with orgasmic dysfunction.</td>
<td>19</td>
<td>A group therapy program including masturbation and assertiveness training. No control group.</td>
<td>The intervention followed a 5-week (10 sessions) manual. Sessions were &quot;semi-structured&quot;. Later sessions allowed for individual tailoring of pace and content. 95% improvement in sexual functioning at post-treatment and 84% improvement at 2-year follow-up.</td>
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<tr>
<td>Study</td>
<td>Participants</td>
<td>Sample size</td>
<td>Intervention</td>
<td>Manual timing and flexibility</td>
<td>Main outcomes</td>
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<tr>
<td>Leiblum &amp; Erdner-Hershfield, 1977</td>
<td>Women with mixed FSD and orgasmic dysfunction</td>
<td>16</td>
<td>A group therapy program including masturbation training and sensate focus, evaluated with 3 groups (mixed FSD, orgasmic dysfunction, mixed FSD with partners).</td>
<td>The intervention followed an 8-week (8 sessions) or 5-week (10 sessions) manual. No information given on manual flexibility or individual tailoring.</td>
<td>Improvements observed in orgasm through masturbation and sexual desire; improvements in marital and sexual satisfaction was greater with partner participation.</td>
</tr>
<tr>
<td>Libman et al., 1984</td>
<td>Women with secondary orgasmic dysfunction</td>
<td>23 couples</td>
<td>Couple therapy was compared to a group therapy program and a minimal-contact bibliotherapy program.</td>
<td>All interventions followed a 14-week format. The couples therapy and group therapy groups attended 15 sessions, while the bibliotherapy group attended 2 sessions. Individualized maintenance programs were designed for each couple.</td>
<td>All treatment groups observed improvements sexual functioning; some improvements maintained at follow-up; the couple therapy program was marginally favoured.</td>
</tr>
<tr>
<td>Masheb et al., 2009</td>
<td>Women with sexual pain due to vulvodynia</td>
<td>50</td>
<td>A CBT program was compared to supportive psychotherapy.</td>
<td>Both treatments followed a 10-week format and were delivered individually. Agendas and homework tasks were devised collaboratively in the CBT sessions. All sessions were monitored to ensure manual adherence.</td>
<td>The CBT group observed greater improvements in sexual functioning as compared to supportive psychotherapy; improvements were maintained at one-year follow-up.</td>
</tr>
<tr>
<td>Masters &amp; Johnson, 1970</td>
<td>Couples with mixed sexual dysfunction</td>
<td>342 couples</td>
<td>Behavioral sex therapy with couples. No control group.</td>
<td>Treatment was in a 5-day residential setting for both partners, using a prescribed program with some level of flexibility.</td>
<td>77%-83% success rate; 82% success rate after 5-year follow-up.</td>
</tr>
<tr>
<td>Mathews et al., 1976</td>
<td>Couples with mixed sexual dysfunctions</td>
<td>36 couples</td>
<td>SD with counselling was compared to behavioral sex therapy with counselling and minimal contact self-help sex therapy.</td>
<td>All treatments followed a 10-week format. Manuals allowed for individual tailoring in the counselling components, although aims and limits were specified.</td>
<td>No significant difference was found between treatments; small trends suggest that behavioral sex therapy with counselling may be superior.</td>
</tr>
<tr>
<td>Study</td>
<td>Participants</td>
<td>Sample size</td>
<td>Intervention</td>
<td>Manual timing and flexibility</td>
<td>Main outcomes</td>
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<tr>
<td>McCabe, 2001</td>
<td>People with mixed sexual dysfunctions.</td>
<td>99</td>
<td>A CBT program. No control group.</td>
<td>The intervention followed a 10-session manual. No information given on manual flexibility or individual tailoring</td>
<td></td>
</tr>
<tr>
<td>McGovern et al., 1975</td>
<td>Women with primary/secondary orgasmic dysfunction.</td>
<td>12</td>
<td>A behavioral treatment program focussing on anxiety reduction, sexual skills training and communication. No control group.</td>
<td>The intervention followed a 15-session manual. The focus of the sessions allowed for individual tailoring to address broader relationship issues.</td>
<td></td>
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<tr>
<td>McMullen &amp; Rosen, 1979</td>
<td>Women with primary orgasmic dysfunction.</td>
<td>60</td>
<td>A video assisted masturbation training program was compared to bibliotherapy and a wait-list control.</td>
<td>Both interventions followed a 6-week format. No information given on manual flexibility or individual tailoring</td>
<td></td>
</tr>
<tr>
<td>Morokoff &amp; LoPiccolo, 1986</td>
<td>Women with primary orgasmic dysfunction.</td>
<td>43</td>
<td>A minimal therapist-contact (MTC) treatment was compared to a full therapist-contact (FCT) treatment.</td>
<td>Both interventions followed a 14-week format (MTC: 4-sessions; FCT: 15 sessions). No information given on manual flexibility or individual tailoring</td>
<td></td>
</tr>
<tr>
<td>Obler, 1973</td>
<td>People with mixed sexual dysfunctions.</td>
<td>64</td>
<td>SD with assertiveness training was compared to traditional group therapy and a no-treatment control.</td>
<td>The SD intervention followed a 15-week (15 sessions) manual. No information given on manual flexibility or individual tailoring</td>
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</table>

Lower levels of sexual dysfunction, more positive attitudes/perceptions regarding sex, and less negative impact on relationship due to sexual dysfunction. 100% of women with primary orgasmic dysfunction improved in sexual functioning; improvements were not observed in the women with secondary orgasmic dysfunction. 60% experienced orgasm at post-treatment; neither of the treatment groups were significantly superior; improvements increased at 12-month follow-up. Both treatment groups observed improvements in orgasm during masturbation and coitus, and sexual satisfaction; increased happiness in marriage was observed in the minimal contact group. Significant improvements in sexual functioning were observed in the SD group but not the psychoanalytic treatment group; results were maintained at 18-month follow-up.
<table>
<thead>
<tr>
<th>Study</th>
<th>Participants</th>
<th>Sample size</th>
<th>Intervention</th>
<th>Manual timing and flexibility</th>
<th>Main outcomes</th>
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<tbody>
<tr>
<td>Payn &amp; Wakefield, 1982</td>
<td>Women with primary orgasmic dysfunction.</td>
<td>11</td>
<td>A group therapy program including masturbation training and discussion groups.</td>
<td>The intervention followed a 5-week (10 sessions) manual. No information given on manual flexibility or individual tailoring.</td>
<td>100% experienced orgasm through masturbation at post-treatment; no participant achieved orgasm during coitus. Greater improvements were observed in the DM group with 90% gaining orgasmic capacity as compared to 53% in the sensate focus group.</td>
</tr>
<tr>
<td>Riley, 1978</td>
<td>Women with primary orgasmic dysfunction.</td>
<td>35</td>
<td>A DM program was compared to a combined sensate focus and supportive psychotherapy program.</td>
<td>Both interventions followed a 12-week (9 sessions) format. No information given on manual flexibility or individual tailoring.</td>
<td></td>
</tr>
<tr>
<td>Sarwer &amp; Durlak, 1997</td>
<td>People with sexual dysfunctions</td>
<td>365 couples</td>
<td>A couples-based group behavioural sex therapy program.</td>
<td>The intervention followed a 7-week (7 sessions) manual. The manual allowed for session content to vary depending on presenting problems and couples' needs.</td>
<td>65% of couples were successfully treated for their sexual dysfunction; approximately 70% of women maintained treatment gains at follow-up.</td>
</tr>
<tr>
<td>Schneiderman &amp; McGuire, 1976</td>
<td>Women with primary orgasmic dysfunction.</td>
<td>20</td>
<td>Group treatment consisting of education, sensate focus and DM. No control group.</td>
<td>The group program followed a 10-week manual. The manual specified some additional exercises for women who had not achieved orgasm by week 6, and for couples where the male was experiencing premature ejaculation.</td>
<td>Orgasm was achieved by 55% of participants, although only 5% achieved coital orgasm; improvements in non-coital orgasm increased to 70% at 6-month follow-up.</td>
</tr>
<tr>
<td>Smith et al., 2008</td>
<td>Women with mixed sexual dysfunctions.</td>
<td>25</td>
<td>A group psychoeducation and brief CBT appointment. No control group.</td>
<td>The intervention consisted of one 2 hour session plus an individual follow up appointment (optional). CBT exercises were patient-based.</td>
<td>Significant improvements in desire, arousal, lubrication, orgasm and satisfaction.</td>
</tr>
<tr>
<td>ter Kuile et al., 2009</td>
<td>Women with lifelong vaginismus.</td>
<td>10</td>
<td>Therapist-aided exposure therapy. No control group.</td>
<td>The intervention followed a 12-18 week structure (1 week of exposure + 2 follow-up sessions). The manual allowed for flexibility in the number of exposure sessions (up to 3 sessions).</td>
<td>9 out of 10 participants reported intercourse post-treatment; results were maintained at 12-month follow-up.</td>
</tr>
<tr>
<td>Study</td>
<td>Participants</td>
<td>Sample size</td>
<td>Intervention</td>
<td>Manual timing and flexibility</td>
<td>Main outcomes</td>
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<tr>
<td>ter Kuile et al., 2007</td>
<td>Women with lifelong vaginismus.</td>
<td>117</td>
<td>Group CBT was compared to minimal assistance bibliotherapy and a wait-list control.</td>
<td>Both interventions followed a CBT manual. The CBT group consisted of 19 sessions, while the bibliotherapy group involved 6 fortnightly telephone calls. No information given on manual flexibility or individual tailoring.</td>
<td>Both treatment groups observed increases in frequency of intercourse, reduced intercourse fear and improvements in non-penetrative sexual interactions.</td>
</tr>
<tr>
<td>ter Kuile &amp; Weijenborg, 2006</td>
<td>Women with sexual pain.</td>
<td>76</td>
<td>A group CBT program. No control group.</td>
<td>The intervention followed a 24-week (12 sessions) manual. Sessions were audio-taped to ensure manual adherence.</td>
<td>Improvements in sexual dissatisfaction, vestibular pain and vaginal muscle tension.</td>
</tr>
<tr>
<td>Trudel &amp; Laurin, 1988</td>
<td>Women with orgasmic dysfunction.</td>
<td>17</td>
<td>CBT bibliotherapy with minimal telephone contact was compared to a wait-list control group.</td>
<td>The intervention followed a 15-week format, and participants were contacted weekly by a therapist. No information given on manual flexibility or individual tailoring.</td>
<td>The treatment group observed improvements in arousal, pleasure, sexual repertoire and satisfaction as compared to the control group; changes maintained at 3-month follow-up.</td>
</tr>
<tr>
<td>Trudel et al., 2001</td>
<td>Women with HSDD.</td>
<td>74</td>
<td>A group CBT program was compared to a wait-list control group.</td>
<td>The intervention followed a 12-week (12 sessions) manual. No information given on manual flexibility or individual tailoring.</td>
<td>74% of the treatment group no longer met criteria for HSDD at post-treatment; improvements decreased to 64% at follow-up.</td>
</tr>
<tr>
<td>van Lankveld et al., 2001</td>
<td>Couples with mixed sexual dysfunction.</td>
<td>199 couples</td>
<td>A CBT bibliotherapy program was compared to a control group.</td>
<td>The intervention followed a 10-week manual. Exercises were tailored to the type of sexual dysfunction being experienced. Telephone contact was offered when needed.</td>
<td>The treatment group observed improvements in sexual functioning (expect for dyspareunia) as compared to the control group; changes maintained at follow-up.</td>
</tr>
<tr>
<td>van Lankveld et al., 2006</td>
<td>Women with lifelong vaginismus.</td>
<td>117</td>
<td>A group CBT program was compared to a therapist assisted CBT bibliotherapy program and a wait-list control group.</td>
<td>The CBT group followed a 10-session manual. Bibliotherapy was accompanied by 6 fortnightly telephone contacts. Some optional exercises were included in the manual. Audio-taped sessions were used to assess manual adherence.</td>
<td>Successful intercourse achieved by 14% of the treatment participants, compared to zero in the control group; improvements increased at 12-month follow-up.</td>
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Table 1 Continued

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<tr>
<th>Study</th>
<th>Participants</th>
<th>Sample size</th>
<th>Intervention</th>
<th>Manual timing and flexibility</th>
<th>Main outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vansteen-wegen et al., 2007</td>
<td>People with sexual dysfunctions.</td>
<td>215</td>
<td>Self-administered video therapy was compared to a wait-list control group.</td>
<td>Full translation not available.</td>
<td>Video therapy did not yield superior results on most outcome variables.</td>
</tr>
<tr>
<td>Wallace &amp; Barbach, 1974</td>
<td>Women with primary orgasmic dysfunction.</td>
<td>17</td>
<td>A group sex therapy program including masturbation training and discussion groups. No control group.</td>
<td>The treatment program followed a 5-week (10 sessions) manual. In later stages of program, homework exercises were individualized.</td>
<td>100% achieved orgasm at post-treatment; 87% orgasmic in partner-related sexual activities at 8-month follow-up.</td>
</tr>
<tr>
<td>Wincz &amp; Caird, 1976</td>
<td>Women with sexual dysfunctions.</td>
<td>21</td>
<td>SD was compared to video SD and a control-cross-over group.</td>
<td>Both interventions followed a structured SD manual. Session attendance was flexible depending on convenience and time necessary to complete all SD items.</td>
<td>Both treatment groups observed significant reductions in sexual anxiety and increases in orgasm occurrence; video desensitisation was more effective than SD.</td>
</tr>
</tbody>
</table>

CBT = cognitive-behavioral therapy; FSD = female sexual dysfunction; HSDD = hypoactive sexual desire disorder
longer met HSDD criteria at post-treatment.

While most of the manualized treatments in Table 1 have targeted a specific FSD (e.g., HSDD, orgasmic dysfunction), a number of research studies have reported positive results for sexual symptoms other than those specifically targeted. The therapeutic techniques used in manualized treatments for FSDs also tend to overlap considerably [56]. For these reasons, the use of manualized treatments aimed at mixed FSDs is supported, and studies investigating manualized treatments for mixed FSDs have found positive results [25, 28, 31-33, 37, 40, 42, 48].

A recent and promising addition to the CBT approach for FSDs involves the inclusion of mindfulness meditation into manualized treatments [8, 20-21]. Two studies have evaluated the incorporation of mindfulness training into a brief psychoeducational group manual for women with sexual desire and arousal problems [20-21]. Although lacking control groups, both studies reported significant increases in sexual desire and reductions in sexual distress.

The use of bibliotherapy and video-therapy manuals for FSDs have also been reported in the literature, and a review of outcome studies suggests that bibliotherapy and video-therapy manuals offer a viable alternate to face-to-face treatment programs [57]. Internet-based interventions are the most recent manualized treatment approach for FSDs and have been applied to mixed FSDs, with preliminary evidence supporting the effectiveness of this approach [25]. Jones and McCabe [25] conducted a study evaluating the effectiveness of a manualized internet-based CBT program, Revive, for women with mixed FSDs. Significant improvements on measures of sexual desire, arousal, orgasm, sexual satisfaction and pain were observed in the treatment group as compared to the control group, as well as improvements in relationship satisfaction, sexual intimacy and emotional intimacy.

Methodological problems

As mentioned earlier, research into psychological interventions for FSDs has been criticised for a range of methodological problems, such as a lack of controlled studies, unclear definitions of “dysfunction”, unclear definitions of outcomes, and the use of small samples [8]. The studies in Table 1 confirm that these methodological problems and inconsistencies are apparent in the literature on manualized treatments for FSD.

From the studies in Table 1, it is evident that many of the studies have not used any form of treatment comparison [e.g. 20], while others have either included a wait-list control [e.g., 35] or compared a treatment approach with another treatment or standard care [e.g., 39]. There is a large discrepancy in sample sizes among the studies, with the lowest sample size being 10 women [43], and the largest being 365 couples [40]. There is also much variation in the length of treatment time for each study, and only some studies contained a follow-up period. These conditions make it very difficult to compare interventions for FSDs, and therefore
may hinder clinical decisions regarding the usefulness of each intervention.

There is also variability in the inclusion criteria used in the studies in Table 1, and the ways in which FSD has been defined. Specifically, there is variation in whether single or mixed dysfunctions were included, whether women with sub-clinical levels of FSD were included, and which psychometric tools were used to establish the degree of dysfunction. The variety of inclusion and exclusion criteria used in these studies reflects current debates surrounding the appropriateness of using a homogeneous group of diagnostically similar participants within psychological outcome studies. These debates raise the question of whether inclusion and exclusion criteria may be more useful if applied less stringently, in order to mimic real world settings [11, 15].

Degree of manual adherence
The studies listed in Table 1 vary in the delivery of the manualized treatments. Differences exist in the timing of the manual’s delivery, not only in the number of sessions outlined in the timeline, but also in the degree of individual tailoring allowed in the timeline. Most of the studies in Table 1 provided strict timelines for their interventions. For example, McMullen and Rosen [35] adhered to a 6-week intervention format, with no indication of individual tailoring due to lack of progress in treatment, timing difficulties, barriers to behaviour change, or any other factor. Meanwhile, some studies in Table 1 did offer flexibility in the number of sessions offered. For example, ter Kuile and colleagues [43] allowed between 1-3 sessions in the initial stages of their intervention, depending on the participants progress through the initial exercises.

As well as variation in manual timelines, the degree of flexibility offered in the content of the interventions also varied between studies in Table 1. Some studies provide descriptions of their manual that suggest their protocol was adhered to stringently, with little room for individual tailoring. For example, ter Kuile and Weijenborg [45] audio-taped their sessions in order to monitor and optimize manual adherence. Meanwhile, other interventions do describe degrees of content flexibility. For example, in the study by Barbach [18], the treatment became flexibly tailored to the individual’s needs in the later sessions of treatment.

In the studies from Table 1 where manual flexibility was described, in either timeline or content, the majority of descriptions were vague and brief, and many studies did not give any information on manual adherence or flexibility. The exception to these vague descriptions of manual flexibility were the studies that specified additional exercises for participants with certain characteristics. For example, Schneiderman and McGuire [41] provided additional “squeeze technique” exercises for women who had a partner experiencing premature ejaculation.

Manualized treatments and research implications
While a review of the literature demonstrates that manualized
treatments are being utilized in FSD research, it is important to explore the benefits of doing so, and the related research challenges.

Benefits of using manualized treatments for FSD research

Manualized treatments in FSD intervention research reflect the benefits seen in other areas of psychotherapeutic intervention. Manualized treatments enable researchers to match diagnoses with current EBP; to design more streamlined treatment protocols and therefore increase internal validity and aid treatment comparisons; to offer clear goals and treatment directions; and to be less reliant on the clinical judgment and personal biases of the treating clinician [13-16]. Manualized treatments can also offer cost-effective and time-efficient options [14], and can be used in conjunction with outcome/measurement tools and randomized control comparisons to produce more rigorous treatment trials. Andersons’s [17] systematic desensitization and directed masturbation interventions demonstrate these benefits well. These interventions were matched to a specific FSD (primary orgasmic dysfunction), were structured and streamlined in their administration, offered clear behavioral goals, did not rely on clinical judgement to a large degree, and were time-efficient. They also utilized a control group comparison and outcome measurement tools.

Research challenges

While it is apparent that the utilization of manualized treatments in FSD research has the effect of increasing methodological rigor, these benefits all rely on stringent adherence to the treatment manual. In reality, it has been recommended that manualized treatments be administered with a degree of flexibility and allowance for individual tailoring [14, 58]. This recommendation is made due to a number of limitations surrounding the use of manualized treatments, such as treatments being too broad or too specific, assuming homogeneity of individuals, including superfluous interventions for certain individuals, and not including enough interventions for others [14, 58]. A rigid treatment protocol may also be unrealistic for clinical dissemination, and therefore the manual’s ability to transfer to effectiveness trials and clinical use must also be considered [15, 40]. Sarwer and Durlak [40] provide a good example of how manual flexibility can aid in the implementation of a manualized treatment in field research.

Although flexibility in manual administration is recommended, the lack of strict adherence to a manualized treatment for FSDs presents new research challenges. The flexible use of treatment manuals raises the question of how much flexibility is appropriate, and how best to incorporate and record this flexibility for the purposes of treatment evaluation and replication. Methodological issues related to this include individuated treatment protocols and variable treatment timelines.

While manualized treatments for FSDs do outline clear procedures and specific interventions to be administered, a certain amount of
flexibility is also essential to accommodate the individual biopsychosocial needs of participants [12, 14]. As a consequence, the ‘dosage’ and ‘administration’ may be slightly (and sometimes largely) different for each participant, depending on their individual circumstances, past experiences and comorbid conditions. Consequently, providing a comprehensive description of treatment methods and variations to aid replication is potentially difficult for manualized treatments of FSDs, and some researchers put more emphasis on this than others. For example, Anderson [17] provides a very short procedures section with no indication of whether the manual incorporated any degree of flexibility. In contrast, Barbach [18] provides a comprehensive description of the manual procedures and also states that, in later sessions, homework tasks were “… assigned according to the specific needs of the individual woman.” (pp. 141). Even with this description, the reader still does not receive a comprehensive indication of how much individual tailoring was allowed for each woman, and what principles guided these decisions. It should be noted that descriptions of individual tailoring are encouraged in the revision of the CONSORT guidelines for non-pharmaceutical interventions [59].

A further issue that arises from the flexible use of manualized treatments for FSDs is that of the treatment timeline. While manualized treatments are often designed with specific timelines (e.g., a 10-week program), interventions for FSDs may better serve their clients by offering participants a flexible timeline. Manualized treatments can offer a guideline for timing, but flexibility may be necessary due to the complex biopsychosocial factors associated with FSDs [4, 7], and the fluctuations that can occur in a woman’s motivation and readiness to change as the treatment progresses [60]. For example, it is common for women to be faced with challenges at different points during treatment that may necessitate them taking more time on certain modules. While this timeline flexibility may introduce confounding variables into the treatment study, this may be more relevant to real-world settings, and the alternative would be to rush women through the treatment. This process could be detrimental to the participant’s progress as well as the conclusions drawn about intervention effectiveness [12, 14]. Jones and McCabe [25], and ter Kuile and colleagues [43], both provide examples of how timeline flexibility can be built into a manualized program.

Lastly, and this is not exclusively related to manualized treatments, all trials evaluating the efficacy of FSD treatments need to consider the appropriate use of control group comparisons, validated outcome measures, and follow-up periods.

In summary, the use of manualized treatment programs for FSDs offers a useful framework for standardizing treatment methods and increasing research standards, but it does not address all issues related to methodological rigor and replication. It is also evident that the rigid application
of treatment manuals is not entirely appropriate for the complex nature of psychological research, and that manualized treatments can only be applied to FSDs if appropriate flexibility is utilized. With appropriate flexibility, manualized treatments offer researchers a balance between scientific rigor and clinical utility [14, 58].

**Research recommendation for the manualized treatment of FSDs**

In order to use manualized treatments effectively in FSD research, there needs to be a balance between manual adherence and flexibility to ensure a fairly streamlined application of evidence-based strategies, while also addressing the individual needs of the participant, regarding both the timeline and the content of the intervention [14, 58]. The following discussion offers recommendations for incorporating appropriate flexibility to a manualized treatments for FSDs while also maximising internal validity, making the manual more appropriate for both research and clinical use.

**Systematic tailoring for individual needs**

In order to increase fidelity to the treatment manual, individual tailoring can be done in a systematic way [14] and therefore aid in the reporting of procedures and in the replication of the study [59]. Such systems can include the use of decision-making rules to facilitate clinical judgment and to decrease personal bias [14]. One such system allows alterations to the manualized treatment by either delaying an intervention, accelerating an intervention, or dropping an intervention [14]. For example, in a flexible manualized treatment for HSDD, participants with higher levels of sexual aversion may delay the sensate focus exercises until they feel comfortable to commence sensual touch, while those more comfortable with sexual touch may move through these exercises at a faster pace.

Whether decision-making rules are based on recommendations from the literature [e.g., 14] or designed specifically for the FSD manual, it is recommended that these decision rules be incorporated into the treatment manual before the research trial begins to improve fidelity to the treatment manual and aid treatment descriptions [58]. The descriptions of such procedures should allow the reader to gain a comprehensive understanding of how much manual flexibility was incorporated into the study, and how these decisions came about.

Participants should also be aware of the extent to which their individual needs will be tailored for, and given opportunities to state these individual needs. For example, Jones and McCabe [25] administered an internet-based manualized treatment for women with mixed FSDs, where they offered unlimited email contact to discuss individual needs and challenges.

**Assessment of potential treatment gaps**

A manualized treatment cannot include the breadth of techniques and interventions to suit the needs of every individual. To do so would result in the treatment being too broad for most participants, and may lead to dissatisfaction and attrition [14].
Therefore, researchers need to assess the specific needs that are outside of their manualized treatment [58], devise protocols regarding the types of extra information/interventions that will be available to participants, and decide how to allow access to these materials. For example, Brotto, Basson and Luria [20] briefly mention sexual abuse in their treatment manual, but do not offer specific information on dealing with the impact of sexual abuse on sexual functioning. If it were evident that a particular woman needed this information, it would be appropriate for this to be available to them, perhaps in the form of an information handout, or through an intervention delivered by the program facilitators. Any additional information/interventions provided should be in alignment with the theoretical basis of the manualized treatment and should be recorded for the purpose of study evaluation and replication.

In the treatment of FSDs, it is not yet known exactly which components of treatment are necessary for any one participant [61]. Therefore, a manualized treatment for FSDs should contain a variety of techniques (e.g., communication exercises, sensate focus, mindfulness meditation), but will also need to judiciously exclude certain techniques so as not to ‘overload’ the participant. For example, the treatment for mixed FSDs described by McCabe [33] included cognitive therapy, sensate focus, and communication exercises, but excluded more specific techniques such as directed masturbation and use of dilators.

Accommodating differing levels of motivation and readiness for treatment
Participants completing a manualized treatment will present with varying levels of motivation and varying degrees of readiness to change their behavior. For example, participants may not be mentally prepared to begin treatment, they may be thinking about treatment but not yet ready to actively participate, or they may be ready for treatment and active behavior change [60]. These differences in motivation and readiness for treatment can have a large impact on treatment success, and therefore accommodating for these differences is recommended [60]. To address this, a manualized treatment for FSDs can be broken up into progressive modules that participants can move through at a speed appropriate to their circumstances. A non-touch module can also be included at the beginning of the treatment to accommodate those participants who are not yet ready for sexual touch. For example, a woman participating in Jones and McCabe’s [25] online CBT program who has not touched her partner sexually in the past 12 months may not be ready to begin sensate focus straight away, as is proposed in the first module, and may benefit from a module that focuses on emotional intimacy and communication.

Study design
The following recommendations are not exclusive to the use of manualized treatments for FSDs, but deserve mention nonetheless. The appropriate use of inclusion and exclusion criteria, control group comparisons, validated outcome measures, and follow-up
periods needs to be considered in all FSD intervention studies. The use of larger sample sizes in future research is also important in determining the efficacy of treatment approaches.

As mentioned earlier, inclusion and exclusion criteria in efficacy research have traditionally been used to recruit a homogeneous group of diagnostically similar participants, but some literature now suggests that inclusion and exclusion criteria may be more useful if applied less stringently, in order to mimic real world settings [11, 15]. In response to this suggestion, it has been proposed that efficacy researchers use a two-tier system of recruitment, which includes one group of participants who meet strict diagnostic criteria, and another group who meet less rigid criteria. For example, Sarwer and Durlak [40] included both women who met diagnostic criteria for a FSD, as well as women who were experiencing sexual difficulties but did not meet the threshold for a FSD. Their study also included women with mixed FSDs, as opposed to one specific type, as would be likely to occur in a clinical setting.

Similar arguments are being made about the usefulness and relevance of no-treatment control groups for evaluating treatment outcomes [11, 15]. More information to guide decisions on the use of inclusion/exclusion criteria and control groups can be found within the literature [11, 15].

**Conclusion/Summary**
Research into psychological treatment options for women with sexual dysfunctions is necessary due the complex biopsychosocial factors involved in precipitating and maintaining FSDs [4, 7]. While FSD intervention research has been criticized for methodological concerns, the use of manualized treatments has offered psychotherapy researchers in the area of FSD a framework to guide research and improve research standards. This framework is consistent with the principles of EBP, increases internal validity through standardized procedures, and aids in the replication and objective comparison of treatment for FSDs [14-16]. While strict adherence to a manualized treatment for FSDs can improve research rigor and fidelity [58], a more flexible approach allows tailoring for individual needs that can be beneficial to both the participant and the research [14, 58]. In order to provide appropriate flexibility while also maximizing internal validity and reliability, the authors recommend that predetermined decision-rules be utilized to guide individual tailoring, that potential gaps in the manual be identified and addressed, and that differing levels of motivation and readiness for treatment be taken into consideration.

Future research would serve to continue investigations into the effectiveness of manualized treatments for FSDs in clinical settings. As well as producing methodologically sound research into the effectiveness of psychological treatments for FSDs, future research should focus on determining the specific components of these treatments that are beneficial to women with sexual dysfunctions.
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Chapter 6

Article 2: Resubmitted After Reviews for Publication in the Journal of Sexual Medicine

Effectiveness of Cognitive Behavioral Therapy Incorporating Mindfulness Training in the Online Treatment of Female Sexual Dysfunction

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Abstract

Introduction. Internet-based treatments for female sexual dysfunctions (FSDs) offer women an anonymous and private treatment alternative to face-to-face interventions.

Aims. The current randomized studies evaluated an online cognitive-behavioral therapy (CBT) program for FSD. Pursuing Pleasure (PP) consisted of sensate focus, communication exercises, and unlimited email contact with a therapist. PP extended upon prior research by incorporating mindfulness meditation and online chat-groups, and assessing partner sexual functioning. Methods. In study 1, a total of 26 women (mean age 33.31, SD = 7.40 years) completed the PP program and were compared to a waitlist control group of 31 women (mean age 33.94, SD = 5.17 years). In study 2, 16 women (mean age 30.75, SD = 5.12 years) from the waitlist control group completed the PP program. Main Outcome Measures. The Female Sexual Function Index, the Female Sexual Distress Scale – Revised, the International Index of Erectile Function, and the Premature Ejaculation Diagnostic Tool. Results. The
results demonstrated that both treatment groups obtained significant improvements in most areas of female sexual functioning, as well as significant reductions in self-reported frequency of FSD, and decreases in associated distress. Partner sexual functioning also improved in some areas. **Conclusions.** These findings add support to the use of internet-based treatments as an alternative to face-to-face therapy for women with FSD. These studies also demonstrate the utility of CBT incorporating mindfulness exercises and online chat-groups in the treatment of FSD.

**Key words.** Sexual Dysfunction; Sexual Functioning; Communication; Internet Treatment; Cognitive-Behavioral Therapy; Psychological Interventions for Female Sexual Dysfunction; Mindfulness; Chat-Groups

**Introduction**

Given the nature of female sexual dysfunction (FSDs), and the clear role that the relationship and other psychosocial factors play in their etiology and maintenance [1, 2], it has been suggested that psychological treatments alone, or combined with medical treatments, may be the most effective interventions for FSDs [2, 3]. Face-to-face psychological interventions have been the main mode of treatment for FSDs since Masters and Johnson’s [4] behavioral sex therapy. More recent interventions for FSDs tend to utilize a cognitive-behavioral therapy (CBT) approach in order to address the cognitive, affective, and attitudinal aspects of FSDs [2]. These approaches have also been adapted into self-help methods such as bibliotherapy [5], with the benefits of increased convenience and privacy.

Internet-based interventions are the most recent treatment approach for FSDs. As well as convenience and privacy, online therapies can simultaneously draw
together a community of clients while maintaining their anonymity [6, 7, 8, 9]. Research into the use of internet-based interventions for sexual dysfunctions is quite limited, and preliminary evidence from studies investigating online CBT treatments for male sexual dysfunctions (MSDs) suggest that internet-based treatment may be a suitable alternative to face-to-face sex therapy [7, 8, 10, 11, 12].

To date, only one controlled study has investigated the effectiveness of an internet-based intervention for FSDs. Jones and McCabe [6] conducted a study evaluating the effectiveness of an internet-based CBT program, called Revive, for women with FSD. Revive included women with mixed FSD due to the high level of comorbidity of sexual dysfunctions found in women [1], and the program consisted of sensate focus, communication exercises and unlimited email contact with a therapist. The main aim of the email contact was to address maladaptive cognitions as well as psychosocial factors involved in FSD [6]. Women who completed the Revive program improved significantly on measures of sexual desire, arousal, lubrication, orgasm, pain, and satisfaction compared to those in the control group and all improvements were maintained at 3-month follow-up [6].

Although Revive [6] was developed as a CBT program, there were significant difficulties in engaging women over email therapy, which limited the program’s ability to provide cognitive therapy [6]. To overcome this limitation, the authors suggested that future internet-based interventions utilize online chat-groups to enhance the cognitive aspects of treatment.

Another recent and promising addition to the psychological treatment of FSDs involves the inclusion of mindfulness - a Buddhist meditation practice [3, 13, 14, 15]. Mindfulness techniques aim to cultivate present-moment awareness and non-judgemental observation of experiences [15]. When applied to FSDs, mindfulness
exercises can help to decrease distractedness and performance anxiety during sexual activity, and increase awareness of pleasurable sensations [13, 14].

The current study was designed to extend upon prior research by evaluating the effectiveness of a new online intervention for women with mixed FSDs, called PursuingPleasure (PP). PP contained sensate focus, communication exercises and unlimited email contact, and was the first treatment for sexual dysfunction to utilize online chat-groups. PP was also the first online sex therapy program to incorporate mindfulness exercises. As well as these significant additions, the PP program included online assessment of partners in order to evaluate the impact that the program had on partner sexual functioning. These extensions on prior research are especially important at this point in time due to the absence of approved medical interventions for FSD, the side effects of medications being investigated, and the likelihood that medical interventions alone will not be suitable for many women with FSD [2].

**Study 1**

**Method**

**Aim**

The aim of study 1 was to evaluate the effectiveness of the PP treatment for women with mixed FSD as compared to a waitlist control. The following hypotheses were proposed: 1) women in the treatment group and their partners will demonstrate significant improvements in sexual functioning as compared to a waitlist control; 2) women in the treatment group will report significant reductions in distress associated with sexual functioning as compared to a waitlist control; and 3) treatment gains will be maintained at 3-months follow-up.
Participants

To be eligible to participate in the study the following inclusion criteria were applied: female, over 18 years of age, currently experiencing sexual difficulties (desire, arousal, orgasm and/or pain), in a stable heterosexual relationship, no significant mental illness, no significant relationship problems (e.g., violence, abuse), English speaking, and regular access to the internet. It was also necessary for partners to be willing to participate in treatment. See Figure 1 for details of recruitment stages.

Materials

Program content was delivered online via a password-protected website. Participants completed online surveys at pre-test, post-test and 3-months follow-up. All chat-groups were conducted in a password-protected chat-room using synchronous (real-time) text conversation.

Demographic Information

Participants provided demographic information, including age, partner’s age, relationship status, and duration of relationship. Women’s perception of their own sexual difficulties was also obtained, including type, duration and frequency of sexual difficulties, as well as their perception of their partner’s sexual functioning.

Female Sexual Function Scale (FSFI)

The FSFI [16] is a 19-item self-report measure designed to assess female sexual function over six domains: sexual desire, arousal, lubrication, orgasmic function, sexual satisfaction, sexual pain. The FSFI is based on the respondents’ past 4 weeks of sexual activity, with lower scores indicating poorer sexual functioning (e.g., lower scores on sexual pain equate to greater pain). Responses to items are summed and multiplied by a domain factor to determine the domain scores. Scores
on all domains are summed to compute the total FSFI score, with a score of \( \leq 26 \) indicating that a woman meets the criteria for clinical levels of FSD [17]. The FSFI has been shown to have high internal consistency (\( \alpha \geq .82 \)), and high test–retest reliability (\( \alpha = .79 - .88 \)) [16]. Reliability scores for the current study were: sexual desire, \( \alpha \geq .81 \); sexual arousal, \( \alpha \geq .91 \); lubrication, \( \alpha \geq .92 \); orgasm, \( \alpha \geq .89 \); satisfaction, \( \alpha \geq .68 \); pain, \( \alpha \geq .85 \), and for the total scale, \( \alpha \geq .89 \). Recommended changes [18] were applied to the FSFI.

**Female Sexual Distress Scale – Revised (FSDS-R)**

The FSDS-R [19] is a 13-item self-report measure designed to assess the degree of personal distress associated with sexual functioning. Scores range from 0 to 52 with higher scores indicating greater distress. Scores of \( \geq 11 \) are indicative of a diagnosis of FSD [19]. The reliability of the FSDS-R for sexually functional and dysfunctional women was established by Derogatis and colleagues [19] (\( \alpha = .87 - .97 \)). The reliability score for the current study was \( \alpha \geq .93 \).

**International Index of Erectile Function (IIEF)**

The IIEF [20] is a 15-item self-report measure of male sexual functioning that covers five domains: erectile function, orgasmic function, sexual desire, intercourse satisfaction, and overall satisfaction. The intercourse satisfaction subscale was not used in the current study due to multicollinearity with the erectile functioning subscale [20]. All items ask about sexual experiences in the previous month, and lower scores are indicative of poorer sexual functioning. High internal consistency has been reported for all subscales (\( \alpha = .71 - .96 \)) [20] and the reliability scores for the current study were: erectile function (\( \alpha \geq .93 \)), orgasmic function (\( \alpha \geq .95 \)), sexual desire (\( \alpha \geq .83 \)), and overall satisfaction (\( \alpha \geq .98 \)).
**Premature Ejaculation Diagnostic Tool (PEDT)**

The PEDT [21] is a 5-item self-report questionnaire designed to measure premature ejaculation (PE) in men. Scores range from 0 to 22, with higher scores indicative of greater ejaculatory dysfunction. Good internal consistency has been reported for the PEDT ($\alpha = .71$) [21], and the reliability score for the current study was $\alpha \geq .86$.

**Treatment**

*PP* was an online CBT intervention for women with FSD and their partners. The program consisted of 6 progressive modules, each lasting approximately 2 weeks (see appendix for a summary of the program). Each module contained psychoeducation and related CBT exercises that addressed cognitive and affective aspects of FSD. Psychoeducation sheets for partners were also available in each module.

Communication exercises, that required couples to write and share letters with each other on various topics relevant to each module, were also included. A list of discussion questions was provided in each module, and couples also had the option of creating questions tailored to their own needs. Sensate focus exercises were used throughout the program, with touching exercises becoming progressively more sexually oriented as the modules proceeded (see appendix).

Mindfulness exercises were used throughout the program to facilitate present moment awareness and manage difficult thoughts and feelings regarding sex and intimacy. Daily non-sexual mindfulness practice (e.g., meditating on the breath) was encouraged throughout the entire program. Mindfulness exercises became more sensually and sexually oriented over the program, and were incorporated into
sensate focus. The mindfulness component of the program was adapted from Brotto, Basson, and Luria’s [22] *Group Psychoeducation Treatment* manual.

The online chat-groups occurred every 2 weeks, contained approximately 4-8 women, and ran for one hour each. All groups (and email contact) were facilitated by a clinical psychology doctoral student specializing in the psychological treatment of FSDs. This facilitator had undergone CBT and mindfulness training throughout her doctoral training, and had been engaging in a personal mindfulness practice for many years. See Hucker and McCabe [23] for further details on the structure and content of the online chat-groups. Participants progressed through the modules at their own pace and were offered unlimited email contact with the therapist.

**Procedure**

Ethics approval for this study was gained from the University Human Research Ethics Committee. See Figure 1 for details of recruitment stages and treatment attrition. Women were recruited to participate in the study via worldwide health websites and Australian university noticeboards, a press release in two Australian newspapers, and through a database of women who previously participated in a project completed by the second author. Women who registered interest via email were sent further information via email and the link for an online plain language statement which provided comprehensive information about the program and the study. Women who were still interested in participating gave online consent via the link, and were randomly assigned to either the treatment group or waitlist control, and sent a link to the online pre-treatment questionnaire. In order to investigate both clinical and sub-clinical levels of sexual difficulties, women were not screened for FSD prior to being accepted into the study. Inspection of pre-test differences between the women who completed treatment and those who dropped
out indicted that the women who dropped out of treatment reported significantly lower sexual desire, sexual arousal, and sexual satisfaction. However, there were no significant differences in the percentage of women who met diagnostic criteria for FSD as based on the FSFI and the FSDS-R. Women in the control group were offered the PP treatment after their final waitlist questionnaire was completed (see study 2).

**Results**

**Demographic information**

The mean age of the treatment group and control group were 33.31 years ($SD = 7.4$) and 31.94 years ($SD = 5.17$) respectively, $t(55) = 0.79, p = .26$. The mean age of partners in the treatment group and control group were 34.77 years ($SD = 7.58$) and 33.16 years ($SD = 5.87$) respectively, $t(55) = -0.90, p = .36$. Relationship duration for the treatment group and control group were 7.94 years ($SD = 5.52$) and 8.84 years ($SD = 5.29$) respectively, $t(55) = -0.63, p = .60$. Sixty-nine percent of the treatment group and seventy-one percent of the control group were married, while the remaining women identified themselves as de facto, partnered and/or cohabitating.

Mean duration of sexual difficulties was 4.1 years for both groups, and the standard deviation was 0.8 years for the treatment group and 0.7 years for the control group, $t(55) = 0.10, p = .65$. The type of sexual difficulties reported by each group is presented in Table 1. Based on clinical cut-offs from the FSDS-R, all women from both groups reported a level of distress that is indicative of a FSD diagnoses. Five (21.7%) women in the treatment group and four (16%) women in the control group did not meet criteria for FSD based on clinical cut-offs of the FSFI. Due to a lack of sexual activity and/or sexual intercourse in the previous 4
weeks, 10 women could not be categorised. Regarding partner sexual functioning, 42.3% of the treatment group and 51.6% of the control group indicated that their partner had some form of MSD.

**Effects of PP on Female Sexual Functioning and Associated Distress**

To compare changes in female sexual functioning and associated distress between the treatment group and control group from pre-test to post-test, a multivariate analysis of variance (MANOVA) was conducted. Due to the FSFI requiring women to have had sexual activity within the past four weeks for most subscales, four women from the treatment group and 10 women from the control group were excluded listwise from this analysis. The between subject factor for the MANOVA was group (treatment vs control) and the repeated measures factor was time (pre-test to post-test). The dependent variables being examined were sexual desire, arousal, lubrication, orgasm, pain, satisfaction and distress. See Table 2 for the means and standard deviations of each dependent variable for both groups. The MANOVA revealed a significant interaction effect for group*time, $F(7, 33) = 8.55$, $p < .001$; Pillai’s Trace = 0.65; partial $\eta^2 = .65$, suggesting that the treatment group observed significant improvements in sex related variables from pre-test to post-test as compared to the control group. The univariate results suggest that the treatment group improved significantly on scores of sexual desire, $F(1, 41) = 4.72$, $p < .05$; partial $\eta^2 = .11$, arousal, $F(1, 41) = 32.14$, $p < .001$; partial $\eta^2 = .45$, lubrication, $F(1, 41) = 9.25$, $p < .01$; partial $\eta^2 = .19$, orgasm, $F(1, 41) = 23.85$, $p < .001$; partial $\eta^2 = .38$, satisfaction, $F(1, 41) = 18.16$, $p < .001$; partial $\eta^2 = .32$, and distress, $F(1, 41) = 24.07$, $p < .001$; partial $\eta^2 = .38$, but not pain, $F(1, 41) = 4.72$, $p = .17$; partial $\eta^2 = .05$, from pre-test to post-test as compared to the control group. Although the results for sexual pain were not significant, the change in means from pre-test to post-test
suggests a trend towards improved pain scores for the treatment group as compared to the control group (see Table 2).

Changes in self-reported frequency of sexual difficulties were also compared pre-test to post-test for both groups (see Table 3). In order to compare changes across time and between groups, this variable was converted into a continuous variable, with higher scores indicating that FSD was experienced more of the time. A repeated measures ANOVA was conducted, with the repeated measure factor being time (pre-test to post-test). This revealed a significant interaction effect for group*time, $F(1, 55) = 15.65, p < .001$; Pillai’s Trace = 0.22; partial $\eta^2 = 0.22$.

These results suggest that the frequency of female sexual difficulties reduced significantly pre-test to post-test in the treatment group as compared to the control group.

**Effects of PP on Male Sexual Functioning**

To compare changes in male sexual functioning between the treatment group and control group from pre-test to post-test, a MANOVA was conducted. The between subject factor was group (treatment vs control) and the repeated measures factor was time (pre-test to post-test). The dependent variables being examined were erectile function, partner orgasmic function, partner sexual desire, partner overall sexual satisfaction, and PE. See Table 2 for means and standard deviations. The MANOVA revealed a significant interaction effect for group*time, $F(5, 49) = 4.09, p < .01$; Pillai’s Trace = 0.30; partial $\eta^2 = .30$, suggesting that partners in the treatment group observed significant improvements in sexual functioning from pre-test to post-test compared to the control group. The univariate results suggest that partners in the treatment group experienced significant improvements in erectile function, $F(1, 53) = 6.43, p < .05$; partial $\eta^2 = 0.11$, partner sexual desire, $F(1, 53) =$
8.20, \( p < .001 \); partial \( \eta^2 = .13 \), and partner overall sexual satisfaction, \( F(1, 53) = 16.95, \ p < .01 \); partial \( \eta^2 = .24 \), but not for orgasmic function, \( F(1, 53) = 2.48, \ p = .12 \); partial \( \eta^2 = .05 \), and PE, \( F(1, 53) = 0.93, \ p = .34 \); partial \( \eta^2 = .02 \), from pre-test to post-test as compared to the control group. Although the results for orgasmic function and PE were not significant, the change in means from pre-test to post-test in the treatment group suggest a trend towards improvement (see Table 2).

**Maintenance of Treatment Gains**

To assess maintenance of treatment gains in both female and male sexual functioning, two repeated measures ANOVAs were conducted for the treatment group. Due to the FSFI requirements, six women from the treatment group were excluded listwise from this analysis, and the ANOVAs for female and male sexual functioning were therefore conducted separately, with the repeated measures factor being time (post-test to 3-month follow-up). Follow-up scores were not compared to pre-test scores as this would not appropriately represent the assessment phases and would potentially conflate the data. The dependent variables being examined in the first ANOVA were female sexual desire, arousal, lubrication, orgasm, pain, satisfaction, and distress. The results revealed a non-significant effect for time, \( F(7, 13) = 1.40, \ p = .28 \); Pillai’s Trace = 0.43; partial \( \eta^2 = .43 \), and the univariate tests revealed non-significant changes for sexual desire, \( F(1, 19) = 1.57, \ p = .23 \); partial \( \eta^2 = .08 \), arousal, \( F(1, 19) = .44, \ p = .53 \); partial \( \eta^2 = .03 \), lubrication, \( F(1, 19) = 0.51, \ p = .48 \); partial \( \eta^2 = .03 \), orgasm, \( F(1, 19) = 0.08, \ p = .79 \); partial \( \eta^2 = .004 \), pain, \( F(1, 19) = 2.33, \ p = .14 \); partial \( \eta^2 = .11 \), satisfaction, \( F(1, 19) = 2.33, \ p = .06 \); partial \( \eta^2 = .17 \), and distress, \( F(1, 19) = 0.29, \ p = .60 \); partial \( \eta^2 = .02 \), from post-test to follow-up. These results suggest that changes in all areas of female sexual functioning were maintained at 3-month follow-up (see Table 4).
The dependent variables in the second ANOVA were erectile function, partner orgasmic function, partner sexual desire, partner overall sexual satisfaction, and PE. The results revealed a significant effect for time, $F(5, 21) = 3.12, p < .05$; Pillai’s Trace = 0.43; partial $\eta^2 = .43$, and the univariate tests revealed non-significant changes for erectile function, $F(1, 25) = 1.59, p = .22$; partial $\eta^2 = 0.06$, partner sexual desire, $F(1, 25) = 3.00, p = .10$; partial $\eta^2 = .12$, and PE, $F(1, 25) = 0.04, p = .85$; partial $\eta^2 = .002$, and a significant change for partner orgasmic function, $F(1, 25) = 6.55, p < .05$; partial $\eta^2 = .21$, and partner overall sexual satisfaction, $F(1, 25) = 7.02, p < .05$; partial $\eta^2 = .22$, from post-test to follow-up. These results suggest that scores on erectile function, partner sexual desire and PE remained stable from post-test to follow-up, but not scores on partner orgasmic function and partner overall sexual satisfaction (see Table 4).

Changes in self-reported frequency of female sexual difficulties were compared post-test to 3-month follow-up (see Table 5). In order to compare changes across time, this variable was converted into a continuous variable, with higher scores indicating that FSD was experienced more of the time. A repeated measures ANOVA was then conducted, with the repeated measure factor being time (pre-test to post-test). This revealed a non-significant interaction effect for group*time, $F(1, 25) = 0.11, p = .75$; Pillai’s Trace = 0.004; partial $\eta^2 = .004$. This result suggests that the reduction in frequency of female sexual difficulties observed in the treatment group at post-test was maintained over the follow-up period.

### Study 2

#### Aim

The aim of study 2 was to evaluate the effectiveness of the PP treatment for the control cross-over group. The following hypotheses were proposed: 1) women in
the control cross-over group and their partners will demonstrate significant improvements in sexual functioning; 2) women in the control cross-over group will report significant reductions in distress associated with sexual functioning; 3) treatment gains will be maintained at 3-month follow-up; and 4) women in the control cross-over group will demonstrate a lower attrition rate than the original treatment group. This fourth hypothesis was made due to beliefs that women who completed the full waitlist period would enter treatment with increased investment and increased motivation.

**Method**

**Participants**

The control cross-over group consisted of women from the control group in study 1 who took up treatment after completing the waitlist period (see Figure 1).

**Materials and Treatment**

Refer to study 1 and the appendix.

**Procedure**

After completing the final waitlist control group questionnaire (from study 1), the control group was offered the *PP* treatment. Twenty-two women accepted the offer of treatment, and the final waitlist control group questionnaires were used as the new baseline. See Figure 1 for details of the cross-over design and program attrition. In total, 16 women in the control cross-over group completed the *PP* program. Inspection of pre-test differences between the women who completed treatment and those who dropped out did not reveal any significant differences.

Nine women from the waitlist control group declined treatment after completing the waitlist period. The following reasons for not taking up treatment were provided: timing not suitable (*n* = 1); feeling better about sexual relationship (*n* =
relationship break-up (n = 1). Six women did not give a reason, and inspection of the data revealed that those who refused treatment had significantly greater orgasmic function and a significantly lower percentage of women meeting criteria for FSD as compared to the women who entered treatment.

Results

Demographic Information

The mean age of the control cross-over group was 30.75 years (SD =5.12 years) and the mean age of their partner was 31.94 (SD = 5.72 years). The mean relationship duration was 8.60 years (SD =4.34). In total 68.80% of the group were married, while the remaining women identified their relationship as de facto, partnered and/or cohabitating. Mean duration of sexual difficulties was 5.56 years (SD =3.72). The types of sexual difficulties reported by the group was: low sexual desire/interest (93.8%), failure to become aroused/lubricated (56.3%), inability to orgasm (37.5%), reduced satisfaction (37.5%), delayed orgasm (31.3%), painful intercourse (18.8%). Based on clinical cut-offs from the FSDS-R, all women in the control cross-over group reported a level of distress that is indicative of a FSD diagnoses. One woman (7.7%) in the control cross-over group did not meet criteria for FSD based on clinical cut-offs of the FSFI, and three women could not be categorised. Regarding partner sexual functioning, 56.25% of the control cross-over group indicated that their partner had some form of MSD. Differences between the original treatment group and the control cross-over group at baseline suggested that the control cross-over group reported significantly greater distress, $t(40) = 4.64, p < .01$, and a higher prevalence of women experiencing painful intercourse., $\chi^2(1) = 6.13 , p < .05$. 
Effects of *PP* on Female Sexual Functioning and Associated Distress

To assess changes in female sexual function and associated distress in the control cross-over group after completing the *PP* treatment, a repeated measures ANOVA was conducted, with the repeated measures factor being time (pre-test to post-test). Due to the FSFI requirements, four women were excluded listwise from this analysis. The results revealed a significant effect for time, $F(7, 5) = 6.60, p < .05$; Pillai’s Trace = 0.90; partial $\eta^2 = 0.90$, and the univariate tests suggest that the control cross-over group improved significantly on scores of sexual desire, $F(1, 11) = 9.72, p < .01$; partial $\eta^2 = 0.47$, arousal, $F(1, 11) = 14.14, p < .01$; partial $\eta^2 = .56$, orgasm, $F(1, 11) = 8.01, p < .05$; partial $\eta^2 = .42$, satisfaction, $F(1, 11) = 18.69, p < .01$; partial $\eta^2 = .63$, and distress, $F(1, 11) = 39.91, p < .001$; partial $\eta^2 = .78$, from pre-test to post-test, but not on scores of lubrication, $F(1, 11) = 3.87, p = .08$; partial $\eta^2 = .26$, or pain, $F(1, 11) = 0.14, p = .72$; partial $\eta^2 = .01$. Although the scores on lubrication were non-significant, inspection of the means from pre-test to post-test reveals a trend towards improvement (see Table 6).

Changes in self-reported frequency of sexual difficulties were compared pre-test to post-test for the control cross-over group (see Table 7). In order to compare changes across time, this variable was converted into a continuous variable, with higher scores indicating that FSD was experienced more of the time. A repeated measures ANOVA was then conducted, with the repeated measures factor being time (pre-test to post-test). This revealed a significant effect for time, $F(1, 15) = 10.48, p < .01$; Pillai’s Trace = 0.41; partial $\eta^2 = .41$. These results suggest that the frequency of sexual difficulties significantly reduced in the control cross-over group from pre-test to post-test.
Effects of PP on Male Sexual Functioning

To assess changes in partner sexual functioning in the control cross-over group, a repeated measures ANOVA was conducted, with the repeated measures factor being time (pre-test to post-test). The results revealed a non-significant effect for time, $F(5, 11) = 0.88, p = .52$; Pillai’s Trace = 0.29; partial $\eta^2 = .29$, and the univariate tests suggest that partners from the control cross-over group did not demonstrate significant improvements in any area of sexual functioning pre-test to post-test: erectile function, $F(1, 15) = 1.67, p = .21$; partial $\eta^2 = .10$, partner orgasmic function, $F(1, 15) = 0.94, p = .36$; partial $\eta^2 = .06$; partner sexual desire, $F(1, 15) = 0.01, p = .93$; partial $\eta^2 = .001$, partner overall sexual satisfaction, $F(1, 15) = 4.19, p = .06$; partial $\eta^2 = .22$, and PE, $F(1, 15) = 2.37, p = .15$; partial $\eta^2 = .14$. Although these results were non-significant, inspection of the means does suggest a trend towards improvement in all areas of partner sexual functioning (see Table 6).

Maintenance of Treatment Gains

To assess maintenance of treatment gains in both female and male sexual functioning, two repeated measures ANOVAs were conducted for the control cross-over group. Due to the FSFI requirements, two women from the control cross-over group were excluded listwise from this analysis, and the ANOVAs for female and male sexual functioning were therefore conducted separately. The repeated measures factor was time (post-test to 3-month follow-up). The dependent variables being examined in the first ANOVA were female sexual desire, arousal, lubrication, orgasm, pain, satisfaction, and distress. The results revealed a non-significant effect for time, $F(7, 6) = 1.72, p = .26$; Pillai’s Trace = 0.67; partial $\eta^2 = .67$, and the univariate tests revealed non-significant changes for all dependent variables from post-test to follow-up: sexual desire, $F(1, 12) = 1.00, p = .34$; partial $\eta^2 = .08$, ...
arousal, $F(1, 12) = .41, p = .53$; partial $\eta^2 = .03$, lubrication, $F(1, 12) = 0.38, p = .55$; partial $\eta^2 = .03$, orgasm, $F(1, 12) = 0.003, p = 1.00$; partial $\eta^2 = .000$, satisfaction, $F(1, 12) = 4.32, p = .06$; partial $\eta^2 = .26$, pain, $F(1, 12) = 0.11, p = .74$; partial $\eta^2 = .01$, and distress, $F(1, 12) = 0.03, p = .87$; partial $\eta^2 = .002$. These results suggest that changes in all areas of female sexual functioning were maintained at 3-month follow-up in the control cross-over group (see Table 8).

The dependent variables in the second ANOVA were erectile function, partner orgasmic function, partner sexual desire, partner overall sexual satisfaction, and PE. The results revealed a non-significant effect for time, $F(5, 9) = 0.29, p = .91$; Pillai’s Trace $= 0.14$; partial $\eta^2 = .14$, and the univariate tests revealed non-significant changes for all partner variables from post-test to follow-up: erectile function, $F(1, 13) = 0.06, p = .81$; partial $\eta^2 = .01$, partner orgasmic function, $F(1, 13) = 0.49, p = .50$; partial $\eta^2 = .04$, partner sexual desire, $F(1, 13) = 1.09, p = .32$; partial $\eta^2 = .08$, partner overall sexual satisfaction, $F(1, 13) = 0.31, p = .59$; partial $\eta^2 = .02$, and PE, $F(1, 13) = 0.30, p = .59$; partial $\eta^2 = .02$. These results suggest that scores on all partner variables remained stable from post-test to follow-up (see Table 8).

Changes in self-reported frequency of female sexual difficulties were compared post-test to follow-up for the control cross-over group (see Table 7). In order to compare changes across time, this variable was converted into a continuous variable, with higher scores indicating that FSD was experienced more of the time. A repeated measures ANOVA was conducted, and this revealed a significant effect for time, $F(1, 15) = 0.33, p = .57$; Pillai’s Trace $= 0.02$; partial $\eta^2 = .02$. This result suggests that the reduction in frequency of female sexual difficulties observed in the control cross-over group at post-test was maintained over the follow-up period.
Discussion

The PP program was the first internet-based intervention for FSD to incorporate mindfulness exercises and online chat-groups. The overlap of different sexual difficulties reported in the PP studies is consistent with past literature describing the high incidence of comorbidity of FSD seen in women [1, 6]. Women who completed the PP program in study 1 demonstrated significant improvements in sexual desire, arousal, lubrication, orgasm, and satisfaction as compared to a waitlist control group. Sexual pain did not appear to improve significantly, although there was a trend towards improved scores, and baseline scores suggest that difficulties with sexual pain were not as great as other sexual problems.

Women who completed treatment in study 1 also demonstrated a significant reduction in self-reported frequency of sexual difficulties, and significant reductions in the distress associated with their sexual functioning, as compared to the waitlist control. The reduction in distress is likely related to improvements in sexual functioning, but may have also been influenced by components of the treatment focussed on normalizing FSDs and reducing associated self-blame. Furthermore, qualitative feedback from the chat-groups suggested that the normalisation and validation that occurred in the groups was one of the most helpful aspects of the chat-groups [23].

Women who completed the PP program in study 2 demonstrated significant improvements in sexual desire, arousal, orgasm, and satisfaction, but not in lubrication and pain. Although the result for lubrication was non-significant, there was a trend towards improved lubrication scores and it is likely that the small sample size impacted this result. Again, baseline scores for sexual pain suggest that difficulties with sexual pain were not as great as other sexual problems in the control
crossover group. All improvements in female sexual functioning, frequency of FSD, and associated distress in both studies were maintained at the 3-month follow-up, and this is consistent with previous research into internet-based CBT treatments for FSDs [6].

Although significant improvements were observed in both treatment groups, not all women experienced complete reversal of symptoms, and most women reported that they were still having sexual difficulties some of the time. These findings are similar to previous face-to-face and internet-based studies into the psychological treatment of FSD [6, 24, 25, 26] and suggest that a full reversal of FSD symptoms may require a longer or more intensive treatment. These imperfect results also suggest that women and partners were not simply trying to please the experimenter with their responses.

Regarding partner sexual functioning, the results from study 1 demonstrated that some aspects of partner sexual functioning improved over the course of the PP treatment as compared to the waitlist control group: erectile function, partner sexual desire, and partner overall sexual satisfaction. Partner orgasmic function and PE did not improve significantly in study 1, but the results did indicate a trend towards improvements in partner orgasmic functioning and PE. Improvements were maintained at 3-month follow-up for scores on erectile function, partner sexual desire, and PE, but not for partner orgasmic function or partner overall sexual satisfaction. Overall, these results indicate that the exercises in the PP program may have been helpful for some areas of partner sexual functioning, but that more targeted interventions are necessary to fully address MSD in couples, such as techniques for delaying ejaculation [27]. The improvements observed may also reflect the interdependent nature of sexual dysfunctions within a couple [28, 29].
The control cross-over group in study 2 did not demonstrate any significant improvements in partner sexual functioning. It is hypothesised that this result is due to the smaller sample size observed in the control cross-over group, and it should be noted that a trend towards improvement was observed on all partner sexual functioning variables. These results remained stable at the 3-month follow-up.

Regarding a comparison of study 1 and study 2, the attrition rate for the treatment group and control cross-over group were 43.48% and 27.27% respectively. Drop-out is common among sex therapy clients in general [6, 8, 25], but the women in study 2 demonstrated a considerably lower drop-out rate than the treatment group. To explain this difference, it is hypothesised that women who completed the full waitlist period entered treatment with increased investment and increased motivation. Despite differing attrition rates, both studies demonstrated a similar pattern of drop-out where women were more likely to leave treatment in the earlier modules (modules 1-3). Based on qualitative feedback, two of the biggest challenges in the earlier stages of treatment related to time management and partner cooperation. Although these issues were addressed in chat-groups and email therapy, not all women were able to resolve them.

Another difference observed between the two studies was that the self-reported frequency of sexual dysfunctions reduced more in the control cross-over group than the original treatment group, and this reduction was maintained at 3-month follow-up. This difference is again hypothesized to be a function of higher motivation after the completion of the waitlist period.

The results of the current studies add support to the use of internet-based treatments as an alternative to face-to-face therapy for women with FSD and their partners [1, 6]. The addition of mindfulness was well received by participants and
extended on traditional sensate focus strategies by facilitating a greater focus on present moment awareness and the management of difficult thoughts and emotions[13, 14, 15]. The addition of chat-groups appeared to allow women to explore the cognitive-affective aspects of their sexual difficulties, and to gain social support. In qualitative feedback, both mindfulness and online chat groups were reported as two of the most helpful aspects of the program, although it is impossible to ascertain which components of the PP program were most effective.

Although the results from these two studies are supportive of the use of internet-based treatments for FSDs, some limitations are in need of discussion. Firstly, the results are not generalizable to women in relationships with significant discord or women experiencing significant mental illness. These women/couples would likely benefit from more intensive psychotherapy. The results also lack generalizability to women in same-sex relationships and single women, and future research could evaluate the effectiveness of online FSD interventions for these groups of women. Also, women with FSDs of a biological etiology would be unlikely to experience significant benefits from the PP program alone.

Secondly, both studies have small samples sizes, which was exacerbated by high attrition and the cross-over design and it is likely that this restricted the power of statistical analyses to detect significant differences. Thirdly, it is likely that both studies contained a highly motivated group of women, due to the voluntary nature of the study, high attrition and cross-over design, and this may not be representative of the greater population of women with FSD.

Lastly, due to the requirements of the FSFI, women who had not experienced sexual activity and/or intercourse in the last four weeks were not represented sufficiently in all results. Also, unlike the FSFI which has a protocol for dealing with
participants who report no sexual activity and/or intercourse [17], the IIEF does not have a similar protocol [30], and different studies deal with these data in different ways [31, 32, 33, 34]. Additionally, in both of these measures there is a strong focus on current sexual functioning and sexual intercourse, and future research needs to be focussed on the development of measures that assess sexual functioning in a more inclusive manner.

References


8 McCabe M, Price E. Internet-based psychological and oral medical treatment compared to psychological treatment alone for ED. J Sex Med 2008;5:2338-2346


Table 1

*Type of female sexual difficulties reported by treatment and control group at pre-test*

<table>
<thead>
<tr>
<th>Type of sexual difficulty</th>
<th>Treatment group (N=26)</th>
<th>Control group (N=31)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low sexual desire</td>
<td>96.2%</td>
<td>96.8%</td>
</tr>
<tr>
<td>Failure to become aroused/lubricated</td>
<td>80.8%</td>
<td>58.1%</td>
</tr>
<tr>
<td>Inability to orgasm</td>
<td>38.5%</td>
<td>41.9%</td>
</tr>
<tr>
<td>Delayed orgasm</td>
<td>23.1%</td>
<td>32.3%</td>
</tr>
<tr>
<td>Painful intercourse</td>
<td>57.7%</td>
<td>41.9%</td>
</tr>
<tr>
<td>Reduced satisfaction</td>
<td>57.7%</td>
<td>51.6%</td>
</tr>
</tbody>
</table>
Table 2

Means and standard deviations of dependent variables at pre-test and post-test for treatment and control groups

<table>
<thead>
<tr>
<th>Dependent variables</th>
<th>Treatment group</th>
<th>Control group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-test</td>
<td>Post-test</td>
</tr>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td>Female questionnaire (N = 22)</td>
<td>(N = 21)</td>
<td></td>
</tr>
<tr>
<td>Sexual desire</td>
<td>2.67 (0.86)</td>
<td>3.55 (0.64)</td>
</tr>
<tr>
<td>Sexual arousal</td>
<td>3.42 (1.06)</td>
<td>4.70 (0.79)</td>
</tr>
<tr>
<td>Lubrication</td>
<td>4.33 (1.16)</td>
<td>5.31 (0.80)</td>
</tr>
<tr>
<td>Orgasm</td>
<td>3.72 (1.52)</td>
<td>4.70 (1.39)</td>
</tr>
<tr>
<td>Sexual pain</td>
<td>4.47 (1.41)</td>
<td>5.00 (1.21)</td>
</tr>
<tr>
<td>Sexual satisfaction</td>
<td>3.30 (1.15)</td>
<td>4.72 (0.59)</td>
</tr>
<tr>
<td>Distress</td>
<td>33.32 (9.65)</td>
<td>19.13 (10.54)</td>
</tr>
<tr>
<td>Partner questionnaire (N = 26)</td>
<td>(N = 29)</td>
<td></td>
</tr>
<tr>
<td>Erectile function</td>
<td>21.85 (11.16)</td>
<td>28.15 (3.74)</td>
</tr>
<tr>
<td>Orgasmic function</td>
<td>8.30 (3.12)</td>
<td>9.35 (1.16)</td>
</tr>
<tr>
<td>Sexual desire</td>
<td>6.88 (1.84)</td>
<td>8.04 (1.51)</td>
</tr>
<tr>
<td>Overall sexual satisfaction</td>
<td>4.42 (2.45)</td>
<td>7.69 (2.05)</td>
</tr>
<tr>
<td>Premature ejaculation</td>
<td>6.35 (4.01)</td>
<td>4.88 (3.61)</td>
</tr>
</tbody>
</table>

*Lower scores are indicative of poorer functioning.

b Higher scores are indicative of poorer functioning.

*Denotes significant changes pre-test to post-test at $p \leq 0.05$; **Denotes significant changes pre-test to post-test at $p \leq 0.01$.

SD=standard deviation.
Table 3

*Self-reported frequency of female sexual difficulties over past month at pre-test and post-test for treatment and control groups – means, standard deviations, and percentage frequencies*

<table>
<thead>
<tr>
<th>Frequency of sexual difficulties</th>
<th>Treatment group (N=26)</th>
<th>Control group (N=31)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-test</td>
<td>Post-test</td>
</tr>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td><strong>Frequency of sexual difficulties</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>About 10% or less</td>
<td>4.08 (0.80)</td>
<td>2.85 (1.08)**</td>
</tr>
<tr>
<td>About 25% of the time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>About 50% of the time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>About 75% of the time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All the time</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Frequency data converted into continuous variable; higher scores indicate that FSD is experienced more of the time

**Denotes significant change pre-test to post-test at p ≤ .01.

SD=standard deviation.
Table 4

*Means and standard deviations of dependent variables at post-test and 3-month follow-up for treatment group*

<table>
<thead>
<tr>
<th>Dependent variables</th>
<th>Post-test Mean (SD)</th>
<th>Follow-up Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Female questionnaire</strong> (N = 20)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Sexual desire&quot;</td>
<td>3.54 (0.64)</td>
<td>3.30 (0.88)</td>
</tr>
<tr>
<td>&quot;Sexual arousal&quot;</td>
<td>4.74 (0.81)</td>
<td>4.57 (1.16)</td>
</tr>
<tr>
<td>&quot;Lubrication&quot;</td>
<td>5.23 (0.97)</td>
<td>5.37 (0.71)</td>
</tr>
<tr>
<td>&quot;Orgasm&quot;</td>
<td>4.62 (1.44)</td>
<td>4.65 (1.40)</td>
</tr>
<tr>
<td>&quot;Sexual pain&quot;</td>
<td>4.97 (1.48)</td>
<td>4.58 (1.40)</td>
</tr>
<tr>
<td>&quot;Sexual satisfaction&quot;</td>
<td>4.76 (0.59)</td>
<td>4.24 (0.93)</td>
</tr>
<tr>
<td>&quot;Distress&quot;</td>
<td>18.06 (10.85)</td>
<td>19.00 (11.16)</td>
</tr>
<tr>
<td><strong>Partner questionnaire</strong> (N = 26)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Erectile function&quot;</td>
<td>28.15 (3.74)</td>
<td>25.08 (9.08)</td>
</tr>
<tr>
<td>&quot;Orgasmic function&quot;</td>
<td>9.35 (1.16)</td>
<td>7.54 (3.36)*</td>
</tr>
<tr>
<td>&quot;Sexual desire&quot;</td>
<td>8.04 (1.51)</td>
<td>7.35 (1.65)</td>
</tr>
<tr>
<td>&quot;Overall sexual satisfaction&quot;</td>
<td>7.69 (2.05)</td>
<td>6.35 (2.26)*</td>
</tr>
<tr>
<td>&quot;Premature ejaculation&quot;</td>
<td>4.88 (3.61)</td>
<td>5.04 (4.05)</td>
</tr>
</tbody>
</table>

*a*Lower scores are indicative of greater dysfunction.

*b*Higher scores are indicative of greater distress associated with sexual functioning.

*Denotes significant changes pre-test to post-test at \( p \leq 0.05 \).

SD=standard deviation.

Note: Post-test means and SD on the female questionnaire variables differ from Table 2 due to listwise exclusions.
Table 5

*Self-reported frequency of female sexual difficulties over past month at post-test and 3-month follow-up for treatment group (N=26) – means, standard deviations, and percentage frequencies*

<table>
<thead>
<tr>
<th>Frequency of sexual difficulties</th>
<th>Post-test</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td>Frequency of sexual difficulties</td>
<td></td>
<td></td>
</tr>
<tr>
<td>About 10% or less</td>
<td>2 (7.7%)</td>
<td>5 (19.2%)</td>
</tr>
<tr>
<td>About 25% of the time</td>
<td>9 (34.6%)</td>
<td>3 (11.5%)</td>
</tr>
<tr>
<td>About 50% of the time</td>
<td>8 (30.8%)</td>
<td>9 (34.6%)</td>
</tr>
<tr>
<td>About 75% of the time</td>
<td>5 (19.2%)</td>
<td>6 (23.1%)</td>
</tr>
<tr>
<td>All the time</td>
<td>2 (7.7%)</td>
<td>3 (11.5%)</td>
</tr>
</tbody>
</table>

*Frequency data converted into continuous variable; higher scores indicate that FSD is experienced more of the time

SD=standard deviation.
Table 6

*Means and standard deviations of dependent variables at pre-test and post-test for the control cross-over group*

<table>
<thead>
<tr>
<th>Dependent variables</th>
<th>Pre-test</th>
<th>Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td><strong>Female questionnaire</strong> (N=12)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Sexual desire</em></td>
<td>2.25 (0.99)</td>
<td>3.50 (0.72)**</td>
</tr>
<tr>
<td><em>Sexual arousal</em></td>
<td>3.00 (1.01)</td>
<td>4.35 (1.10)**</td>
</tr>
<tr>
<td><em>Lubrication</em></td>
<td>3.90 (1.55)</td>
<td>5.03 (1.00)</td>
</tr>
<tr>
<td><em>Orgasm</em></td>
<td>2.77 (1.30)</td>
<td>4.40 (1.62)*</td>
</tr>
<tr>
<td><em>Sexual pain</em></td>
<td>4.80 (1.43)</td>
<td>5.00 (0.84)</td>
</tr>
<tr>
<td><em>Sexual satisfaction</em></td>
<td>2.93 (0.93)</td>
<td>4.73 (0.91)**</td>
</tr>
<tr>
<td><strong>Distress</strong></td>
<td>34.97 (7.13)</td>
<td>18.24 (9.74)**</td>
</tr>
<tr>
<td><strong>Partner questionnaire</strong> (N=16)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Erectile function</em></td>
<td>22.06 (10.70)</td>
<td>26.44 (7.28)</td>
</tr>
<tr>
<td><em>Orgasmic function</em></td>
<td>8.44 (2.80)</td>
<td>9.13 (1.45)</td>
</tr>
<tr>
<td><em>Sexual desire</em></td>
<td>7.06 (1.57)</td>
<td>7.13 (2.03)</td>
</tr>
<tr>
<td><em>Overall sexual satisfaction</em></td>
<td>5.19 (2.46)</td>
<td>6.75 (2.27)</td>
</tr>
<tr>
<td><strong>Premature ejaculation</strong></td>
<td>9.00 (5.33)</td>
<td>6.31 (4.03)</td>
</tr>
</tbody>
</table>

*Lower scores are indicative of greater dysfunction.

*Higher scores are indicative of greater dysfunction.

*Denotes significant changes pre-test to post-test at $p \leq 0.05$; **Denotes significant changes pre-test to post-test at $p \leq 0.01$.

SD=standard deviation.
Table 7

*Self-reported frequency of female sexual difficulties over past month at pre-test, post-test and 3-month follow-up for the control cross-over group (N=16) - means, standard deviations, and percentage frequencies*

<table>
<thead>
<tr>
<th>Frequency of sexual difficulties</th>
<th>Pre-test</th>
<th>Post-test</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td>About 10% or less</td>
<td>3.93 (0.77)</td>
<td>2.63 (1.20)**</td>
<td>2.88 (1.02)</td>
</tr>
<tr>
<td>About 25% of the time</td>
<td>0 (0)</td>
<td>4 (25.0)</td>
<td>2 (12.5)</td>
</tr>
<tr>
<td>About 50% of the time</td>
<td>5 (31.3)</td>
<td>7 (43.8)</td>
<td>9 (56.3)</td>
</tr>
<tr>
<td>About 75% of the time</td>
<td>7 (43.8)</td>
<td>2 (12.5)</td>
<td>2 (12.5)</td>
</tr>
<tr>
<td>All the time</td>
<td>4 (25.0)</td>
<td>1 (6.3)</td>
<td>1 (6.3)</td>
</tr>
</tbody>
</table>

*Frequency data converted into continuous variable; higher scores indicate that FSD is experienced more of the time

**Denotes significant change pre-test to post-test at $p \leq .01$.

SD=standard deviation.
Table 8

Means and standard deviations of dependent variables at post-test and 3-month follow-up
for the control cross-over group

<table>
<thead>
<tr>
<th>Dependent variables</th>
<th>Post-test</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td><strong>Female questionnaire (N = 13)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>aSexual desire</td>
<td>3.65 (0.83)</td>
<td>3.37 (0.80)</td>
</tr>
<tr>
<td>aSexual arousal</td>
<td>4.48 (1.09)</td>
<td>4.25 (1.17)</td>
</tr>
<tr>
<td>aLubrication</td>
<td>5.08 (1.00)</td>
<td>5.25 (0.99)</td>
</tr>
<tr>
<td>aOrgasm</td>
<td>4.40 (1.57)</td>
<td>4.43 (1.56)</td>
</tr>
<tr>
<td>aSexual pain</td>
<td>5.14 (0.76)</td>
<td>5.26 (1.03)</td>
</tr>
<tr>
<td>aSexual satisfaction</td>
<td>4.71 (0.85)</td>
<td>4.12 (0.93)</td>
</tr>
<tr>
<td>bDistress</td>
<td>18.37 (8.93)</td>
<td>17.79 (9.48)</td>
</tr>
<tr>
<td><strong>Partner questionnaire (N = 14)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>aErectile function</td>
<td>27.71 (4.79)</td>
<td>27.21 (5.98)</td>
</tr>
<tr>
<td>aOrgasmic function</td>
<td>9.36 (1.01)</td>
<td>9.00 (2.29)</td>
</tr>
<tr>
<td>aSexual desire</td>
<td>7.29 (1.77)</td>
<td>7.64 (1.95)</td>
</tr>
<tr>
<td>aOverall sexual satisfaction</td>
<td>7.00 (2.00)</td>
<td>6.64 (2.84)</td>
</tr>
<tr>
<td>bPremature ejaculation</td>
<td>6.07 (3.56)</td>
<td>5.71 (2.95)</td>
</tr>
</tbody>
</table>

*Lower scores are indicative of greater dysfunction.

bHigher scores are indicative of greater dysfunction.

SD = standard deviation.
Figure 1. Flowchart of recruitment and attrition

300 women responded to study advertisements

Online consent from 102 couples after receiving PLS

52 women + partners randomly assigned to treatment group and completed pre-treatment questionnaire

1 woman screened out due to mental illness; 5 women withdrew; 46 women began treatment

26 women (56.52%) + partners completed the program and the post-treatment questionnaire. Attrition (20 women; 43.48%): 4 in module 1. Reasons: time commitment (3); partner unsupportive (1). 9 in module 2. Reasons: time commitment (4); relationship ended (1); expectations of treatment not met (2); natural disaster (2). 4 in module 3. Reasons: time commitment (1); partner unsupportive (1); expectations of treatment not met (1); no reason (1). 1 in module 4. Reason: ambivalence about receiving treatment. 1 in module 5. No reason given. 1 in module 6. No reason given.

All 26 women + partners completed the 3-month follow-up questionnaire

11 women withdrew from the study

39 women + partners randomly assigned to wait-list control and completed pre-waitlist questionnaire

1 woman screened out due to mental illness; 31 women + 29 partners completed post-waitlist questionnaire

Control group offered treatment; 22 women began program; 9 women declined

16 women (72.72%) + partners completed the program and the post-treatment questionnaire. Attrition (6 women - 27.27%): • 3 in module 1. Reasons: time commitment (3). • 2 in module 2. Reasons: partner unsupportive (1); no reason (1). • 1 in module 4. Reason: expectations of treatment not met.

15 women + 14 partners completed the 3-month follow-up questionnaire
# Appendix: Summary of Program

## Module 1

This module is intended to allow couples to emotionally reconnect before beginning touch exercises, and for women to start thinking about their attitudes towards sex. A “no sex rule” is explained to couples. Psychoeducation is provided on the different types of FSDs and common myths about sex. Women complete a written exercise to explore the usefulness of their current beliefs about sex, and couples begin communication exercises in the form of discussion letters. Non-sexual mindfulness (meditating on the breath) is introduced as a 5-minute daily practice.

## Module 2

This module includes psychoeducation on female sexual anatomy and possible causal, perpetuating and protective factors involved in FSDs. Women complete a written exercise to explore the development and maintenance of their FSD. Couples continue the communication exercises, and women are introduced to sensual mindfulness (mindfulness in the shower) to draw attention to the pleasurable sensations of their bodies. Sensate focus is introduced to couples with non-sexual body touching sessions.

## Module 3

This module provides psychoeducation on female sexual desire/interest and factors that may negatively or positively impact this. Women are introduced to CBT and complete a written CBT exercise focussed on factors that may be impacting sexual desire/interest. Couples continue communication exercises and mindfulness is incorporated into sensate focus in self-touching sessions. Couples continue non-sexual massages.
**Module 4**

This module includes psychoeducation on male sexual anatomy and the relationship between body image and sexual enjoyment. Women complete a written CBT exercise on body image and sex. Couples continue communication exercises. Genital touching is introduced to sensate focus sessions and mindful awareness is used to facilitate present moment awareness and manage difficult thoughts and feelings.

**Module 5**

Module 5 contains psychoeducation on sexual intercourse in a way that aims to make definitions of “sex” more broad and flexible, and to enable increased enjoyment during penetration. Women complete a written CBT exercise focussed on thoughts and feelings during intercourse. Couples continue communication exercises but are given the option of continuing the letters, or discussing the questions without the use of letters. Penetration is introduced to sensate focus sessions and mindfulness is used to increase present moment awareness and manage difficult thoughts and feelings.

**Module 6**

This final module provides psychoeducation on sexual erotica, toys and aids, as well as an explanation of medical interventions for FSDs. Couples continue communication exercises, either with letters or without. Couples continue intercourse in sensate focus sessions with a focus on mindful awareness. Women complete a written exercise focussing on gains made throughout PP and anticipated difficulties following the program, and use this to create a relapse prevention plan.
Chapter 7

Article 3: Resubmitted After Reviews for Publication in the Journal of Sex & Marital Therapy

An Online, Mindfulness-Based, Cognitive-Behavioral Therapy for Female Sexual Dysfunction: Impact on Relationship Functioning

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Abstract

This article presents the evaluation of an online treatment for female sexual dysfunction, as it relates to relationship functioning. PursuingPleasure was an online, mindfulness-based, cognitive behavioral therapy for FSD. In study 1, 26 women completed treatment and changes were compared to a waitlist control group (N = 31). In study 2, 16 women from the control group then completed treatment. No control group was used in study 2. Results demonstrated that both treatment groups observed significant improvements in sexual intimacy and communication, and emotional intimacy improved significantly in the study 1 treatment group. Improvements were maintained at follow-up.

Key words: Sexual dysfunction, mindfulness, cognitive behavioural therapy, relationship functioning, online intervention, psychological treatment
Introduction

Female sexual dysfunctions (FSDs) often occur within the context of a relationship, and relationship factors have been consistently identified as contributing to the precipitation and maintenance of FSDs (Basson, 2000; Hawton, Catalan, & Fagg, 1991). It also appears that the association between FSDs and relationship factors may be bi-directional in nature (Basson, 2000) and such factors include relationship quality and duration (Kelly, Strassberg, & Turner, 2006; Witting et al., 2008), and power dynamics within the relationship (McCabe & Cobain, 1998). Communication difficulties and low levels of intimacy between partners may also play a central role in the development and maintenance of FSDs (Kelly et al., 2006; McCabe, 1991; McCabe, 1997).

Due to the central role of these relationship factors, sex therapy interventions should ideally include both members of the couple, and target common relationship factors through communication and intimacy interventions. These methods are recommended based on the understanding that relationship factors may act as a barrier to improvements in sexual functioning, and previous research has demonstrated that partner engagement and cooperation in treatment is associated with better prognosis for FSDs (LoPiccolo & Stock, 1986).

Internet-based cognitive behavioural therapy (CBT) has recently been introduced as a novel method for the treatment of FSDs. This platform of therapy utilizes traditional cognitive and behavioral approaches to sex therapy (e.g., Masters & Johnson, 1970; McCabe, 2001), while also offering increased convenience, privacy and anonymity. Internet-based interventions demonstrate some similarities to the various self-help methods that have been developed for FSDs, such as bibliotherapy and videotherapy (van Lankveld, 2009). In addition to the benefits
inherent in self-help methods, such as privacy and convenience, internet-based interventions can offer a more interactive treatment and draw together a community of clients while maintaining their anonymity (Jones & McCabe, 2010; Leusink & Aarts, 2006; McCabe & Price, 2008; Tate & Zabinski, 2004).

Preliminary evidence suggests that as well as addressing sexual functioning, online CBT for male sexual dysfunction can also be effective in increasing relationship functioning, and may be a suitable alternative to face-to-face sex therapy (Giles & McCabe, 2009; Leusink & Aarts, 2006; McCabe & Price, 2008; McCabe, Price, Piterman, & Lording, 2008; van Diest, van Lankveld, Leusink, Slob, & Gijs, 2007).

In relation to FSD, Jones and McCabe (2011) investigated the effectiveness of an internet-based CBT program for mixed FSDs, the *Revive* program. *Revive* consisted of five online modules that included sensate focus, communication exercises and unlimited email contact with a therapist. The main aim of the email contact was to provide cognitive therapy alongside the predominantly behavioral online modules (Jones & McCabe, 2011). As well as targeting sexual functioning in women, *Revive* also aimed to address relevant relationship problems, and the results of this study suggested that the treatment group improved significantly in measures of communication and intimacy as compared to the control group, but not in overall relationship satisfaction.

The authors of *Revive* commented on various limitations in their study. Firstly, there were significant problems in engaging participants in cognitive therapy over email (Jones & McCabe, 2011) and this may have limited the extent to which both sexual and relationship factors were addressed. To overcome this limitation, the authors suggested that future internet-based interventions utilize online chat-groups
to enhance the cognitive aspects of the program. Another limitation in the Revive program was that, although partners were required to participate in the exercises, they were never directly addressed by the therapist and they received no psychoeducation about FSDs or relationship functioning (Jones & McCabe, 2011). It has previously been suggested that providing partners with psychoeducation, and also validating and normalising their experiences throughout treatment, may help in forming a stronger partner alliance and potentially lead to better treatment outcomes (LoPiccolo, & Stock, 1986; Schneidman & McGuire, 1976).

Finally, the authors of Revive suggested that future online interventions for FSDs incorporate mindfulness meditation, a recent addition to the psychological treatment of FSDs (Althof, 2010; Brotto, Basson, & Luria, 2008a; Brotto et al., 2008c; Jones & McCabe, 2011). Mindfulness meditation is a Buddhist meditation practice that aims to cultivate present moment awareness and non-judgemental observation of experiences (Kabat-Zinn, Lipworth, & Burney, 1985). In the context of FSDs, mindfulness exercises can help to decrease cognitive distractions and anxiety during sexual activity, while increasing present moment attention and the awareness of pleasurable sensations (Brotto et al., 2008a, c; Brotto, Seal, & Rellini, 2012; Silverstein, Brown, Roth, & Britton, 2011).

Pursuing Pleasure (PP) is an online, mindfulness-based, CBT program for FSD that aims to extend upon prior research into the internet-based treatment of FSD. PP contains sensate focus, communication exercises and unlimited email contact with a therapist, and is the first online treatment for sexual dysfunction to incorporate mindfulness exercises. PP is also the first online treatment for sexual dysfunction to utilize online chat-groups as a platform for cognitive therapy and social support.
While it is important to assess the impact that PP had on the sexual functioning of the women and partners in treatment (reported in Hucker & McCabe, submitted for publication), it is also relevant to assess changes in relationship functioning due to the relationship factors that may be involved in the maintenance of FSDs. The current studies evaluated the impact on the PP program on such relationship factors.

**Study 1**

**Method**

*Aim*

The aim of study 1 was to evaluate the effectiveness of the PP program, as it relates to relationship functioning, for women with mixed FSD as compared to a waitlist control. It was hypothesized that the women in the treatment group would demonstrate significant improvements in relationship functioning as compared to a waitlist control, and that treatment gains would be maintained for 3-months following the completion of PP.

*Participants*

All participants were female, over 18 years of age, currently experiencing sexual difficulties (related to desire, arousal, orgasm and/or pain), in a stable heterosexual relationship, reported no significant mental illness and no significant relationship problems (e.g., violence, abuse), were English speaking, and had regular access to internet. It was also necessary for partners to be willing to participate in treatment.

This study excluded women in same-sex relationships due to past research into the online treatment of FSD focussing on women in heterosexual relationships only, and a lack of research literature focussing on therapeutic interventions for women.
with FSD in same-sex relationships. Regarding mental illness and relationship problems, women were not formally screened for mental illness or significant relationship problems, but rather these exclusion criteria were communicated to women via email prior to them being accepted into the study. Two women who had completed the pre-test assessment (one from the treatment group and one from the control group) were excluded from the study due to disclosure of current mental illness (see Figure 1).

Materials

Program content was delivered online via a password-protected website. Participants completed online surveys at pre-treatment, post-treatment and 3-month follow-up. All chat-groups were conducted in a password-protected chat-room using real-time text conversation.

Demographic Information

Participants provided information on their age, relationship status, and relationship duration. Women also reported on their perception of their own sexual difficulties, including type, duration and frequency of sexual difficulties, and their perception of their partner’s sexual functioning.

Sexual Function Scale (SFS)

The SFS (McCabe, 1998) is a self-report questionnaire developed to assess a range of etiological factors involved in sexual dysfunction. The communication and relationship satisfaction subscales were used, with participants asked to decide which response best describes their current relationship. Lower scores are indicative of poorer communication within the relationship and lower relationship satisfaction. High internal consistency has been reported for all subscales ($\alpha = 0.60–0.90$;
McCabe, 1998) and the reliability scores for the current study were: communication ($\alpha \geq 0.67$) and relationship satisfaction ($\alpha \geq 0.73$).

**The Personal Assessment of Intimacy in Relationships (PAIR) Scale**

The PAIR scale is a self-report questionnaire that measures five areas of intimacy in relationships (Schaefer & Olson, 1981). The sexual intimacy and emotional intimacy subscales were used and participants were asked to complete the subscale as it applies to their current relationship. Scores on each subscale range from 6 to 30 with lower scores indicating poorer levels of intimacy. The reliability of the PAIR has been established by Schaefer and Olson (1981; $\alpha = 0.70$). The reliability for emotional intimacy in the current study was as expected ($\alpha \geq 0.77$), while the alpha level for sexual intimacy was much lower than expected ($\alpha \geq 0.38$). This low alpha result for sexual intimacy is most likely due to the small sample size leading to imprecision in alpha estimates (Charter, 2003). However, the reliability score did improve at post-test ($\alpha \geq 0.65$) and follow-up ($\alpha \geq 0.63$).

**Female Sexual Function Scale (FSFI)**

The FSFI (Rosen, et al., 2000) is a 19-item self-report assessment tool aimed at measuring women’s sexual functioning. The FSFI is based on respondents’ past 4 weeks of sexual activity and contains six subscales (desire, arousal, lubrication, orgasm, pain, satisfaction) with lower scores indicating poorer sexual functioning. Scores on all subscales are summed to compute the total FSFI score, with a score of $\leq 26$ indicating that a woman meets the criteria for clinical levels of FSD (Wiegel, Meston, & Rosen, 2005). The FSFI has been shown to have high internal consistency ($\alpha \geq .82$), and high test–retest reliability ($\alpha = .79 – .88$) (Rosen, et al., 2000). Reliability scores for the current study were: sexual desire, $\alpha \geq .81$; sexual
arousal, $\alpha > .91$; lubrication, $\alpha > .92$; orgasm, $\alpha > .89$; satisfaction, $\alpha > .68$; pain, $\alpha > .85$, and total score, $\alpha > .89$.

**Female Sexual Distress Scale – Revised (FSDS-R)**

The FSDS-R (DeRogatis, Clayton, Lewis-D’Agostino, Wunderlich, & Fu, 2008) is a 13-item self-report measure that assesses the degree of personal distress associated with female sexual functioning. Scores range from 0 to 52 with higher scores indicating greater distress. Scores of $\geq 11$ suggest a level of sexual function-related distress that is indicative of a diagnosis of FSD (DeRogatis et al., 2008). The reliability of the FSDS-R was established by Derogatis and colleagues (2008; $\alpha = .87 - .97$). The reliability score for the current study was $\alpha > .93$.

**Treatment**

*PP* was an online, mindfulness-based, CBT treatment for women with mixed FSD (see appendix for a summary of the program content). The aim of the *PP* program was two-fold: 1) To decrease the symptoms of sexual dysfunction that women were experiencing, through both sexual activity-based and relationship-based interventions; and 2) To decrease the level of distress associated with sexual functioning. To achieve these aims, the program consisted of both change-based interventions (e.g., challenging negative automatic thoughts, behavioural exercises) and acceptance-based interventions (e.g., mindfulness, normalising through psychoeducation).

The program consisted of 6 progressive online modules, the first lasting a minimum of one week, and the others lasting a minimum of two weeks each. All women began the program at the same time and were encouraged to finish each module within two weeks, although the program did allow for flexible timing depending on the needs of each couple. Each module contained psychoeducation
and related CBT exercises that aimed to help women identify and challenge negative automatic thoughts and beliefs about sexuality and sexual activities. Each module included print-outs for partners that covered information on female sexuality, FSDs, and associated relationship issues, as well as explanations of the treatment exercises. These print-outs also incorporated statements aimed at normalizing the process for men, and validating their experiences of treatment. Each module also contained communication exercises and sensate focus exercises for the couples to complete together.

Mindfulness exercises were used throughout the program to assist women in cultivating present moment awareness, and the use of mindfulness was encouraged during sensate focus to help women manage difficult thoughts and feelings, and remain more present and aware. The mindfulness exercises were adapted from Brotto, Basson, and Luria’s (2008b) Group Psychoeducation Treatment manual, where mindfulness is introduced in a gradual step-down manner. In PP, mindfulness was firstly introduced through basic non-sexual mindfulness exercises focusing on a present moment experience (e.g., meditating on the breath, mindfulness of thoughts). Women were encouraged to practice this exercise for 5-minutes each day throughout the program. More sensory-focused mindfulness exercises were then introduced, such as mindful eating, mindful movement and an exercise involving sensual body awareness while having a shower or bath. In later modules, mindfulness exercises became more sexually oriented and were incorporated into sensate focus sessions.

The online chat-groups ran for one hour each and occurred every 2 weeks, containing approximately 4-8 women in each group. All groups (and email contact) were facilitated by a clinical psychology doctoral student specializing in the
psychological treatment of FSDs. This facilitator had undergone CBT and mindfulness training throughout her doctoral training, and had been engaging in a personal mindfulness practice for many years. The chat-groups were run with a loose structure: greetings, review of module exercises and experiences of the program over the past two weeks, discussion of challenges and barriers to change, specific intervention suggestions (if necessary), closing of session. In addition, the concluding sessions had a greater focus on reflection and relapse prevention. During the chat-groups, the facilitator guided women to focus on the causal and maintaining factors of their sexual difficulties, and to explore barriers to change throughout the treatment, as well as potential solutions. The facilitator drew upon CBT and mindfulness techniques to reinforce the concepts from the PP program. Participants were also offered unlimited email contact with the therapist. See Hucker and McCabe (in press) for further details about the content of the chat-groups and the themes that emerged from these discussions.

Each module concluded with a hurdle requirement, which comprised of a list of questions summarising the exercises that should be completed before moving to the next module. Women were required to agree that they had achieved these goals and were ready to move on, by marking the questions electronically, before being provided with the password to access the next module of PP.

Procedure

Ethics approval was gained for these studies from the University Human Research Ethics Committee. Women were recruited via worldwide health websites, a press release in two Australian newspapers, noticeboards in an Australian university, and through a database of previous participants in a project completed by the second author. This database included women from a general Australian
population recruited via similar methods to the current study, and were not exclusively women with FSD. See Figure 1 for a summary of the recruitment stages and study attrition. Women registered interest via email and were then sent a reply email explaining the inclusion and exclusion criteria. Those still interested were sent a link to the online plain language statement that provided comprehensive treatment information for couples, and the couples gave consent via the plain language statement website. Women were then randomly assigned to either the treatment group or waitlist control, and all participants completed a pre-test online questionnaire. In total, 26 women completed treatment and 31 women in the control group remained for the full wait-list period. All participants completed the post-test questionnaire, and all treatment participants completed the 3-month follow-up questionnaire.

In order to investigate women with both clinical and sub-clinical levels of FSD, women were not formally screened for FSD before being accepted into the study. Clinical and sub-clinical levels of FSD were determined based on clinical cut-offs of the FSFI and the FSDS-R. Inspection of pre-test differences between the treatment group and the women who dropped out of treatment indicated that the women who dropped out reported significantly lower levels of sexual desire, sexual arousal, and sexual satisfaction. However, there were no significant differences on relationship variables, and no significant difference in the percentage of women who met diagnostic criteria for FSD. Women who completed the wait-list period were then offered the PP treatment (see Study 2).

Results

Demographic information
The mean age of the women in the treatment group and control group were 33.31 years ($SD = 7.4$) and 31.94 years ($SD = 5.17$) respectively, $t(55) = 0.79$, $p > 0.05$. Relationship duration for the treatment group and control group were 7.94 years ($SD = 5.52$) and 8.84 years ($SD = 5.29$) respectively, $t(55) = -0.63$, $p > 0.05$. Sixty-nine percent of the treatment group and seventy-one percent of the control group were married, while the other women identified themselves as de facto, partnered and/or cohabitating.

Regarding sexual functioning, the mean duration of sexual difficulties was 4.1 years for both the treatment and the control group (treatment $SD = 0.8$ years; control $SD = 0.7$ years), $t(55) = 0.10$, $p > 0.05$. See Table 1 for a summary of the types of sexual difficulties reported by each group. Based on clinical cut-offs from the FSDS-R, all women from the treatment group and control group reported a level of sexual function-related distress that is indicative of a FSD diagnoses. Based on clinical cut-offs of the FSFI, five women (21.7%) in the treatment group and four women (16%) in the control group did not meet criteria for FSD. Due to a lack of sexual activity and/or intercourse in the previous 4 weeks, ten women (three from the treatment group; seven from the control group) could not be categorised. Lastly, 42.3% of the treatment group and 51.6% of the control group indicated that their partner had some form of sexual difficulty.

*Effects of PP on Relationship Functioning*

To compare changes in relationship functioning between the treatment group and control group from pre-test to post-test, a multivariate repeated measures analysis of variance (MANOVA) was conducted. The between subject factor for the MANOVA was group (treatment vs control) and the repeated measures factor was time (pre-test and post-test). The dependent variables were sexual intimacy,
emotional intimacy, communication, and relationship satisfaction. See Table 2 for the means and standard deviations of the dependent variables. The MANOVA revealed a significant interaction effect for group*time, $F(4, 51) = 5.29, p < 0.01$; Pillai’s Trace $= 0.29$, suggesting that the treatment group observed significant improvements in relationship variables from pre-test to post-test as compared to the control group. The univariate results suggest significant improvements in the treatment group on scores of sexual intimacy, $F(1, 55) = 18.54, p < 0.01$; partial $\eta^2 = 0.26$, emotional intimacy, $F(1, 55) = 4.93 , p < 0.05$; partial $\eta^2 = 0.08$, and communication, $F(1, 55) = 4.69, p < 0.05$; partial $\eta^2 = 0.08$, but not for relationship satisfaction, $F1, 55 = 1.29, p = 0.26$; partial $\eta^2 = 0.02$, from pre-test to post-test as compared to the control group.

**Maintenance of Treatment Gains**

To assess maintenance of treatment gains in relationship functioning, post-test scores on dependent variables were compared to 3-month follow-up scores for the treatment group. Paired samples $t$-tests demonstrated no significant differences at the $P < 0.01$ level for sexual intimacy, $t(25) = 2.42, p = 0.02$, emotional intimacy, $t(25) = 1.93, p = 0.07$, communication, $t(25) = 1.24, p = 0.23$, and relationship satisfaction, $t(25) = 0.54, p = 0.60$. These results demonstrate that the benefits of the program were maintained over a 3-month follow-up period (see Table 3).

**Study 2**

**Aim**

The aim of study 2 was to evaluate changes in relationship functioning after the control cross-over group completed the PP treatment. It was hypothesized that the control cross-over group would experience similar improvements in relationship functioning as the original treatment group. It was also hypothesised that
participation after the waitlist period would result in lower attrition due to a belief that engagement in the full waitlist period would lead to an increased level of motivation upon entering treatment.

Method

Participants

The waitlist control group was offered the PP treatment after their final waitlist questionnaires were completed. Most women in the control group who did not start treatment (n = 5) did not indicate why, but those who did respond (n = 3) indicated timing issues, a lack of interest, and a relationship breakdown.

Materials and Treatment

Refer to Study 1.

Procedure

Twenty-two women accepted the offer of treatment after being in the waitlist control group and completing the final waitlist questionnaire (from study 1). These questionnaires were used as the new baseline for study 2. Of the women who accepted the offer of treatment, a total of 16 completed the PP program and the post-test questionnaire, and 15 women completed the 3-month follow-up questionnaire (see Figure 1).

Results

Demographic Information

The mean age of the women in the control cross-over group was 30.75 years (SD = 5.12 years). The mean relationship duration of this group was 8.60 years (SD = 4.34), and 68.80% reported being married, while the remaining women identified as de facto, partnered and/or cohabitating. Types of sexual difficulties reported
were: low sexual desire/interest (93.8%), failure to become aroused/lubricated (56.3%), inability to orgasm (37.5%), delayed orgasm (31.3%), painful intercourse (18.8%), and reduced satisfaction (37.5%). Based on scores from the FSDS-R, all women in the control cross-over group reported a level of sexual function-related distress that is indicative of a FSD diagnoses. Based on clinical cut-offs of the FSFI, one (7.7%) woman in the control cross-over group did not meet criteria for a FSD diagnosis, and three women could not be categorised due to a lack of sexual activity and/or sexual intercourse in the 4 weeks preceding assessment. Lastly, 56.25% of the control crossover group indicated that their partner had some form of sexual difficulty.

Effects of PP on Relationship Functioning

To assess changes in relationship functioning in the control cross-over group, paired samples t-tests were conducted to compare pre-test to post-test scores for all dependent variables. The results suggested that the control cross-over group demonstrated significant improvements in sexual intimacy, $t(15) = -3.25, p < 0.01$, and communication, $t(15) = -2.53, p < 0.05$, but not for emotional intimacy, $t(15) = -1.50, p = 0.15$, and relationship satisfaction, $t(15) = -1.45, p = 0.17$. Due to the reduced sample size in the control crossover group, effect sizes, presented as eta squared ($\eta^2$) in Table 4, were calculated for each t-test. The effect sizes for sexual intimacy and communication were large, according to Cohen (1988), and the effect sizes for emotional intimacy and relationship satisfaction were moderate. See Table 4 for a summary of means, standard deviations and effect sizes for the control cross-over group pre-test to post-test.

Maintenance of Treatment Gains
To assess maintenance of treatment gains in relationship functioning, post-test scores from the control cross-over group on all dependent variables were compared to 3-month follow-up scores. Paired samples t-tests demonstrated no significant differences at the $P < 0.05$ level for any of the variables: sexual intimacy, $t(14) = 0.75, p = 0.46$, emotional intimacy, $t(14) = 0.37, p = 0.72$, communication, $t(14) = 0.68, p = 0.51$, and relationship satisfaction, $t(14) = -0.35, p = 0.72$. These results demonstrate that the benefits of the program were maintained over a 3-month follow-up period. See Table 5 for a summary of means, standard deviations and effect sizes for the control cross-over group post-test to 3-month follow-up.

**Discussion**

As well as aiming to improve women’s sexual functioning, the PP program aimed to target relationship factors involved in female sexual functioning. Women who completed the PP program in study 1 demonstrated significantly greater improvements in sexual intimacy, emotional intimacy and communication as compared to the control group. This is consistent with past evaluations of the online treatment for FSDs (Jones & McCabe, 2011), and is not surprising given that the program consisted of communication- and intimacy-based exercises. Despite these improvements, the treatment group in study 1 did not report significantly greater improvements in overall relationship satisfaction as compared to the control group, and this is also consistent with prior research (Jones & McCabe, 2011). On inspection of the content of the relationship satisfaction subscale used (also used by Jones and McCabe), it is likely that this result is due to the subscale measuring aspects of relationship functioning not addressed in the program, such as division of labour, differing religious beliefs, financial conflict, and parenting, and this result may therefore not represent a limitation of the PP program itself.
In study 2, the control crossover group demonstrated similar significant improvements in sexual intimacy and communication, but did not demonstrate significant improvements in emotional intimacy. It is hypothesised that this lack of significant findings for emotional intimacy is due to the smaller sample size observed in the control crossover group, and it should be noted that a moderate effect size was observed for changes in emotional intimacy pre-test to post-test. Similarly to the results in study 1, this group did not demonstrate significant changes in overall relationship satisfaction.

In both studies, all significant improvements were maintained at the 3-month follow-up as hypothesized. Overall, the results from study 1 and study 2 suggest that improvements in some areas of relationship functioning can be achieved through an online, mindfulness-based, CBT treatment for FSD, and add further support to the use of online treatments as an alternative to face-to-face treatment for FSD in heterosexual relationships. In qualitative feedback from the women in both studies, the mindfulness exercises, online chat groups and communication exercises were reported as some of the most helpful aspects of the program. However, it is not possible to ascertain which of the various components of the PP program were the effective in the improvements observed over the PP studies.

Regarding the hypothesis that the control crossover group would demonstrate lower attrition, this was confirmed with the control crossover group losing only 27.27% of participants, while the treatment group lost 43.48% of participants. Additionally, the attrition in the treatment group was similar to that reported in previous internet-based and face-to-face studies for sexual dysfunction and it has been noted that attrition is commonly high amongst sex therapy clients (Jones & McCabe, 2011; McCabe & Price, 2008; Sarwer & Durlak, 1997). It is hypothesised
that the lower attrition demonstrated in the control crossover group was due to the women in study 2 entering treatment with a higher level of motivation after completing the waitlist period. It is also possible that other confounding variables could explain this difference in attrition, such as the knowledge that other women (from study 1) had already managed to complete treatment.

Despite the positive results from the PP studies, there were several limitations in need of discussion. Firstly, although study 1 included a larger sample size than the Revive program (Jones & McCabe, 2011), both of the PP studies involved small samples sizes, which were exacerbated by attrition and the crossover design of the study. These small sample sizes limit the generalizability of the results and may have restricted the power of statistical analyses to detect significant differences. Future research could therefore serve to replicate these results with a larger sample. Second, due to the use of volunteers in the study, it is possible that both studies contained a group of women more motivated than the greater population of women with FSDs. This limitation is particularly relevant to the control crossover group, who were likely to be especially invested in the treatment after engaging in the entire waitlist period, as hypothesized in study 2. Thirdly, all data were collected by self-report which is inevitably subjective in nature. These data included the hurdle requirement for each module, and although it was assumed that participants were being honest in their reports of exercises completed, there was no way to ascertain which, or how many, exercises had been completed.

A fourth limitation of the study relates to the exclusion criteria of the studies. Although the results are supportive of the use of internet-based treatments for FSD in heterosexual relationships, the results from the PP studies may not be generalizable to all women experiencing FSDs, such as women in relationships with
significant discord, women experiencing significant mental illness, women in same-sex relationships, and single women. Future research could serve to develop a modified internet-based intervention for FSD in single women, with less focus on couple exercises, and greater focus on intergenerational, individual and past relationship factors. Future research could also explore the use of either an online program specifically targeted to women with FSD in same-sex relationships, or an internet-based intervention for FSD that accommodates women in both heterosexual and non-heterosexual relationships.

Finally, the PP studies lacked a comparison to medical interventions for FSD, or a combined medical and psychological intervention group. Given the multiple determinants of FSD, combined medical and psychological treatment for FSD is likely to be beneficial to women (Althof, 2010) and future research could serve to evaluate the effectiveness of a combined medical and psychological treatment approach for FSD.

References


Table 1
Types of sexual difficulties reported by treatment and control group at pre-test assessment

<table>
<thead>
<tr>
<th>Type of sexual difficulty</th>
<th>Treatment group (N=26)</th>
<th>Control group (N=31)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low sexual desire</td>
<td>96.2%</td>
<td>96.8%</td>
</tr>
<tr>
<td>Failure to become aroused/lubricated</td>
<td>80.8%</td>
<td>58.1%</td>
</tr>
<tr>
<td>Inability to orgasm</td>
<td>38.5%</td>
<td>41.9%</td>
</tr>
<tr>
<td>Delayed orgasm</td>
<td>23.1%</td>
<td>32.3%</td>
</tr>
<tr>
<td>Painful intercourse</td>
<td>57.7%</td>
<td>41.9%</td>
</tr>
<tr>
<td>Reduced satisfaction</td>
<td>57.7%</td>
<td>51.6%</td>
</tr>
</tbody>
</table>
Table 2

Means and standard deviations of dependent variables at pre-test and post-test for treatment and control groups.

<table>
<thead>
<tr>
<th>Dependent variables</th>
<th>Treatment group (N = 26)</th>
<th>Control group (N = 31)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-test</td>
<td>Post-test</td>
</tr>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td>&quot;Sexual intimacy&quot;</td>
<td>20.84 (3.04)</td>
<td>23.12 (2.71)**</td>
</tr>
<tr>
<td>&quot;Emotional intimacy&quot;</td>
<td>23.28 (3.79)</td>
<td>24.32 (3.34)*</td>
</tr>
<tr>
<td>&quot;Communication&quot;</td>
<td>20.41 (2.62)</td>
<td>25.04 (3.02)*</td>
</tr>
<tr>
<td>&quot;Relationship satisfaction&quot;</td>
<td>31.44 (3.11)</td>
<td>34.12 (3.93)</td>
</tr>
</tbody>
</table>

*Lower scores are indicative of poorer functioning

Changes pre-test to post-test: * P < 0.05; ** P < 0.01

SD=standard deviation.
Table 3

Means and standard deviations of dependent variables at post-test and 3-month follow-up for treatment group (N = 26)

<table>
<thead>
<tr>
<th>Dependent variables</th>
<th>Post-test Mean (SD)</th>
<th>Follow-up Mean (SD)</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual intimacy</td>
<td>23.19 (2.68)</td>
<td>22.35 (2.76)</td>
<td>2.42</td>
</tr>
<tr>
<td>Emotional intimacy</td>
<td>24.31 (3.27)</td>
<td>23.45 (3.40)</td>
<td>1.93</td>
</tr>
<tr>
<td>Communication</td>
<td>24.92 (3.02)</td>
<td>24.13 (3.48)</td>
<td>1.24</td>
</tr>
<tr>
<td>Relationship satisfaction</td>
<td>34.12 (3.93)</td>
<td>33.80 (4.85)</td>
<td>0.54</td>
</tr>
</tbody>
</table>

*Lower scores are indicative of poorer functioning

SD=standard deviation.
Table 4
Means and standard deviations of dependent variables at pre-test and post-test for the control crossover group (N = 16)

<table>
<thead>
<tr>
<th>Dependent variables</th>
<th>Pre-test</th>
<th>Post-test</th>
<th>t</th>
<th>η²</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual intimacy</td>
<td>19.51 (3.43)</td>
<td>23.06 (2.69)</td>
<td>-3.25</td>
<td>0.41</td>
</tr>
<tr>
<td>Emotional intimacy</td>
<td>22.51 (4.36)</td>
<td>24.06 (2.82)</td>
<td>-1.50</td>
<td>0.13</td>
</tr>
<tr>
<td>Communication</td>
<td>23.56 (2.58)</td>
<td>26.25 (2.82)</td>
<td>-2.53</td>
<td>0.30</td>
</tr>
<tr>
<td>Relationship satisfaction</td>
<td>32.31 (4.44)</td>
<td>34.26 (3.79)</td>
<td>-1.45</td>
<td>0.12</td>
</tr>
</tbody>
</table>

*Lower scores are indicative of poorer functioning
SD=standard deviation
Table 5

Means and standard deviations of dependent variables at post-test and 3-month follow-up for control crossover group (N = 15)

<table>
<thead>
<tr>
<th>Dependent variables</th>
<th>Post-test</th>
<th>Follow-up</th>
<th>t</th>
<th>$\eta^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Sexual intimacy</td>
<td>23.00 (2.78)</td>
<td>22.13 (3.85)</td>
<td>0.75</td>
<td>0.04</td>
</tr>
<tr>
<td>*Emotional intimacy</td>
<td>24.27 (2.79)</td>
<td>23.87 (2.93)</td>
<td>0.36</td>
<td>0.01</td>
</tr>
<tr>
<td>*Communication</td>
<td>26.27 (2.91)</td>
<td>25.60 (2.50)</td>
<td>0.68</td>
<td>0.03</td>
</tr>
<tr>
<td>*Relationship satisfaction</td>
<td>33.94 (3.70)</td>
<td>34.53 (4.16)</td>
<td>-0.35</td>
<td>0.01</td>
</tr>
</tbody>
</table>

*Lower scores are indicative of poorer functioning

SD=standard deviation.
Figure 1. Flowchart of recruitment stages and attrition

300 women responded to study advertisements

Online consent from 102 couples after receiving PLS

52 women randomly assigned to treatment group and completed pre-treatment questionnaire

11 women withdrew from the study

39 women randomly assigned to wait-list control and completed pre-waitlist questionnaire

1 woman screened out due to mental illness; 5 women withdrew; 46 women began treatment

1 woman screened out due to mental illness; 31 women + 29 partners completed post-waitlist questionnaire

26 women (56.52%) completed the program and the post-treatment questionnaire. Attrition (20 women; 43.48%):
- 4 in module 1. Reasons: time commitment (3); partner unsupportive (1).
- 9 in module 2. Reasons: time commitment (4); relationship ended (1); expectations of treatment not met (2); natural disaster (2).
- 4 in module 3. Reasons: time commitment (1); partner unsupportive (1); expectations of treatment not met (1); no reason (1).
- 1 in module 5. No reason given.
- 1 in module 6. No reason given.

Control group offered treatment; 22 women began program; 9 women declined

16 women (72.72%) completed the program and the post-treatment questionnaire. Attrition (6 women - 27.27%):
- 3 in module 1. Reasons: time commitment (3).
- 2 in module 2. Reasons: partner unsupportive (1); no reason (1).

All 26 women completed the 3-month follow-up questionnaire

15 women completed the 3-month follow-up questionnaire
Appendix: Summary of Program

<table>
<thead>
<tr>
<th>Module 1</th>
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<tbody>
<tr>
<td>This module is intended to allow couples to emotionally reconnect before beginning touch exercises, and for women to start thinking about their attitudes towards sex. A “no sex rule” is explained to couples. Psychoeducation is provided on the different types of FSDs and common myths about sex. Women complete a written exercise to explore the usefulness of their current beliefs about sex, and couples begin communication exercises in the form of discussion letters. Non-sexual mindfulness exercises (e.g., meditating on the breath, mindfulness of thoughts, mindful eating) are introduced as a 5-minute daily practice.</td>
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<table>
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<tr>
<th>Module 2</th>
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<tbody>
<tr>
<td>This module includes psychoeducation on female sexual anatomy and possible causal, perpetuating and protective factors involved in FSDs. Women complete a written exercise to explore the development and maintenance of their FSD. Couples continue the communication exercises, and women are introduced to a mindfulness exercise focussing on body awareness (mindfulness in the shower/bath) to draw attention to the pleasurable sensations of their bodies. Sensate focus is introduced to couples with non-sexual body touching sessions. Participants are encouraged to use mindfulness skills (such as focusing on body sensations, noticing thoughts without judgement, letting go of expectations, and imagining thoughts floating away down a river), to remain present and to manage difficult thoughts and emotions.</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Module 3</th>
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<tbody>
<tr>
<td>This module provides psychoeducation on female sexual desire/interest and factors that may negatively or positively impact this. Women complete a written CBT exercise focussed on factors that may be impacting sexual desire/interest. Couples continue communication exercises and non-sexual massages. Self-touching is introduced and participants are encouraged to use mindfulness skills to remain present and to manage difficult thoughts and emotions.</td>
</tr>
</tbody>
</table>
Module 4
This module includes psychoeducation on male sexual anatomy, and the relationship between body image and sexual enjoyment. Women complete a written CBT exercise on body image and sex. Couples continue communication exercises. Genital touching is introduced to sensate focus sessions and participants are encouraged to use mindfulness skills to help them remain present and to manage difficult thoughts and emotions.

Module 5
Module 5 contains psychoeducation on sexual intercourse in a way that aims to make definitions of “sex” more broad and flexible, and to enable increased enjoyment during penetration. Women complete a written CBT exercise focussed on thoughts and feelings during intercourse. Couples continue communication exercises but are given the option of continuing the letters, or discussing the questions without the use of letters. Penetration is introduced to sensate focus sessions and participants are encouraged to use mindfulness skills to help them remain present and to manage difficult thoughts and emotions.

Module 6
This final module provides psychoeducation on sexual erotica, toys and aids, as well as an explanation of medical interventions for FSDs. Couples continue communication exercises, either with letters or without. Couples continue intercourse in sensate focus sessions with a focus on mindful awareness. Women complete a written exercise focussing on gains made throughout PP and anticipated difficulties following the program, and use this to create a relapse prevention plan.
A Qualitative Evaluation of Online Chat-groups for Women Completing a Psychological Intervention for Female Sexual Dysfunction

Abstract

Due to the embarrassment that can surround female sexual dysfunctions (FSDs), online interventions offer an anonymous and private treatment alternative. Jones and McCabe (2011) evaluated an online cognitive-behavioral treatment for FSDs. Whilst significant improvements were observed in sexual functioning, the treatment was primarily a behavioral intervention due to difficulties engaging participants in cognitive-therapy over email. To address this limitation, the use of chat-groups was incorporated into a new online treatment for FSDs—the *PursuingPleasure (PP)* program. Thirty-eight women participated in the *PP* chat-groups. The goals of the chat-groups were to address and overcome challenges as women progressed through *PP*, and to create a social support network where group therapy processes could be utilized. The chat-groups aimed to address misunderstandings, monitor changes, and receive feedback. A qualitative analysis of the chat-groups revealed that they helped to facilitate the cognitive-affective aspects of the program, as well as fulfil their other intended functions. This study demonstrates how the use of chat-groups in the online treatment of FSDs is a useful addition to internet-
based treatment. Feedback suggests that the chat-groups were one of the most helpful aspects of the program, although a small group of women reported finding the groups unhelpful.

Key words:

female sexual dysfunction, treatment, chat-groups, internet therapy

Given the nature of female sexual dysfunctions (FSDs) and the clear role that psychosocial factors play in their etiology and maintenance (Basson, 2000; McCabe et al., 2010), it has been suggested that psychological treatments alone, or a combination of medical and psychological treatments, may be the most effective interventions for FSDs (Althof, 2010; McCabe et al., 2010). Currently, there are no medications for the treatment of FSDs approved by the U.S. Food and Drug Administration, and therefore, there is a continuing need to develop and refine psychological interventions for FSD (Rowland, 2007).

Face-to-face psychological interventions for FSDs have been the main treatment approach since the development of Masters and Johnson’s (1970) behavioral sex therapy. More recent treatments for FSDs tend to utilize a broader cognitive-behavioral therapy (CBT) approach which aims to address the cognitive and attitudinal aspects of sexual dysfunctions (McCabe et al., 2010). A recent and promising addition to the CBT approach for women with sexual dysfunctions involves the inclusion of mindfulness - a Buddhist meditation practice (Althof, 2010; Brotto, Basson, & Luria, 2008; Brotto et al., 2008; Hahn, 1975). Mindfulness techniques facilitate present-moment awareness in an attempt to decrease distractedness during sexual activity, and increase awareness of pleasurable sensations (Brotto, Basson et al., 2008; Brotto et al., 2008).

Self-help methods for FSDs include bibliotherapy and video-therapy (van Lankveld, 2009). The benefits of using self-help methods include convenience, privacy and increased
self-efficacy (van Lankveld, 2009). These methods may be especially suited to women who do not want to seek face-to-face treatment for sexual problems for various reasons, such as embarrassment, anxiety, or geographical isolation.

Internet-based interventions are the most recent approach for treating FSDs. These interventions have been applied to a range of FSDs, with preliminary evidence supporting their use as a more private and convenient alternative to face-to-face treatments (Hall, 2004; Jones & McCabe, 2011). Jones and McCabe conducted a study evaluating the effectiveness of an internet-based CBT program, Revive, for women with mixed FSDs.

Significant improvements on measures of sexual desire, arousal, orgasm, sexual satisfaction and pain were observed in the treatment group as compared to the control group, as well as improvements in relationship satisfaction, sexual intimacy and emotional intimacy.

Although Revive was developed as a CBT program, there were significant problems in engaging participants over email therapy. This limited the program's ability to target maladaptive cognitions and attitudes surrounding sexual activity (Jones & McCabe, 2011) and suggests that many important psychological and interpersonal factors may not have been addressed (Jones & McCabe, 2011; McCabe et al., 2010). To overcome this limitation, the authors suggested that future internet-based interventions utilize online chat-groups to enhance the cognitive aspects of the program (Jones & McCabe, 2011).

The current study was designed to extend upon the research of Jones and McCabe (2011). PursuingPleasure (PP) is an internet-based program for the treatment of women with mixed FSDs, which utilizes unlimited email contact and online chat-groups every two weeks with a therapist specialising in sex therapy. The use of chat-groups was intended to mimic the cognitive therapy that occurs in face-to-face sex therapy to overcome the challenges faced within the program. The chat-groups were also intended to facilitate group processes that occur in group sex therapy (Mills & Kilmann, 1982). Group processes such as
self-disclosure, normalisation, validation, social support, learning from other's experiences, and offering guidance and support to others, have been identified as helpful interventions in the treatment of FSDs (Gehring & Chan, 2001), and these techniques have been used in a range of outcome studies for the treatment of FSDs (e.g., Brotto, Basson et al., 2008; Brotto et al., 2008; Smith, Beadle, & Shuster, 2008).

Due to the absence of face-to-face contact in PP, the secondary functions of the chat-groups were to address any misunderstandings of the online program content, to monitor cognitive and behavioral changes over time, and to receive ongoing feedback about the program. Through a qualitative analysis of the content of the PP chat-groups, this article investigates the degree to which the chat-groups fulfilled their intended therapeutic functions.

**Method**

**Participants**

The University ethics review board approved all research materials and procedures. Women were recruited to participate in the PP program via worldwide health websites and Australian university noticeboards, a press release in 2 Australian newspapers, and through a database of women who previously participated in a project completed by the researchers. The following inclusion criteria were applied: over 18 years of age, in a stable heterosexual relationship, experiencing sexual difficulties (in desire, arousal, orgasm and/or pain), no significant mental illness, and no significant relationship problems (e.g., violence, abuse), English speaking, regular access to internet. It was also necessary for partners to be willing to participate in communication exercises and sensate focus sessions. Information in the form of a Plain Language Statement (PLS) was therefore given to both members of the couple to ensure informed consent.
In total, 300 women responded at the initial phase of recruitment and 102 of these women submitted their consent forms after receiving the PLS. Ninety-one continued on to be randomly assigned (treatment group = 52, wait-list control group = 39). In order to investigate both clinical and sub-clinical levels of sexual difficulties, women were not formally screened for a FSD diagnoses.

Of the 52 women randomly assigned to the treatment group, one woman was screened out due to mental illness, and 13 women dropped-out before beginning treatment and/or attending a chat-group. The total sample used in this study was 38 women who started the program and attended at least one chat-group. Twenty-six of these women went on to finish the program. The mean age of the chat-group participants was 33.79 years (SD = 7.76 years, range = 23–53 years). Of these women, 94.7% reported a lack of sexual interest, 80.8% reported problems with sexual arousal, 71.1% reported difficulties achieving orgasm, and 60.5% reported painful intercourse. Women who dropped out of the program stated various reasons, such as difficulties with timing, unrealistic expectations of the program, and partners being uncooperative. Women in the wait-list control were offered the online treatment once the treatment group had completed the program.

Materials

All program content was delivered online via the PP website. Participants and their partners completed online surveys at pre-treatment, post-treatment and a 3-month follow-up, which measured sexual, relationship and emotional functioning. All chat-groups were conducted in a password-protected chat-room that allows synchronous (real-time) text conversation. No microphones or head-sets were used.

Procedure

The PP program is a password-protected online CBT intervention consisting of 6 progressive modules, each lasting approximately 2 weeks. Each module contains
psychoeducational readings and related CBT exercises. Psychoeducation sheets for partners are also available in each module. The first module is a non-touch module to cater to women needing to spend time reconnecting with their partner before beginning sensate focus. Nonsexual sensate focus is introduced in module 2, and body touching exercises become progressively more sexually oriented over the remaining modules. Each module contains mindfulness practice and communication exercises. The communication exercises require couples to write letters to each other on various topics relevant to each module, and then to discuss the content of the letters together. The mindfulness exercises begin with basic non-sexual mindfulness exercises (e.g., meditating on the breath), and become more sexually oriented over the program. Participants progressed through the modules at their own pace, and data were collected at the end of each module to monitor the number of exercises completed. Participants were offered unlimited email contact with the sex therapist and participated in chat-groups every two weeks. The amount of email contact used by participants varied greatly.

The online chat-groups contained 4–8 women and ran for one hour each. Women were allocated to a chat-group depending on their evening availability, and not on the basis of age, length of relationship, nature or duration of sexual problem or any other variable. Women generally remained in the same chat-group over the course of the program.

All groups were facilitated by a sex therapist specializing in the treatment of FSDs. The chat-groups were run with the following loose structure: greetings, review of exercises and experiences from the PP program over the previous 2 weeks, discussion of experiences and challenges brought up by group members, homework suggestions (if appropriate), closing of session. In the concluding sessions, there was a greater focus on reflection and relapse prevention. The group discussions were moderated by the sex therapist, who
guided the groups to focus on the causal and maintaining factors of FSDs, and to explore sexual avoidance and barriers to change.

The therapeutic processes and techniques that were utilized in the chat-groups included developing therapeutic relationships and group cohesion, giving permission for honest disclosure, validating experiences, offering psychoeducation, exploring and challenging cognitive distortions, addressing barriers to change, instructions for mindfulness meditation, suggesting specific behavioral interventions, and reinforcing concepts from the *PP* program content.

**Data analysis**

While quantitative methods were used to evaluate the effectiveness of the overall program (currently being analyzed), the open-ended nature of the chat-group discussions provided a rich source of information to analyze the usefulness of the chat-groups as an adjunct to the online modules. By reviewing the content of the chat-groups, rather than just the quantitative outcomes, a richer understanding could be gained into the processes that occurred within the groups to facilitate the goals of the program.

To aid the qualitative analysis, field notes were written by the chat-group facilitator to summarize the content of each chat-group into themes and subthemes. These summaries were written during each chat-group and provided the basis for the qualitative analysis. The chat-group summaries were independently reviewed by the facilitator and the second author for confirmatory and disconfirmatory evidence of the groups’ two primary goals of overcoming challenges identified in the program and providing social support, as well as their three secondary functions of addressing misunderstandings, monitoring changes over time, and receiving participant feedback. To facilitate this analysis, the themes and subthemes of each chat-group were independently categorized using the proposed goals of the chat-groups, as well as a category for themes or subthemes that did not align with the stated purposes of the groups. The two data analysts
then compared results and referred to the original transcripts for clarification of any categorization differences. No major differences existed after the original transcripts were consulted. The facilitator and second author then collaboratively chose representative responses to illustrate the results of the qualitative analysis. These responses were de-identified in order to protect the privacy of the women in the group.

**Results**

It should be noted that formal assessments of changes in the domains of sexual functioning, relationship functioning and emotional functioning were collected via online questionnaires at pre-program, post-program and 3-month follow-up. The detailed results of these questionnaires are currently being analyzed. Preliminary quantitative changes in sexual functioning are as follows: At pre-test, 73.1% of women reported experiencing sexual problems more than 50% of the time, and 0% of women reported experiencing sexual problems 25% of the time or less. At post-test, the percentage of women reporting sexual problems more than 50% of the time had decreased to 26.9%, and 42.3% of women reported experiencing sexual problems 25% of the time or less.

**Overcoming challenges identified in the program**

Much of the discussion in the chat-groups focussed on the challenges that women faced while completing PP, and the various barriers to change. Women in the chat-groups identified and discussed the intergenerational, individual and relationship factors that contributed to their sexual difficulties, the psychological, environmental and contextual factors that maintained their dysfunction, and the current barriers to behavior and attitude change.

The main causal attributions for FSDs discussed within the chat-groups included life stage changes, time management, low prioritization of sex and relationship, sexual myths, lack of non-sexual intimacy, negative attitudes about sex, familiarity of partner, lack
of time for self, negative body image, cognitive distraction during sex, and negative intergenerational messages about sex. Some specific quotes that illustrate these themes are as follows:

“It’s tough finding time for each other - and we both work so feel quite tired often.”

“...time poverty is my biggest relationship issue...”

“...initially I think for me it was my upbringing.”

“I have had issues with pain... especially since child birth...”

“I am so inside my own head, over analysing everything, stressing about everything, that I have trouble relaxing and just having fun”

Over the program, the women faced many challenges that were discussed and addressed via the chat-group discussions. The challenges that the women discussed included difficulties making time for exercises, being distracted during mindfulness meditation, dealing with negative cognitions, avoiding exercises, pessimism about the program, lack of partner support, and communication difficulties (especially regarding sexual needs and desires). To overcome these challenges and barriers, the facilitator used cognitive therapy techniques such as psychoeducation, Socratic questioning, reviewing the evidence, thought monitoring, and solution-focussed questions. Some specific quotes that illustrate these interventions are as follows (quotes from facilitator):

“Over the next week, I’d like you to notice all the little things that make the touch exercises and communication exercises just a little bit more enjoyable.”

“Ok, would you like to tell us a bit more about what comes up that makes it hard to move on?”

*Regarding sensate focus sessions:* “How can it be made less of an exercise, and more a mutual experience?”
“Can everybody share one positive change they have noticed so far?

As well as the issues and difficulties that the women came into the program to address, the chat-groups also offered a platform for discussing and addressing any new issues that arose during the program. For example, one woman reported that once she had achieved orgasm through the program exercises, she then became fearful of the “letting go” that was required in order for her to achieve orgasm again. Partner reactions and relationship issues that arose once women were more sexually active were also discussed and addressed in the groups.

Lastly, the disclosure of difficulties within these groups allowed the sex therapist to use email follow-up with particular women for further discussion and cognitive therapy. This enabled the program to be more individualized to each woman’s specific needs. Below is an excerpt from a follow-up email sent by the facilitator:

“Hello ladies, I just wanted to follow-up on the conversation we had on Wednesday night about delayed ejaculation. I have looked into this, and yes there can be an association between smoking (nicotine or marijuana) and delayed ejaculation because of the physiological effect this can have on the vascular system...”

**Social support and normalization**

As well as having real-time interactions with the therapist, the chat-groups also allowed women to interact with, and seek advice from, a variety of other women experiencing similar sexual concerns. These interactions created a social support network where problems could be normalised, and individual experiences could be validated. The following quotes demonstrate how comforting this was for the women in the groups:

“It feels so good to know that I’m not alone”

“So far, I’ve found it such a relief so many people are in my shoes”
“I wasn’t sure about this chat-group but already I feel better”

There were various experiences that were shared by many of the women in the program, allowing women to feel validated and normalized. A lower desire for sex than their partner was commonly discussed, as well as a decrease in sexual desire and enjoyment with increasing age and length of relationship, and an increase in sexual pain. Avoidance of intimacy and affection, due to concerns that this would lead to a demand for sex, was also a common experience among women in the groups. Feelings of guilt and shame over sexual difficulties were disclosed by many women, and they also discussed feeling a lack of womanhood or femininity due to sexual problems. Some of the ways that women validated and normalized each other in the chat-groups is demonstrated in the quotes below:

“I can relate to all those feelings”

“I feel the same - guilty all the time”

“Sounds similar to a conversation my husband and I had!”

“ME TOO!!!!!!!!!”

As well as social support, the group environment provided an opportunity for various group interventions such as brainstorming and problem-solving, insightful questioning, sharing tips and advice, sharing similar experiences, sharing resources (books, stores, websites), and offering new perspectives. The group members also provided a positive environment for change by encouraging those who were struggling, identifying and acknowledging small changes, and celebrating achievements. The quotes below illustrate some of the group processes that occurred in the chat-groups (all quotes are from group members, not the facilitator):

*In response to another woman’s issue with her partner:* “The letter writing may be a really useful communication tool during this time - and for future”
“...the other tip is to occasionally find some headspace - some time out where you don’t have to think about it”

“...and are you able to flag for him when this is what’s driving your behavior, so he knows straight away?”

“I've found the touch exercises particularly difficult. How have others gone with them?”

The therapist facilitated these group processes by attempting to build group cohesion, encouraging all members to be involved in the discussions, and initiating group problem-solving. The following quotes illustrate some of these techniques (quotes from facilitator):

“Ok, what do others think about this?”

“Who would like to offer [name] some encouragement?”

“What do you think about this situation [name]?”

“I’m wondering where the shame that some of you spoke about actually comes from?”

**Clarifying program content**

Although much time was dedicated to the quality of the online program content and structure, the chat-groups gave women an opportunity to ask questions and to clarify any misinterpretations and misunderstanding of the readings and the exercises. The questions and concerns that emerged regarding the program content and structure included concerns about timing and commitment, questions about specific exercises, and confusion about the definition of certain words and phrases used in the modules. Some specific quotes are as follows:

“Will each module add more activities/content on top of what was previously done?”
“If you and your partner are communicating honestly and very openly, is it ok to just sit and discuss them without the writing?”

*Regarding sensate focus:* “What do you think about using social lubricants like drinking?”

When questions or misunderstandings were brought up by one individual in the group, other women often reported having a similar question or misunderstanding. The facilitator then had the opportunity to address these issues. The quote below illustrates one instance of this:

*Participant:* “It’s hard to explain, but as an example, my husband will say I don’t know how to massage, I’m not good at it.”

*Moderator:* “This has actually come up a bit, and maybe the word “massage” has given the wrong idea... It's more about finding out what kind of touch you like...”

**Assessing changes over time**

The online nature of *PP* did not allow for any face-to-face contact, and therefore the chat-groups provided an opportunity for the therapist to observe changes in the women over time. These changes included benefits from the program, changes in cognitions and attitudes towards partner and sex, changes in partner behavior and attitude (as reported by the women), changes in sexual functioning, changes in relationship and changes in self-image. The following quotes demonstrate some of the changes that were reported in the chat-groups:

“Previously I’ve been not spending much time on the communication exercises...this week I’ve been making them a priority and I must admit they have provided some nice outcomes for us...”

“My hubby is thrilled. I think he sees the light at the end of the tunnel”
“We now agree that we cannot get anywhere unless we are completely honest. It is making a big difference”

The content and processes of the chat-groups also changed over time. In general, the groups became more positive and more solution-focussed as most women were experiencing positive gains from the program and then sharing these within the groups. The women also became more involved in each other’s journeys and achievements, and were able to share more experiences and advice with each other as they progressed through the modules. The role of the facilitator also changed within the chat-groups, with the groups being more self-directed and needing less facilitation over time.

**Receiving participant feedback**

During the chat-groups, women were able to give feedback to the facilitator about various aspects of the program, including the chat-groups themselves. Women gave feedback on the effectiveness of specific aspects of the program (e.g., mindfulness, communication exercises), as well as the program as a whole. They also gave feedback about the most challenging parts of the program, and suggestions for how to improve certain aspects of the program to make it more beneficial. The following quotes illustrate some of the feedback provided:

*In response to relapse prevention planning:* “Module 5 & 6 are great fun and I definitely think creating a plan so that you don’t fall into the same trap is really useful.”

“Sensate focus has been incredibly helpful”

“I found the first 2 modules the hardest to get in to, so maybe a bit more emailing at the start could be good”

“I wonder if problem solving how to organise/schedule more time in the earlier few
chat-groups might be a good thing to try”

Feedback about the chat-groups was generally very positive, and many women stated that the chat-groups were one of the most helpful parts of the program. Various women also talked specifically about the benefits of having an anonymous chat-group and how this allowed them to self-disclose about very sensitive topics. Some specific quotes are as follows:

“Chat-groups are the best”

“It’s a nice community... to talk or discuss with, I really enjoyed the chat-groups”

“I’ve found both the differences and the similarities supportive - some comments make me feel ‘oh, others have that same experience, that’s nice to know’ and other comments make me feel ‘I don’t have that problem - that’s lucky’!!”

“How I think it works better being more anonymous around these topics which are so personal, I can be more honest”

As well as many positive comments, there was a small group of women (n = 3; 7.9% of the original 38 women) who provided negative feedback about the chat-groups through email contact with the facilitator. For example, one woman described the chat-groups as “hard because other women were doing well and giving me unsolicited advice.” The other negative comments were similar in nature and represented a group of women who did not appreciate discussing the experiences and success of other women in the program. These women were offered support over email to discuss the challenges they were facing in the program.

A topic of feedback that came up numerous times in the chat-groups was the idea of having chat-groups for male partners to attend. This was suggested for various reasons, such as partners not having anyone to talk to, partners feeling left out and wanting more involvement, partners not taking responsibility for their role in the sexual problems, and
the need for more teamwork. The following quotes illustrate some of the feedback provided on this topic:

“My husband wondered whether a chat-group for partners might be helpful as well.”

“What if you made an invitation to women to invite their partners to a chat-group later on in the programme? As an option?”

**Discussion**

The findings from this study support the use of online chat-groups as an adjunct to internet-based treatments for women with sexual dysfunctions. The addition of chat-groups to an online treatment for FSDs allowed women to further explore the cognitive-affective aspects of their sexual difficulties by exploring the challenges that arose over the program. The group setting also allowed women to gain social support and encouragement from women with similar concerns, as well as being involved in group therapy interventions. The chat-groups also gave women the opportunity to clarify any misunderstandings about the program content, and offered the facilitator an opportunity to assess changes over time and to receive ongoing feedback about the program. While all of these processes were useful in and of themselves, the online discussions also allowed for email follow-up to help women tailor the program to their individual needs and address their personal challenges and barriers to change.

The internet is increasingly being used for a range of mental health services due to the advantages that this treatment format has to offer. Internet-based therapies decrease some of the barriers to receiving treatment, such as inconvenience, time constraints, physical disability, travel costs and geography (Jones & Stokes, 2009; Tate & Zabinski, 2004), while also offering a sense of anonymity and invisibility, and an ability to draw together a community of people who may have previously been unable to interact (Tate & Zabinski, 2004).
While there are many advantages of the online treatment format for FSDs, it is important that treatment programs utilizing this approach not sacrifice the active ingredients in face-to-face sex therapy. Extending upon the research of Jones and McCabe (2011) by incorporating the online chat-groups, the PP program capitalised on the advantages of online therapy (e.g., convenience and anonymity) while also more closely mimicking face-to-face sex therapy and group sex therapy processes to further enhance the cognitive-affective aspects of the program. This enabled PP to comprehensively address both the behavioral and the cognitive-affective aspects of FSDs and therefore tailor the program to the individual needs of each woman, which had not been accomplished in the Revive program (Jones & McCabe, 2011).

By utilising online chat-groups to ensure that both the behavioral and the cognitive-affective aspects of FSDs are addressed, internet-based treatments for FSDs can offer a convenient alternative for women wishing to seek psychological treatment. Feedback from women within the study suggests that the chat-groups were one of the most helpful aspects of the program for many of them, and that these groups facilitated their progress through the program. Although most of the feedback was positive, a small group of women provided negative feedback about the chat-groups. The comments from these women suggest that a small subgroup of women struggling with the program may not benefit from the chat-groups.

In response to many women in the PP program reporting that anonymous disclosure and privacy were very important aspects of the chat-groups for them, future research could serve to explore the importance of anonymity in group sex therapy for FSDs. Future research into the use of combined internet-based psychological treatments and medical treatments for FSDs would also be useful.
References


Chapter 9
Discussion

This chapter will discuss the findings from the PP studies and their contribution to the research area of manualised treatments for FSD. It will integrate the findings from all four articles and include a brief discussion of the evaluation of the program, as well as an overview of the qualitative evaluations and feedback supplied by the participants and their partners. This will be followed by a discussion of the challenges encountered while administering the online treatment. Implications for research and treatment in the area of FSD will be explored, as well as limitations of the studies. Lastly, recommendations for future research will be discussed.

Evaluation of the PursuingPleasure Program

The following hypotheses informed the implementation of the PP program: 1) Women in the treatment groups and their partners will demonstrate significant improvements in sexual functioning; 2) Women in the treatment groups will report significant reductions in distress associated with sexual functioning; 3) Women in the treatment groups will report significant improvements in relationship functioning; and 4) Treatment gains will be maintained for 3-months following the completion of treatment.

Female sexual functioning. The hypothesis that women in the treatment groups would demonstrate significant improvements in sexual functioning was supported by the results of the PP studies. Women in study 1 reported improvements in sexual desire, arousal, lubrication, orgasm, and satisfaction as compared to a
waitlist control group, and women in study 2 demonstrated significant improvements in sexual desire, arousal, orgasm, and satisfaction. Although the result for lubrication was non-significant in study 2, there was a trend towards improvement and it is likely that the small sample size impacted this result. Sexual pain was the one domain that did not improve significantly in either treatment group, although there was a small trend towards improved scores, and the baseline mean scores for sexual pain demonstrated that pain-related FSD was not as severe as other FSDs. Improvements in multiple domains of sexual functioning is consistent with prior research on internet-based treatment of mixed FSD, and is not surprising given that many women have sexual dysfunctions in multiple phases of sexual response (Jones & McCabe, 2011).

Changes in the self-reported frequency of sexual difficulties in both treatment groups supplied additional support for the effectiveness of the PP program. In both the original treatment group and the control crossover group, there were significant decreases in the self-reported frequency of sexual difficulties from pre-test to post-test. These results were also consistent with prior research (Jones & McCabe, 2011). Despite positive results, many women did not experience a complete reversal of symptoms, and most women still experienced sexual difficulties some of the time. Rather than being a limitation of the PP program, these results are consistent with past research using both internet-based and face-to-face treatments (Hawton et al., 1986; Jones & McCabe, 2011; McCabe, 2001; Sarwer & Durlak, 1997), and demonstrate the inherent difficulties in treating FSDs. These difficulties may be related to the diverse etiology of FSDs, the heterogeneity of women with FSDs, and the lack of approved medical treatments to address biological aspects of female sexual functioning.
**Male sexual functioning.** According to the women in the studies, a large proportion of male partners in both treatment groups had some form of MSD. Results regarding the hypothesis that partners in the treatment groups would demonstrate significant improvements in sexual functioning were only partially supported in the PP studies. At post-test assessment in study 1, significant improvements were reported in EF, partner sexual desire and partner overall sexual satisfaction as compared to the waitlist control group. These significant improvements were not seen in study 2, although all variables demonstrated a trend towards improvement. Significant improvements were not reported in either treatment group for PE and partner orgasmic function (ability to achieve ejaculation and/or orgasm). The improvements reported in study 1 are consistent with prior research into the effectiveness of online treatment for ED, where significant improvements in scores of EF have been consistently reported at post-test (McCabe et al., 2008; van Deist et al., 2007; van Lankveld et al., 2009). The results from study 1 are also consistent with prior research investigating the use of internet-based interventions for PE, where symptoms have been reported to be more resistant to change (McCabe et al., 2008; van Deist et al., 2007; van Lankveld et al., 2009).

**Distress associated with sexual functioning.** Personal distress associated with sexual functioning is an important aspect of FSD (APA, 2000; Shifren et al., 2008), and was therefore included as a variable in the PP studies. Significant improvements in distress were reported in both treatment groups. In addition, qualitative data from PP (emails, chat-group transcripts and assessments) suggested that women’s levels of sexual functioning related distress decreased over time, and that their perceptions of their sexual difficulties changed throughout the program.
For example, women reported an increased perception of their sexual difficulties as a joint responsibility in the relationship, a decrease in self-blame regarding their FSD, and increased awareness of positive aspects of their sexuality.

**Relationship functioning.** The hypothesis that women in the treatment groups would report significant improvements in relationship functioning was partially supported by the results from study 1, where women reported significant improvements in sexual intimacy, emotional intimacy and communication as compared to the control group, but not for overall relationship satisfaction. In study 2, similar significant improvements were reported in sexual intimacy and communication, but not for emotional intimacy or relationship satisfaction. A trend towards improvement and a moderate effect size was observed in study 2 for changes in emotional intimacy pre-test to post-test and it is hypothesised that the smaller sample size may have impacted this result. These finding are consistent with prior research (Jones & McCabe, 2011) and suggest that the areas of relationship functioning that significantly improved were those that were specifically addressed in the online treatment through the communication and intimacy exercises. Regarding the relationship areas that did not improve over the course of treatment, it is possible that this was due to a ceiling effect, but this could not be confirmed due to a lack of normative data available for these measures.

**Effectiveness of PP at 3-month follow-up.** The hypothesis that women’s treatment gains would be maintained at the 3-months follow-up was supported by results from the PP studies, with all significant changes and trends towards improvement in female sexual functioning, self-reported frequency of sexual
difficulties, associated distress, and relationship function being maintained at the 3-month follow-up. These results are consistent with prior research (Jones & McCabe, 2011) and provide further evidence for the long-term effectiveness of internet-based interventions for FSDs. Regarding partner sexual functioning, significant improvements and trends towards improvement on EF, partner sexual desire, and PE were maintained at 3-month follow-up, but not partner orgasmic function or partner overall sexual satisfaction. These results suggest that the PP program may have been helpful in improving some areas of partner sexual functioning, but that more targeted interventions may be necessary in FSD treatment to address co-existing MSDs.

Observations between treatment groups. The results from the PP studies suggest that some differences existed between the changes observed in the original treatment group and the control crossover group. In the areas of attrition and self-reported frequency of sexual difficulties, the control crossover group demonstrated better results than the original treatment group. However, some significant improvements that were reported in the original treatment group were not reported in the control crossover group. To explain this difference, it is possible that some women who had participated in the entire waitlist period may have built up a sense of positive anticipation and developed a high level of motivation to remain in the program once it was offered. Changes in lubrications, emotional intimacy and partner sexual functioning that were significantly improved in study 1 were also improved in study 2, but not to a significant degree. The lack of significant findings for these variables in study 2 may have been due to the smaller sample size in the control crossover group.
Qualitative Feedback and Recommendations

Qualitative data were collected via online assessment, emails between therapist and participants, and chat-group transcripts. Over these media, information was gathered from women and partners, including the challenges that couples faced throughout the treatment, perceptions of the most helpful components within PP, and recommendations for future online FSD treatment programs.

Challenges during treatment and barriers to change. The challenges that women faced throughout the program, and the barriers to behaviour and attitudinal change, were reported via email therapy, chat-group discussions and the post-test and follow-up questionnaires. Common challenges and difficulties that the women discussed included time management, being distracted during mindfulness meditation, negative thoughts and affects related to sex, avoidance of exercises, and pessimism about the program and their progress. Where possible, these issues were addressed through email therapy and chat-group discussions using both cognitive and behavioural interventions.

Mindfulness-related challenges. Regarding mindfulness practice, comments that came up frequently in the chat-groups included women worrying that they were not doing mindfulness correctly, and that they struggled to remember to do the daily mindfulness practice. By not doing mindfulness correctly, women were referring to being distracted by thoughts and feelings during mindfulness practice. Cognitive and affective distraction is one of the common obstacles in mindfulness training (Harris, 2007; Harris, 2009; Kabat-Zinn, 2003) and women’s experiences were therefore validated and normalised through reassurance that distraction is normal and to be expected, and that the practice would become easier with regular practice (Kabat-
Zinn, 2003). Over the course of the treatment, women were repeatedly encouraged to non-judgementally acknowledge their distractions, and then gently bring their attention back to the present moment focus. It was also explained that this process of noticing distractions and refocussing may have to occur thousands of times over the space of a mindfulness practice, and that this is the practice of mindfulness and they therefore are doing it correctly.

Women were also encouraged to discover their preferences with mindfulness to help them engage with their daily practice. Preferences included internal or external focus, indoor or outdoor practice, and time of day to practice. Women also reported their difficulties in finding time for mindfulness practice and remembering to do daily practice. Finding a routine for mindfulness practice was encouraged, as well as using reminders such as phone-alerts and notes in their diary.

Partner-related challenges. As well as individual challenges that arose over the program, there were also a range of partner-related challenges that became apparent both at the beginning of treatment, and as women became more motivated and more aware of their sexuality in later modules. The partner-related challenges that were reported included partners not prioritising treatment or making time for exercises, men noticing small changes in their partner and then wanting to rush into sexual intercourse, partners not being supportive of the “no sex rule” at the beginning of the program, partners being pessimistic about treatment outcomes, partners not taking responsibility for their role in the sexual dysfunction, communication difficulties within the couple (especially regarding the communication of sexual needs and desires), and conflict resolution. These issues were explored over email therapy and chat-group discussions, and were very distressing challenges for some women.
**Most helpful and least helpful components of treatment.** Through the online assessments and chat-group discussions, women were asked which of the program components they found most helpful. The most common comments included the chat-groups, the mindfulness exercises, the communication exercises, the psychoeducation, and the sensate focus sessions. Other components of the program mentioned as the most helpful by some participants were: the CBT exercises, the resources page, the program structure, the flexible timing, the relapse prevention planning, the email therapy and the “no sex rule” during the early stages of treatment.

From the partner questionnaires, the most commonly reported helpful components of the program were the communication exercises and the sensate focus techniques. Men also mentioned the relaxation and mindfulness exercises, psychoeducation, scheduling of couple-time, and abstinence from sex as helpful components of the program.

As well as reflecting on the helpful components of the program, women were also given the opportunity to report the aspects of the program that they found least helpful. These answers were varied and inconsistent, and demonstrated the importance of including a variety of techniques within a manualised treatment for women to experiment with and adapt to their individual needs. The least helpful components of the program reported by some individual women included: the “quiet vagina” technique, the self-touch exercise, the “no sex rule”, and the sexual anatomy explanations.

Many women commented on the timing of the program, but these comments were also quite varied and inconsistent: some women stated that the flexible timing was appropriate, others commented that the timing was too flexible, and still others
stated that the timing should have been more flexible and that the program should run over a 12-month period. This again demonstrates the heterogeneous nature of women with FSDs, and the need for a flexible manualised treatment in order to accommodate for differing treatment needs.

Although the mindfulness exercises and online chat-groups were consistently reported as two of the most helpful aspects of the PP treatment, two women (4.76% of the combined treatment groups) reported that they found the mindfulness exercises one of the least helpful components of the program, and four women (9.52% of the combined treatment groups) reported that they found the online chat-groups one of the least helpful aspects of the program.

From the men who commented in the questionnaires, the least helpful aspects of the program included the rigidity and repetition of the communication exercises, the perceived lack of male involvement in treatment, the prolonged abstinence period, the poor quality of the erotica resources, the time commitment, and the repetitive questionnaires. As with the comments from the women, the comments about the least helpful aspects of the program were more varied and individual for the men compared to the most helpful aspects of the program.

**Recommendations for improvements.** A variety of recommendations for improvement were made by the women who completed the PP treatment, and their partners. These recommendations came under three main categories: 1) Program structure and content; 2) Program timing; and 3) Partner involvement.

Regarding program structure, some women and partners suggested that fewer exercises per week would make the program less time pressured and more enjoyable. For example, one women suggested that rather than a prescriptive 3
sensate focus sessions per week, that women are suggested to complete between 1-3 session per week. It was also suggested that more focus be put on time management and scheduling in earlier modules, and that motivational and “check-in” emails be sent on a more regular basis. Regarding content, it was suggested that more resources be included in the resources page, that case studies be presented, that information be provided for couples with co-existing male HSDD, and that psychoeducation include more information on the physiology of female sexual response. It was also suggested by one woman that a more varied representation of female sexuality and femininity be presented in the program content and web design (e.g., colour scheme and picture selection), and some men suggested that communication questions be more varied and that partner handouts provide more in-depth information.

Regarding program timing and commitment, some women and men suggested that the timing of the program should be more strict (e.g., strictly two-weeks per module to keep momentum) while others suggested that the program should be less time pressured and more flexible (e.g., spread across 12-months). Regardless of the timing of the program, women and partners suggested that it would be helpful to have a more detailed description of program timing and expectations of each member of the couple before beginning treatment, and that more time could be spent in earlier modules discussing and problem-solving this issue.

Regarding partner involvement, many women and men suggested that male partners be more involved in treatment. A common suggestion to increase partner engagement was that monthly online chat-groups for partners be added to the PP program. Others suggested that men be given responsibility for certain tasks in the
program so as to increase their involvement and engagement in the process. One final suggestion from one partner was that women receive some one-on-one support via individual online chat-rooms or online video-conferencing.

**Challenges in the Delivery of Pursuing Pleasure**

During the development and implementation of *PP*, a number of anticipated and unanticipated challenges arose. These challenges included technical difficulties, treatment engagement, program timing, and difficult couple dynamics.

**Technical challenges.** Due to the online nature of the program, it was anticipated that technical difficulties would be encountered, especially in the online chat-groups. The challenges that arose in the online chat-groups included time delays (either for the therapist or the participants) due to slow connections, and connection problems resulting in women arriving late to groups, dropping in and out throughout a group, or missing an entire group. Another challenge that arose was time zone differences. The *PP* online therapist was located in Melbourne (Australian Eastern Standard Timing), but due to the accessible nature of the program, participants were not all from the same time zone. Most women were spread over the states and territories of Australia, some of which have different time zones, and a small number of women were completing the treatment from New Zealand, Europe, and Northern America. Women were informed that the chat-groups would be run in Australian Eastern Standard Timing, but some women experienced difficulties in calculating the timing of the online chat-groups for themselves, and this resulted in some late arrivals or missed chat-groups, especially when timing changed due to day-light savings in Australia.
**Participant engagement and motivation.** Over the course of therapy with both treatment groups, it became apparent that some women were more willing to engage in email therapy than others, despite regular encouragement to access the therapist via email for extra help and support. Due to the variation in engagement levels, some women did not get as much individualised attention as others. For example, women who wrote emails to the therapist about their difficulties in treatment received individualised replies and suggestions, while women who did not communicate their individual difficulties to the therapist did not receive this individualised service. It is not known what impact this had on treatment outcomes, and it is possible that women who did not use the email contact as regularly felt that they did not need as much individual support, or preferred to approach treatment in a more independent manner. It is also possible that these women felt embarrassed or did not have the confidence to approach the therapist over email.

Helping women to maintain motivation over the course of therapy was a challenge in both treatment groups. From the feedback women provided, their motivation for treatment was impacted by several factors: time poverty, feeling incompetent at certain exercises (e.g., mindfulness), negative cognitions and affect, lack of privacy for exercises, pessimism about the program, lack of partner support, and communication difficulties with their partner. These issues were addressed using cognitive, behavioural and mindfulness strategies over email therapy and online chat-groups. Some areas of concern were repeatedly talked about in chat-groups and email therapy (e.g., time poverty, lack of privacy), and it became apparent that these concerns may have acted as distractions from other, more personal, etiological factors involved in FSD such as body- and genital-shame and guilt about female sexual enjoyment.
In response to difficulties with engagement and motivation, it was apparent that a certain amount of email contact needed to be initiated by the therapist in the form of reminders, “check-ins” and motivational messages. The challenge encountered in this approach was the decision about how much or how little to contact women between the chat-groups. In order to strike a balance between allowing participants their autonomy while also offering support and encouragement, the therapist utilised particular time points to send reminders and check-in emails to participants (e.g., at the beginning of a new module, in the middle of a module, at the end of a module). It was also decided that when a participant had not engaged in email contact for over two weeks (even after therapist contact), the therapist would initiate email contact to check-in with the woman and offer a motivational message.

**Treatment timing.** The *PP* program was offered with a loose time structure so as to accommodate for individual progress. Women and partners were told that each module was designed to be completed in approximately two weeks, but that this timing was flexible. In many ways, the flexible timing worked to the advantage of the participants, allowing them appropriate time in each module. However, the timing of the program also gave rise to some challenges. Firstly, due to timing flexibility, women in the online chat-groups were not necessarily in the same module as each other, and this resulted in some conversations within the groups being more relevant to women in a certain modules than others. For example, discussion about making sexual intercourse more enjoyable would be relevant to women in modules 5 and 6, but not necessarily to women in modules 3 and 4. Although this posed a challenge at times, the discussions regarding later modules
did appear to be helpful for most women in the earlier modules as they had the opportunity to hear about other women’s achievements and suggestions. Women in later modules also appeared to appreciate the conversations about earlier modules because they had the opportunity to reflect on their own progress and offer support to those in earlier modules.

Another challenge that arose due to flexible timing of the PP program was that some women delayed moving into later modules for quite some time due to their fears about reintroducing sexual touch and intercourse after a period of abstinence. To address this, women were encouraged to seek email support regarding their fears and apprehensions, and women who had delayed moving onto the next module for over 3 weeks were asked directly about their progress and any apprehensions they may have had via emails from the therapist. Women who were moving through the program at a slower pace were also regularly encouraged to keep a certain amount of “momentum” throughout the program by consistently making time for the exercises and email contact.

**Couple dynamics.** Women who identified as being in a relationship with high relationship discord where excluded from the PP program. Nonetheless, there were several instances where difficult couple dynamics arose, and where couples therapy may have been indicated. For example, one couple found that the communication exercises generally led them towards conflict rather than connection, and found it very difficult to then move into sensate focus. Although couples therapy may have been helpful at certain stages of therapy for some couples, the PP program was designed in a manner that meant that all cognitive therapy occurred through the woman, either in the online content, the chat-groups or the email therapy. This was
generally useful for women, but did not necessarily address all relationship issues relevant to their FSD. This therapeutic situation also meant that only one side of the couple narrative was being told throughout therapy, except in the assessment questionnaires. This made it difficult for the therapist to remain objective and gain a sense of the couple’s scenario, and difficulties with this set-up have been reported in past internet-based interventions for sexual dysfunction (Hall, 2004). The absence of partners in the therapeutic dialogue may have influenced why so many partners suggested that future internet-based treatments for FSD involve the men more thoroughly throughout the treatment.

**Implications for the Treatment of FSD**

Drawing upon the information presented in the four articles, as well as further qualitative data discussed above, a range of implications for the treatment of FSDs warrant discussion. These implications relate to the use of internet-based interventions for FSDs, the incorporation of mindfulness training for FSDs, the use of online chat-groups for women with FSDs, the therapeutic relationship developed over internet-based therapy, the etiological factors related to FSDs, the involvement of partners in FSD treatment, and the application of manualised treatments for FSDs.

**Internet-based interventions for FSD.** Preliminary evidence for the effectiveness of internet-based treatments for mixed FSD was established in the *Revive* study by Jones and McCabe (2011). The *PP* studies have provided further evidence to support the use of internet-based interventions for a range of FSDs. Like the *Revive* study, the *PP* studies demonstrated improvements in sexual and relationship functioning for women with mixed FSDs through the use of online
treatment. Both the *Revive* and the *PP* studies have demonstrated that women with high motivation, an appropriate reading level and a stable, supportive relationship are likely to benefit from internet-based treatment for FSDs, and that this treatment approach can be an effective and anonymous alternative to face-to-face therapy. Women who may not be suitable for internet-based treatment of FSDs include women in a relationship with high relationship discord or physical/sexual abuse, women with low motivation to address FSD and relevant relationship issues, and women with FSDs of a primarily biological etiology, although internet-based treatment may still be effective as a supplementing therapy to address other etiological factors that may be involved. The effectiveness of internet-based treatment for FSDs currently lacks generalisability to single women and women in same-sex relationships, but this does not necessarily mean that internet-based treatment would not be effective for these women. Regarding male partner sexual functioning, although the results from the *PP* studies indicate that some areas of male sexual functioning improved following the *PP* treatment, the overall results do suggest that adjunctive treatments for MSDs may be suitable for couples with co-existing MSD and FSD. This may be especially relevant for PE and male orgasmic disorders.

**Mindfulness training for FSDs.** The *PP* program was the first internet-based intervention for sexual dysfunction to incorporate mindfulness training. The addition of mindfulness training to the online treatment of FSDs was in response to preliminary evidence of the effectiveness of mindfulness training for women with sexual desire and arousal disorders (Althof, 2010; Brotto et al., 2008a, 2008b, 2008c). As well as other studies published more recently (Brotto et al., 2012a,
2012b, 2012c), the PP studies add further support for the use of mindfulness training with women experiencing sexual difficulties. In addition, women reported that the mindfulness exercises were one of the most helpful aspects of the treatment, and this is consistent with prior research (Brotto et al., 2008a, 2008b). These results suggest that not only is mindfulness training helpful for women with FSD, but that it also has face validity for women, which may help them to further integrate mindfulness into their sex lives after treatment has concluded.

Prior studies involving mindfulness training for FSDs, and the PP studies, have used the format of introducing mindfulness in a non-sexual context first, and then making the exercises more sensually and sexually oriented. This gradual introduction of mindfulness gives women the opportunity to learn basic mindfulness skills, and troubleshoot any problems that arise, before incorporating mindfulness into sexual activity. The use of non-sexual mindfulness at the beginning of treatment, rather than simply incorporating it into sensate focus, may have the added advantage of generalising the benefits of mindfulness into other areas of women’s lives, such as addressing stress, anxiety and mood. This was not measured directly in the PP studies, but some women did report benefits of mindfulness in other areas of life such as their general stress levels and mood, and prior research has shown an increase in mood and overall wellbeing among women with FSDs who have undergone mindfulness training (Brotto et al., 2008b).

This approach to mindfulness training for FSDs slotted well into sensate focus, which also begins with a focus on non-sexual aspects of the practice and then gradually becomes more sexually oriented. Some clinicians may wonder how mindfulness training for FSDs differs from traditional sensate focus techniques which already incorporate a focus on sensory experiences and aim to decrease
performance anxiety. From the experiences of women in the PP studies, as well as prior research into mindfulness and female sexuality (Brotto et al., 2008a, 2008b; Brotto et al., 2012a, 2012b, 2012c; Silverstein et al., 2011), it appears that mindfulness offers the following unique components to traditional sensate focus; 1) Mindfulness training teaches women how to cultivate greater present-moment awareness and focus during sensate focus exercises; 2) Mindfulness exercises teach women new skills for managing cognitive and affective distractions during sexual activity; 3) Mindfulness training helps women develop the ability to manage distressing thoughts or emotions triggered before, during or after sex; 4) Mindfulness practice can lead to a heightened awareness of genital arousal during sexual activity; 5) A mindful stance during sensate focus encourages a less judgemental stance towards self and partner; and 6) Mindful awareness allows for a greater focus on letting go of expectations and predictions about sex and the outcome of sexual activity (e.g., orgasm, lubrication). Therefore, mindfulness training appears to offer women benefits above and beyond those offered by traditional sensate focus alone, and mindfulness can easily be incorporated into sensate focus exercises after basic mindfulness skills are acquired.

**Online chat-groups as an adjunct to internet-based FSD treatment.** As well as the novel addition of mindfulness training, the PP program was the first internet-based intervention for sexual dysfunction to use online chat-groups. The chat-groups functioned as an interactive way to engage women in cognitive therapy and offered them a space to discuss challenges and barriers to change as they arose over the treatment. During the Revive program (Jones & McCabe, 2011), the authors noted considerable difficulties engaging women in email therapy during the treatment. By
utilising online chat-groups, not only did women in the PP program have an extra medium to undertake cognitive therapy, but it also appeared to assist the therapeutic relationship between the therapist and the women, and therefore encouraged women to engage more in the email therapy.

The feedback provided by PP participants suggested that one of the most helpful aspects of the online chat-groups for women with FSDs was the ability to communicate with other women experiencing similar difficulties, and to obtain and deliver social support in an anonymous forum. Due to FSD being a private, embarrassing, and sometimes shameful topic for many women (Barak & Fisher, 2003; Hall, 2004; Jones & McCabe, 2011; Skarderud, 2003), this feedback suggests that providing women with FSDs an opportunity to have their experiences validated and normalised by their peers is incredibly important to them, and potentially a significant factor in the long-term benefits of FSD treatment. Women in the online chat-groups offered validation and support to each other over a range of topics, including low sexual desire, mismatched desire with their partner, a decrease in sexual enjoyment over time, an increase in sexual pain over time, the impact of motherhood and lifestyle stress on sexuality, a lack of non-sexual intimacy in their relationship, and feelings of guilt and shame related to their FSDs. It was also raised in the chat-groups that women did not often get to talk about sex and sexual difficulties with their friends or family, and that they therefore had a limited ability to gain support, validation and normalisation outside of therapy.

As well as offering a space for therapy and social support during FSD treatment, the online chat-groups were also useful for more administrative tasks such as addressing misunderstandings, collecting feedback and assessing progress over time. Without face-to-face contact, gathering this sort of information over the course
of therapy can be quite difficult, and it has been suggested that providing a space for clarifications is particularly important during internet-based treatment for sexual dysfunctions due to the inherent difficulties in portraying information accurately in written format alone (Hall, 2004).

**The online therapeutic relationship.** Within the literature on internet-based therapies, there has been some debate over the ability to form a therapeutic relationship or therapeutic alliance over the internet (Cook & Doyle, 2002). The ability to form a therapeutic alliance over the course of therapy is significant, given the body of research that has established the therapeutic relationship as one of the common factors in successful treatment outcomes (Donahey & Miller, 2000; Lambert, 1992). Past research has demonstrated that an effective therapeutic relationship can be established over the internet, and that an online therapeutic alliance is comparable to those established in face-to-face therapy (Alemi et al., 2007; Cook & Doyle, 2002; Rotondi et al., 2005). The experiences of the therapist from the *PP* studies, who attended to the email therapy and the online chat-groups, were consistent with prior research on the ability of online therapists to form trusting and collaborative relationships with clients despite the absence of face-to-face contact. Through the online chat-groups and emails, the therapist demonstrated the ability to form relationships where honest and open disclosure of sensitive information was apparent, where empathy and validation were communicated, where humour was utilised, where collaboration occurred, where misunderstandings were discussed, and where progress was celebrated.

Comments within the chat-groups and the emails, as well as qualitative feedback from the online assessment, demonstrated that the participants were
willing to form a trusting, honest and open relationship with the therapist. For example, one woman commented:

\[ I \text{ found the online chats a great way to discuss sexual issues... I was able to be more honest and open in my discussions... I also found Alice, the facilitator, to be excellent in all aspects, getting us to reveal information, encouraging us with constant positive reinforcement and empathy and keeping in touch and keeping us on track. (PP participant) \]

Qualitative reflections provided by participants suggested that some aspects of the therapy that seemed to especially help the development of the therapeutic relationship over email and chat-groups included the therapist’s expressed empathy, validation and normalisation, the flexibility of interventions used by the therapist (i.e., a client centred approach within the CBT framework), the use of humour, and the therapist’s follow-up with individuals after concerns were expressed in chat-groups.

**Etiological factors.** Drawing upon information from the emails, the online chat-groups and the online assessments, the *PP* studies revealed a range of etiological factors related to FSDs that are consistent with prior research. The following factors, categorised as predisposing, precipitating and/or perpetuating, where reported in relation to the etiology of FSDs by the women in the *PP* studies:

Predisposing factors included a history of sexual abuse, sexually conservative/strict upbringing, religious upbringing, negative messages about sex from family-of-origin, sexual myths, negative attitudes about sex and intimacy,
genital pain conditions, and unhelpful sexual messages from the media and popular culture.

Precipitating factors included life stage changes (especially pregnancy, childbirth and motherhood), increased lifestyle/work stress, decreased time available for relationship, low prioritisation of sex and intimacy, familiarity of partner, loss of sexual desire as relationship progressed, genital pain conditions, lack of time for self, negative body-image, and cognitive distraction during sex.

Perpetuating factors included poor time management or lack of available time for sex, low energy and fatigue related to career, parenting and housework/chores, poor body-image, poor genital self-image, identity issues related to motherhood (e.g., loss of identity as a sexual woman, body belonging to baby), relationship conflict, partner familiarity, partner hygiene, lack of privacy from children or extended family, negative sexual schema, negative beliefs and attitudes about sex, low sexual self-confidence, media and popular culture representations of female sexuality, genital pain conditions, guilt and shame, lack of time for self, and cognitive distraction during sex.

These findings demonstrate the heterogeneous nature of women with FSDs, and the range of biological, intergenerational, individual and relationship factors that can be involved in FSDs. These findings support the use of a biopsychosocial model to understand FSDs and to plan appropriate treatments.

**Involvement of partners in treatment.** One of the most common recommendations received in the qualitative feedback, was that partners be more involved in treatment. These recommendations came from women wanting their partners to have an opportunity to be more involved, and also from men who felt
that their involvement over the PP program had not been sufficient, despite efforts to engage men through the PP psychoeducation handouts and the online assessments.

The idea of online chat-groups for partners was brought up frequently by participants in order to address the lack of partner involvement, but previous research into male engagement in online discussions of sexual dysfunction raises doubts about the effectiveness of online partner chat-groups. For example, in Hall’s (2004) online sex therapy program, partners were invited to exchange emails directly with the therapist, but Hall noted that it was difficult to engage partners in email therapy. In addition, McCabe and colleagues (2008) suggested that the high attrition rate in their internet-based treatment for ED may have been due to difficulties in engaging men over the internet. Men have also been observed as resistant to discussing sexual issues over online message boards (Chisholm, 2012). Despite the doubts raised by these findings, they do not conclusively suggest that online partner chat-groups would be unhelpful, and future research would be needed to assess whether this is a suitable addition to the online treatment of FSD.

While the addition of online chat-groups for partners is one way to address complaints about partners not being sufficiently involved in treatment, other alternatives could also be considered. To address couple dynamics and partner involvement, it has been suggested that web-cam or video-conference technology could be used for couples in internet-based treatments for sexual dysfunction (Hall, 2004). For example, the current content of PP could be supplemented with monthly Skype sessions for couples, or these sessions could be arranged as required based on therapist and client assessment. Other options to increase partner involvement include moderated online message boards for partners, partner email contact with
the online therapist, more comprehensive handouts for partners, and assigning more therapeutic responsibilities to partners, such as exploring their own beliefs and myths about sex and completing CBT and mindfulness exercises. At this stage, it is difficult to evaluate what may be the best approach in increasing partner involvement over the internet, but past and current research suggest that this may be an important factor in the treatment outcomes for couples in treatment for FSDs (Hall, 2004; Jones & McCabe, 2011; van Lankveld et al., 2009). Additionally, increased partner engagement may potentially have a positive influence on the degree to which male sexual functioning improves during online FSD treatment.

Regarding psychoeducation for partners, one area that may not have been sufficiently addressed in the PP online content and the partner handouts, was the impact of MSDs (e.g., ED, HSDD) on female sexuality. This gap in information was raised by one of the PP participants and could be addressed in future internet-based interventions for FSDs by further psychoeducation and online discussions with partners or jointly with couples.

**Manualised treatments for FSD.** During the design phase of the PP program and the writing of article 1, a range of recommendations were identified for the flexible use of manualised treatments for FSDs. The three main areas of recommendation to enhance both treatment outcomes and research rigor included: 1) Systematic tailoring for individual needs; 2) Assessment of potential treatment gaps within manual; and 3) Accommodating differing levels of motivation and readiness for treatment. The PP program provides a demonstration of how these recommendations can function within a manualised treatment.
The PP program provided participants with a manualised treatment that included psychoeducation, CBT exercises, mindfulness exercises, communication exercises, email therapy, and online chat-group for all participants in order to provide interventions appropriate for mixed FSDs and a diversity of etiological factors. To provide a more individualised treatment, a number of options were available to women in order to provide flexibility in a systematic manner. These options included flexible timing to accommodate for the speed at which couples worked through the modules. This flexible timeframe also allowed for the delaying or acceleration of certain exercises depending on the needs of the couple. For example, some women found the two week period unnecessary for module 1 and were advised that they could complete this module in one week if they preferred. Certain women also found that, due to vaginal pain, they needed to delay certain touch exercises until they felt ready to complete them.

The communication exercises were offered with some flexibility for individual needs by allowing couples to create individualised discussion questions (with the help of the therapist if necessary) if they found that the set questions were not relevant to them, and by allowing couples in later modules to decide whether discussions with letters or discussions without letters suited them better. Tailoring to individual needs was structured into the mindfulness exercises by offering different exercises for women to experiment with, in order for women to identify their individual practice preferences. For example, some women preferred external mindfulness for their daily practice, such as observing nature, rather than a daily practice of the ‘mindfulness of breath’ exercise. Experimentation to discover individual preferences was also encouraged throughout the sensate focus exercises.
Another way in which PP demonstrated systematic individual tailoring for participants was through the decision to use mindfulness and CBT techniques for any relationship or sexual concerns that were not covered in the PP content. This involved the use of concepts already covered in the PP modules to address any other concerns that arose, and these interventions were provided over email therapy and in the online chat-groups. For example, mindfulness and CBT techniques were used to address sexual pain concerns that were not specifically addressed in the PP modules.

Lastly, in order to inform participants that their individual needs could be tailored for, participants were informed about this at the very outset of treatment through an email that read:

*Feel free to email me with any questions or concerns you have at this point. The program covers a lot of different sexual difficulties, so if you would like to tell me any details about your individual sexual concerns, you are welcome to email me so that I can help to make this program suit your needs.* (PP therapist)

Women were also regularly reminded, via emails, online content and online chat-groups, to contact the therapist about individual treatment needs. These methods demonstrate some ways in which systematic tailoring for individual needs can be incorporated into internet-based treatments of FSDs.

Regarding the assessment of potential treatment gaps, the PP program provided a variety of techniques for participants, but also aimed not to overload participants with too much content. While designing the PP program, the potential gaps in information were identified, such as specific techniques for sexual pain and achieving orgasm, and generic emails that addressed these topics were developed for
women seeking this information. This demonstrates a viable way to cover treatment gaps in a systematic and replicable way in the online treatment of FSD.

Finally, in order to address differing levels of motivation and readiness for treatment, the PP program demonstrated the use of a non-touch module at the beginning of treatment in order to accommodate for women who were not ready for the touch exercises, and needed time to reconnect with their partner. Flexibility in timing throughout the entire program was used to address differing levels of readiness for treatment at different stages of treatment. For example, some women completed the first few modules relatively quickly, yet they needed a longer time in later modules due to their resistance in addressing their difficulties with sexual intercourse. In addition, the PP therapist utilised email therapy and the online chat-groups to address motivational issues and resistance to therapy. Rushing women into treatment may have a negative impact on treatment outcomes (Donahey & Miller, 2000), and the PP program demonstrated techniques that can be incorporated into internet-based treatment for FSDs in order to accommodate for women’s differing levels of motivation and readiness for treatment.

**Limitations and Recommendations for Future Research**

There were a number of limitations to the current research in need of discussion. These limitation and recommendations for future research are described below.

Although the PP studies included a larger sample size than previous internet-based intervention for FSDs (Hall, 2004; Jones & McCabe, 2011), both treatment groups in the PP studies had the limitation of a small sample size. These small samples sizes resulted in the findings being less generalisable than if a larger sample had been possible, and may have restricted the power of statistical analyses to detect
significant differences. A number of factors led to the small sample sizes observed in the PP studies. Firstly, although the recruitment methods led to 300 women registering their interest, two thirds of these women did not respond after viewing the Plain Language Statement. It is unclear why so many women decided not to participate after reading more information about the program, but it can be speculated that they had similar reasons to the women who dropped out from treatment, such as the time commitment being too great and partners being unsupportive. It is also likely that some women wanted treatment for sexual difficulties, but were not interested in being part of the study and the randomisation process. The large non-response rate may also reflect other aspects of this population of women with FSDs, such as readiness for treatment, beliefs about FSD etiology (i.e., assumptions that FSD is biological in nature), and unrealistic expectations about treatment timing in the age of Viagra.

A second factor that impacted the sample size was the high attrition observed in the original treatment group, and the moderate attrition observed in the control crossover group. Various methods were used to retain participants in the program, however it appeared that the time commitment and partner involvement required did not suit all couples. A third factor that impacted on the sample size was the lack of funding available to undertake these studies. A lack of funding for non-pharmacological treatments of FSD is well documented within the literature (e.g., Bradley & Fine, 2009; Rowland, 2007), and this resulted in limited marketing of the studies and only one therapist being available to implement the PP treatment.

Lastly, the crossover design of the studies resulted in the control crossover group being even smaller than the original treatment group. It is predicted that this smaller sample size restricted the power of statistical analyses to detect significant
differences in the trends towards improvement that were observed in the control crossover group. Despite the sample size limitations, the PP studies demonstrated the effectiveness of the online treatment for both female sexual functioning and some areas of relationship function. A larger sample in future research would be useful in replicating these results with a wider variety of women.

A second limitation present in the PP studies is that of a biased sample of women with FSDs. Due to the voluntary and self-selected nature of the participants, and the high attrition, it is possible that both studies contained a highly motivated group of women. This is especially relevant for the women in the control cross-over group who maintained treatment motivation over the full waitlist period. Due to this, it is possible that both treatment groups may not represent the full spectrum of FSD severity and may therefore not be representative of the greater population of women with FSDs. The results from the PP studies should therefore need to be applied with caution to other women with more severe types of FSD, and future research could serve to assess the effectiveness of online interventions for women with more severe FSDs. The findings from the studies are also not generalisable to women with significant mental health issues or women in relationships with high relationship discord, and these women are likely to benefit from a more intensive form of treatment.

Due to the exclusion criteria, the findings also cannot be generalised to women in same-sex relationships and single women, although it is possible that these women would benefit from a modified version of the PP program. Future research could serve to develop a modified version of the PP program for single women with less focus on relationship factors and couple exercises, and a greater focus on intergenerational, individual and past relationship factors, exercises that
can be completed alone, and the transferring of skills into future relationships. Future research could also explore the use of either an online program specifically targeted to women in same-sex relationships, or an internet-based intervention that accommodates both homosexual and heterosexual couples by modifying psychoeducational content and using gender-neutral language to describe couple-based exercises. Women with FSDs of a purely biological etiology would also be unlikely to experience significant benefits from the PP program alone. Despite this, internet-based treatment for FSDs could be beneficial as a supplementary therapy alongside medical interventions, in order to address psychological and relationship factors that may be perpetuating or exacerbating the sexual difficulties.

A fourth limitation of the PP studies involved the measurement of sexual functioning and relationship functioning. All data were collected via self-report, which is inevitably subjective in nature and therefore less reliable than objective measures. Although less reliable, self-report measures of sexual function are appropriate due to the lack of objective tools for measuring constructs such as sexual desire/interest and satisfaction, and due to the documented discordance that commonly occurs between objective and subjective perceptions of female sexual response (Chivers & Rosen, 2010; Jordan et al., 2011). Another limitation in the measurement of FSD occurred due to the nature of the FSFI (Rosen et al., 2000), whereby certain women were not represented sufficiently in all of the findings. In particular, this measurement tool did not sufficiently capture the experiences of women in the PP program who had not been engaging in sexual activity during the four weeks leading up to assessment. Given the high prevalence of women with HSDD, and other sexual dysfunctions and relationship characteristics that can lead to a low frequency of sexual activity, this FSD assessment measure may have failed
to capture important information about these women in treatment. This is also an unresolved and largely unreported issue in the assessment of MSDs using measures such as the IIEF (Rosen, Cappelleri, & Gendrano, 2002; Rosen et al., 1997).

Finally, a fifth limitation of the PP studies was the lack of a comparison to medical interventions for FSDs, or a combined medical and psychological intervention. Due to the lack of currently approved medical treatments for FSDs, the option of medical comparison or combination therapy for FSDs was not available. Given the multiple determinants of FSDs, combined medical and psychological treatment for FSDs is likely to be beneficial to women (Althof, 2010) and future research could serve to evaluate the effectiveness of a combined medical and psychological treatment approach for FSDs. McCabe and Price (2006) compared an internet-based psychological treatment for MSDs with a combination of oral medication and internet-based psychological treatment. A similar study format could be utilised to evaluate combined medical and psychological treatment for FSDs.

Conclusion

Research into psychological treatment options for FSDs is especially important at this point in time due to the high rates of FSD, the distress that sexual difficulties can cause women, and the strain that this can put on relationships. There is also a need for improved psychological management of FSDs in the absence of approved medical interventions and concerns regarding the side effects of medical interventions currently under investigation (David et al., 2006a; Jordan et al., 2011; Wylie & Malik, 2009). Furthermore, a focus on medical treatment may not be suitable for all women with FSDs, and it is currently suggested that combined approaches may be more suitable for women with FSDs rather than medical
interventions alone, due to the biopsychosocial factors impacting sexual functioning in women (Althof, 2010). It is therefore likely that psychological approaches will continue to be highly relevant despite future innovations in medical interventions.

This thesis, and the articles presented within it, extended upon past research in two important ways. Firstly, it evaluated the way in which FSD treatment research is conducted, and offered recommendations for the improvement of research rigor whilst also providing a treatment that is suitable to the individual needs of women and their partners. Secondly, it documented the development, implementation and evaluation of a new online intervention for mixed FSDs – the PP program. The PP program extended upon prior research by incorporating mindfulness training for women with FSD, by utilising online chat-groups for cognitive therapy and social support, and by assessing male partner sexual functioning before and after FSD treatment. The results from the PP studies provided further evidence of the effectiveness of internet-based interventions to address multiple areas of sexual dysfunction in women, as well as some aspects of relationship functioning. These studies also demonstrated how some domains of male partner sexual functioning can be improved following the online treatment of FSDs.

The PP program was the first internet-based treatment for FSDs to incorporate mindfulness training, a recent addition to the treatment of female sexual desire and arousal disorders. In line with past research (Brotto et al., 2008a, 2008b; Brotto et al, 2012b, 2012c), mindfulness training was incorporated in a gradual manner, beginning with non-sexual mindfulness exercises and gradually introducing more sensually and sexually oriented exercises in later modules. Feedback from the participants, and observations throughout the treatment, demonstrated that the
mindfulness training was one of the most important aspects of the program for many women, and that mindfulness training led to improvements both in and out of the bedroom.

The PP program was also the first internet-based treatment for FSDs to incorporate online chat-groups as a platform for intervention. The online chat-groups were designed to supplement the email therapy, and provided a space for women to receive cognitive therapy and discuss the challenges that arose for them over the program. The online chat-groups also provided a platform for social support, and offered the therapist a place to address misunderstandings, observe ongoing changes, and receive feedback about the program. Observations within the chat-groups, and feedback from participants, suggested that the online chat-groups were also one of the most important aspects of the program for many women. This appeared to be especially due to the opportunity for women to be validated during chat-groups, and for their experiences of FSD to be normalised, by discussing topics that are usually too taboo to discuss with friends and family.


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Brown Co.


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Appendix 1

Human Ethics Research Approval

DEAKIN UNIVERSITY

Human Ethics Research

Office of Research Integrity
Research Services Division
70 Elgin Road Burwood Victoria
Postal: 221 Burwood Highway
Burwood Victoria 3125 Australia
Telephone 03 9251 7123 Facsimile 03 9244 6881
research-ethics@deakin.edu.au

Memorandum

To: Prof Maritta Mc Cabe
School of Psychology

B

cc: Miss Alice Hucker

From: Deakin University Human Research Ethics Committee (DUHREC)

Date: 15 October, 2010

Subject: 2010-194
Incorporating mindfulness into an internet-based intervention for female sexual dysfunctions (FSDs)

Please quote this project number in all future communications

The application for this project was considered at the DU-HREC meeting held on 27/08/2010.

Approval has been given for Miss Alice Hucker, under the supervision of Prof Maritta Mc Cabe, School of Psychology, to undertake this project from 15/10/2010 to 15/10/2014.

The approval given by the Deakin University Human Research Ethics Committee is given only for the project and for the period as stated in the approval. It is your responsibility to contact the Human Research Ethics Unit immediately should any of the following occur:

* Serious or unexpected adverse effects on the participants
* Any proposed changes in the protocol, including extensions of time.
* Any events which might affect the continuing ethical acceptability of the project.
* The project is discontinued before the expected date of completion.
* Modifications are requested by other HRECs.

In addition you will be required to report on the progress of your project at least once every year and at the conclusion of the project. Failure to report as required will result in suspension of your approval to proceed with the project.

DUHREC may need to audit this project as part of the requirements for monitoring set out in the National Statement on Ethical Conduct in Human Research (2007).

Human Research Ethics Unit
research-ethics@deakin.edu.au
Telephone: 03 9251 7123
Appendix 2

Advertisement for Recruiting PP Participants

Are you currently experiencing any problems in your sex life?

Are you a female over 18 years?

Are you in a stable heterosexual relationship?

If you answered yes to these questions, then you may be interested in participating in a Deakin University study investigating an online treatment for female sexual problems. Participation is confidential and anonymous and can occur from the comfort of your own home. Please email Alice Hucker at alhu@deakin.edu.au if you are interested in finding out more details about this study.

Thank you!
Plain Language Statement for Females Interested in PP

DEAKIN UNIVERSITY

PLAIN LANGUAGE STATEMENT AND CONSENT FORM

TO: Female Participant

Plain Language Statement

Date: 22/8/2010

Full Project Title: Incorporating mindfulness into an internet-based intervention for female sexual dysfunctions.

Principal Researcher: Professor Marita McCabe

Associate/Student Researcher: Alice Hucker

This Plain Language Statement and Consent Form is 5 pages long. Please make sure you have all the pages.

1. Your Consent

You are invited to take part in this research project.

This Plain Language Statement contains detailed information about the research project. Its purpose is to explain to you as openly and clearly as possible all the procedures involved in this project before you decide whether or not to take part in it.

Please read this Plain Language Statement carefully. Feel free to ask questions about any information in the document. You may also wish to discuss the project with a relative or friend or your local health worker. Feel free to do this.

Once you understand what the project is about and if you agree to take part in it, you will be asked to tick the "I Consent" box. By ticking the "I Consent" box, you indicate that you understand the information and that you give your consent to participate in the research project.

You can revisit this online Plain Language Statement and Consent page at any time. You may also want to print a copy of this document for your own records.

2. Purpose and Background

The purpose of this project is to investigate the effectiveness of an internet-based treatment program for women with various sexual problems. The project is being conducted by a postgraduate student as part of the Doctor of Psychology (Clinical) degree at Deakin University.
A total of 60 women will participate in this project, and their partner must also be willing to participate in certain aspects of the study.

Previous research has shown that some women experiencing problems with sexual desire, arousal, orgasm and pain can benefit from face-to-face psychological therapy. More recent research has provided preliminary evidence that this psychological treatment can be delivered over the internet as a convenient alternative to face-to-face therapy. Recent research has also found that a form of relaxation/meditation called ‘mindfulness’ is useful for some women experiencing sexual problems. This study aims to assess the effectiveness of an internet-based treatment program that addresses women’s problems with sexual desire, arousal, orgasm and pain, and also incorporates mindfulness techniques. The study also aims to gather information about male partners to help identify factors that are related to treatment success.

You and your partner are invited to participate in this research project because more research is needed to determine whether internet-based treatments are useful for female sexual problems.

The results of this research may be used in a thesis to help researcher Alice Hucker to obtain a postgraduate degree.

3. Procedures

Participation in this project will involve taking part in an internet-based treatment program. The program will be broken up into 6 modules and will last for a minimum of 10 weeks in total, depending on how long you decide to spend on each module. Modules will be delivered through a password protected web-site and will require internet access at home.

The program will require you to:

- Read information about sexual anatomy, sexual responses, common sexual myths, possible causes and possible solutions to your sexual problems;
- Practice mindfulness (relaxation/meditation) exercises;
- Participate in communication exercises with your partner (e.g., writing each other letters about your feelings);
- Participate in touch exercise. These will be a mixture of self-touching (solo) and partner touching (mutual). In early modules the touching will be non-sexual (e.g., solo body exploration, mutual massages) and then gradually become more sexually oriented (e.g., solo self-stimulation, mutual touching of genitals and breasts) and eventually incorporate sexual intercourse;
- Engage in regular email contact with student therapist, Alice Hucker, for individual support and counselling;
- Participate in fortnightly web-based discussion groups (lasting one-hour each) with a small group of women also participating in the internet-based treatment program.

As well as taking part in the treatment program, both you and your partner will be required to fill out an online questionnaire before and after the treatment program and at a 3-month follow-up. The questionnaire will take no longer than 20 minutes to complete each time and will ask you about your sexual functioning, past sexual experiences and your current relationship. This information will help to determine how useful the treatment program has been for women experiencing sexual problems.
If you agree to participate in this study, you will be randomly allocated to either participate in the treatment program straight away, or to be part of a control group who will fill out the questionnaires but not take part in the treatment program. This is necessary so as to compare the women in the treatment program to women not undergoing treatment. All women who are assigned to the control group will have the opportunity to participate in the treatment program after the 3-month follow period.

Over the course of the study, continual review and monitoring will take place in order to detect and address any problems participants may experience.

4. Possible Benefits
Possible benefits from participating in the treatment program include an increase in sexual desire and satisfaction, and an increase in general relationship satisfaction. We cannot guarantee or promise that every participant will experience these positive outcomes. Possible benefits from the study in general include gaining information about the effectiveness of internet-based interventions for female sexual problems and the usefulness of mindfulness techniques in online treatment.

5. Possible Risks
It is possible that you may feel discomfort at time due to the sensitive and private nature of the topics being raised in the treatment program. If you do, at any time, feel anxious or upset about anything in the program, unlimited email contact with the Alice Hucker is available for support and counselling. If, at any stage, you feel so uncomfortable that you wish to withdraw from the study, you are free to do so without risk of incurring any consequences.

6. Other Treatments Whilst on Study
It is important to tell your doctor and the research staff about any treatments or medications you may be taking, including non-prescription medications, vitamins or herbal remedies and any changes to these during your participation in the study.

7. Alternatives to Participation
Standard treatment for women with sexual problems is face-to-face psychological therapy. Preliminary evidence has found internet-based therapy to be an effective alternative to traditional face-to-face treatments. For those readers not wanting to take part in this study, an alternate option would be to seek face-to-face therapy with a clinician experienced in sexual functioning.

8. Privacy, Confidentiality and Disclosure of Information
To maintain confidentiality, you will not be asked to give your name or any other identifying information. You will have the opportunity to create and use an anonymous email address if you prefer.

Storage of the data collected will adhere to the University regulations and be kept securely on a password-protected hard disk for 6 years, after which it will be destroyed. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report, as only aggregated data will be reported.

Any information obtained in connection with this research project that can identify you will remain confidential and will only be used for the purpose of this research project. It will only be disclosed with your permission, except as required by law. If you give us your permission by signing the Consent Form, we plan to use the results as part of the thesis requirement for the Doctor of Psychology degree.
In any publication of the results, information will be provided in such a way that you cannot be identified.

9. **Results of Project**

If you would like to be informed of the aggregate research findings, please contact Alice Hucker at alhu@deakin.edu.au.

10. **Further Information or Any Problems**

If you require further information or if you have any problems concerning this project you can contact the researchers responsible for the project. This includes Alice Hucker (alhu@deakin.edu.au; 0423046041) and Marita McCabe at marita.mccabe@deakin.edu.au (9244 6856).

11. **Complaints**

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact:

The Manager, Office of Research Integrity, Deakin University, 221 Burwood Highway, Burwood Victoria 3125, Telephone: 9251 7129, Facsimile: 9244 6581; research-ethics@deakin.edu.au.

Please quote project ID 2010-194.

12. **Participation is Voluntary**

Participation in any research project is voluntary. If you do not wish to take part you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. If your partner decides to withdraw from the study, you will still be free to continue with the program.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your relationship with those treating you or your relationship with Deakin University.

Before you make your decision, a member of the research team will be available so that you can ask any questions you have about the research project. You can ask for any information you want. Tick the "I Consent" box only after you have had a chance to ask your questions and have received satisfactory answers.

If you decide to withdraw from this project, please notify a member of the research team before you withdraw. This notice will be helpful to the researchers and allow them to inform you if there are any special requirements linked to withdrawing. If you decide to withdraw from the study, your data will still be stored and disposed of as outlined in section 8 (Privacy, Confidentiality and Disclosure of Information).

13. **Reimbursement for your costs**

You will not be paid for your participation in this trial.

14. **Ethical Guidelines**

This project will be carried out according to the National Statement on Ethical Conduct in Research Involving Humans (June 1999) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.
The ethical aspects of this research project have been approved by the Human Research Ethics Committee of Deakin University.
DEAKIN UNIVERSITY

PLAIN LANGUAGE STATEMENT AND CONSENT FORM

TO: Male Participant

Plain Language Statement

Date: 22/8/2010

Full Project Title: Incorporating mindfulness into an internet-based intervention for female sexual dysfunctions.

Principal Researcher: Professor Marita McCabe

Associate/Student Researcher: Alice Hucker

This Plain Language Statement and Consent Form is 5 pages long. Please make sure you have all the pages.

1. Your Consent

You are invited to take part in this research project.

This Plain Language Statement contains detailed information about the research project. Its purpose is to explain to you as openly and clearly as possible all the procedures involved in this project before you decide whether or not to take part in it.

Please read this Plain Language Statement carefully. Feel free to ask questions about any information in the document. You may also wish to discuss the project with a relative or friend or your local health worker. Feel free to do this.

Once you understand what the project is about and if you agree to take part in it, you will be asked to tick the “I Consent” box. By ticking the “I Consent” box, you indicate that you understand the information and that you give your consent to participate in the research project.

You can revisit this online Plain Language Statement and Consent page at any time. You may also want to print a copy of this document for your own records.

2. Purpose and Background

The purpose of this project is to investigate the effectiveness of an internet-based treatment program for women experiencing sexual problems, and the experiences of their partners. The project is being conducted by a postgraduate student as part of the Doctor of Psychology (Clinical) degree at Deakin University.
A total of 60 women will participate in this project, and their partner must also be willing to participate in certain aspects of the study.

Previous research has shown that some women experiencing problems with sexual desire, arousal, orgasm and pain can benefit from face-to-face psychological therapy. More recent research has provided preliminary evidence that this psychological treatment can be delivered over the internet as a convenient alternative to face-to-face therapy. Recent research has also found that a form of relaxation/meditation called ‘mindfulness’ is useful for some women experiencing sexual problems. This study aims to assess the effectiveness of an internet-based treatment program that addresses women’s problems with sexual desire, arousal, orgasm and pain, and also incorporates mindfulness techniques. The study also aims to gather information about male partners to help identify factors that are related to treatment success.

You are invited to participate in this research project because more research is needed to determine whether internet-based treatments are useful for female sexual problems.

The results of this research may be used in a thesis to help researcher Alice Hucker to obtain a postgraduate degree.

3. Procedures

Participation in this project will involve supporting your partner’s participation in an internet-based treatment program for female’s experiencing sexual problems. This will involve:

- Filling out an online questionnaire before and after your partner undertakes the treatment program, and at a 3-month follow-up. The questionnaire will take no longer than 15 minutes to complete each time and will ask you about your current sexual functioning and relationship;
- Reading information about female sexual problems;
- Participating in communication exercises with your partner (e.g., writing each other letters about your feelings);
- Participating in touch exercise with your partner. Some of these exercises will be non-sexual (e.g., mutual massages) and some will be sexually oriented (e.g., mutual touching of genitals and breasts, sexual intercourse);

The program your partner will participate in will last for a minimum of 10 weeks in total, depending on how long she decides to spend on each phase of the program. The entire program will be internet-based.

Your partner will be randomly allocated to either participate in the treatment program straight away, or to be part of a control group who will not take part in the treatment program. If your partner is allocated to the control group, you will both still be required to fill out the questionnaires. All women who are assigned to the control group will have the opportunity to participate in the treatment program after the 3-month follow period.

Over the course of the study, continual review and monitoring will take place in order to detect and address any problems participants may experience.

4. Possible Benefits

Possible benefits from participating in the treatment program include an increase in sexual desire and satisfaction for your partner and your yourself, and an increase in general relationship satisfaction. We cannot guarantee or promise that every participant will experience these positive outcomes. Possible benefits from the study in general include
gaining information about the effectiveness of internet-based interventions for female sexual problems, the influence of male partner characteristics on treatment success and the usefulness of mindfulness techniques in online treatment.

5. **Possible Risks**

It is possible that you may feel discomfort at time due to the sensitive and private nature of the topics being raised in the questionnaires. If, at any stage, you feel so uncomfortable that you wish to withdraw from the study, you are free to do so without risk of incurring any consequences.

6. **Alternatives to Participation**

Standard treatment for women with sexual problems is face-to-face psychological therapy. Preliminary evidence has found internet-based therapy to be an effective alternative to traditional face-to-face treatments.

7. **Privacy, Confidentiality and Disclosure of Information**

To maintain confidentiality, you will not be asked to give your name or any other identifying information.

Storage of the data collected will adhere to the University regulations and be kept securely on a password-protected hard disk for 6 years, after which it will be destroyed. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report, as only aggregated data will be reported.

Any information obtained in connection with this research project that can identify you will remain confidential and will only be used for the purpose of this research project. It will only be disclosed with your permission, except as required by law. If you give us your permission by signing the Consent Form, we plan to use the results as part of the thesis requirement for the Doctor of Psychology degree.

In any publication of the results, information will be provided in such a way that you cannot be identified.

8. **Results of Project**

If you would like to be informed of the aggregate research findings, please contact Alice Hucker at alhu@deakin.edu.au.

9. **Further Information or Any Problems**

If you require further information or if you have any problems concerning this project you can contact the researchers responsible for the project. This includes Alice Hucker (alhu@deakin.edu.au; 0423046041) and Marita McCabe at marita.mccabe@deakin.edu.au (9244 6856).

10. **Complaints**

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact:

The Manager, Office of Research Integrity, Deakin University, 221 Burwood Highway, Burwood Victoria 3125, Telephone: 9251 7129, Facsimile: 9244 6581; research-ethics@deakin.edu.au.

Please quote project ID 2010-194.
11. **Participation is Voluntary**

Participation in any research project is voluntary. If you do not wish to take part you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. Your partner will still be free to continue the program if you choose to withdraw.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your relationship with Deakin University.

Before you make your decision, a member of the research team will be available so that you can ask any questions you have about the research project. You can ask for any information you want. Click the “I Consent” box only after you have had a chance to ask your questions and have received satisfactory answers.

If you decide to withdraw from this project, please notify a member of the research team before you withdraw. This notice will be helpful to the researchers and allow them to inform you if there are any special requirements linked to withdrawing. If you decide to withdraw from the study, your data will still be stored and disposed of as outlined in section 8 (Privacy, Confidentiality and Disclosure of Information).

12. **Reimbursement for your costs**

You will not be paid for your participation in this trial.

13. **Ethical Guidelines**

This project will be carried out according to the *National Statement on Ethical Conduct in Research Involving Humans* (June 1999) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.

The ethical aspects of this research project have been approved by the Human Research Ethics Committee of Deakin University.
Appendix 5

Example of PP Website Layout

PursuingPleasure: Welcome Ladies

Welcome to PursuingPleasure - an online program for women wanting more pleasurable sex and a more intimate relationship. This is an opportunity for you and your partner to revitalize your sex lives!

Tackling sexual problems can be daunting and embarrassing, but you’ve taken the first step!

Many women have sexual difficulties, but with the help of special techniques, you can experience a more satisfying sex life. Here is some feedback from women who have already completed a similar online program:

“It was an excellent program. We both got so much out of it. It enabled us to talk about sex and our needs and feelings in a way we had never done before.”

“Excellent! Loved it!”

“Overall, I personally found it very, very useful...there were various hurdles and challenges but...we were able to get through to the end of the program.”

By dedicating time and energy to the PursuingPleasure program, you will see results! As well as increased sexual satisfaction, women who have completed similar programs have also experienced greater relationship satisfaction and intimacy with their partners.

While PursuingPleasure is a program for women, it also gets your partner involved in the process. Past experience has shown that couples who tackle sexual problems together have more success in resolving sexual concerns. Information for your partner will be provided in each module of the program and your partner will participate in communication and touch exercises (described below). By working together, you and your partner can achieve a more fulfilling and pleasurable relationship.

In order to complete the entire program you will need patience, perseverance, a positive attitude and lots of support. Unlimited email support will be available from me (Alice), a training psychologist specialising in women’s sexual difficulties. I will be able to reply to your emails within 24 hours (except on weekends when there may be more of a delay). You will also take part in fortnightly online chat-groups (from Module 2 onwards) with other women experiencing similar problems.

Lastly, PursuingPleasure offers a range of sexual techniques and suggestions for you to try, but it is important to note that there are no rights or wrongs in this program. The aim is to enable you to discover your own sexual preferences and to communicate these with your partner.

Welcome to the journey towards a more pleasurable and satisfying sexual relationship.

Program Requirements

What is required of you to complete PursuingPleasure?

• Commitment: This program requires you to regularly commit time and energy in order to achieve any benefits. There are 6 modules, each of which will take approximately 2 weeks to complete. Therefore, you and your partner will need to commit at least 12 weeks to completing PursuingPleasure. You will need to dedicate at least 2 one-hour sessions per week participating in the couple exercises, plus other plan in time for the other exercises you will do on your own. Past experience has shown that the more time you put into the program, the more success you will have!

• Partner Involvement: It is important that both you and your partner work together in this program. Therefore, it is essential that
Welcome to PursuingPleasure - an online program for women wanting more pleasurable sex and a more intimate relationship. This is an opportunity for you and your partner to revitalize your sex lives!

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- Partner Involvement: It is important that both you and your partner work together in this program. Therefore, it is essential that your partner is motivated, supportive and co-operative, and willing to do the readings and work through the exercises with you.

- Internet access: It is vital that you have regular internet access, preferably in your own home. Throughout most of the program, you will be able to decide when you access the web-site, but once a fortnight (from Module 2 onwards) you will be required to be online for a one-hour chat-group at a specified time (to be advised).

- Questionnaires: In order to gain feedback about PursuingPleasure and help more couples in the future, it is essential that you and your partner fill out another questionnaire after you complete the program, and after a 3-month follow-up period.

Lastly, sometimes medical conditions can be associated with certain sexual concerns. Therefore, I encourage you to seek a medical check-up either before or during the PursuingPleasure program. Talking to your GP about sex can be quite embarrassing, but I highly recommend that you seek a check-up to make sure that a physical condition won’t interfere with your progress in the program. Feel free to email me alhu@deakin.edu.au if you have any concerns about this.

Program Outline

PursuingPleasure is broken up into 6 modules, each expected to take approximately 2 weeks to complete (although it is up to you how long you spend on each module).

Each module contains important readings on female sexuality and relationships, as well as communication exercises, sensate focus (touch exercises) and mindfulness/relaxation techniques.

Each module will also have a printout for your partner to help him support you through the program. Below is a description of the different components of the program:

Readings
The way you think about sex and your body can influence how much you enjoy being sexual with your partner. Each module will contain readings and small writing tasks to help you identify unhelpful thoughts and beliefs about sex and your body. The writing tasks should be completed in a notebook or word document that you can keep private. You don’t have to share what you write with anybody else, but you may wish to discuss things that come up in these exercises with me over email or in the online-chat groups.

Communication Exercises
The quality of your relationship with your partner can be strongly related to the quality of your sex life together. Many aspects of your relationship may impact on your feelings about love-making. The communication exercises are designed to give you and your partner the opportunity to become more aware of each other's thoughts and feelings about different aspects of your relationship. Becoming more in-tune with your partner's feelings, and vice-versa, can really help to deepen intimacy, strengthen your relationship and make sex a more positive experience. Each module will contain discussion questions for you and your partner to complete together - a minimum of 3 discussion questions per week need to be completed.
**Mindfulness/Relaxation Exercises**

Many women find it difficult to get in the mood for being sensual and sexual when they are feeling tense, worried or distracted by a million different things! It's easy to let our minds become filled with everyday worries such as: Who is picking up the kids tomorrow? How will I finish that report in time? Am I putting on weight? And so on and so on...

Recent research has shown that these worries and distractions can really inhibit sexual arousal and enjoyment. Therefore, it's important to find ways to stay *in the moment* during sexual experiences. **Mindfulness exercises** are a special type of relaxation technique that can help you to stay in the present moment and experience more pleasurable sensations during sex. Each module will contain exercises to help you develop mindfulness skills to apply in the bedroom and for life in general.

**Sensate Focus**

Sensate focus involves a series of sensual touch exercises aimed to help you and your partner re-discover what types of touch you find pleasurable. Sensate focus is a common and effective technique for couples experiencing sexual problems.

Sensate focus begins in Module 2 (where you and your partner will try non-sexual massages) and continues over the rest of the program. As the program progresses, sensate focus will involve more sexually oriented touch exercises, and there will also be the opportunity for you to explore your own body.

As well as being a pleasurable experience for to share as a couple, sensate focus aims to decrease anxiety and worry that may be associated with sensual and sexual touching. Sensate focus will also help you to communicate about the types of touch that feel good and turn you on so that you can have more pleasurable sexual experiences!

To enable you to achieve the benefits from this program, the first 4 modules of *PursuingPleasure* will not involve any sexual intercourse. In fact, there will be a no intercourse rule up until Module 5. It is very important for you to discover other aspects of pleasure and sensuality before applying these techniques to sexual intercourse. If you rush this process, you are less likely to achieve the full benefits of this program. If you approach these exercises with a playful and open mind they can be a very enjoyable experience and really expand your sexual repertoire.

**Information for you Partner**

You can either print out the introductory information sheet for your partner from the link below, or send it to him via email by entering HIS email address below. This sheet will explain the program to him and the importance of the no intercourse rule to him. If he is finding it difficult to last the distance without sexual release, he is encouraged to masturbate as regularly as he desires. Some couples have mixed feelings about masturbation, but masturbation occurs in many long-term relationship and marriages and is not a sign of a failing relationship. Masturbation is a normal and healthy expression of sexuality. It is preferable for your partner to masturbate during this program than to put pressure on you to engage in sexual intercourse before Module 5.

Click [here](#) to print your partner's information sheet.
Click [here](#) to send the link to your partner via email.

*PursuingPleasure* really can help you to achieve a more pleasurable and satisfying sexual relationship if you are willing to put in the time and energy required to see results. If you are not willing to make a commitment to the program, it is unlikely that you will experience any benefits in your sex life or relationship.

**Feel free to email me** (alhu@deakin.edu.au) **if you have any questions.**
PursuingPleasure: Module 1

Welcome to the first module of PursuingPleasure. It takes a lot of courage and motivation to tackle sexual difficulties, so congratulations on taking the first step.

In this module you will:

- Read about different types of sexual difficulties;
- Explore common sex myths;
- Complete regular communication exercises with your partner;
- Complete regular mindfulness exercises on your own.

There will be no sensate focus (touch exercises) in this module and remember the no intercourse rule until Module 5 (this includes any genital touching at this stage). This will allow you to slow down the process of sex and give yourself an opportunity to work on your concerns without the pressure of performing in bed. I suggest that you spend 1-2 weeks on Module 1 before moving onto Module 2.

Step 1:
Read through Common Sexual Concerns and Sexual Beliefs, and complete the What Are My Sexual Beliefs? exercise in your notebook. Also print out the information sheet for your partner and ask him to read this.

Step 2:
Read through the Communication Exercises and the Mindfulness: Tuning In exercises. Plan in times with your partner to complete the communication exercises and plan in time with yourself to practice the mindfulness exercise.

Remember to email me (alhu@deakin.edu.au) if you have any questions or concerns.

Common Sexual Concerns

There are various sexual concerns that women experience. While some women only experience one particular sexual difficulty, it is common to experience more than one sexual difficulty at a time. Below is a list of the common sexual concern experienced by women.

<table>
<thead>
<tr>
<th>Sexual Concern</th>
<th>Common Experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low sexual desire or lack of interest</td>
<td>Little or no interest in sexual activity; lower sex-drive than partner; no spontaneous thoughts or fantasies about sex; avoidance of sexual situations; concern or distress.</td>
</tr>
<tr>
<td>(this is the most common sexual concern experienced by women)</td>
<td></td>
</tr>
<tr>
<td>Lack of arousal</td>
<td>Difficulty becoming physically aroused (lack of vaginal excitement - swelling, lubrication/wetness); difficulty becoming mentally 'turned-on'; lack of pleasurable sexual sensations; concern or distress.</td>
</tr>
<tr>
<td>Lack of orgasm or inconsistent orgasms</td>
<td>Difficulty experiencing orgasm; orgasms may be dependent on partner/situation or may have never had an orgasm; may or may not desire sex and become aroused; concern or distress.</td>
</tr>
</tbody>
</table>
Painful sex

Vaginal pain during foreplay and/or intercourse; uncomfortable sex; difficulties with penetration; fear of penetration; concern or distress.

Sexual phobia

Intense fear of sexual activities; avoidance of sex; concern or distress.

Do any of these descriptions sound like your experiences? Maybe you can relate to more than one of these concerns. It's also possible that your experiences differ from these descriptions because every woman's experience is different.

Some women have experienced sexual problems their whole lives, while others may be experiencing difficulties that have arisen more recently. For some women, the difficulties only occur in certain situations or only with their current partner, while for others, the difficulties occur in every sexual situation and have occurred with other partners in the past. How would you describe the sexual concerns you are experiencing?

You may have noticed that the description of each sexual difficulty includes concern or distress. Some women have sexual difficulties but are not concerned about them at all. For example, a woman may experience orgasms when masturbating but never during intercourse with her partner, but she may be quite satisfied with this situation. In other circumstances, the woman may not feel concerned about the sexual problem, but her partner might. For example, the women who only has orgasms during masturbation might have a partner who is very upset by her lack of orgasm during intercourse. In order to help you through this program, I'd like you to have a think about who is concerned about your sexual difficulties: You, your partner, neither of you, or both of you?

Sexual Beliefs

As we were growing up we were all taught certain messages about sex and sexuality. These messages came from our family, our friends, our teachers and religious leaders, our sexual partners, and the media. These messages were probably a mixture of positive and negative, and also a mixture of fact and fiction. Below are some common myths taught to us about sex and sexuality:

10 Common Myths About Sex

Myth #1
Sex is dirty
Some parents give off the message that sex is dirty and bad by not talking about sex or referring to sex in a negative way. Sex is actually a natural and loving act.

Myth #2
Women shouldn't desire/enjoy sex as much as men
Women are capable of desiring and enjoying sex just as much as men. Enjoying and desiring sex does not say anything about you as a person except that you appreciate your sexuality and enjoy being intimate and sexual with your partner.

Myth #3
I have to have sex whenever my partner wants it
Having sex is always a choice and you should never feel forced into any kind of sexual activity - it is a mutual decision between you and your partner.
Myth #4
Sex stops after childbirth / menopause / midlife
Different life stages can bring challenges to your sex life, but many couples continue a healthy and enjoyable sex life well into old age. It is likely that you and your partner's sexual needs and preferences will change over time, but sex can continue to be a pleasurable activity for you to share together.

Myth #5
My genitals are ugly/smelly/yucky
Your genitals are just as nature intended, and they are very attractive to most men, who find the look, texture, taste and smell of a woman's vagina to be very pleasing and arousing. Many women also like the look of their vaginas and liken them to a beautiful flower.

Myth #6
Sex needs to be spontaneous to be worthwhile
Spontaneous sex is usually a feature of new relationships. In long-term relationships, a satisfying sex life often includes planned sex or 'sex-dates'. Given the busy lifestyles we lead, it's not surprising that planned sex is sometimes essential. And there is no good reason why planned sex can't be just as satisfying as spontaneous sex.

Myth #7
Normal women have orgasms every time they have intercourse
A large proportion of women do not orgasm every time they have intercourse and many women need extra clitoral stimulation to orgasm during penetration. In fact, only 15-20% of women can achieve an orgasm from penetration alone! Plus, women can still experience satisfying and enjoyable sex without reaching orgasm everytime.

Myth #8
My partner should automatically know how to please me; if you're in love sex should automatically be wonderful
Remember your partner does not have a vagina! It's therefore unrealistic to expect him to know what feels good for you. Both you and your partner have a responsibility to communicate how you like to be touched. We will discuss this a lot more in later modules.

Myth #9
Only penetration is real sex
Sex can actually mean a variety of things to different people - not just penetration and intercourse. Other definitions commonly include manual sex (hand-jobs, fingering), oral sex, phone sex, and anal sex. The most important thing is that you and your partner feel sexually satisfied at the end, no matter what that means to you.

Myth #10
My partner's sexual needs come before my own
Your man's sexual needs are not more important than your sexual needs, and both of you should feel satisfied at the end of a sexual encounter.

Did any of these sexual myths sound familiar to you? Feel free to email me (alhu@deakin.edu.au) if you would like to discuss these myths further.

**Exercise: What Are My Sexual Beliefs**

When negative sexual beliefs like the ones above become part of how we think about sex, this can impact our motivation to have sex and our enjoyment of foreplay and intercourse. This exercise gives you the opportunity to think about what you're sexual beliefs are and where they might have come from. Use your notebook for this exercise.
Step 1: On one side of a page, list your beliefs about sex and sexuality (try to list at least 5 beliefs you currently hold). Some of them might be the same or similar to the myths discussed above.
For example, I should always say yes to sex if my partner wants it.

Step 2: On the other side of the page, try to identify where you might have picked up each belief from (e.g., parents, religion, friends, school, past partners, current partner, magazines, TV, movies).
For example, I think this belief comes from the way my past partners have talked about and demanded sex. Magazines and my high school friends (when I was growing up) also talked about always needing to please men.

Step 3: Go through each belief and decide whether it is a useful or helpful belief to have, or if it makes you feel negative about sex and your sexuality.
For example, this belief does not make me feel good about sex, it makes me feel pressured and resentful. I don't think it's a useful belief to hold - for myself or for my relationship.

This next section of Module 1 includes communication exercises and mindfulness exercises. You need to continue making time for these exercises until you move onto the next module in 1-2 weeks time.

The discussion questions will give you and your partner the opportunity to become more aware of each other's thoughts and feelings about your relationship, about the sexual difficulties you are experiencing, and about entering this program. The mindfulness exercises will be done alone and will help you to start developing new skills to apply to your sex life in later modules.

**Communication Exercises**

Below are a series of discussion questions. You and your partner are to choose one question at a time and spend around 10 minutes writing a letter to each other answering and discussing that question. When you are both ready, swap letters and read them over privately. Read them twice to make sure you have really absorbed what your partner has written. Then you and your partner are to spend around 10 minutes talking about what was written in the letters and your thoughts and feelings in response to the letters.

If there is a question you especially don't want to choose, it is likely that you will benefit from choosing that question and having that discussion. It might feel hard at the time, but being brave and discussing your feelings will be beneficial to your relationship.

Keep a record in your notebook of which questions you've discussed, and please email me (alhu@deakin.edu.au) if you have any concerns or difficulties with these exercises. Try to do at least 3 questions per week, until you proceed to Module 2.

You will need to schedule in time with your partner to make sure you both commit to these exercises. Remember that these letters are private, and should not be shown to anyone else!!!

**Extra info:**

- Click here to view a sample communication letter;
- If you need help describing your feelings, click here;
- Click here to read about good techniques for sharing feelings and resolving conflict.

Women who do these exercises with their partner commonly report that it greatly enhances the quality of their relationship and allows them to receive more emotional support from their partner!
Discussion Questions:

What attracted you to your partner at the very beginning of your relationship?

What are the most important and valuable aspects of your relationship?

How do you feel about being part of this program together?

What do you expect to achieve from participating in this program with your partner?

How do you feel about sharing thoughts and feelings about your sex life?

What are your thoughts about not having sexual intercourse with your partner for a while (the no sex rule)?

How do you think sexual myths and unhelpful beliefs have influenced your sex life together?

How do you feel about spending quality time with your partner? What does ‘quality time’ mean to you?

What activities do you find most enjoyable to do with your partner?

If you would like more discussion questions, feel free to email me alhu@deakin.edu.au.

Remember to:

- Choose one question at a time;
- Spend around 10 minutes writing;
- Spend around 10 minutes talking;
- Do at least 3 questions per week;
- Record the questions you have completed.

Mindfulness: Tuning-In

‘Mindfulness’ is the practice of being aware, relaxed and attentive in the present moment. The mindfulness exercises you will be doing in this module will teach you how to be more present and aware in day-to-day activities. You will need to practice this mindfulness exercise for 5 minutes per day during this module.

Regular mindfulness practice will help you in later modules when we apply these skills to sexual situations. Mindfulness can help you to feel more sexually interested, responsive and relaxed.

Breathing Exercise

The first mindfulness exercise we will try is a breathing exercise. You may have tried other relaxation techniques that involve focusing on the breath. This exercise is similar, but has a slightly different focus. Read the instructions below and then try the exercise.

Find a comfortable place to sit where you can be alone and away from distractions for at least 5 minutes. As you sit down, you may want to close your eyes or hold a soft-gaze so
you are not distracted. As you're sitting there, bring your attention to your breathing: the sensation of air being drawn into the mouth or nose, past the throat and into the lungs. Be aware of the air leaving your body as you slowly exhale. Is the air warm or cold? Does it make any sound as it passes back through your nose or mouth?

Continue to focus your attention on your breathing for the next few minutes. There is no need to make judgements about this process, just be aware of the small details involved. Does your body relax slightly as you exhale? Is there a scent in the air you are breathing? Does your chest or stomach move when you inhale and exhale? Try to use all of your senses in this process: What does the breath sound like? Does the breath have a taste or a texture? Enjoy this intimate moment with your breath and enjoy the stillness surrounding you and your breath.

You might find that you start to get distracted. In fact, I'd be surprised if you didn't - the brain is very good at distracting us. When you do notice thoughts or images or worries arising, the aim is not to get annoyed at them or push them away, but to simply notice the distraction and say to yourself "There's a thought" or "There's a worry" and then gently bring your awareness back to the breath. Some people like to imagine their thoughts drifting away down a river, or being taken away on a conveyor belt. Whatever technique works for you is fine. You may have to do this many times, gently bringing yourself back into present moment awareness again and again, and this is really the key to mindful awareness. Continue this exercise for at least 5 minutes.

Please read the instructions again if necessary. You are now ready to try this exercise.

Mindful awareness is something that will benefit both non-sexual and sexual aspects of your life BUT practice is essential! Over the course of this module you will need to practice 5 minutes of mindfulness every day. If you miss one day, don't stress, but do get back into it the next day. If, after a few sessions, you feel you would like to try an extension of this exercise, here are some ideas:

- Try this breathing exercise while stretching or going for a walk. Remember to keep bringing your attention back to the breath.

- Try being completely mindful and present while listening to a favourite song. If your thoughts start distracting you, remember to acknowledge them and then gently bring your full awareness back to the music.

- Try mindful eating: choose a meal or a piece of food and make sure you are free from distractions (no TV, music or conversations). Eat slowly while allowing yourself to notice all the textures, tastes and smells of the food.

- Try bringing your full awareness to a simple activity such as washing the dishes or getting dressed. Remember to notice all the small details of the activity and engage all of the senses (smell, touch, taste, sound, sight). Gently bring your attention back to the activity if your thoughts wander off.

Here is an example of how to schedule in the exercises for this module. If you plan ahead you are more likely to fit in all of the exercises and not feel overwhelmed by the time commitment. The more time you put into the program, the more benefits you will see.
To do:

- 3 x discussion letters per week;
- 5 minutes of mindfulness practice each day (e.g., mindfulness of breath exercise, mindfulness while eating).

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<th>Sunday</th>
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</thead>
<tbody>
<tr>
<td><strong>AM</strong></td>
<td>5 mins mindfulness of breath</td>
<td>Complete sexual beliefs exercise</td>
<td>5 mins mindfulness of breath</td>
<td>5 mins mindfulness of breath</td>
<td>Mindfulness while eating</td>
<td></td>
<td>5 mins mindfulness before lunch</td>
</tr>
<tr>
<td><strong>PM</strong></td>
<td>Read through Module</td>
<td>Discussion letter</td>
<td></td>
<td></td>
<td>Discussion letter after lunch</td>
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</tbody>
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<tr>
<th></th>
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<th>Sunday</th>
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<tbody>
<tr>
<td><strong>AM</strong></td>
<td>5 mins mindfulness at breakfast</td>
<td></td>
<td>5 mins mindfulness at breakfast</td>
<td>5 mins mindfulness of breath</td>
<td>5 mins mindfulness of breath</td>
<td>Discussion letter over breakfast</td>
<td></td>
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<tr>
<td><strong>PM</strong></td>
<td></td>
<td>5 mins mindfulness at lunch break</td>
<td>Discussion letter</td>
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**Information for your Partner**

Click [here](#) to access the Module 1 information sheet for your partner. Please print this sheet off and give it to your partner to read over the next week.
Are you ready to move onto Module 2?

You should not spend any less than 1-2 weeks on this module. To see if you are ready to move onto Module 2, please read the statements below. These statements summarise the goals of Module 1. If you agree with ALL statements below and feel ready to move onto Module 2, please fill in the boxes below, enter your email address and press submit.

___ Have you completed all readings and questions in this module?

___ Have you completed communication exercises regularly (approximately 3 per week)?

   How many discussion questions did you complete? ___

___ Have you completed mindfulness practice regularly (approximately once a day)?

   How many mindfulness sessions did you complete? ___

___ Has your partner done the readings for this module?

___ Are you and your partner ready to begin exercises that involve non-sexual physical touch (e.g., massages)?

Email address: ______________
Pursuing Pleasure: Module 2

Welcome to Module 2. It's fantastic that you’ve completed Module 1 and are continuing on the journey towards a more enjoyable sex life!

In this module you will:

- Read about the female sexual anatomy;
- Explore common reasons behind female sexual difficulties;
- Complete regular communication exercises with your partner;
- Complete regular mindfulness exercises on your own;
- Start non-sexual touch exercises with your partner;
- Attend fortnightly online chat-groups.

I suggest that you spend approximately 2 weeks on this module. You may feel anxious about beginning sensate focus and this is very common, especially if it has been a while (or a long while) since you and your partner have been intimate together. For this reason, you will begin with non-sexual touch exercises with the aim of re-discovering pleasurable affection and non-sexual intimacy. If you are feeling especially uncomfortable about beginning sensate focus please email me to discuss this (alhu@deakin.edu.au). Also remember the no intercourse rule which includes any sexual or genital touching at this point.

Step 1:
Read through Female Sexual Anatomy and Why am I experiencing sexual problems? and complete the questions within these readings in your notebook. Print out the Module 2 information sheet for your partner and ask him to read this. Alternatively, you can click here to send the link to your partner via email.

Step 2:
Read through the Communication Exercises, the Mindfulness: Body Awareness exercises, and the Sensate Focus exercises. Plan in times with your partner to complete the communication exercises and sensate focus sessions, and plan in time with yourself to practice the mindfulness exercises.

Step 3:
Participate in fortnightly online chat groups with other women in the program. I will send you an email with more details about this. Write down the dates and times to make sure you don’t forget!!

I understand that there is a lot to do in this module, and this may seem daunting with all of your other family and work responsibilities. To help you out please refer to the sample timetable at the end of the module for how you could fit the module's activities into the next fortnight.

Female sexual anatomy

To understand your sexual difficulties better, it can be useful to understand your sexual anatomy. Below are some pictures and descriptions about different parts of the vulva (the external genitalia you can see) and the vagina (the internal parts you can't see). The shape and appearance of the vulva varies substantially for each woman, so please don't be concerned if your vulva looks different from the pictures.

As you look at these pictures you may feel a desire to look at or touch your own genitals. Feel free to do so, but don't feel like you have to just yet. You will have an opportunity in Module 4 to do some self-exploration of your body and genitals.
**External anatomy**

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**The Clitoris**

This little bud of vascular tissue is the main **pleasure centre** of the female sexual anatomy. In fact, the clitoris has no other known function than giving pleasure during stimulation! The size of the clitoris varies from woman to woman, and a smaller clitoris **does not** mean less **pleasure or sensitivity**.

You may also be able to see a little fold of skin above the clitoris, called the **clitoral hood**. Although we can only see the clitoris and clitoral hood, this is only the **tip of the ice-berg**. Underneath the skin, the clitoris spreads out in a large V shape and has **more nerve endings** than the male penis.

The clitoris and the little ridge above the clitoris (called the **clitoral shaft**) can be stimulated during foreplay and intercourse to increase sexual **pleasure and arousal**. Some women find the clitoris too sensitive to be touched directly, and prefer to be stimulated **around the edges** of the clitoris or **on the clitoral shaft**. Some women like being stimulated directly on the clitoris but may need to instruct their partner how **hard or soft** they like the pressure to be.

**Labia Majora and Labia Minora**

The **labia majora** are the larger outer lips of the vulva and they protect the inner parts of the vulva. The **labia minora** are the smaller inner lips, and these lips protect the vaginal opening. These inner lips are often likened to **flower petals**. As well as having protective roles, both sets of lips have **lots of nerve endings** that can be stimulated during fore-play and love-making.

The colour, size and appearance of the labia can **vary considerably** from woman to woman. To see pictures of a **variety of different vulvas**, visit [http://www.scarleteen.com/resource/advice/betty_dodsons_vulva_illustrations](http://www.scarleteen.com/resource/advice/betty_dodsons_vulva_illustrations).

**Urethral opening**

Below the clitoris is a very small opening called the **urethra** - where you urinate from.
**The Vagina**

Below the urethral opening is the vaginal opening. During sexual activity, the vaginal walls stretch to accommodate for the penis to enter. During birth, the vagina lengthens and stretches even more to accommodate for a baby. The vagina is quite capable of accommodating for sexual intercourse.

The vagina regularly produces vaginal discharge or fluid to keep the vagina clean and healthy. During sexual stimulation, this discharge usually increases to lubricate the vagina. Some women do not produce much natural lubricant and may use a bottled lubricant to increase sexual pleasure and decrease discomfort due to dryness. A lack of natural lubrication does not necessarily mean that a woman is not mentally aroused, and this can sometimes confuse her partner. A range of bottled lubricants are available at supermarkets, chemists, sex stores or online. Visit [http://www.dvice.com.au/sex-toys/lubricants](http://www.dvice.com.au/sex-toys/lubricants) to see some popular and tested lubricants for women.

Lastly, the G-spot is a little gland within the vagina which some women find very pleasurable to stimulate (others do not feel much when it is touched). It can be difficult to locate, but typically the G-spot is located 1-3 inches inside the vagina, on the front vaginal wall (the wall on the side of your stomach). The G-spot often has a slightly rougher texture than the rest of the vaginal wall and can be stimulated with fingers, a vibrator or the penis.

**The Anus**

The anus has lots of nerve endings surrounding it, and some couples like to experiment with anal-play and anal-sex (e.g., touching, licking, penetration). It’s a good idea to use a bottled lubricant if you are planning on any anal-play or anal-sex.

**Internal anatomy**

The internal sexual anatomy of a woman includes the vaginal passage, the cervix, the uterus, the fallopian tubes and the ovaries. These are all involved in menstruation, pregnancy and child birth. Only the first third of the vaginal passage is sensitive to touch in most women, and most sexual stimulation occurs from the clitoris, labia and vaginal opening.
If you have any questions about the female sexual anatomy, or any concerns about your genitals, please feel free to email me (alhu@deakin.edu.au).

**Why am I experiencing sexual difficulties?**

While a misunderstanding of the female sexual anatomy can lead to sexual concerns, there are usually *multiple factors* that lead to a women experiencing sexual difficulties. There are also factors that can decrease a woman's likelihood of experiencing a sexual difficulty. We can think of the factors involved as **The Four P’s**:

- 1. Certain factors can **Predispose** you to a sexual difficulty - predisposing factors are things that make it *more likely* that you will develop a sexual concern;
- 2. Certain factors can **Precipitate** a sexual difficulty - precipitating factors are things that act as a *trigger* for a sexual difficulty to start occurring;
- 3. Certain factors can **Perpetuate** a sexual difficulty - perpetuating factors are things that *keep the problem in place* and are often called **maintaining factors**;
- 4. Lastly, certain factors are **Protective** - protective factors *reduce your likelihood* of experiencing or maintaining a sexual difficulty.

The aim of exploring The Four P’s is to think about which factors you can work on to improve your sex life. Identifying perpetuating/maintaining factors and building up your protective factors will be especially helpful in finding solutions to your sexual difficulties.

Let's begin by looking at some common factors involved in women's sexual concerns:

**1. Predisposing factors**

*What factors from your biology/genetics and your past have influenced your sex life?*

Below is a list of factors that may make it more likely that a woman develops a sexual difficulty:

**Biological factors**

- Mental health issues such as depression and anxiety;
- Certain medical conditions, sexually transmitted infections and a history of drug or alcohol abuse.

**Social/cultural factors**

- Negative sexual attitudes, rules and beliefs taught to you by your family, society/media and/or your religious group;
- Poor sex education and/or negative messages about sex and genitals.

**Psychological factors**

- Low self-esteem and poor body image;
- Negative attitudes about sex and masturbation;
- Performance anxiety - anxiety about what you're partner thinks about you in bed (e.g., anxiety about not being able to get lubricated or not being able to orgasm).
Interpersonal factors

- Sexual abuse or unwanted sexual attention (recently or in the past);
- Negative early sexual experiences and relationships.

Exercise: Do any of these factors seem to fit with how your sexual difficulties came about? Take a moment to write down which of these factors may have predisposed you to developing sexual difficulties. Can you think of any other factors?

2. Precipitating factors
What factors might have triggered the onset of your sexual difficulties? What was occurring just before the concerns started? Below is a list of factors that may act as triggers:

Biological factors

- Changes in mental or physical health (e.g., illness, surgery, menopause, childbirth, new medication);
- Hormonal changes.

Psychological factors

- Increased stress or anxiety;
- Life-stage changes (menopause, pregnancy, childbirth, infertility);
- Increased performance anxiety;
- Flashbacks from sexual abuse.

Interpersonal factors

- Conflict with your partner and relationship problems;
- Infidelity in your relationship;
- Your partner developing a sexual problem (e.g., lack of erection, premature ejaculation, lack of desire/interest);
- A humiliating sexual experience with your partner;
- Lack of ‘sexual compatibility’ with your partner (clumsiness, awkward sex, discomfort, partner’s lack of sexual skills).

Contextual factors

- Lack of time, energy or privacy;
- Increased responsibilities at work or home.

Exercise: Do any of these factors seem to relate to the onset of your sexual problem? Take a moment to write down which of the factors may have triggered your sexual difficulties. Can you think of any other factors?

3. Perpetuating factors
What factors might be keeping your sexual difficulties in place? Below is a list of factors that may act to maintain a sexual concern:

Biological factors

- Ongoing illness;
- Ongoing mental health issues.
Psychological factors

- Negative attitudes, beliefs and rules about sex and masturbation;
- Performance anxiety and lack of sexual confidence;
- Stress and anxiety;
- Poor body image and low self-esteem;
- Negative attitudes about life-stage changes and sex (menopause, pregnancy, childbirth, infertility);
- Flashbacks and negative feelings related to sexual abuse.

Interpersonal factors

- Relationship problems and continuing conflict;
- Lack of communication and lack of non-sexual intimacy (i.e. intimacy that does not lead to sex);
- Partner's sexual difficulties;
- Lack of 'sexual compatibility' with your partner;
- Lack of attraction towards partner;
- Resistance to communicate about sexual matters with partner.

Social/cultural factors

- Cultural and religious messages about women and sexuality;
- Sexual myths and negative attitudes;
- The media's portrayal of "good sex".

Contextual factors

- Lack of time, energy or privacy.

Exercise: Could any of these factors be maintaining your sexual difficulties? Take a moment to write down which of the factors may be perpetuating your sexual difficulties. Can you think of any other factors?

4. Protective factors

What factors help to resolve sexual difficulties? Below is a list of factors that are related to positive sexual experiences. While some of these factors are unchangeable, some can be enhanced to help you with your sexual difficulties - and these changeable factors will be targeted throughout PursuingPleasure.

Biological factors

- Good physical and mental health.

Psychological factors

- Positive attitudes about sex and masturbation;
- Positive body-image;
- Low stress and anxiety;
- Realistic expectations about sex and life-stage changes;
- A flexible definition of sex.

Interpersonal factors

- Good communication skills;
- Increased non-sexual intimacy;
- Attraction to your partner;
- Being open minded about trying new sexual activities together;
- Partner not having a sexual problem or currently receiving treatment for this;
- Communicating about sexual needs and problems.

**Social/cultural factors**

- Positive messages and realistic expectations about sex;
- Positive role-models in loving relationships.

Lastly, getting professional help for your sexual concerns (as you are doing now) is a **big protective factor** because this will help you to work on the perpetuating factors that can be changed and the protective factors that can be built up.

**Exercise:** Take a moment to write down which of these protective factors you think you already have, and which ones you think will be important to work on over the program. Can you think of any other factors that might help?

Throughout *Pursuing Pleasure* you may find it useful to revisit The Four P's (you may even like to print them out now). This will be especially important if you find yourself stuck and frustrated and just don't know why - thinking about The Four P's might help to shed some light on what it is that is challenging you within the program.

Please email me (alhu@deakin.edu.au) if you would like to discuss what you have written or have any questions about The Four P's.

This next section of Module 2 includes communication exercises, mindfulness exercises and sensate focus. You need to continue making time for these exercises until you move onto the next module.

The discussion questions will give you and your partner the opportunity to discuss the program so far and talk about your relationship and non-sexual intimacy. The mindfulness exercises will help you to start applying mindfulness skills to more sensual activities. Lastly, sensate focus will allow you to enjoy sensual (intimate but non-sexual) massages with your partner.

**Communication Exercises**

Remember to:

- Choose one question at a time;
- Spend around 10 minutes writing and then swap letters;
- Spend around 10 minutes talking about your thoughts and feelings;
- Schedule in time with your partner to make sure you both commit to these exercises - try to do at least 3 questions per week;
- **Always do a communication exercise before a sensate focus session** (this will help you to feel more comfortable and open in the touch sessions);
- Record which questions you have completed.
Discussion Questions:

What are the most interesting and enjoyable activities that you have done together in the past?

What do you like best about your relationship together?

What are some qualities or characteristic that you enjoy about your partner?

Did anything surprise you while learning about the female sexual anatomy?

What did you think while reading about common causes of female sexual difficulties (the Four P's)?

How do you feel about the amount of non-sexual affection and intimacy in your relationship?

How do you usually show love, affection and/or admiration to your partner and vice-versa?

How do you feel about being naked with your partner?

How do you feel about the non-sexual sensate focus sessions in this module?

How do you feel about the way your partner expresses affection and intimacy?

How do you feel about touching each other in a sensual but non-sexual way?

How do you feel about the way you communicate together on a day-to-day basis?

How do you feel about the program is going so far?

If you would like more discussion questions, please email me (alhu@deakin.edu.au).

Mindfulness: Body Awareness

Well done on your mindfulness practice in Module 1. Practice really is the key to developing the mindfulness skills that will help you to get more satisfaction and enjoyment out of your sex life! The mindfulness exercises in this module will be aimed at increasing your awareness of pleasurable body sensations.

Bath/Shower Exercise:

Now that you have learnt how to practice basic mindfulness skills, it’s time to try these in a more sensual context. To get the most out of this exercise, you will need to practice it for 10-15 minutes once per week while in Module 2. It is important that you plan times when you can take 10-15 minutes without being interrupted. On the days that you don’t do this exercise, you will need to practice 5 minutes of basic mindfulness, as in Module 1.

Find a time when you can be uninterrupted for 10-15 minutes. Either run a warm bath or prepare yourself for a warm shower. You may like to dim the lighting or light some candles. You may also like to burn some incense or fragrant oil and play some soft or sensual music.

As you move your body into the warm water, pay attention to your surroundings. Notice the steam rising off the hot water and any smells that might be in the air. Notice the sound of the moving water and how the light plays on the water’s surface or droplets. There is no need to make judgements about this process, just be aware of the small details involved.
Now bring your attention to your body. What sensations can you feel? Is your body getting warmer? How does it feel to have water covering your skin? Choose a soap or body wash and start to slowly lather your skin. Try to use all of your senses in this process: Notice the texture of your hands on your skin; notice the smell of the soap; observe any sensations occurring inside your body; notice the different textures of your skin and hair. Take your attention to your arms, your shoulders, your breasts, your stomach, your bottom, your legs and your feet. Are there any parts of your body you’ve never touched before? Notice the colour of your skin and the shape of different body parts. Do some parts feel more pleasurable to touch than others? You might be surprised to discover how enjoyable it feels to touch your arms or breasts or feet or any other body part. Enjoy this intimate time with your body without judgement.

Touching your own body can bring up a range of feelings and emotions. You might find that both positive or negative thoughts and emotions start to arise. When you notice these, acknowledge them and then gently bring your awareness back to your body. Certain thoughts may come up about the aspects of your body that you appreciate. There will also be aspects of your body that you don’t appreciate so much. Acknowledge these thoughts as they come up, but try not to dwell on them. If you are not feeling any positive emotions towards this experience, try saying to yourself: “This is my body. My body is my own and it is alive and precious. The aspects of my body that I appreciate include... (e.g., my soft skin, my strong legs, my womanly curves, etc.)”. How does saying this to yourself influence your experience? How does your body feel now?

Continue being present and aware of your body as you finish your shower/bath and dry your skin off. For the rest of the day/night, be aware of your body and bodily sensations as you go about your usual activities.

Please read the instructions again if necessary. You are now ready to try this exercise.

Remember to:

- Practice this mindfulness exercise **once per week** while in Module 2;
- Practice **5 minutes** of basic mindfulness (e.g., mindfulness of the breath) every other day.

If you want to do some other **sensual body awareness** exercises, here are some other ideas:

- While slowly applying moisturiser to your body try being mindful of the sensations on your skin. Remember to keep bringing your attention back to your body if your thoughts wonder off.

- While you slowly get dressed or undressed, take notice of the feeling of the different textured fabrics on your body and the aromas you can smell. If your thoughts start distracting you, remember to acknowledge them and then gently bring your full awareness back to the activity.

- Try being mindful of your body and bodily sensations as you dance to a sensual or sexy song. How does your body like to move? How does this make your body feel inside and out?

**Sensate Focus - Sensual Massages**

Sensate focus sessions are an effective technique to help you and your partner discover and communicate about the types of touch you find **pleasurable**. The sessions also help to reduce any **anxiety and worry** that may be associated with touching. Some women find
these sessions to be daunting at first and try to put them off, but it is very important to gather some courage and give these exercises a try. You may be surprised at how much you and your partner enjoy them! If you are feeling worried about starting these exercises, or have any questions about sensate focus please email me (alhu@deakin.edu.au) and we can discuss your thoughts and worries.

The sensate focus sessions in this module will involve exchanging non-sexual body massages with your partner. There will be no genital or breast touching and remember the no intercourse rule until Module 5. If either you or your partner find it difficult to have sensual massages without sexual release, feel free to masturbate on your own afterwards.

You will need to complete at least 3 sessions per week. Each session will take approximately 1 hour so it is important to schedule in time with your partner so that you can complete these sessions without being rushed or interrupted.

The amount of sessions that you complete is strongly linked to how successful you will be in the program.

Sensate Focus Instructions

- Begin each session by sharing a discussion letter. This will help to increase the communication and intimacy between you and your partner before you start.

- Make sure you are feeling relaxed, comfortable and open to the experience. Click here for some ideas to make you feel more comfortable and ready.

- Prepare a room together for the session: you may like to warm the room up, dim the lights or light candles (don’t do session in complete darkness), burn some oil or incense, close the curtains, and/or play some sensual or relaxing music.

- Decide who will massage first and who will receive the massage first.

- When you’re ready to begin, the person receiving the massage should remove their clothes and get comfortable on the bed. You may like to begin on your stomach, but remember to roll over onto your back later on.

- The toucher then begins to explore their partner’s body in a non-sexual way. Ask your partner where they would like you to start (back, feet, shoulders, etc.) and then begin caressing your partner’s body. Slowly work over each part of your partner’s body (except the genitals and breasts) and try to use a variety of techniques such as stroking, scratching, massaging, kissing and fondling.

- The toucher may like to use massage oil. The receiver should roll over at some point to allow the caressing of both sides of the body.

- If you are the receiver you will need to communicate to your partner how you like to be touched. You may like to tell him when something feels good, moan or make encouraging noises, or gently guide his hand to where it feels good. Remember, it is your responsibility to communicate how you like to be touched.

- The receiver will also need to communicate when the touch does not feel so good. Simply being silent or motionless may not get the message across. You
may like to politely tell him that his touch is too hard/too soft/too fast etc. or gently guide his hand to where it feels good. It is good to follow-up a comment about what doesn't feel good with a comment about what does feel good. For example: "It feels a bit rough when you touch me like that, but I really like it when you lightly scratch my skin."

- As the receiver, bring you attention to the **sensations of your body**. Draw upon the **mindfulness awareness skills** you have been practicing. Let thoughts come and go, and keep bringing your attention back to your body. If negative feelings arise, try saying to yourself: "My body is alive and precious. My body can be pleasured and enjoyed."

- If you are the toucher, you will need to **listen** to your partner's verbal and non-verbal signals and alter your touching accordingly.

- Remember **no genital or breast touching** is to occur in these sessions. If your partner starts to touch your vulva or breasts, politely remind him that he needs to steer away from those areas in this module. You could say something like this: "I know you want to touch me sexually, but remember it's important to just be sensual together for now."

- After the receiver has been touched for **20-30 minutes**, it is time to **swap roles**. Make sure you both get **equal amounts of time** of touching and being touched.

- The receiver should **not** feel any pressure to become aroused or feel sexual. All the receiver needs to do is **enjoy** the sensual massage and **communicate** to their partner.

- After you have both had a turn, you might like to take a moment to talk about the experience with your partner, share a cuddle and have a glass of wine together.

Here is an example of how to **schedule in the exercises** for this module. If you **plan ahead** you are more likely to fit in all of the exercises and not feel overwhelmed by the time commitment. Remember, the more time you put into the program, **the more benefits you will see**.

**To do:**

- 3 x discussion letters per week;
- 1 x Mindful Body Awareness exercise per week;
- 3 x sensate focus sessions per week (with a discussion letter beforehand);
- 5 minutes of basic mindfulness practice on the days that you don't do the body awareness exercise;
- 1 x online chat-group per fortnight.

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**Information for you Partner**

Click [here](#) to access the Module 2 information sheet for your partner. Make sure he reads it all before your first sensate focus session.

Alternatively, you can click [here](#) to send the link to your partner via email.

**Are you ready to move onto Module 3?**

You should spend at least 2 weeks on this module. To see if you are ready to move onto Module 3, please read the questions below. These questions summarise the goals of Module 2. In order to move onto Module 3, you should be able to answer “yes” to all of these questions.

- Have you completed all readings and questions in this module?
- Have you completed communication exercises regularly (approximately 3 per week)?
  
  How many discussion questions did you complete overall? ____
- Have you completed mindfulness exercises regularly (approximately once a day)?
- Have you completed sensate focus sessions regularly (at least 3 times a week)?
  
  How many sensate focus sessions did you complete overall? ____
- Have you attended at least one discussion group during this module?
- Are you ready to begin exercises that involve looking at and touching your own genitals?

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PursuingPleasure: Module 3

Welcome to Module 3 of PursuingPleasure. By now you are already beginning to gain some of the skills necessary to revitalise your sex life and enhance the quality of your relationship. Your commitment to the program really will pay off!

In this module you will:

- Explore female sexual desire and interest;
- Explore the benefits of sex and intimacy;
- Do regular communication exercises with your partner;
- Continue practicing mindfulness;
- Explore your own body and genitals;
- Continue non-sexual touch exercises with your partner;
- Attend fortnightly online chat-groups.

Step 1:
Read the information on Female Sexual Desire/Interest and Positive Benefits of Sex, and complete the Problem-Solving for Your Sex Life exercise in your notebook. Print out the Module 3 information sheet for your partner and ask him to read this. Alternatively, you can click here to send the link to your partner via email.

Step 2:
Read through the communication exercise and the solo sensate focus exercise. Plan in times with your partner to complete the communication exercises and sensate focus sessions. Also plan in time with yourself to complete the solo body explorations and daily mindfulness practice.

Step 3:
Participate in fortnightly online chat-groups. Write down the dates and times to make sure you don’t forget!!

A sample timetable is provided at the end of this module to demonstrate how these activities can fit into your lifestyle. It is important to plan when you will complete the different exercises. Remember, the more time you put, the more you get out.

Female Sexual Desire/Interest

Females have three main phases of sexual response:
1) desire or interest;
2) arousal (physical and mental);
3) orgasm or resolution (when arousal diminishes).

Sexual desire/interest (sometimes called “libido” or “sex drive”) is an important aspect of female sexuality and often influences the other two phases of arousal and orgasm. Unfortunately, sexual desire can easily become inhibited if a woman's emotional and/or stimulation needs are not met. Some facts about desire:

- While some women have spontaneous desire for sex, many women experience "responsive desire" - a desire for sex in response to your partner's initiation or after a sexual encounter has already begun;
- Many couples have one partner who wants more sex than the other;
- Many women become disinterested in sex when their non-sexual intimacy needs are not being met (eg. affection, communication, emotional support);
- Many women become disinterested in sex when they are stressed, upset or are not having their emotional needs met;
Life-stage changes such as menopause, pregnancy and childbirth may change a woman's levels of desire (but this does not have to be permanent).

Because female sexual desire is influenced by so many different factors, even if you know that sex will feel good, numerous other factors may still influence your degree of sexual interest. This is sometimes hard for males to understand, and the information sheet for your partner will help to explain this.

Below is a list of factors that commonly inhibit women's sexual interest:

**Negative beliefs about female sexuality**
Beliefs that women should not desire, fantasise about, or enjoy sex can inhibit sexual desire by causing guilt and shame. Some women also feel that they may lose control if they start to desire and enjoy sex. It is important to remember that feeling sexual desire does not change who you are as a person or make you an immoral or uncontrollable women. Sexual desire is a normal and positive part of womanhood and sexual relationships.

**Relationship issues**
If there is conflict or a lack of trust in your relationship, you may well be less interested in sex. Women who feel there is a power imbalance in their relationship (e.g., finances or decision making) often feel less sexual interest and sometimes use sexual avoidance as a way to gain power. If relationship issues are impacting on your sexual desire, it is important that healthy and honest communication occurs between you and your partner to address these issues. You will have the opportunity to talk about relationship issues in the communication exercises in this module.

**Unpleasant experiences during sex**
Both emotional and physical discomfort/pain can lead to less desire for sex. Trauma from the past, or feeling pressured to do a sexual activity you do not enjoy, may bring up emotional pain. If the latter is the case, it is your responsibility to communicate to your partner the sexual activities you don't like, and it is his responsibility to be sensitive to this.

Experiencing pain during sex can be distressing and lead to sexual avoidance. Strategies for overcoming pain during sex can be discussed with me over email.

**Lack of sexual stimulation**
A lack of sexual stimulation might occur if: 1) you haven't communicated how you like to be touched; or 2) you have communicated but he continues to not quite get it right. If reason 1 is true for you, this program will help you to identify and communicate the types of touch that turn you on. If reason 2 seems to be occurring, your partner may need more specific instructions from you, or you could politely direct him to a book or website on sexual pleasuring, foreplay and love-making. Â See the Resource List for more details. He will also be given some resources in the information sheet.

**Negative body image**
Negative feelings about your body can cause you to feel unattractive and unsexy. The bodily changes that occur as we get older may also make us feel less sexy than we used to. These negative feelings may lead us to avoid being naked in front of our partner and avoid sexual contact. Body image and its relationship to female sexuality will be discussed in more detail in Module 4.

**Lack of attraction**
There may be things about your partner that you find unattractive such as poor hygiene
(e.g., bad breath, body odour), physical appearance (e.g., overweight, wearing daggy clothing), or the way he speaks to you or touches you. Some things that you find unattractive cannot be changed, but it may be possible to address certain things (e.g., hygiene, clothing, touching) through respectful communication. You will have an opportunity to address this in the communication exercises.

**Lifestyle and stress**
Stress and a lack of time are sure-fire desire killers! There are 2 aspects to this:
1. It is unreasonable to expect yourself to have sexual energy and desire if you are chronically stressed and tired. In order to be interested in sex, you need to make sure you are not over-worked or under-slept!
2. It's common to make sexual time a low priority. If sex is on the bottom of your to-do list, then you simply won't be interested in doing it. As you progress through this program and learn how to make your sex life more enjoyable, the aim is for you to start putting love-making higher on your priority list.

**Other factors**
These include fear of pregnancy (lack of contraception), hormonal changes, illness and certain medications. You may want to talk to your GP if you think these factors may be influencing your interest in sex. Mental health problems such as depression, anxiety and substance abuse can also impact sexual desire.

**Positive Benefits of Sex**
While there are many factors that can dampen your sex drive, let's take a look at some of the positive benefits of sex within a healthy sexual relationship.

As you read through the list, write down any of the benefits that you currently experience from sex. Underneath that, write down any of the benefits that you aim to experience by the end of this program.

As you progress through the program you can come back to this list to see if you are starting to enjoy more of the benefits you are wanting from a sex.

**Benefits of sex commonly experienced by women:**

- Pleasure and joy (physically and emotionally)
- Increased intimacy and closeness with your partner
- Boosted self-esteem
- Exercise (sex burns a lot of calories!)
- Sexual satisfaction
- A sexually satisfied partner
- Improved mood (from the release of endorphins)
- More couple-time
- Stress-relief and relaxation
- Reduced aches and pains (through the release of endorphins)
- Better and deeper sleep (after sex)
- More fun and playfulness
- Enhanced spirituality (for some people, making-love can be a profoundly spiritual experience)

**Problem-Solving for Your Sex Life**
If you identified with some of the factors above that inhibit sexual desire, then it is likely that they are acting as perpetuating factors of your sexual concerns and need to be addressed.
Some of the specific suggestions mentioned may help to solve some difficulties, but further problem-solving may be necessary. This section will describe the cognitive-behavioural therapy (CBT) model for problem-solving.

The CBT model is based on the assumption that our thoughts and beliefs influence how we feel about things (our emotions) and how we then behave.

This model will help you to explore the way you are thinking about sex, and find some positive solutions. Choose an issue that you think may be negatively impacting on your sexual desire to try this model step-by-step in your notebook. You may like to choose one of the factors from the section above on female desire. Feel free to email me (alhu@deakin.edu.au) if you are finding this exercise difficult.

**Step 1: Think about the issue you have chosen.** Pick a situation that has happened recently where this issue was apparent. As you imagine this situation, try to identify any negative emotions that you felt or that you can feel now while thinking back. Name the emotions and write them down.

For example, the issue is stress and time. Last Tuesday I worked all day and got home late feeling exhausted. When my husband initiated sex in bed that night, I immediately felt frustrated and resentful.

**Step 2: As you think back to the situation, try to identify where those feelings were coming from.** To do this, try to remember what thoughts were running through your mind. Also try to identify what beliefs about sex, relationships and your body were brought up. Write these down.

For example, when my husband started touching me sexually I thought "I'm too tired for this", "My husband should know I'm too tired for sex!" and "He doesn't care about me, he just wants to get his rocks off."

My thoughts seem to focus around the belief that sex is a chore and that it's ok for sex to be a low priority. My thoughts also focussed on the belief that my husband should be able to read my mind and know what I'm thinking.

**Step 3: Now write down what actions you took as a consequence of these thoughts and emotions.** Also identify how these actions made you feel.

For example, when I had these negative thoughts and emotions I slapped my husband's hands away and rejected his sexual contact. I then slept badly feeling resentful and unsupported.

**Step 4: Now go back to the thoughts you identified in Step 2.** Re-examine these thoughts and beliefs and try to challenge them. Go through each thought/belief individually and try asking yourself some of these questions:

- Is this a rational or irrational thought/belief?
- Would your partner agree with this thought/belief?
- Would somebody who felt positive about sex think in this way?
- Is this thought/belief a reflection of any negative family/religious/cultural/media messages about sex?
- What is the evidence for and against this thought/belief?
- Is this thought/belief helpful?

For example, the thought "He doesn't care about me, he just wants to get his rocks off!" might be an over-reaction and not really true. He loves me and cares about me and might...
not understand that my stress decreases my interest in sex. Maybe stress doesn't do that to him. If I asked him he would probably tell me that he wants me to enjoy myself, not just get his rocks off. Somebody who feels positive about sex might think that it's important to make more time for sex and even use sex for stress relief and a good night's sleep. My belief reflects messages from society that say men are sexually selfish. This belief is not really helpful, it just makes me go silent and feel resentful of him.

To address irrational or unhelpful thoughts and beliefs, you now need to come up with alternative and more helpful self-statements to say to yourself. For each thought or belief you identified in step 2, try to come up with at least 1 new helpful self-statement.

For example, instead of the thinking "I'm too tired for this!" I could say to myself "I am too tired now, but I can plan to make more time for sex." Instead of "My husband should know I'm too tired for sex!" I could say to myself "My husband does not necessarily understand how I feel right now." And, instead of "He doesn't care about me, he just wants to get his rocks off!" I could say to myself "It's ok that he wants to be intimate with me, that doesn't mean he doesn't care."

Here are some other positive statements that may relate to other issues:

- There is nothing wrong with being a sexual woman;
- I have a right to have my needs met;
- I am beautiful and womanly;
- I don't need to listen to what magazines and movies say is right;
- It is helpful to communicate about what sexual activities I do and do not enjoy;
- I can choose to enjoy sex with my partner;
- Sex is fun for lots of couples, and it can be for us as well;
- The things I am learning in this program are helping me to enjoy sex more;
- I am stressed now but maybe sex could help me to relax.

Write down each helpful self-statement you come up with and look at them regularly.

Step 5: The last step is to brainstorm things that could help next time a similar situation occurs. Write down any ideas that come to mind, and make sure you include your new helpful self-statements.

For example, when I am feeling too tired for sex and feel like my husband doesn't understand, I could say my helpful self-statements to myself. To make sure I am not too tired for sex every night of the week, I could ask my husband to help out with certain chores around the house that add to my stress. I can also remind myself that sex can be good for stress relief and help to give me a good night sleep.

This 5-step CBT model can be useful for many situations. Now that you have gotten a handle of how to do it, go back and try the 5 steps again with the other issues that came up from the readings above (do at least another 2). Doing this exercise will give you a big list of helpful self-statements to tell yourself and a range of possible options to enhance your sexual desire. But remember, to gain the benefits you can't just write these solutions down, you need to act on them to make a difference!

If you would like to discuss any of the issues that have come up for you, or any trouble you are having with the problem solving exercise, please email me (alhu@deakin.edu.au).

This next section of Module 3 includes communication exercises, solo mindful sensate focus, and continuing your daily mindfulness practice.
The discussion questions will give you and your partner an opportunity to talk about sexual desire and some of the things you identified as inhibiting your desire and interest. This is also a good opportunity to discuss any of the ideas you came up with in the problem-solving exercise.

You will continue to do non-sexual touch sessions with your partner while also doing some solo touch exercises. These give you an opportunity to look at and touch your own genitals and discover more about the types of touch you enjoy. This is a very important stage in the program.

**Communication Exercises**

Remember to:

- Choose one question at a time;
- Spend 10 minutes writing and then 10 minutes talking;
- Do at least 3 questions per week;
- Always do a communication exercise before a senate focus session with your partner;
- Record which questions you have completed.

**Discussion Questions:**

What positive benefits do you currently experience from sex? What benefits would you like to receive from sex by the end of this program?

How do you feel about female sexual desire (e.g., often being more responsive than spontaneous, being influenced by many non-sexual factors)?

How do you feel about having a lower or higher sex drive than your partner?

What aspects of your relationship do you think influence your sex life together (e.g., conflict, attraction, communication, trust, finances)?

How do stress, mood and time influence your sex life? Do these things make love-making a low priority in your relationship?

Are there certain sexual activities that you really don't enjoy? Are there certain sexual activities that you would really like to try?

What factors do you think are negatively influencing your sex life together (e.g., conflict, lack of affection, lack of communication, stress, negative beliefs about sex, fear of pregnancy, hygiene)?

What kinds of things could you and/or your partner do to make sex more enjoyable?

How do you feel when your partner massages your body? What do you like best?

How do you feel about communicating about the ways you do and do not like to be touched?

How do you feel about the way your partner communicates their sexual preferences to you?

How do you feel about the program so far?
If you would like more discussion questions, feel free to email me (alhu@deakin.edu.au) and let me know.

**Mindful Sensate Focus - Solo Sessions**

These sensate focus sessions are for you to complete on your own. You will also incorporate mindfulness practice into these sessions. Meanwhile, you and your partner can *continue to do sensual massages* as often as you like (maybe 2-3 times per week). There is still no genital touching allowed in these sessions but you can *include breast touching*. Remember you are taking things slow so as to decrease pressure and anxiety in sexual situations and learn how to make sexual experiences more pleasurable.

The solo touch sessions will give you a chance to become more comfortable with your body, to explore what your genitals look like and feel like, and to experiment with pleasurable touch. The guidelines for the solo session are only a rough guide and you should explore as much of your body as you like. Your partner may also like to spend some time pleasuring himself alone. You will need to complete **at least 2** solo sessions (or one per week) before moving onto Module 4.

Remember:

- The **no intercourse rule** until Module 5;
- There is no pressure to become aroused, this is simply an opportunity to learn;
- Don't try to bring yourself to orgasm;
- Always complete a discussion letter before doing a **couple touch session** (you do not need to do a discussion question before a solo touch session);
- Keep practicing basic mindfulness for **5 mins a day** to help you incorporate these skills into sensate focus!

**Self-observation and self-touch exercise:**

Now that you have learnt about female genitals and seen pictures of other women's genitals, it is time to get to know your own. In order for you to know what types of touch you enjoy and how to communicate this with your man, it is vital that you get to know what your vulva looks like and feels like. You may like to print off the anatomy diagrams from Module 2 to help you with this exercise. You will also need a **hand mirror**.

Some women feel uncomfortable about **touching themselves** because they are Â embarrassed or have a belief that masturbation is dirty or wrong. Masturbation is a **natural and healthy** expression of your sexuality and is very helpful in increasing the pleasure you experience in your sex life. If you are struggling to do these exercises or would like to discuss your experiences, please send me an email (alhu@deakin.edu.au).

Find a time when you can be uninterrupted for at least 10-15 minutes. You may like to have a warm bath or shower before you begin, or rub some nice oil or lotion on your body. You may also like to light some candles, burn some fragrant oil or play some relaxing/sensual music.Â As you prepare yourself and your room for your solo session, practice your mindfulness skills by bringing your attention to your body: observe any sensations in your body; feel the texture and heat of your skin; feel your feet on the floor or the water on your skin. Observe any thoughts, feelings or images that come to your mind, acknowledge them, and then gently bring your attention back to your body.

**Part 1: Self-observation**

Once you feel ready, prop yourself again the headboard of your bed or some pillows. Placing the hand-mirror between your legs, notice the colour and texture of your pubic hair and labia majora. When you open your legs a bit wider, notice your labia minora.
Both sets of lips protect your vagina and also add to sexual pleasure.

At the top of your vulva you will see your clitoris. The clitoris is the main source of pleasure during foreplay and sex. Notice a little ridge above the clitoris, called the clitoral shaft. This can also be touched for sexual pleasure during foreplay and intercourse. As you look at these different parts remember to practice being mindful and present in the moment. If you are feeling negative towards your body or the experience try saying to yourself: "This is my body. It is alive and womanly. It is okay to explore my own body."

When you feel ready, spread your inner lips apart and notice your vaginal opening. You may also be able to see your urethra. You may notice some moistness or discharge from your vagina, and this is how the vagina keeps itself clean and healthy, and also how the vagina lubricates itself for sex.

As you observe your vulva, notice the colours, shapes and textures and remember that every woman's genitals look different. You may be able to smell a slight odour and this is also natural. Remember that the vulva is often likened to a blossoming flower and that most men adore the sight, texture, taste and smell of a woman's vulva (that's why it is sometimes called a woman's peach or honey-pot). If any thoughts distract you, remember to keep bringing your attention back to the here and now, or say some helpful and positive self-statements to yourself.

**Part 2: Self-touch**

Take a moment to relax before starting the touch aspect of the session. Bring your attention to your body and notice any sensations you are feeling on your skin or inside your body. Take a few deep breaths, feeling the air flow into your lungs and out again. Notice the rise and fall of your chest.

Because the brain is such an important part of sexuality, before beginning the self-touch it can be helpful to use some imagery and positive thoughts. Try imagining yourself as a sensual and sexual woman who enjoys sex and say to yourself: "**I am a sensual and sexual woman worthy of pleasure and sexual satisfaction.**" Saying positive statements like this can help to increase positive associations with sexual touch and also to increase arousal. Say statements like these as often as you like during the session. Some other statement you may like include:

- I enjoy being sexual and sensual;
- I am a powerful and sexual woman;
- It's ok to love and enjoy my own body;
- I am sexy, I am womanly, I am beautiful;
- I am a loved woman and deserve sexual pleasure.

When you feel ready and are comfortable on your bed (sitting or lying down), start by stroking your arms, your legs and your belly. Try different types of touch to see what feels good. Keep your attention on the sensations of your body and repeat your positive statements if you start to feel negative about the experience.

When you feel you have explored these parts enough, move your touch to your breasts. Which parts of your breasts feel the nicest to be touched: The outer edges? The nipples? And what kind of touch feels good: Tickling? Pinching? Caressing? Spend some time enjoying the touch of your womanly breasts and remember that every woman likes to be touched in a different way, there is no wrong or right.

Once you feel ready to move on, slowly creep your hands down your belly to your pubic hair (or pubic mound if you have removed your hair). Touch and caress your pubic
hair/mound and notice the texture of the skin there. If you get distracted by thoughts or feel negative about the experience, remember to acknowledge the thoughts and bring your attention back to the sensations you are feeling.

Now run your finger along your labia majora (you may also be able to feel your labia minora if they hang outside your outer lips). What do your labia feel like? Do they like to be stroked? Pulled? Tickled? Slowly spreads your legs wider and let your fingers explore your vulva. You may like to use some baby-oil or lubricant to do this. While your fingers explore, try to locate your clitoris and the clitoral shaft above. How do these sensitive and pleasurable parts like to be touched? Remember you are not trying to bring yourself to orgasm - you do not even need to become aroused. Just focus your attention on the sensations and remind yourself that you are a sensual and sexual women, worthy of pleasure. You may also like to say some positive statement to yourself like: "It is natural to enjoy my own body."

Finally, locate your vagina entrance. Let your fingers explore the skin around the opening where lots of nerve endings live. Try inserting your finger as much or as little as you like to feel the inside of your vagina. What does this feel like? How does it liked to be touch? Continue this, and touching the rest of your vulva for as long as you like.

If this has been a hard or confronting experience, do something nice for yourself afterwards such as drinking a glass of wine, eating a treat or playing your favourite song. If you experience pain during this exercise, please email me (alhu@deakin.edu.au) and we can discuss some special techniques for you to try.

Please read the instructions again if necessary. You are now ready to try this exercise.

Remember to:

- Do a solo sensate focus session at least twice before moving onto Module 4. Getting to know your body better will really help when it comes to genital touching with your partner.

- Practice daily mindfulness (e.g., mindfulness of breath, mindfulness while walking) for 5 mins per day.

- To continue with non-sexual massages with your partner as often as you like. You can introduce breast touching now, but NOT genital touching. Always do a communication exercise beforehand.

Here is a sample of how you could schedule in the exercises for this module. Plan ahead and you are more likely to fit in all of the exercises! Remember, the more time you put into the program, the more benefits you will see!!
To do:

- 3 x communication exercise per week;
- 2 x solo sensate focus sessions;
- As many sensual massages as you like (maybe 2-3 per week);
- Daily mindfulness practice;
- 1 x online chat group per fortnight.

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<td>5 mins mindfulness while listening to music</td>
<td>Solo sensate focus after morning shower</td>
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<td>Read Module 3 after dinner</td>
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**Information for you Partner**

Click [here](#) to access the Module 3 information sheet for your partner. Make sure he reads it all before your first sensate focus session.

Alternatively, you can click [here](#) to send the link to your partner via email.
Are you ready to move onto Module 4?
You should spend at least 2 weeks on this module. To see if you are ready to move onto Module 4, please read the questions below. These questions summarise the goals of Module 3. In order to move onto Module 4, you should be able to answer “yes” to all of these questions.

___ Have you completed all readings and questions in this module?

___ Have you completed communication exercises regularly (approximately 3 per week)?
   How many communication sessions did you complete? ____

___ Have you completed at least 2 solo sensate focus sessions?
   How many solo sensate focus sessions did you complete? ____

___ Have you been practicing mindfulness regularly (approximately once a day)?

___ Have you attended at least one online chat-group during this module?

___ Are you ready to begin exercises that involve genital touching with your partner?

Email address: ________________
Pursuing Pleasure: Module 4

Welcome to Module 4! You are over half-way now and you should congratulate yourself for sticking with the program despite the challenges. By this stage you are starting to understand what types of touch and intimacy turn you on, and you are learning how to communicate better as a couple. These are vital stepping-stones to a more pleasurable sex life and relationship!

In this module you will:

- Explore the male sexual anatomy;
- Explore negative body-image;
- Problem-solve ways to increase body-image;
- Do regular communication exercises with your partner;
- Continue practicing mindfulness;
- Introduce genital touching into sensate focus sessions;
- Attend fortnightly online chat-groups.

I suggest that you spend approximately 2 weeks on this module, but it is up to you when you are ready to move on (see checklist at the bottom of the page).

Step 1:
Read the information on Male Sexual Anatomy and Your Body and Your Sexuality, and complete the Problem-Solving - Body Image exercises in your notebook. Print out the Module 3 information sheet for your partner and ask him to read this. Alternatively, you can click here to send the link to your partner via email.

Step 2:
Read through the communication exercises and the mindful sensate focus exercises. Plan in times with your partner to complete the communication exercises and sensate focus sessions. Remember a communication exercise always comes before sensate focus. Also plan in time with yourself to complete regular mindfulness practice.

Step 3:
Participate in fortnightly online chat-groups. Write down the dates and times to make sure you don’t forget!!

A sample timetable is provided at the end of the module. Remember to email me (alhu@deakin.edu.au) if you are finding any of the exercises challenging or just need some extra support.

Male sexual anatomy

In order to enjoy your partner sexually, it is a good idea to have an understanding of what goes on downstairs.
The head of the penis is the bulbous end of the penis where the urethra is found (where men both urinate and ejaculate from). The head has lots of nerve endings and many men enjoy this area being stroked and licked.

The corona is the ridge around the head of the penis, where the head meets the body of the penis. Some men find this area very sensitive and stimulating to touch, especially on the underside of the penis.

The shaft is the body of the penis. When aroused, the shaft fills with blood and the penis becomes erect. Large veins and pubic hair can sometimes be seen on the shaft and this is perfectly normal. When giving a man manual stimulation (a “hand-job”), the woman holds the penis and moves her hand-grip up and down the shaft of the penis. Some men like a soft grip, while others like a firm grip, and some men like to use a lubricant for this.

The foreskin is a loose ring of skin that covers the shaft and head of the penis when not erect and is only apparent on uncircumcised men. Circumcised men do not have foreskin and whether you're man is circumcised or not shouldn't make any difference to his or your sexual pleasure and satisfaction.

The testes are located in the skin sack that hangs down underneath the penis (the scrotum). This is where semen is produced, and many men like their testes to be fondled, tickled and licked.

The anus of a man is rich in pleasurable nerves, and the prostate gland (or male G-spot) resides inside. Some men (both heterosexual and homosexual) like their anus to be stimulated, while other men feel very uncomfortable about this.

If you are interested in learning more about sexual techniques to stimulate your partner, there are a variety of resources to look at. Here are a few websites to check out:

[http://sexuality.about.com/od/tipstechniques/ht/give_a_handjob.htm](http://sexuality.about.com/od/tipstechniques/ht/give_a_handjob.htm)

[http://sexuality.about.com/od/oralsex/ht/fellatio.htm](http://sexuality.about.com/od/oralsex/ht/fellatio.htm)
Your Body and Your Sexuality

As mentioned in previous modules, negative body-image can have a negative impact on sexual desire, arousal and enjoyment.

Negative body-image often includes:

- A dislike of certain parts of your body;
- Insecurities about your attractiveness;
- Issues regarding your weight;
- Comparing yourself to more attractive women;
- Negative attitudes about aging and body changes;
- Discomfort with your genitals;
- Avoiding looking at yourself in the mirror;
- Discomfort with being naked in front of your partner.

Many concerns about our bodies come from a distorted image of female beauty and sexiness in magazines, television, movies and advertising. You may have also picked up body-negative attitudes from your family and friends.

For women (and some men), body-image and sexuality have a very close relationship. It can be very difficult to desire or enjoy sex when you feel unsexy, unattractive and ugly. When we feel this way about our bodies, there are usually negative and unhelpful thoughts going through our minds (e.g., "I feel so fat and ugly today"), and uncomfortable sensations in our bodies (e.g., heavy chest, tight stomach). These unhelpful thoughts and sensations can distract us from sexual desire and pleasure and make us feel sad, guilty, and undeserving of attention and affection.

One way that women are commonly distracted by body-image is by becoming a spectator of the sexual experience. "Spectatoring" means that rather than focussing on the here and now in a sexual situation, you start focusing on how you look. Does my bum look fat from this position? Can he feel my cellulite when he touches me there? Does he find me attractive? Spectatoring can also cause you to think or worry about what you should be doing during sex, instead of enjoying what you are doing and what you are feeling. Both of these forms of spectatoring can cause performance anxiety.

Spectatoring is a recipe for unsatisfying sex - but you now have mindfulness skills to help you stay in the moment.

Some common body-negative thoughts that can lead to sexual avoidance and spectatoring include:

- My partner can't find me attractive/sexy when I look like this;
- I'm too fat, I'm too ugly, I'm too manly, I'm too skinny;
- My breasts are too small/too big;
- My body isn't as nice as it used to be;
- My partner must not be as attracted to me as he used to be;
- I hate my body;
- I don't deserve to be loved and touched;
- Women over 30/40/50/60/70 shouldn't have sex anymore;
- My genitals are disgusting/smelly/ugly;
- My body will never be the same after pregnancy/childbirth;
I was a lot more attractive/thinner/fitter when we first got together;

In order to have more enjoyable sexual experiences, you need to have a more positive and healthy relationship with your body.

**Problem-Solving: My Body-Image**

This exercise is very similar to the problem-solving techniques used in Module 3 and uses the **5-step CBT model**. The CBT model is based on the assumption that our **thoughts and beliefs** influence how we **feel about sex** and **how we act in sexual situations**.

This model will help you to challenge the negative ways you are thinking about your body and your sex-life, and find some positive alternative thoughts and solutions.

Think back to a recent **sexual experience** that you think may have been **influenced by negative body-image**, then use the step-by-step guide below to guide your problem-solving.

Record all your answers in your notebook.

**Step 1:** Think about the recent situation you have chosen. As you imagine this situation, try to identify any negative emotions that you felt or that you can feel now. **Name the emotions and write them down.**

For example, last week when my husband initiated sex he grabbed the flabby part of my stomach. When he did this, I immediately felt shameful about my body.

**Step 2:** As you think back to the situation, try to identify where those feelings were coming from. To do this, try to remember what thoughts were running through your mind. Also try to identify what beliefs about sex, relationships and your body were brought up. **Write these down.**

For example, when my husband touched my stomach I thought "I'm not attractive anymore", "My husband can't find me sexy" and "He shouldn't touch this body." Â My thoughts focussed around the belief that I am unworthy of sexual attention when I'm not happy with my body.

**Step 3:** Write down what actions you took as a consequence of these thoughts and emotions. Also identify how these actions made you feel.

For example, when I had these negative thoughts and emotions I instantly rejected my husband's sexual contact and rolled away from him in bed. I then felt guilty for rejecting him and sad for our sex life.

**Step 4:** Now go back to the thoughts you identified in Step 2. Re-examine these thoughts and beliefs and try to challenge them. Go through **each thought/belief individually** and try asking yourself some of these questions:

- Is this a rational or irrational thought/belief?
- Would my partner agree with this?
- Would somebody who felt positive about sex and their body think in this way?
- What would my best friend say about this?
- Is this thought/belief a reflection of any negative family or cultural messages about sex and my body?
- What is the evidence for and against this thought/belief?
- Is this thought/belief helpful or unhelpful?

For example, the thought "My husband can't find me sexy" might be a bit irrational. He wouldn't initiate sex if he found me so unattractive. If I asked him he would probably tell me he still finds me attractive. Somebody who is positive about sex and their body would think that they must be attractive if somebody wants to make-love to them. This belief reflects
messages from magazines and movies about the type of body I should have to feel sexy. This thought is not helpful, it just makes me feel bad and guilty and not enjoy intimacy with my husband.

To address irrational or unhelpful thoughts and beliefs, you now need to come up with alternative and more helpful statements to say to yourself. For each thought or belief, try to come up with at least 1 new helpful self-statement. For example, instead of thinking "My husband can't find me sexy" I could say to myself "My body has changed over the years, but I am still attractive to my husband."

Write down the alternative statements you come up with and look at them regularly to remind yourself that you are a beautiful woman who deserves love and intimacy.

Here are some other body-positive statements you might like to use:

- I don't need to listen to magazines and movies, I can decide what is attractive;
- There is nothing wrong with being a curvy woman;
- I am a sexual and sensual woman;
- Small breasts are just as sexy as big breasts;
- I have a right to have my sexual needs met no matter how I look;
- I am beautiful and womanly;
- I don't really like my (bottom/stomach/wrinkles, etc.), but I do like my (legs, eyes, breasts, lips);
- I feel unattractive but I am learning how to be more positive about my body;
- An aging woman can still be sexy;
- Beauty on the inside makes me beautiful on the outside.

Step 5: The last step is to brainstorm things that could help in situations where negative body-image interrupts your sexual interest and enjoyment. Write down any ideas that come to mind. Make sure you include your new helpful self-statements and your mindfulness skills!

For example, when I am feeling yuck about my body in sexual situations I could say to myself: "My husband still thinks I'm attractive." I also know that nice fragrances and silky material makes me feel sexy, so I could buy a nice scent and lingerie and put it on before sex. I could also ask my husband to tell me the things about me he thinks are sexy. I can use my mindfulness skills to stay in the moment and enjoy the pleasant sexual sensations instead of thinking about how my body looks.

Try thinking of another situation related to body-image and do this exercise again. Doing this exercise will give you a list of helpful self-statements and a range of possible solutions to try in order to increase your body-image and decrease spectatoring. But remember, to gain the benefits you can't just write these solutions down, you need to act on them to make a difference.

If you have any concerns you would like to discuss further, or are finding it hard to problem-solve, feel free to email me at alhu@deakin.edu.au and we can talk about it more.

This next section of Module 4 includes communication exercises, mindful sensate focus sessions, and continuing your daily mindfulness practice.

The discussion questions will give you and your partner an opportunity to talk about body-image and other things that may have come up for you over the program. This is also a good opportunity to discuss any of the ideas you came up with in the problem-solving exercise.
Communication Exercises

Remember to:

- Choose one question at a time;
- Spend around 10 minutes writing;
- Spend around 10 minutes talking;
- Schedule in time with your partner to make sure you both commit to these exercises - you do not need to do every question listed, but try to do at least 3 questions per week;
- Always do a communication exercise before a senate focus session;
- Record which questions you have completed.

Discussion Questions:

What are some special memories you have of your partner?

What do you find attractive about your partner's body? How do you communicate that to them? If you don't, how could you communicate that to them in the future (e.g., tell them directly, pay special attention to those areas in massage)?

How do you think negative body-image may be influencing your sex-life? What kinds of things could you and/or your partner try to make this less of an issue?

What do you think about the media's portrayal of female beauty and sexiness?

How do you feel about touching each other in a sexual way?

How do you feel about giving and receiving oral sex?

How do you feel about communicating how you like your genitals to be touched?

How do you feel about the way your partner communicates how they like to be touched?

Are there certain ways you really don't enjoy being touched? Are there certain ways you would really like to be touched?

What kinds of things could you and/or your partner do to make the sensate focus sessions more enjoyable?

How are you feeling about the no intercourse rule?

What do you enjoy about intimacy with your partner?

How do you feel about your progress in this program so far?

What has been the most helpful aspect of the program so far?

If you would like more discussion questions, feel free to email me at alhu@deakin.edu.au.

Mindful Sensate Focus - Genital Touching

These sensate focus exercises are for you to complete with your partner. It is very similar to previous exercises except that you will now introduce genital touching. You will also incorporate mindful awareness into these sessions.
Although these sessions are more sexually oriented than past modules, remember you are still taking things slow. You should use these sessions to experiment with the types of genital touching you find pleasurable and not put any pressure on yourself to become or remain aroused. If you are feeling concerned about reintroducing genital touching, please email me (alhu@deakin.edu.au) so that I can support you through this challenge.

You will need to complete at least 3 sessions per week. Each session will take approximately 1 hour so it is important to schedule in time with your partner so that you can complete these sessions without being rushed or interrupted.

Remember:

- The no intercourse rule until Module 5;
- Always share a discussion letter before doing a sensate focus session;
- Keep practicing mindfulness for 5 mins a day.

Sensate Focus Instructions

- Begin each session by sharing a discussion letter.
- Before you start the session, make sure you are feeling relaxed, comfortable and open. Try to approach the experience with an attitude of curiosity and playfulness. Click here if you need some help to relax.
- Prepare the room together (heating, lighting/candles, oil/incense, curtains, music).
- Decide who will massage first and who will receive the massage first.
- When you’re ready to begin, both toucher and receiver should remove their clothing. The receiver can then lie down on their back and get comfortable on the bed.
- The toucher then begins to explore their partner's body. Start with non-genital areas such as the feet, arms, back or legs. Slowly work over these parts for about 10 minutes and try to use a variety of techniques.
- When the receiver is ready, they should let their partner know that they may begin touching their genitals. Try a range of different techniques such as fondling, tickling, stroking, rubbing, kissing, licking and sucking. Let your partner know if there is any particular type of touch you don't like to give or receive, but also approach this exercise with an attitude of open mindedness and experimentation.
- As the receiver, bring you attention to the sensations of your body and genitals. Draw upon your mindfulness skills to stay present and aware. Let thoughts come and go and keep bringing your attention back to your body. If negative feelings arise, try saying some helpful self-statements to yourself. For example:
  - My body is alive and precious;
  - My body can be pleasured and enjoyed;
  - I am a sexual and sensual woman;
  - I am a loved woman and deserve sexual pleasure.
- You may also like to use some of the self-statement you thought up in the problem-solving exercises. Look over these statements before you begin the exercise.
- The receiver needs to communicate what feels good and not so good, and the toucher needs to listen to these messages and alter their touching accordingly. If
the message is not getting across, the receiver may need to be more direct by either saying something more specific or gently guiding the toucher's hand. It's good to follow-up a comment about what doesn't feel good with a comment about what does feel good.

- It is normal and natural to make noises in response to the touching, such as moans and sighs. Letting yourself make noises when something feels good will help to guide your partner, and may also help to get you more in the mood.

- Remember the no intercourse rule. If your partner starts to initiate intercourse, politely remind him that you are not allowed to include intercourse yet. You could say something like this: "I know you want to have sex now, but remember it's important to take things slow and not have sex yet."

- After the receiver has been touched for 20-30 minutes, it is time to swap roles. Make sure you both get equal amounts of time of touching and being touched. If you start to have negative thoughts while touching your partner's genitals, remember to use your mindfulness skills to stay present and non-judgemental.

- The receiver should not feel any pressure to become aroused. All the receiver needs to do is enjoy the sensual massage and communicate to their partner. Orgasm and ejaculation is not encouraged at this stage.

- After you have both had a turn, you might like to take a moment to talk about the experience with your partner, share a cuddle and a glass of wine together. Many women enjoy cuddles and affection after a sexual experience to increase intimacy and satisfaction.

Below are some special touching techniques that may be useful in these sessions. You partner will also be told about these techniques in the information sheet.

The teasing approach
This technique is about building up anticipation instead of just rushing genital stimulation – it involves touching and teasing:

- Before you touch your partner's genitals, caress the sensitive areas around the genitals (inner thighs, lower abdomen, pubic hair).
- Then briefly start touching your partner's penis and scrotum.
- Soon after, move your attention back to non-genital areas such as his thighs and stomach (especially the sensitive areas surrounding the genitals).
- Then return your attention back to his penis and scrotum.
- Keep alternating as often as you like, and you may like to try using both manual and oral stimulation to tease and pleasure your partner.
- Remember you are not trying to make your partner ejaculate.
- This technique should be fun and cheeky, so try to enjoy the building of anticipation.

Waxing and waning technique
It is natural for arousal to come and go in waves and this technique helps to take the pressure off you and your partner remaining sexually aroused throughout the whole session:

- Once you have spent some time pleasuring your partner, stop caressing him for a few minutes to allow his arousal to subside.
- While you are not stimulating him, you may like to spend some time kissing, massage his feet, sipping on some wine or just have a relaxed chat.
- Then resume caressing his body and genitals again.
- Try repeating this 2 or 3 times.
• Remember these sessions are supposed to be fun and enjoyable, so treat this technique like a bit of a sexy game.
• Don’t be concerned if your arousal or your partner’s arousal does not return on some occasions, just enjoy the sensual time together.

Remember:

• To use your **mindfulness skills** and **positive self-statements** when you start feeling anxious, negative or distracted;
• There is no pressure to feel aroused during the session â€“ just enjoy the sensations and try to relax;
• To be open minded and playful!
• To practice **daily mindfulness** (e.g., mindfulness of breath, mindfulness while walking) for **5 mins per day**.

Here is an example of how to **schedule in the exercises** for this week. It’s very important at this stage to keep putting in time, energy and effort. Please email me at alhu@deakin.edu.au if you have any concerns about the exercises in this module.

**To do:**

• 3 x communication exercise per week;
• 3 x sensate focus sessions per week (with a discussion letter beforehand);
• 5 mins daily mindfulness practice;
• 1 x online chat group per fortnight.

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**Sunday** |        |        |        |        |              |        |
**Information for you Partner**

Click [here](#) to access the Module 3 information sheet for your partner.

Alternatively, you can click [here](#) to send the link to your partner via email.

Make sure he reads it all **before** your first couple sensate session.

**Are you ready to move onto Module 5?**

You should spend at least 2 weeks on this module. To see if you are ready to move onto Module 5, please read the questions below. These questions summarise the goals of Module 4. In order to move onto Module 5, you should be able to answer "**yes**" to all of these questions.

___ Have you completed all readings and questions in this module?

___ Have you completed communication exercises regularly (approximately 3 per week)?

  How many communication sessions did you complete overall? ___

___ Have you completed at least 3 sensate focus sessions per week?

  How many sensate focus sessions did you complete overall? ___

___ Have you been practicing mindfulness regularly (approximately once a day)?

___ Have you attended at least one online chat-group during this module?

___ Are you ready to start experimenting with penetration and intercourse?

Email address: _______________
Pursuing Pleasure: Module 5

Welcome to Module 5! You are now well on your way towards a more rewarding sex life and intimate relationship. By now, you and your partner are getting comfortable with genital touching and are ready to begin experimenting with the style of intercourse that YOU find pleasurable. But there is still no need to rush, the process of introducing intercourse will be done gradually over Modules 5 and 6 to help you integrate your new skills and knowledge and continue practicing what you have learnt in Modules 1-4.

In this module you will:

- Explore ways to make intercourse more enjoyable;
- Learn kegel exercises to increase sexual sensitivity;
- Address negative thoughts associated with sexual intercourse;
- Do regular communication exercises;
- Continue practicing mindfulness;
- Begin sexual intercourse with your partner;
- Attend fortnightly online chat-groups

Step 1:
Read the information on Intercourse - More Than Just Penetration and Kegel Exercises and complete the Thought Predictions exercises in your notebook. [Print out the Module 5 information sheet] for your partner and ask him to read this. Alternatively, you can click here to send the link to your partner via email.

Step 2:
Read through the communication exercises and mindful sensate focus and plan in time with your partner to complete these exercises. Remember a communication exercise always comes before sensate focus. Also plan in time with yourself to complete regular mindfulness practice.

Step 3:
Participate in fortnightly online chat-groups. Write down the dates and times to make sure you don't forget!!

It is normal to feel a bit nervous about introducing intercourse into the sensate focus sessions. The readings and thought exercises should be useful, and you can also email me at alhu@deakin.edu.au for extra support.

Intercourse - More Than Just Penetration

Before introducing sexual intercourse back into your love-making (which will occur in the mindful sensate focus sessions), there are a few important pointers to keep in mind:

Initiation and refusal
The way that you or your partner initiate sex, and the response to this initiation, can have a large impact on your sex life. Many couples get stuck in a repetitive pattern of the same person always initiating sex, and the initiation always happening in the same way (e.g., your man starts nibbling on your ear as you both get into bed).

Some things to keep in mind:

- In any relationship, there will be times when one partner initiates and the other refuses;
- It is ok to refuse a sexual invitation but it is important to do this in a sensitive and non-hurtful way;
- It is a good idea to try to initiate sex equally instead of one person always taking responsibility - or at least aim for a bit of balance.
- The way a partner initiates sex can sometimes be a turn-off and it is important to communicate about this;
- As you become more mindful in sex and develop more positive attitudes about sex, it will be easier to say yes to sexual invitations more often and initiate sex more often.

You will have a chance to talk about your patterns of initiation and refusal in the communication exercises.

The warm-up
Even after all the delicious body exploration you and your partner have been doing, many couples quickly forget all about the warm-up to sex and go straight for penetration. While this can sometimes be enjoyable (often referred to as "the quicky"), it is usually preferable to spend some time getting warmed up in foreplay before attempting penetration. Foreplay can include a sensual massage, sexy talking, deep kissing, and breast and genital touching/licking. Take as much time as you need to get warmed up for intercourse.

Maximising pleasure
Try to approach love-making with the aim of mutual pleasure and satisfaction, not just something to get over and done with. Ways to maximise pleasure include:

- Giving yourself permission to enjoy sex and approaching intercourse from a place of relaxation;
- Being present and mindful of the sensations you are experiencing;
- Remembering all the positive benefits of sex;
- Making sure you are getting your emotional and intimacy needs met outside of the bedroom;
- Communicating your likes and dislikes;
- Taking things nice and slow if you are in any pain or discomfort;
- Using a bottled lubricant;
- Finding the sexual positions that you and your partner both enjoy (some positions to maximise pleasure will be discussed later on).

Outside the bedroom
Remember that stress and tensions outside the bedroom can impact your experience in the bedroom. Reflect on the Four P's as well as the problem-solving exercises done over Modules 3 and 4 to ensure you are doing all you can to create a positive mental environment for enjoyable love-making.

Planning ahead
As mentioned in Module 3, it is too easy to get caught up in life events and leave sex at the bottom of the to-do list. Ways to combat this tendency include:

- Reflecting on the current and possible benefits of sex;
- Planning in regular times to have sex with your partner - many a couple has proven that scheduled sex is no less enjoyable than spontaneous sex!
- Problem-solve with your partner about ways of decreasing stress and increasing time and privacy for intimacy and sex.

Lastly, the amount of times per week that a couple wants to have intercourse will be completely individual to each couple. Some couples may be very happy with sex once a week while others will want it every second night. This will also change over time as circumstances and life-stages change. When one partner wants to have sex a lot less or a
lot more often than the other, negotiation needs to occur so that both partners can be reasonably satisfied with the situation.

Feel free to email me at alhu@deakin.edu.au if you want to discuss any of these suggestions further, or work out other ways to maximise your enjoyment of intercourse.

**Kegel Exercises**

These exercises strengthen the kegel (pelvic floor) muscles that encircle the vagina, urethra and anus. Kegel exercises can enhance pleasurable feelings during intercourse, and are also useful for urinary incontinence as we age. Give these exercises a try:

- Locate the kegel muscles (pelvic floor) - do this by trying to stop urine flow when you are sitting on the toilet. If you can stop the flow, you have found the kegel muscles! You can also check you are using the right muscles by inserting a finger into your vagina. When you squeeze tight you should be able to feel the vaginal opening tighten around your finger.
- Once you have located the kegel muscles, lay on the floor and gently squeeze your pelvic floor. Hold this for about 5 seconds and then release. Do four or five squeezes each morning and night.
- As you get better at this, try increasing to 10 squeezes each time, holding each squeeze for 5 seconds.
- Once you have this down, you can practice squeezing and releasing your pelvic floor anywhere - while standing in the grocery queue, while driving, while watching TV, anywhere you like

**Thought Predictions**

You have already learnt how negative thought patterns can influence how you approach and experience sexual situations. This exercise aims to identify some of the unhelpful or distressing thoughts that may arise as you introduce intercourse into the sensate focus sessions, and to explore some ways of dealing with these thoughts. The exercise is based on the cognitive-behavioural therapy (CBT) model, but is a little different from the 5-step problem-solving model in previous modules. Record this exercise in your notebook.

**Step 1:** Close your eyes and imagine a scenario where you and your partner are beginning to start a sensate focus session. You are kissing and touching each other’s bodies, and you know that soon you will attempt penetration. As you are imagining this situation, what emotions or feelings come up? Or what feelings can you imagine coming up? Are any of these emotions or feelings negative? Write them down.

For example, when I imagine me and my partner starting to head towards intercourse I feel tense and anxious.

**Step 2:** As you imagine the situation, what thoughts are running through your mind? What beliefs about sex, relationships and your body does this situation bring up? Write these down.

For example, when I imagine being in this situation I am having the thoughts "This is going to be a chore", "This won't feel good" and "I just want it over and done with."

**Step 3:** Next, identify what your goals would be in this situation (eg. to have an enjoyable experience, to be mindfully present, to remain relaxed, to feel sensual and sexual, to feel connected to your partner, to communicate your sexual needs, etc). For example, I want to be able to have pleasurable sex with my partner and enjoy the intimacy with him. I also want to be able to communicate what feels good to me during intercourse. I want to remain mindful and present.
Step 4: Now go back to the thoughts you identified in Step 2. Re-examine these thoughts and beliefs and try to challenge them by coming up with at least one alternative statement that is more helpful and more positive and will help you to achieve your goal in the sexual situation. Go through each thought/belief individually and use questions like the ones below to guide you:

- Is this thought/belief helpful or unhelpful?
- What is the evidence for and against this thought/belief?
- Would my partner agree with this thought/belief?
- Would somebody who felt positive about sex think in this way?
- What would I tell a friend if she was in this situation?
- Is this thought/belief a reflection of any negative social messages about sex?

Write down each alternative statement you come up with and look at them regularly. You may like to look back at the statements you wrote in Modules 3 and 4, and the statements suggested in the readings from these modules. For example, instead of "This is going to be a chore" I could say to myself "I am open to this experience and to where it will take us." Instead of "This won't feel good" I could say to myself "If something doesn't feel right I can let my partner know." And, instead of "I just want it over and done with" I could say to myself "I want to stay in the present moment and enjoy this experience."

Step 5: Brainstorm things that could help you enjoy intercourse more. Write down any ideas that come to mind. Make sure you include your new helpful statements and your mindfulness skills. For example, I can read my new statements before sensate focus. I can draw upon my mindfulness skills to stay in the present moment and enjoy any pleasurable sensations. I can make sure I am feeling relaxed before we begin by having a bath or meditating. I can let my partner know I am nervous and that I need to take things slow. I can communicate to my partner what feels good and when something doesn't feel right.

You may like to imagine another scenario and do this exercise again.

Read over your self-statements and the other ideas you have come up with before beginning sensate focus and remember to put your ideas into action!

This next section of Module 5 includes communication exercises, sensate focus sessions, and continuing your mindfulness practice.

The discussion questions will give you and your partner an opportunity to talk about sexual intercourse and how to make it more enjoyable for you both. This is also a good opportunity to discuss any of the ideas you came up with in the thought prediction exercise.

**Communication Exercise**

During this module, you have 2 choices:

- Continuing to write and swap letters (the same as previous modules) or;

- Discuss the question without using letters. Do this by allowing one person to speak about their thoughts and feelings on the issue for 5 minutes, and then the other to speak about their thoughts and feelings on the issue for 5 minutes. Take turns for who goes first each time. Then have a discussion for around 10 minutes in response.
If you like, you can sometimes write letters and sometime just talk, it is entirely up to you and your partner.

Remember to:

- Choose one question at a time;
- Schedule in time with your partner to make sure you both commit to these exercises - try to do at least 3 questions per week;
- Always do a communication exercise before a sensate focus session with your partner;
- Record which questions you have completed.

**Discussion Questions:**

How do you feel about the way you communicate with your partner about difficult issues and differing opinions?

How do you feel about the changes that have been occurring in your relationship during this program?

Do you enjoy foreplay before intercourse? Is there anything you and/or your partner can do to make foreplay more enjoyable?

How do you feel about starting to have intercourse with your partner in sensate focus sessions?

How do you feel about planning in time for sex together (as opposed to relying on spontaneous sex)?

How do you feel about communicating during intercourse (e.g., if you want to change positions or slow things down)?

How do you feel about the way your partner communicates during intercourse?

Are there certain things you really do not like during intercourse? Are there certain things you would really like to try during intercourse (e.g., clitoral stimulation, breast touching, looking into each other's eyes)?

What kinds of things could you and/or your partner do to make sexual intercourse more enjoyable?

How has the program changed the way you think about sex and intimacy in your relationship?

How do you feel about your progress in the program so far? Have you achieved any of your goals?

What are your current concerns about your sex-life together?

If you would like more discussion questions, feel free to email me (alhu@deakin.edu.au) and let me know.
Mindful Sensate Focus - Intro to Intercourse

These sensate focus sessions are for you to complete with your partner. They will begin like the sessions in Module 4 with general **body touching** and **genital stimulation**, and then introduce penetration. You will also incorporate mindfulness into these sessions to help you stay present and relaxed and experience more pleasurable sensations.

*The more mindful you are of pleasant sensations, the more enjoyable they will feel.*

Now that you will start to incorporate intercourse into sensate focus, it is especially important to remember to take things slow! These sessions should be a **positive and enjoyable** experience, not a rush or a hassle. You should use these sessions to experiment with how you like intercourse to play out.

You will need to complete at least **3 sessions per week**. Each session will take **approximately 1 hour** so it is important to schedule in time with your partner so that you can complete these sessions without being rushed or interrupted.

If, after body touching and foreplay, you do not feel emotionally or physically ready to try intercourse, **that is ok**. Let your partner know that it’s not the right time and try again another day/night. Try not to leave it too long before you try again - **no more than 3 days**. If you leave it longer than this, it is likely that your worry and anxiety will increase even more. It is common for women to feel worried or anxious at this stage of the program, so please feel free to email me at alhu@deakin.edu.au and we can discuss your concerns.

Remember:

- **Always** share a discussion letter beforehand;
- There is no pressure to become aroused or have an orgasm in these sessions - just enjoy the pleasurable sensations moment-by-moment and relax into the experience;
- Keep practicing mindfulness for **5 mins a day** to help you utilise these skills during sexual situations.

**Sensate Focus Instructions**

- Begin each session by sharing a discussion letter.
- Make sure you are feeling relaxed and open to the experience. Click [here](#) for ideas to get you in the mood.
- Prepare the room together.
- Start the session as you have in other modules with **general body touching first** and then **genital touching** once you and your partner are ready. There will be no designated toucher or receiver this time, so feel free to experiment with taking turns as well as touching each other at the same time. Also feel free to experiment with new types of touches and caresses and try some teasing and waxing and waning.
- Remember to draw upon what you have learnt about touch and to communicate with your partner either verbally or non-verbally. If you start to feel negative emotions, use your helpful self-statements and your mindfulness skills to remain...
present in the experience. You may also like to use some positive statements like the ones below:

- I am a sexual and sensual woman;
- My body is alive and precious;
- My body can be pleasured and enjoyed;
- I am sexy, I am womanly, I am beautiful;
- I am loved and deserve sexual pleasure.

- Neither of you should feel any pressure to become aroused or lubricated. All you need to do is enjoy the sensations and communicate with your partner. Orgasm/ejaculation should be avoided at this stage - there is no need to put extra pressure on yourself.

- When you are ready, indicate to your partner that you would like to start penetration. Some positions that can enhance the sexual experience are discussed below. This is a good time to apply lubricant or put on a condom if necessary.

- You and your partner can work together to insert his penis into your vagina. If you feel any pain or discomfort, take this step very slowly. There is a tendency for people to go silent upon penetration but it is vital that you keep communicating with your partner throughout intercourse.

- Remember you are taking this nice and slow. For the first few sessions, once his penis is inside your vagina just sit still for a little while (no rocking or thrusting) and just feel each other in this position. This is called the "quiet vagina" technique and gives you a chance to relax into intercourse. Be aware of any sensations in your body and any emotions that arise. Draw on your mindfulness skills and positive self-statements if necessary.

- Repeat the quiet vagina technique whenever you want to. You may also go back to massage, manual or oral stimulation at any time.

- When you and your partner are feeling comfortable to move on (and this may be after several sessions) you may like to try some of these techniques: squeeze and relax your kegel muscles around your partner's penis; gently thrust or rock together; ask your partner to touch your breasts or clitoris; touch your own breasts or clitoris; touch his scrotum; use the waxing and waning technique (by having intercourse for brief periods, then returning to body and genital caressing for a few minutes, and then returning back to intercourse again).

- Many women get a sore vagina when the thrusting is too hard and/or too fast. Try to start out nice and slow and build momentum gradually.

- When you feel ready to end the session, let your partner know. At this stage, avoid ending with orgasm/ejaculation. Afterwards you might like to share a kiss and a cuddle, take a moment to talk about the experience, or have a glass of wine together. Many women love cuddles and intimacy after sex, and it is important to let your partner know this.

Below are some sexual positions that may be useful in these sessions. Your partner will also be told about these in the information sheet:
Female on top
This position allows you to have more control over how fast and how deeply your partner’s penis enters your vagina. How to do this: While your man is lying on his back, hop on top of him and bend your knees so that you are sitting above his pelvis. Either you or your partner can then guide his penis inside you. Then you can move your hips up and down or forwards and backwards - whatever feels good to you both. From this position you can easily make eye contact with your man and lean in for some passionate kissing!

Coital alignment technique
This position is similar to the standard missionary position (man on top), but allows for more clitoral stimulation. How to do this: Your partner goes on top, as in the standard missionary position, but then moves his body upward a little, so that the base of his penis, or his pubic bone, applies pressure to your clitoris. Then you both rock back and forth keeping pressure on the clitoris.

Clitoral stimulation
In any position you try, you can always ask your partner to touch your clitoris or breasts at the same time, or touch them yourself.

Remember:
- Try to approach sex from a state of relaxation and openness;
- Use your mindfulness skills and positive self-statements if you start feeling anxious or distracted;
- You can back out of intercourse if it’s just not feeling right at the time;
- There is no pressure to feel aroused during these sessions - just enjoy the sensations and try to relax;
- To use a bottled lubricant if you want - just make sure you have it on hand (e.g., in the bedside drawer);
- To be open-minded and playful!
- To also practice daily mindfulness (e.g., mindfulness of breath, mindfulness while walking) for 5 mins per day.

As I'm sure I’ve said enough times now - the more time you put into the program, the more benefits you will see. I hope by now you have a bit of a routine of how to schedule the exercises into your busy week.

To do:
- 3 x communication exercise per week;
- 3 x sensate focus sessions per week (with communication exercise beforehand);
- 5 mins daily mindfulness practice;
- 1 x online chat group per fortnight.

Information for you Partner
Click here to access the Module 5 information sheet for your partner.
Alternatively, you can click here to send the link to your partner via email.
Make sure he reads it all before your first couple sensate session.
Are you ready to move onto Module 6?
You should spend at least 2 weeks on this module. To see if you are ready to move onto Module 6 (the last module!!), please read the questions below. These questions summaries the goals of Module 5. In order to move onto Module 6, you should be able to answer "yes" to all of these questions.

___ Have you completed all readings and questions in this module?

___ Have you completed communication exercises regularly (approximately 3 per week)?

    How many communication sessions did you complete overall? ____

___ Have you completed at least 3 sensate focus sessions per week?

    How many sensate focus sessions did you complete overall? ____

___ Have you been practicing mindfulness regularly (approximately once a day)?

___ Have you attended at least one online chat-group during this module?

___ Are you ready to continue experimenting with sexual intercourse?

Email address: ________________
PursuingPleasure: Module 6

Congratulations, you have made it all the way to Module 6 - the last module of PursuingPleasure!

This module is all about consolidating what you have learnt over the program and planning for the future.

The order of this module is a little different from all the previous ones.

In this module you will:

- Do regular communication exercises with your partner;
- Continue practicing mindfulness;
- Continue sexual intercourse with your partner;
- Attend fortnightly online chat-groups;
- Plan for any problems that may arise in the future;
- Explore some options to further enhance your sex life.

Step 1:
Read through the communication exercises and mindful sensate focus. Plan in times with your partner to complete these exercises. And keep practicing regular mindfulness.

Step 2:
As you are working through the exercises, read the information on What Else - Sexy Extras, Other Interventions and Looking to the Future and complete the Anticipating Difficulties exercise. Print out the Module 6 information sheet for your partner and ask him to read this. Alternatively, you can click here to send the link to your partner via email.

Step 3:
Participate in fortnightly online chat-groups.

By now, you probably have a system or a routine for fitting in all the activities. Make sure you keep this up for the Module 6 activities:

To do:

- 3 x communication exercise per week;
- 3 x sensate focus sessions per week (with communication exercise beforehand);
- 5 mins daily mindfulness practice;
- 1 x online chat group per fortnight.

Communication Exercises

During this module, you can either:

- Write and swap letters or;
- Discuss the question without using letters.
The list of questions in this module is shorter than usual to allow you and your partner to decide on the topics of the other questions. You may like to discuss things brought up in this module or any other topic that you think is important to discuss. If you and your partner have any trouble thinking up new question, feel free to email me at alhu@deakin.edu.au and we can work some out together.

Remember to:

- Do at least 3 questions per week;
- Always do a communication exercise before a sensate focus session;
- Keep a record of the questions you have completed.

Discussion Questions:

How do you feel about coming to the end of the program?

What has changed in your relationship over the course of the program?

What have been the most important aspects of the program?

What difficulties might emerge in the future? What could you and your partner do to address these difficulties?

Do you have any concerns about ending the program?

How do you feel about experimenting with some of the sexual extras described below (fantasy, erotica, vibrators, dress-up, etc.)?

How do you feel about continuing to make couple dates after the program has finished?

Remember you can make up more questions of your own.

**Mindful Sensate Focus - Continuing Intercourse**

These sensate focus sessions will continue on from Module 5, but now you can incorporate orgasm and ejaculation into intercourse. You don't need to try and reach orgasm or make your partner ejaculate, simply relax and allow it to happen if it does. Remember that most women do not orgasm in every sexual encounter, and many women still feel sexually satisfied without an orgasm everytime.

These sessions should be a positive and enjoyable experience to share with your partner, so try not to rush them or see them as a chore. Use these sessions to be sensual, mindful and intimate and develop the type of sexual relationship you want to continue into the future.

You will need to complete at least 3 sessions per week. Spend at least 1 hour in each session. Make sure you choose times when you won't be rushed or interrupted.

If you have always been doing the sessions at night-time, maybe now is a time to try some daytime sessions to add a bit of variety. You could also try a different room of the house if you feel comfortable.
If, after body touching and foreplay, you do not feel emotionally or physically ready to try intercourse, simply let your partner know that it's not the right time and try again another day/night. Remember not to leave it too long before you try again (no more than 3 days).

It is not unusual to still be having some troubles at this stage. If you are having any concerns about intercourse or reaching orgasm at this point, feel free to email me at alhu@deakin.edu.au and we can discuss what to do next.

Remember:

- **Always** share discussion letter before doing a sensate focus session;
- Don't focus on arousal and orgasm, just relax and enjoy it if it does come;
- Keep practicing mindfulness for **5 mins a day** to help you be more mindful during sexual intercourse.

**Sensate Focus Instructions**

- Begin each session by doing a **communication exercise**.

- Make sure you are feeling **relaxed and open** to the experience. Click [here](#) for ideas to make you feel more comfortable.

- Prepare the room together.

- Start the session with **general body touching** and then **genital touching**. There will be no designated toucher or receiver.

- Remember to draw upon your mindfulness skills, positive self-statements and communication skills. Some useful positive self-statements include:
  - I am a sexual and sensual woman;
  - My body is alive and precious;
  - My body can be pleasured and enjoyed
  - I am loved and deserve sexual pleasure.

- Neither of you should feel any pressure to become aroused or lubricated. All you need to do is **enjoy** the sensations and **communicate** with your partner.

- When you are ready, indicate to your partner that you would like to begin penetration. This is a good time to apply lubricant if you wish, or put on a condom. You may like to try the positions suggested in Module 5, or any others you enjoy.

- If you feel any pain or discomfort when inserting his penis, take this step very slowly and keep communicating. You can also email me for more tips on reducing discomfort/pain during sex.

- You may like to begin with the "quiet vagina" technique or some very slow thrusting/rocking to give you a chance to relax into intercourse. Many women need to start nice and slow to enjoy intercourse. Be present and aware of any sensations in your body and any emotions that arise. **Draw on your mindfulness skills and positive self-statements if necessary.**

- When you and your partner are feeling comfortable, start moving, rocking and thrusting in the ways that you both enjoy. Gradually increase the speed and intensity of intercourse as you get more into it - but don't rush this.Â You may also like to try some different positions or any of these techniques squeeze and relax your kegel muscles around your partner's penis; gently thrust or rock together; ask
your partner to touch your breasts or clitoris; touch your own breasts or clitoris; touch his scrotum; use the waxing and waning technique.

- Don't focus on arousal or orgasm, but if you or your partner feel that orgasm or ejaculation is imminent, let it happen and enjoy the sensations.
- If your partner ejaculates before you are sexually satisfied, let him know what he can do to satisfy you (e.g., oral or manual stimulation, using a vibrator). Make sure you are both satisfied by the end of the session.
- When you feel ready to end the session, let your partner know. If cuddles and intimacy are important to you after sex, then make sure you let your partner know and spend some time being intimate after intercourse.

Remember:

- Use your mindfulness skills and positive self-statements when you start feeling anxious or distracted;
- You can back out of intercourse at any time if it's just not feeling right - communicate this with your partner;
- Use lubrication if you want - just make sure you have it on hand (e.g., bedside table);
- Sex doesn't have to be serious; it can be fun and playful!
- To practice daily mindfulness (e.g., mindfulness of breath, mindfulness while walking) for 5 mins per day.

**Looking to the Future**

As you near the end of the program, it is time to look to the future and explore what you are going to do next. While there will be no more formal exercises to complete after you finish the program, it is important that you keep practicing what you have learnt in this program. To do so, I suggest the following:

- **Keep up your mindfulness practice** - You are much more likely to maintain the benefits from this program if you keep up your daily mindfulness practice and your mindfulness in the bedroom. Continuing this practice will help you to keep entering sexual situations in a relaxed and mindful way for the long run (not to mention the benefits mindfulness has on life in general);
- **Keep scheduling in couple time** - Couples who continue to plan in regular sensual and sexual time together are more likely to maintain a healthy and happy sex life for the long run. Make sure you plan in both sexual and non-sexual couple dates to ensure that your needs are being met.
- **Keep communicating** - If you don't want to slip into old patterns of relating, keep discussing your thoughts and feelings with your partner. You can do this by sharing letters or just set aside time to have a good chat. And don't let sex silence you! Keep communicating in bed like you have been in the sensate focus sessions.

This next section lists some other suggestions to help you continue on your sexual growth journey:

**Have Realistic Expectations: Lapse vs. Relapse**

All couples have periods of time when their sex life is less satisfying than other times, and this is no reason to panic! Even though you may feel a lot more positive about your sex
life right now, it is very likely that you will have times when you don't feel so good about sex again.

It is very important to recognise that lapses are expected, and a lapse is not necessarily a relapse.

What to do?? If you recognise a lapse when it is occurring, you can draw upon your new skills and knowledge (e.g., mindfulness, communication, sensuality, the positive benefits of sex, etc.). You may like to read over the modules again and re-do some of the exercises. This way, a lapse does not have to turn into a relapse!

After a Bad Experience
If you have a negative or embarrassing sexual experience with your partner, it is important not to over-react. See it for what it is: Just one bad experience.

What to do?? Talk about it. And, if possible, approach the situation with light-heartedness and humour. It is also important to make sure you and your partner reconnect sexually within 1-3 days (the sooner the better). If you don't do this, it is likely that sexual anxiety will start to build-up and lead to sexual avoidance.

Have a Flexible Definition of Sex
Couples who have a flexible definition of sex are more likely to experience a satisfying sex life. A flexible definition of sex means:

- Understanding that sex is more than just intercourse; it is also kissing, fondling, stroking, licking and caressing;
- Understanding the importance of sensuality in its own right;
- Acknowledging that sex does not always have to end with intercourse/penetration;
- Acknowledging that orgasm does not always have to be a part of sex.

What to do?? Just like in the early stages of sensate focus, try having some intimate or sexual times that don't end in intercourse. This could mean passionate tongue-kissing, a sensual massage, a touch session in the shower, or a long session of oral sex. These non-intercourse times will also help to add variety to your bedroom, and variety is the spice of sex-life!!

Anticipating Difficulties
One of the best ways to prevent relapse is by anticipating what difficulties may come up, and having a plan for how to tackle them.

This plan will be very individual for each couple, but there are some common difficulties that should be mentioned, as well as some ideas for tackling each. Printing off a copy of the modules from this program is a good resource for the future when the website will no longer be available.

As you read through this list, start thinking about which difficulties you think might come up for you in the future.

Feeling too tired/stressed/grumpy to prioritise couple time and sex
If tiredness and stress seem to be getting in the way, there are 2 things to think about:

- How can you adapt your life to make couple time a priority? Perhaps you need to schedule in couple time on less stressful days or plan in some relaxation time
before couple time. You may also be able to ask your partner to help you out with certain responsibilities to make more time for love-making.

- Are you using tiredness/stress/grumpiness as an excuse to avoid sexual time? If you think this might be the case, it may be helpful to explore your emotions and thought process using the CBT 5-Step model (from past modules).

**Negative thoughts getting in the way**
If negative thoughts about sex, your relationship or your body are making sex and couple time a negative experience, it may be helpful to explore your emotions and thought process using the CBT 5-Step model. You can also revise the problem-solving you have already done around certain thoughts and situations, go over your positive self-statements, and revise the mindfulness exercises.

**Avoiding practicing what you’ve learnt**
It is a good idea to explore the reasons that lead to avoidance of sexual time with your partner and/or mindfulness practice. Are your emotional and non-sexual intimacy needs being met? Are negative thoughts getting in the way? Is it a lack of time or stress? Nutting-out why the avoidance is occurring will help you to come up with new solutions. It may be helpful to review the factors that commonly inhibit women’s sexual interest in Module 3.

**Feeling bad or emotional after sex**
If negative thoughts and feelings are coming up during or after sex, it may be helpful to explore your emotions and thought process using the CBT 5-Step model. You may also like to review the Four P’s in Module 2 to explore what may be precipitating and perpetuating these feelings.

**Your partner wants to go back to how things were**
It is possible that your partner will feel uncomfortable by your new sexual awareness and enjoyment and want to go back to the way things were. Many people initially feel uncomfortable about change. It is important to discuss why he feels this way, and what is it about the changes that make him uncomfortable. You can also voice how important these changes are to you and try to work through this issue with him without having to go back to the old ways.

**Not getting your emotional, non-sexual and/or sexual needs met by your partner**
If you feel that your needs are not being met within the relationship, it is important to discuss this with your partner. Past experience has shown that being as clear and specific as possible really helps (and not relying on mind-reading), and coming up with solutions together (not just demanding things) will increase the likelihood that changes occur. If this remains unresolved and becomes a big problem, you may like to find a good couples therapist in your local area.

**Feeling stuck, depressed or hopeless**
If you feel really stuck, or like things are going backwards or becoming worse, you may want to seek out some individual or couples therapy. You can do therapy face-to-face or over the internet, depending on your preference. Finding a therapist who specialises in sexual and couples issues is a good idea. See the Resources page for more details.

**Sabotaging your own progress**
Sometimes we sabotage our own progress without meaning to. This can be because we are scared of change and subconsciously want to keep the status-quo. One reason this can occur is if we fear that solving one problem might potentially open up a new problem (e.g., If I no longer experience pain during sex, then my partner will want sex more often). If you think you may be sabotaging your own progress, try thinking about why this might be occurring. Exploring your thoughts with the CBT 5-Step model may be helpful. You may also like to review the Four P’s in Module 2, talk to your partner about it, or discuss
Partner's sexual problems are interfering
If your partner has difficulties with maintaining erections, ejaculating too fast, or low sexual desire, this can have a big impact on your sexuality. A lot of the exercises in this program are good for male sexual concerns as well (e.g., sensate focus and communication) but he may like to seek out medical and/or psychological help for his own difficulties. In the mean time, it is important to communicate about these issues and there are also many self-help resources for men's sexual difficulties. See the Resources page for more details.

Now that we've gone through some of the common problems that women experience after ending treatment, it's time for you to come up with your own individualised relapse prevention plan:

Step 1: Brainstorm all the possible difficulties that may arise for you after this program is finished. You can use the list above, but also try to think if there are any other difficulties that may arise for you. Write these down.
For example, I anticipate that my negative body-image may resurface and interfere with my sexual enjoyment. I also anticipate that my emotional needs might stop being met after we no longer have the program exercises to do. List as many as possible.

Step 2: Go through each anticipated difficulty and try to think of what the warning signs of that difficulty might look like (ie. how would you know that the difficulty was arising?). Write these down.
For example, I would know that my body-image was interfering with our sex life again if I started to have negative thoughts about my body during sex and found myself spectatoring and avoiding physical contact. I would know that my emotional needs are not being met anymore when I start feeling resentful of my boyfriend and start getting emotional after sex.

Step 3: Write down any possible solutions to the anticipated difficulties. Remember you can draw upon your mindfulness skills, your positive self-statements, communication letters, sensate focus exercises, couple dates, the readings and exercises from Pursuing Pleasure, and any other resources (self-help books, websites, talking to a close friend, counselling).
For example, I could review Module 4 and the problem-solving exercise I did on body-image, and read my positive self-statements before any couple dates. I could also focus on being mindful in sexual situations, instead of spectatoring. Doing exercise with my friends also helps me feel better about my body, so I could fit that in once a week. I could also express to my partner the importance of keeping up our non-sexual couples dates and communication time, and schedule these in so he doesn't forget!! I could also remind him of how important it is for me to have cuddles and kisses before and after we have sex.

Make sure you go through every anticipated difficulty - the more detailed and specific the plan, the better. Doing this exercise will give you a thorough relapse prevention plan to help you in the future. It is a good idea to read over this plan every few months and to act on the solutions if necessary! If you ever feel like things really aren't going so well anymore, I suggest you seek out some individual or couples therapy.

Seeking out further help does not mean you have failed. Many couples need some booster-sessions to help them get back on track again.

What Else - Sexy Extras
As you continue to develop your sexual style as a couple, you may want to try experimenting with some new activities. These activities may help to enhance your sex life
further, but it is up to you whether you give them a go or not. But remember, it won’t hurt to try.

For more information on any of the ideas listed below, see the Resources page.

**Fantasy**
The use of sexual fantasy can help get your mind in the mood! A fantasy is any sexy daydream that you enjoy (e.g., your man giving you copious amounts of oral sex on a deserted beach in the tropics). The wonderful thing about fantasies is that you can tailor them to your exact desires! You can have fantasies on your own, or you may like to share them with your partner.

It is important to remember that fantasising about something or someone is very different from actually acting out these things. Therefore, you do not need to feel guilty about the content of your fantasies, they are yours to enjoy. Your fantasies may include:

- A new sexual activity with your partner;
- Being with a different lover;
- Something that you consider naughty or cheeky (e.g., being spanked);
- Being with many lovers at the one time;
- Having sex in new locations - private or public;
- Having sex with another woman.

If this is new to you, it can be a good idea to read some fantasies written by other women. Some popular fantasy authors include Nancy Friday and Anais Nin, and there are many different style of fantasy literature to choose from. There is a list of fantasy literature on the Resources page.

**Erotica**
Erotica can take many forms such as books, films and art works with sexual content. Erotica can help to ignite sexual feelings and research has shown that women respond physically to erotica just as much as men.

Why not try exploring some different kinds of erotica to see what kind you like? You can hire out books from the library, look up websites, visit exhibitions and visit sex stores (they have all kinds of erotica). It is a good idea to locate books and films that are made by women for women. See the Resource list for some suggestions.

**Vibrators**
Vibrators can be very helpful in boosting sexual arousal and pleasure! By applying the vibrator to the clitoris during foreplay or intercourse, you can enjoy a lovely buzzing sensation that really enhances sexual enjoyment. Some women also enjoy a vibrator being inside their vagina during foreplay.

Some couples are uncomfortable with the use of vibrators because they consider them to be artificial or cheating somehow. But why not think of vibrators as a helpful and enjoyable addition to your sex life? In the words of Sheryl Crow: "If it makes you happy, it can’t be that bad!"

Vibrators come in all shapes and sizes and can be bought online or at any sex store (there should be one in your neighbourhood or close by).
Visit [http://www.dvice.com.au/sex-toys/vibrators/] to see some different shaped vibrators and costs.

For some tips on how to get comfortable with a vibrator and get maximum enjoyment from it, visit [http://sexuality.about.com/od/vibrators/ht/use_a_vibrator.htm]

**Other possibilities**

**Sexy Talk** - It can be fun and sexy to introduce sexy talking into the bedroom (or before you get to the bedroom). Different couples have different preferences, but some common themes of sexy talking include describing a fantasy, saying what you like in sexy words (e.g., “Baby, it feels so good when you slowly lick my nipples”), repeating certain phrases, or just saying whatever turns you on at the time.

**Dress-up** - Some couples like to dress up during sex in order to increase arousal or act out a fantasy. This may involve a full-blown doctor-and-nurse costume set, or simply involve some sexy lingerie and a business tie!

**Tantric Sex** - This is the spiritual art of love-making passed down from ancient Indian traditions. Many couples find that reading about Tantric Sex, or attending workshops, helps to refresh and revitalise their love-life together.

For more information on all of these sexy extras, see the Resource page. In particular, the book *Becoming Orgasmic* by Julia Heiman & Joseph Lopiccolo has a lot of good ideas around the use of erotica, fantasy and vibrators.

**Other Interventions**

**Pursuing Pleasure** is a psychological treatment program for female sexual difficulties, but there are also a range of medical treatments that may benefit some women. If you have come to the end of the program and are still feeling concerned about your sexual difficulties, you may be interested in seeking out medical help. Below is a list of possible medical treatments for sexual difficulties. I do not offer these options as suggestions but as something you may like to look look into further.

Research into the use of medical treatments for female sexual problems is very limited at this stage, and you should consult a medical practitioner before beginning any medical treatment.

**Vaginal Dilators**
These are vaginal inserts that can be helpful for women experiencing sexual pain. They come in a set from the size of your pinkie-finger to the size of an average penis and are used to help the vaginal muscles relax with penetration.

**Hormone Therapy**
The use of an estrogen cream has been shown to help some women with sexual pain problems. The use of testosterone patches has been found to help some women with low sexual desire. There is no long-term data on these medical strategies and therefore they should be approached with caution. Seek out advice from a medical practitioner if you are interested.

**Buproprion**
This is an anti-depressant that has been related to increases in female sexual arousal,
orgasm and satisfaction in some women, but not sexual desire. There is very little research into this intervention at this point.

Only some women will benefit from medical interventions and it is vital that you seek advice from your medical practitioner before trying any medical treatment.

Information for you Partner

Click [here](#) to access the Module 6 information sheet for your partner.

Alternatively, you can click [here](#) to send the link to your partner via email.

Make sure he reads it all before your first couple sensate session.

Are you ready to finish PursuingPleasure??

You should spend at least 2 weeks on this module. To see if you are ready to FINISH THE PROGRAM, please read the questions below. These questions summaries the goals of Module 6. In order to finish the program, you should be able to answer "yes" to all of these questions.

___ Have you completed all readings and questions in this module?

___ Have you completed communication exercises regularly?

  How many communication sessions did you complete? ___

___ Have you completed at least 3 sensate focus sessions per week?

  How many sensate focus sessions did you complete? ___

___ Have you been practicing mindfulness regularly?

___ Have you attended at least one discussion group during this module?

___ Are you ready to continue your sexual growth journey on your own?

Email address: ______________
Now that you have finished, there is just one last requirement. Could you please fill out the POST-PROGRAM SURVEY to help me gather information about PursuingPleasure. This information is vital for getting feedback and for helping more women in the future! I will also send you another survey in 3 months time to see the long-term benefits of the program. I really appreciate your feedback.

IF YOU AGREE WITH ALL OF THE STATEMENTS ABOVE...

CONGRATULATIONS!!!!!!

You have now finished PursuingPleasure and are ready to keep practicing your new skills and knowledge on your own (and with your partner!). You have done so well to get to the end of the program and you should be very proud of yourself and your partner!! I hope you have gained a lot through the program and that all your hard work has paid off. But remember, keeping your sex life healthy and happy is an ongoing process and you need to keep practicing what you have learnt. It is a good idea to print off all of the modules from PursuingPleasure so you can refer back to the readings and exercises at any time.
Pursuing Pleasure: Resources

Here is a list of resources that may be useful to you and your partner:

Couple Issues

Men are from Mars, Women are from Venus
by John Gray

The Dance of Anger
by Harriet Lerner

The New Couple: The 10 New Laws of Love
by Maurice Taylor & Seana McGee

Other self-help titles available from www.recoveroz.com.au

For further professional help there are a range of couple/marital therapy services available online, or you can search for a therapist in your local area. Websites like that of The Australian Psychological Society have listings of potential therapists for face-to-face sessions.

Enhancing Sexual Skills

For women:

http://sexuality.about.com/od/tiptechniques/ht/give_a_handjob.htm

http://sexuality.about.com/od/oralsex/ht/fellatio.htm

http://sexuality.about.com/od/tiptechniques/ht/intercourse_ht.htm

For men:

The Big O: Orgasms- How to Have Them, Give Them, and Keep Them Coming
by Lou Paget

The Multi Orgasmic Man: Sexual Secrets Every Man Should Know
by Mantak Chia & Douglas Abrams

Sexual Skills For The Christian Husband
by Robert Irwin

Fantasy and Erotica

My Secret Garden: Women's Sexual Fantasies
by Nancy Friday

Forbidden Flowers: More Women's Sexual Fantasies
by Nancy Friday

Delta of Venus
by Anais Nin
Best Women's Erotica 2010
short stories edited by Violet Blue

Erotic Films (couple oriented pornography) - Look for works by Candida Royalle and Petra Joy, or any other director/company that makes couple oriented or feminist erotica.

Erotic Art can be found in various art galleries and exhibitions. There are also many websites that offer erotic art such as www.eroticartists.org

**Female Sexual Difficulties - More Help**

Becoming Orgasmic
By Heiman & Lopiccolo

Enhancing Sexuality: A Problem-Solving Approach to Treating Dysfunction
By John Wincze

Tantric Orgasm for Women
By Diane Richardson

Other self-help titles available from www.recoveroz.com.au

There are a range of sex therapy services available online, or you can search for a therapist in your local area. Websites like that of The Australian Psychological Society have listings of potential therapists for face-to-face sessions.

**Mindfulness**

Mindfulness For Beginners
by Job Kabat-Zinn

Full Catastrophe Living
by Job Kabat-Zinn

The Happiness Trap
by Dr Russ Harris

**Sex Stores**

D-vice - www.dvice.com.au

SexyLand - www.sexyland.com

Club X - www.clubx.com.au

Or you could Google search a sex store in your local area.

**Tantric Sex**

The Heart of Tantric Sex
by Diana Richardson

Tantric Orgasm for Women
By Diane Richardson
There are also a range of workshops available from tantric organisations such as Tantric Blossoming at www.tantricblossoming.com.
Pursuing Pleasure: Sample Letter

Here is an example of a discussion question and how you could write a discussion letter.

Q. How do you feel about watching television every night as a couple?

Dear James,

I like watching TV every night. I find it entertaining and I feel relaxed and comfortable being there with you. When you have to work late and I am home alone, having the TV on helps me not to feel lonely. But sometimes I feel bored with it too. Some nights I'd like to turn it off and just talk with you or maybe think of something else we could do together. We used to do lots of things together like walking and going out to restaurants and I think I'd like to do some more of those things again. I miss being more active and having new experiences together.

Love,

Danielle

Dear Danielle,

Some nights I feel tense and cranky when I come home from work. Watching the telly helps me to unwind and feel a bit more relaxed. And yet I feel unhappy about watching TV every evening. I feel like I should be doing more with my life but I'm not sure what. I feel lazy just sitting there night after night, especially when there's nothing on. I wish I had more energy when I come home from work, then maybe I wouldn't just want to watch TV.

Love,

James
**Pursuing Pleasure: Sharing Feelings**

Below are some tips for communicating effectively with your partner. There is a list of feeling words to use when you are stuck for words, some pointers for communicating feelings and some 'rules' for arguing (resolving conflict). Here is a list of feeling words that may be helpful in the communication exercises with your partner:

<table>
<thead>
<tr>
<th>Feeling</th>
<th>Feeling words</th>
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<tr>
<td><strong>Happiness and</strong></td>
<td><strong>Feeling words</strong></td>
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<td><strong>Satisfaction</strong></td>
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<td><strong>Broken-hearted</strong></td>
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Effective Communication

It can sometimes be hard to communicate with your partner, especially about sensitive issues or topics that make you feel uncomfortable. Some couples also get into unhelpful patterns of communication that either end in an argument or a dead-end. Try the strategies below if you think you and your partner might need some help in this area.

Tips for sharing feelings:

- **Take turns** - don’t let one person do all the talking and don’t talk over each other.
- **Use "I feel..." statements** - by starting a sentence with "I feel" (e.g., I feel hurt when you don’t look at me when we are making love) helps the other person to not feel blamed during the conversation (as opposed to "You make me feel...") statements.
- **Don’t try to change your partner’s feelings** - effective communication should lead to a new understanding of each other’s points of view, it shouldn’t lead to one person forcing their opinion on the other.
- **Listen and show interest** - stay focused on the conversation at hand and don’t get distracted by things around you. It may be a good idea to turn off the TV or radio when you want to be heard properly, and it is a must during the communication exercises!
- **Let your partner know you are listening and understanding** - by nodding, saying "hmm" or "yea" or responding with an empathic comment when they finish speaking - "I understand you are feeling quite upset honey."
- **Don’t give advice** - it is much more important to listen and accept your partner’s feelings than offer any advice (unless you have directly been asked for advice).
- **Be honest and share openly** - the more open and honest your communication can be, the closer you can become as a couple. In saying this, remember that some thoughts and memories may not be helpful to a situation and it is at your discretion that you share these or not.
- **Always speak with respect** - avoid name-calling, sarcasm, passive-aggressive comments, bringing up the past to hurt your partner, or just being flat-out rude. This is a sure fire road for arguments and dead-end conversations.

Playing Fair - Rules for Arguing:

- **Don’t bottle things up** - try to get things of your chest as soon as they come up. The more you bottle up your feelings, the more likely you are to become explosive or disrespectful during an argument.
- **Communicate respectfully** - even when things are heated it’s important to keep your cool and talk to your partner respectfully. Take turns and avoid name-calling, insults, sarcasm, passive-aggressive comments, or bringing up the past to hurt your partner. Speak to your partner the way you would want to be spoken to.
- **Stick with it** - don’t leave the argument unfinished. You may need to take a small break to gather your thoughts but come back and finish things up before the end of the day. Don’t take the argument to bed!!!
Pursuing Pleasure: Getting in the mood

Here are some suggestions to help you relax and get in the right frame-of-mind for sensate focus with your partner:

- Have a hot shower or bath;
- Spend some time doing mindfulness of the breath;
- Listen to some soft sensual music;
- Go for a walk;
- Put on some nice clothes and perfume;
- Read over your helpful self-statements;
- Have a glass of wine;
- Put on some scented body lotion;
- Think about the positive benefits of sex (more about this in Module 3);
- Light some candles and burn some scented oil;
- Read some erotic literature (more about this in Module 6);
- Think about a time when you enjoyed being sensual or sexual;
- Think about a sexy scene from a film that you enjoyed watching.

Remember to always share a discussion letter before doing sensate focus.
Men’s Business: What’s this all about?

Hello. Your partner has just begun PursuingPleasure - an online program for women with sexual concerns. My name is Alice Hucker and I will be guiding your partner through the program. She has been brave enough to seek out help and it’s great that you’ve agreed to support her through the program. By participating in this program, you and your partner are on the road towards a more satisfying and enjoyable sex life and a more rewarding relationship.

But what’s this got to do with you?

Relationships play a very important role in women’s sexual interest and satisfaction. Good communication and support is necessary for women to work through sexual difficulties. Your role in supporting your partner through this program is to participate in communication exercises and touch exercises in order to increase the quality of your sex life together and your relationship in general.

Some men feel a bit strange about their partner seeking help for sexual difficulties. Some men feel embarrassed or think that they should be able to fix it situation themselves. While some sexual problems can be solved without help, many women seek out and benefit from professional help with sexual difficulties. This program really can help your partner work through their sexual concerns, but it is only with your support, encouragement and cooperation that they can achieve significant results.

PursuingPleasure is broken up into 6 modules that take approximately 2 weeks each to complete. In each module you will receive an information sheet that will help to explain female sexual problems and how you can help. Below is a description of the parts of the program that you will be involved in:

Communication Exercises
Many aspects of a relationship can impact on women’s feelings about sex and good communication can really enhance your sex life together. The communication exercises give you and your partner the opportunity to become aware of each other’s thoughts and feelings about different aspects of your relationship, including the sexual concerns. Becoming more in-tune with your
partner’s feelings, and vice-versa, can really help to increase relationship and sexual satisfaction.

**Sensate Focus**

Sensate focus involves a series of *sensual touch* exercises aimed to help your partner discover what types of touch she finds pleasurable. Sensate focus is a common and effective technique for resolving sexual problems.

In order for these techniques to work, you and your partner need to **slow down** the process of sex. For this reason, there will be a **ban on sexual intercourse** until Module 5. This may sound difficult, but it’s very important for your partner to re-discover other aspects of **pleasure and sensuality** before applying these techniques to sexual intercourse. If you rush this process, your partner will **not** achieve the benefits of this program. If you approach these exercises with a **playful and open mind**, they can be very **enjoyable** and expand your **sexual repertoire**. You may even be surprised by what you discover about **your own** sexual pleasure throughout these sessions.

Remember, the **no intercourse rule** is only temporary! If you are finding it difficult to last the distance without sexual release, I encourage you to **masturbate** as regularly as you desire. Some couples have mixed feelings about masturbation, but masturbation occurs in many long-term relationship and marriages, and is **not** a sign of a failing relationship. Masturbation is a normal and healthy expression of sexuality. It is **preferable** for you to masturbate during this program than to put pressure on your partner to break the no intercourse rule.

**Questionnaires**

In order to assess the benefits of *Pursuing Pleasure*, it is essential that you fill out a brief (5 minute) questionnaire before the program begins, after your partner has finished the program, and after a 3-month follow-up period. The questionnaire will be available online and will ask you about your sex life together and how the program has gone. This information is vital for helping more couples in the future!

So, welcome to the journey you are about to embark upon with your partner. Past experience has shown that these techniques **really work** and can improve your sex life together and your relationship for the long-run!
Men’s Business: Module 1

Welcome to Module 1. Your involvement is really appreciated and is crucial in your partner’s journey through PursuingPleasure. This module includes information about sexual problems and some communication exercises. There will be no touch exercises in this module and remember the no sex rule until module 5. This rule is crucial to ensure that your partner can takes the time to work through her sexual difficulties.

Female Sexual Concerns
Many women experience sexual problems over their lifetime. Below is a list of common sexual problems experienced by women.

<table>
<thead>
<tr>
<th>Sexual Problem</th>
<th>Common Experiences</th>
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<tr>
<td>Low sexual desire/interest</td>
<td>Little or no interest in sexual activity; avoidance of sexual situations; concern or distress.</td>
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<tr>
<td>(the most common problem experienced by women)</td>
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<tr>
<td>Lack of arousal</td>
<td>Difficulty becoming physically aroused; difficulty becoming mentally ‘turned-on’ for sex; concern or distress.</td>
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<tr>
<td>Lack of orgasm</td>
<td>Never experiencing orgasm; concern or distress.</td>
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<tr>
<td>Inconsistent orgasms</td>
<td>Orgasms are only experienced on certain occasions; often no orgasm is experienced; concern or distress.</td>
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<tr>
<td>Painful sex</td>
<td>Vaginal pain during foreplay and/or intercourse; concern or distress.</td>
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<tr>
<td>Sexual phobia</td>
<td>Intense fear of sexual activities; avoidance of sexual activities; concern or distress.</td>
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</table>

It is not only women who can experience sexual problems. Many men also experience sexual difficulties such as premature ejaculation, difficulties getting or maintaining an erection and low sexual desire (lack of libido). Sexual difficulties can be very upsetting to both partners and can affect many aspects of the relationship.

Sexual Beliefs
As we were growing up we were all taught messages about sex and sexuality. These messages came from our family, our friends, our teachers and religious
leaders, our sexual partners and the media. These messages are often a mixture of fact and fiction and influence how we think about sex as an adult. Below are some common myths taught about sex:

<table>
<thead>
<tr>
<th>Common Myths About Sex</th>
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<tbody>
<tr>
<td><strong>Myth #1: Sex is dirty</strong>&lt;br&gt;Sex is actually a natural and loving act.</td>
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<tr>
<td><strong>Myth #2: Women can't enjoy sex as much as men</strong>&lt;br&gt;Women are capable of enjoying and desiring sex just as much as men.</td>
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<tr>
<td><strong>Myth #3: My partner should want sex whenever I want it</strong>&lt;br&gt;Having sex is always a choice and nobody should feel forced into having sex. It is a mutual decision between you and your partner.</td>
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<tr>
<td><strong>Myth #4: Sex stops after childbirth / menopause / midlife</strong>&lt;br&gt;Different life stages can bring up challenges to your sex life, but many couples continue a healthy and enjoyable sex life well into old age.</td>
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<tr>
<td><strong>Myth #5: Sex needs to be spontaneous to be worthwhile</strong>&lt;br&gt;Planned sex is common in long-term relationships. Given the business of our lives, it's not surprising that planned sex is sometimes essential. There is no good reason why planned sex can’t be just as satisfying as spontaneous sex.</td>
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<tr>
<td><strong>Myth #6: Normal women have orgasms every time they have sex</strong>&lt;br&gt;A large proportion of women do not orgasm every time they have sex and many women need extra clitoral stimulation to orgasm during penetration. In fact, only 15-20% of women can achieve an orgasm from penetration alone!</td>
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<tr>
<td><strong>Myth #7: My partner should automatically know how to please me</strong>&lt;br&gt;It is unrealistic to expect another person to know exactly what feels good for you or for you to know exactly what feels good for your partner. Each partner has a responsibility to communicate how they like to be touched.</td>
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<tr>
<td><strong>Myth #8: Only penetration is real sex</strong>&lt;br&gt;Sex can mean a variety of things including manual sex (hand-jobs, fingering), oral sex or penetration. Sex does not always have to include penetration or orgasm. The most important thing is that you and your partner both feel sexually satisfied at the end, no matter what that means to you.</td>
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<td><strong>Myth #9: My sexual needs come before my partner’s</strong>&lt;br&gt;Both partner’s sexual needs are equally important and both partners should feel satisfied at the end of a sexual encounter.</td>
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<tr>
<td><strong>Myth #10: If my partner has a sexual problems it must be my fault</strong>&lt;br&gt;Many factors influence the sexual problems that women experience and it is nobody's fault. We will explore the common reasons behind women's sexual difficulties in later modules.</td>
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It is possible that unhelpful sexual beliefs and sexual myths have influenced your partner's sexual problems and her sexual interactions with you, and she will be spending some time thinking about this over Module 1.

**Communication Exercise**

This communication exercise will give you and your partner the opportunity to discuss each other’s thoughts and feelings about your relationship, about the sexual difficulty, and about entering this program.

Below are a series of discussion questions. You and your partner are to choose one question at a time, and spend around **10 minutes writing** a letter to each other answering that question. When you are both ready, swap letters and read them over privately. Read them twice to make sure you have really understood what your partner has written. Then you and your partner are to spend around **10 minutes talking** about what was written in the letters and your thoughts and feelings in response to the letters.

If there is a question you especially don’t want to choose, it is likely that you will benefit from choosing that question and having that discussion. It might feel hard at the time, but being brave and discussing that topic will be beneficial to your relationship.

You and your partner should try to do at least **4 questions per week** over this module. You and your partner will need to schedule in time to make sure you both commit to these exercises. Remember that these letters are private, and should **not** be shown to anyone but you and your partner.

**Discussion Questions:**

- What attracted you to your partner at the very beginning of your relationship?

- What are the most important and valuable aspects of your relationship?

- How do you feel about being part of this program together?

- What do you expect to achieve from participating in this program with your partner?

- How do you feel about sharing thoughts and feelings about your sex life?

- What are your thoughts about not having sex with your partner for a few weeks?
• How do you think sexual myths have influenced your sex life with your partner?

• How do you feel about the differences you have regarding sexual desire and sexual preferences?

• How do you feel about spending quality time with your partner? What does ‘quality time’ mean to you?

• What activities do you find most enjoyable to do with your partner?

Sample Letter:
Here is an example of a question and how to write a letter for this exercise.

Q. How do I feel about us watching television every night?

Dear James,

I like watching TV every night. I find it entertaining and I feel relaxed and comfortable being there with you. When you have to work late and I am home alone, having the TV on helps me not to feel lonely. But sometimes I feel bored with it too. Some nights I’d like to turn it off and just talk with you or maybe think of something else we could do together. We used to do lots of things together like walking and going out to restaurants and I think I’d like to do some more of those things again.

Love,
Danielle

Dear Danielle,

Some nights I feel tense and cranky when I come home from work. Watching the telly helps me to unwind and feel a bit more relaxed. And yet I feel unhappy about watching T.V. every evening. I feel like I should be doing more with my life but I’m not sure what. I feel lazy just sitting there night after night, especially when there’s nothing on. I wish I had more energy when I come home from work, then maybe I wouldn’t just want to watch TV.

Love,
James

If you are finding it hard to come up with the right words while writing your letter, here is a list of feeling words that may be helpful:
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Secret Men's Business: Module 2

Your partner is now up to Module 2 of Pursuing Pleasure. Some men find it hard to understanding how their partner’s sexual difficulties came about so this sheet includes information about female sexual anatomy and common factors underlying female sexual difficulties.

This module also includes communication exercises and sensual (but non-sexual) touch exercises. Please remember the no intercourse rule until Module 5, and there is no breast or genital contact at this point. This rule is crucial to ensure that your partner takes the time to work through her sexual difficulties and so that you can both explore new forms of sensual and sexual expression. Why no breast touching as well? For many women, the touching of breasts is just as sexual as the touching of the vagina.

Female Sexual Anatomy
You may already know most of this information, but it is useful to go over it so as to have a good understanding of your partner’s sexual anatomy.

**The Clitoris** is the main sexual pleasure centre for women. The size of the clitoris varies from woman to woman, and a smaller clitoris does not mean less pleasure or sensitivity. Both the clitoris and areas around the clitoris can be stimulated during foreplay and intercourse, although some women find the clitoris too sensitive to be touched directly, and prefer to be stimulated around the edges of the clitoris or just above it on the clitoral shaft. She can let you know how she likes her clitoris to be touched.

**Labia Majora** are the larger outer lips and **Labia Minora** are the smaller inner...
Both sets of lips have lots of nerve endings and can be stimulated during sex play by *fondling* and licking. The size and appearance of these lips vary considerably from woman to woman.

**Urethral opening** is where she urinates from.

**The Vagina** - during sexual activity, the vaginal walls stretch to accommodate for the penis to enter. The vagina regularly produces a discharge to keep itself clean and healthy and during sexual intercourse, this discharge usually increases to *lubricate* the vagina. Some women do not produce much natural lubricant and therefore may like to use a bottled lubricant to increase pleasure and enjoyment. A lack of lubrication does not necessarily mean that a women does not feel sexually aroused!

You may have heard of a little gland within the vagina called the **G-spot**. Some women find stimulation of the G-spot very pleasurable. Typically, the G-spot is located 1-3 inches inside the vagina, on the front vaginal wall (the side closest to her stomach). The G-spot often has a slightly rougher texture than the rest of the vaginal wall and can be stimulated with fingers, a vibrator or the penis.

**The Anus** - Some couples like to experiment with *anal-play* and *anal-sex* (e.g., touching, licking, penetration). Other couples prefer not to use the anus in sexual activities. This needs to be a mutual decision that you discuss together. For couples who are interested, it is a good idea to use a lubricant to increase sexual pleasure and decrease discomfort.

**Why does my partner have sexual difficulties?**

A range of factors may act to predispose, trigger or maintain your partner’s sexual difficulties. Below is a list of common factors involved in sexual difficulties:

**Common factors involved in female sexual difficulties**

**Biological**
- Physical or mental health issues
- Hormonal changes
- Medications, alcohol and other drugs
- Negative attitudes/beliefs about sex and masturbation
- Low self-esteem and poor body-image

**Psychological**
- Performance anxiety (in bed)
- Stress and general anxiety
- Life-stage changes (menopause, pregnancy, childbirth)
- Past sexual abuse
Relationship conflict
Lack of communication
Lack of non-sexual intimacy/affection

**Interpersonal**
Partner’s sexual difficulties (premature ejaculation, erection difficulties, lack of sexual desire/interest)
Negative early sexual experiences and relationships
Partner’s infidelity or breaking of trust

**Social**
Cultural/religious messages about sex (e.g., sexual myths)
Media’s portrayal of good sex and acceptable appearance

**Contextual**
Mood, lack of energy, lack of time, inconvenience, lack of privacy, increased responsibilities at home/work

As I said earlier in the program, relationship issues can impact on a woman’s sexuality, but this does not mean that blame should be assigned to anybody. Sexual difficulties usually arise from a range of different factors.

There are some factors that can also help to resolve sexual problems. These include:

- Good physical and mental health;
- Positive attitudes about sex and masturbation;
- Positive body-image;
- Low stress and anxiety;
- Supportive partner and good communication;
- Sufficient non-sexual intimacy and affection from partner;
- Partner receiving treatment for any sexual problems;
- Communicating about sexual needs and problems.

**Communication Exercises**
Remember to:

- Choose one question at a time;
- Spend around 10 minutes writing and then swap letters;
- Spend around 10 minutes talking about your thoughts and feelings;
- Schedule in time with your partner to make sure you both commit to these exercises - try to do at least 3 questions per week;
- **Always do a communication exercise before a sensate focus session.**

**Discussion Questions:**

- What are the most interesting and enjoyable activities that you have done together in the past?
- What do you like best about your relationship together?
• What are some qualities or characteristic that you enjoy about your partner?

• Did anything surprise you while learning about the female sexual anatomy?

• What did you think while reading about the common causes of female sexual difficulties?

• How do you feel about the amount of non-sexual affection and intimacy in your relationship?

• How do you usually show love, affection and/or admiration to your partner and vice-versa?

• How do you feel about being naked with your partner?

• How do you feel about the non-sexual sensate focus sessions in this module?

• How do you feel about the way your partner expresses affection and intimacy?

• How do you feel about touching each other in a sensual but non-sexual way?

• How do you feel about the way you communicate together on a day-to-day basis?

• How do you feel the program is going so far?

**Sensate Focus**
Sensate focus sessions are an effective technique to help you and your partner discover and communicate what types of touch you find pleasurable. The sessions also help to reduce any anxiety and worry that your partner may feel in bed, and allow you both to discover new forms of sensual and sexual expression (rather than just the old in-out-in-out).

The sensate focus sessions in this module will involve exchanging sensual, non-sexual body massages with your partner. There will be no genital or breast touching and remember the no intercourse rule until Module 5. If you find it difficult to have sensual massages without sexual release, feel free to masturbate on your own afterwards. It is very important not to pressure your partner into sexual touching or sex!

You will need to complete at least 3 sessions per week. Each session will take approximately 1 hour so it is important to schedule in time with your partner so that you can complete these sessions without being rushed or interrupted.
The amount of sessions that couples complete is strongly linked to how **successful** they are in resolving sexual problems!

**Sensual massage instruction:**

- Begin each session by sharing a **discussion letter** with your partner. Make sure you are feeling relaxed and ready before starting the massage.

- Prepare a room together (e.g., warm the room up, dim the lights, light candles, burn some oil or incense, close the curtains, play some sensual or relaxing music). Don't do the sessions in complete darkness.

- Decide who will massage first and who will receive the massage first.

- When you're both ready to begin, the person receiving the massage first should remove their clothes and get comfortable on the bed. You may like to begin on your stomach but make sure you roll over onto your back later on.

- The toucher then begins to **explore their partner's body**. Ask your partner where they would like you to start (back, feet, shoulders, etc) and then begin **caressing** your partner's body. Slowly work over each part of their body (except the genitals and breasts) and try to use a **variety of techniques** such as stroking, scratching, massaging, kissing and fondling.

- The toucher may like to use massage oil to increase enjoyment. The receiver should roll over at some point to allow the caressing of both sides of the body.

- As the receiver, you will need to communicate to your partner how you like to be touched. You may like to **say** when something feels good, **smile**, moan or make encouraging noises, or gently guide her hand to where it feels good. Remember, it is your responsibility to communicate how you like to be touched.

- You will also need to communicate when her touch **does not** feel so good. Simply being silent may **not** get the message across so you may like to **politely tell her** that her touch is too hard/too soft/too fast etc. or gently guide her hand to where it feels good. It is good to follow-up a comment about what doesn't feel good with a comment about what does feel good. For example: "**It feels a bit rough when you touch me like that, but I really like it when you lightly scratch my skin.**"

- As the toucher, you will need to **listen** to your partner's verbal and non-verbal signals and alter your touching accordingly. If the message is not getting across, the receiver may need to be more direct by either saying
something more specific or gently guiding the toucher’s hand.

- Remember **no genital or breast touching** is to occur in these sessions.

- After the receiver has been touched for **20-30 minutes**, it’s time to **swap roles**. Make sure you both get **equal amounts of time** of touching and being touched. You might like to switch the order each time you have a sensate focus session.

- The receiver should **not** feel any pressure to become aroused or feel sexual. All the receiver needs to do is **enjoy** the sensual massage and **communicate** with their partner.

- After you have both had a turn, you might like to take a moment to talk about the experience with your partner, share a cuddle and have a glass of wine together.

**I hope you enjoy these sessions together!**
Secret Men's Business: Module 3

Your partner is now up to Module 3 of *PursuingPleasure*. This module looks at female sexual desire and interest and how it can be influenced and dampened by many factors. Some men find their partner’s lack of interest in sex to be confusing and frustrating and this information sheet is intended to help you understand why there might be differences in the amount of interest you and your partner have for sex.

This module also includes regular communication exercises and more non-sexual massages (the same as Module 2, but you can now include breast touching as well). By this stage, you may be feeling frustrated about the no intercourse rule, but remember if you and your partner rush this process you won’t see the benefits of the program and the sexual concerns will most likely persist.

Female sexual desire and interest
Sexual desire and interest, or "sex drive", is an important aspect of female sexuality, but it can easily become inhibited if a woman’s emotional and sexual needs are not being met.

Some facts:

- Some women only experience "responsive desire" - sexual interest or desire in response to sexual stimulation;
- Many couples have one partner who wants more sex than the other;
- Many women become disinterested in sex when their non-sexual intimacy needs are not being met (e.g., cuddling, holding hands, loving communication);
- Many women become disinterested in sex when they are stressed, upset or are not getting their emotional needs met (e.g., lack of emotional support, not feeling listened to);
- Life-stage changes such as menopause, pregnancy and childbirth may alter a woman's levels of desire;
- Even if sex feels good, numerous other factors may dampen a woman's degree of sexual interest.

Below is a list of factors that commonly decrease women's sexual interest. There are also some tips listed for helping to increase your partner’s sexual desire, but remember that these are not instant cures. A problem that has been in place for a long time takes time to change - but little things can help.

Factors commonly associated with decreased sexual interest:
Negative beliefs about female sexuality - such as beliefs that women should not desire sex, fantasise about sex, or enjoy sex.

Relationship issues - including conflict, trust issues, lack of emotional support, power imbalance (e.g., in finances or decision making) and infidelity. **Communication is the key** to resolving these sexual fire extinguishers.

Unpleasant experiences during sex - such as emotional distress and physical discomfort. It is your partner's responsibility to let you know if anything makes them feel uncomfortable, and it is **your responsibility to listen**.

Lack of sexual stimulation - it is your partner's responsibility to clearly communicate what types of touch she likes, and it is **your responsibility to listen** and adapt your style. If you are at all concerned about your level of sexual skill, there are many books and websites that give tips on foreplay and love-making. If you are interested, some of these are listed at the end of this information.

Negative body image - this often makes women feel unattractive and unsexy. **Telling** your partner the things that **you find attractive about her** (e.g., soft skin, womanly curves, husky voice) can sometimes make her feel a little more loved and a little sexier. She will also have the chance to work on body-image issues later in the program.

Lack of attraction - things like bad breath, body odour and poor hygiene can lead to lack of sexual attraction. Make sure you make an effort to be clean and presentable when you want to be intimate with your partner.

Stress and lack of time - if you're partner is stressed and overworked, then sex is probably on the bottom of her to-do list. This program aims to help her make sex and intimacy a higher priority. Meanwhile, there may be ways **you could help out** around the house to **decrease her stress** and give her a bit more energy to prioritize sexy-time (e.g., picking the kids up, helping with chores).

Other - fear of pregnancy, hormonal changes, illness, medications, alcohol or substance abuse.

The moral of the story: A woman needs both her sexual and non-sexual needs met to desire and enjoy sex.

**One final tip that many men forget:**

If you only ever give your wife affection **when you want sex** (or turn every intimate moment into a sexual moment), your partner is likely to feel used and unloved. **Women need non-sexual affection too!!!!!** So, make sure you kiss and cuddle, hold hands, massage her shoulders, and stroke her hair at times.
when you are not looking for sex and she will feel appreciated and loved. If she is not used to you doing this, you may need to let her know that you are not looking for sex - that you just want to show her love and affection.

Communication Exercises
The discussion questions will give you and your partner an opportunity to talk about sexual desire and the things that can put the sexual fire out.

Remember to:

- Spend around 10 minutes writing;
- Spend around 10 minutes talking;
- Schedule in time with your partner to make sure you both commit to these exercises - try to do at least 3 questions per week;
- Always do a communication exercise before a senate focus session.

Discussion Questions:

- What positive benefits do you currently experience from sex? What benefits would you like to receive from sex by the end of this program?
- How do you feel about female sexual desire being different from male sexual desire (e.g., often being more responsive than spontaneous, being influenced by many non-sexual factors)?
- How do you feel about having a lower or higher sex drive than your partner?
- What aspects of your relationship do you think influence your sex life together (e.g., conflict, attraction, communication, infidelity)?
- How do stress, mood and time influence your sex life? Do these things make love-making a low priority in your relationship?
- Are there certain sexual activities that you really don’t enjoy? Are there certain sexual activities that you would really like to try?
- What factors do you think are negatively influencing your sex life (e.g., conflict, lack of affection, lack of communication, stress, low energy, negative beliefs about sex, fear of pregnancy, hygiene)?
- What kinds of things could you and/or your partner do to make sex more enjoyable?
- How do you feel when your partner massages your body? What do you like best?
- How do you feel about communicating with your partner about the ways
you do and do not like to be touched?

- How do you feel about the way your partner communicates their sexual preferences to you?
- How do you feel about the program so far?

**Sensate Focus**
You and your partner will continue to do sensual massages over this module. There is still no genital touching allowed in these sessions, but you can include breast touching now. Remember you are taking things slowly so as to decrease pressure and anxiety and allow your partner to learn how to have more pleasurable sexual experiences. You can always masturbate alone afterwards if you feel the need.

You and your partner can do these massages as often as you like over this module. The instructions are the same as Module 2.

Remember:
The no sex rule.
There is no pressure to arouse yourself or your partner and you should not try to reach orgasm.
Always complete a discussion question before doing a sensate focus session.

**Resources:**

**Books to enhance love-making**

The Multi Orgasmic Man: Sexual Secrets Every Man Should Know
by Mantak Chia & Douglas Abrams

The Heart of Tantric Sex
by Diana Richardson

Sexual Skills For The Christian Husband
by Robert Irwin

The Big O: Orgasms: How to Have Them, Give Them, and Keep Them Coming
by Lou Paget

**Sexual tips:**

http://sexuality.about.com/od/tipstechniques/u/Sex_How_Tos_and_Sex_Tips.htm#s5

http://www.ivillage.co.uk/relationships/sex/hots/articles/0.,172_666561,00.h
Sexual communication:

http://www.ehow.com/how_4457285_communicate-better-during-sex.html

http://www.ehow.com/how_5251934_talk-her-during-sex.html
Secret Men's Business: Module 4

Hello. Your partner is now up to Module 4 - which is more than half way! Your support in the process is so valuable. By this stage your partner is starting to understand what types of touch and intimacy turn her on, and also learning how to communicate her needs better. These are vital stepping-stones to a more pleasurable sex life!

This module explores male sexual anatomy, as well as the influence of a woman's body-image on her sexuality. This module also includes regular communication exercises as you are now very familiar with, and sexual touch exercises that now include genital touching.

Male sexual anatomy
You may be very familiar with your own sexual anatomy, but many men have never really been taught much about their equipment downstairs. If you are interested in knowing a bit more about the male sexual anatomy you may like to visit these websites:

http://www.scarleteen.com/article/body/anatomy_mans_best_friend_male_se
xual_anatomy
http://medicalimages.allrefer.com/large/male-reproductive-hygiene.jpg

Body-image and female sexuality
Negative body-image can have a very negative impact on a woman’s sexual desire and enjoyment.
Negative body-image often includes:

- A dislike of certain body parts;
- Insecurities about attractiveness;
- Issues regarding weight or weight gain/loss;
- Comparisons to someone more attractive;
- Negative attitudes about aging and body changes;
- Discomfort with genitals (look, smell, taste);
- Discomfort and avoidance of being naked in front of a partner.

Body concerns often stem from unrealistic images of attractiveness found in the media, as well as messages from family, friends and sometimes from partners. It can be very difficult for women to desire or enjoy sex when they feel unsexy and unattractive (even if you think they are very attractive!). In this module, your partner will get the chance to explore body-image issues that may be affecting her sexuality and her relationship with you.

So what role can you play in this??

Many women feel that they do not deserve love and affection. They may think
they are too fat/ugly/old to be loved, or too unattractive to deserve sexual attention. In fact, your partner may not even understand why you are attracted to her.

Therefore, while she is working on these issues, it is your job to help out by making sure she knows that you still find her sexually attractive (even if her appearance has changed a lot since you first got together). You will have an opportunity to express this in the communication exercises, but it is also important to make her feel attractive on a regular basis by reminding her of the things that make her sexy and appealing to you. You may also like her to do the same so that you both feel more loved and attractive.

**Communication Exercise**

Remember to:

- Choose one question at a time;
- Spend around 10 minutes writing;
- Spend around 10 minutes talking;
- Schedule in time together to make sure you both commit to these exercises at least 3 times per week;
- Always do a communication exercise before a senate focus session.

**Discussion Questions:**

- What are some special memories you have of your partner?
- What do you find attractive about your partner's body? How do you communicate that to them? If you don't, how could you communicate that to them in the future (e.g., tell them directly, pay special attention to those areas in massage)?
- How do you think negative body-image may be influencing your sex-life together? What kinds of things could you and/or your partner try to make this less of an issue?
- What do you think about the media's portrayal of female beauty and sexiness?
- How do you feel about touching each other in a sexual way?
- How do you feel about giving and receiving oral sex?
- How do you feel about communicating how you like your genitals to be touched?
- How do you feel about the way your partner communicates how they like to be touched?
• Are there certain ways you really don’t enjoy being touched? Are there certain ways you would really like to be touched?

• What kinds of things could you and/or your partner do to make the sensate focus sessions more enjoyable?

• How are you feeling about the no sex rule?

• What do you enjoy about intimacy with your partner?

• How do you feel about your progress in this program so far?

• What has been the most helpful aspect of the program so far?

**Sensate Focus - Genital Touching**

The sensate focus sessions in this module are very similar to previous sessions except you will now introduce **genital touching**. Although these sessions are now more sexually oriented, remember you are still taking things slow. These sessions are aimed at experimenting with different types of genital touching to see what is most pleasurable, not about achieving orgasm/ejaculation. Remember the **no intercourse rule**, and if you are finding it hard to have genital touching without sexual release, feel free to **masturbate on your own** afterwards.

You and your partner will complete at least 3 **sessions per week**. Each session will take **approximately 1 hour** so it is important to schedule in time together so that you can complete these sessions without being rushed or interrupted. The amount of sessions completed is **strongly linked** to how **successfully** your partner will resolve her sexual concerns!

Remember:

• **The no sex rule** until Module 5;
• **Always** share a discussion letter before doing a session;
• **There is no pressure** to ‘perform’ - this means no pressure to arouse your partner and no pressure for you to become or stay aroused;
• **Do not aim for orgasm or ejaculation**, just relax and have fun.

**Sensate Focus Instructions**

• **Begin each session by sharing a discussion letter.** This will help to increase communication and intimacy before you start.

• Before you start, make sure you are feeling **relaxed**, **comfortable** and **open** to the experience. Try to approach the experience with an attitude
of curiosity and playfulness.

- Prepare the room together (heating, lighting/candles, oil/incense/curtains, music).

- Decide who will massage first and who will receive the massage first.

- Both toucher and receiver should remove their clothing. The receiver can then lay down on their back ready to begin.

- The toucher then begins to explore their partner's body. **Start with non-genital** areas such as the feet, arms or legs. Slowly work over these parts for about 10 minutes and try to use a **variety of techniques** such as stroking, scratching, massaging, kissing and fondling.

- When the receiver is ready, they should let their partner know that they may begin touching their genitals. Start slow and soft and try a range of different techniques such as fondling, tickling, stroking, rubbing, kissing, licking and sucking. Let your partner know if there is any particular type of touch they don’t like to give or receive, but also approach this exercise with an **attitude of open mindedness and experimentation**.

- As the receiver there is no need to focus on your level of arousal or on ejaculation, just enjoy the experience. Ejaculation is not encouraged at this point but if you do happen to ejaculate, clean up together and continue the massage.

- The receiver needs to **communicate** what feels good and not so good, and the toucher needs to **listen** to these messages and alter their touching accordingly. If the message is not getting across, the receiver may need to be more direct by either saying something more specific or gently guiding the touchers hand. It’s good to follow-up a comment about what doesn’t feel good with a comment about what does feel good.

- Remember the **no sex rule**. If you start to feel an overwhelming desire for intercourse, you need to tell your partner to stop touching you for a moment while you let the arousal subside (see below: waxing and waning). If you rush into intercourse at this stage, you and your partner are **unlikely to see the full benefits** of the program. Remember, you can always masturbate on your own later on.

- After the receiver has been touched for 20-30 minutes, it is time to **swap roles**. Make sure you both get equal amounts of time of touching and being touched.

- After you have both had a turn, you might like to take a moment to talk about the experience with your partner, share a cuddle or have a glass of wine together.
Below are some special touching techniques that many couples enjoy:

The teasing approach
This technique is about building up anticipation instead of just rushing genital stimulation; it involves touching and teasing:

- Before you touch your partner’s genitals, caress the sensitive areas around the genitals (inner thighs, lower abdomen, pubic hair).
- Then briefly start touching your partner’s vagina.
- Soon after, move your attention back to non-genital areas such as her thighs and stomach (especially the sensitive areas surrounding the genitals).
- Then return your attention back to her vagina.
- Keep alternating as often as you like, and you may like to try using both manual and oral stimulation to tease and pleasure your partner.
- Remember you are not trying to make your partner orgasm.
- This technique is supposed to be fun and cheeky, so try to enjoy the building of anticipation.

Waxing and waning technique
It is natural for arousal to come and go in waves and this technique helps to take the pressure off you and your partner remaining sexually aroused throughout the whole session:

- Once you have spent some time pleasuring your partner, stop caressing her for a few minutes to allow arousal to subside.
- While you are not stimulating her, you may like to spend some time kissing, massage her feet, sip on some wine or just have a relaxed chat.
- After a few minutes resume caressing her body and genitals again.
- Repeat this 2 or 3 times per session.
- Remember these sessions are supposed to be fun and enjoyable, so treat this technique like a bit of a sexy game.
- Don’t be concerned if your arousal or your partner’s does not return on some occasions, just enjoy the sensual time together.
Secret Men's Business: Module 5

Your partner is now starting Module 5, the second last module of Pursuing Pleasure. This module is quite significant because you and your partner will begin to have sexual intercourse in the sensate focus sessions. YES, the no sex rule is over! But there is still no need to rush!!! The process of introducing intercourse will be done gradually over Modules 5 and 6 to help your partner integrate her new knowledge and relaxation skills into sexual intercourse. Your partner may need a lot of emotional support and patience in this module as this can feel like a big step for her.

This module covers important information about sexual intercourse, that you will then have an opportunity to discuss during your communication exercises. Just like past modules, this module includes regular communication exercises, as well as sensate focus sessions that introduce sexual intercourse (penetration).

**Intercourse - more than just penetration**

Before introducing sexual intercourse back into your love-making there are a few important pointers to keep in mind:

**Initiation and refusal**

The way that you or your partner initiates sex can have a large impact on your sex life. Many couples get stuck in a repetitive pattern of the same person always initiating sex (usually the man), and the initiation always happening in the same way (e.g., nibbling on her ear as you both get into bed at night).

Some things to keep in mind:

- In any relationship, there will be times when one partner initiates and the other refuses;
- It is a good idea to initiate sex equally instead of the one person always taking that responsibility - or at least aim for a bit more balance;
- The way a partner initiates sex can sometimes be a turn-off so it is important to communicate about your initiation preferences;
- Your partner is more likely to say yes to your invitations or initiate herself when her emotional or non-sexual needs are being met within the relationship.

You will have a chance to talk about your patterns of initiation and refusal in the communication exercises.

**The warm-up**

Many couples quickly forget all about the warm-up to sex and go straight for penetration. While this can sometimes be enjoyable (the ol' "quickly"), it is usually preferable to spend time in foreplay before attempting penetration. Foreplay can include a sensual massage, sexy talking, deep kissing, and breast...
and genital touching/licking. Take as much time as you both need to get warmed-up for intercourse.

Maximising pleasure
Try to approach love-making with the aim of mutual pleasure and satisfaction. Ways to maximise pleasure include:

- Approaching intercourse from a place of relaxation and openness;
- Having a slow warm-up;
- Communicating your likes and dislikes and listening to your partner’s verbal and non-verbal communication;
- Using a bottled lubricant;
- Finding the sexual positions that you BOTH enjoy (some positions to maximise pleasure will be discussed later on).

Outside the bedroom
Remember that stress and relationship tensions outside the bedroom can impact things in the bedroom. It is important that your partner is feeling loved, appreciated and relaxed before intercourse.

Planning ahead
To help your partner get sex back up to its rightful place on the to-do list (instead of being last priority), you and your partner can:

- Plan in regular times to have sex - many a couple has proven that scheduled sex is no less enjoyable than spontaneous sex!
- Problem-solve ways of decreasing stress and increasing available time and privacy for sex;
- Communicate about blocks to sexual interest and how to solve them (refer to Module 3 readings).

Lastly, the amount of times per week that a couple wants to have intercourse will be completely individual to each couple. Some couples may be very happy with sex once a week while others will want it every single night. This will also change over time as circumstances and life-stages change. When one partner wants to have sex a lot more often than the other, negotiation needs to occur so that both partners can be reasonably satisfied with the situation. Sex every night may not be a realistic expectation.

Communication Exercises
During this module, you have 2 choices:

- Continuing to write and swap letters (the same as previous modules or);
- Discuss the question without using letters. Do this by allowing one person to speak about their thoughts and feelings on the issue for 5 minutes, and then the other to speak about their thoughts and feelings for 5 minutes. Then have a discussion for around 10 minutes in response. Take turns for who goes first each time.
If you like, you can sometimes write letters and sometime just talk, it is entirely up to you and your partner.

Remember to:

- Choose one question at a time;
- Schedule in time with your partner to make sure you both commit to these exercises - try to do at least **3 questions per week**;
- **Always** do a communication exercise **before** a senate focus session.

**Discussion Questions:**

- How do you feel about the way you communicate with your partner about difficult issues and differing opinions?
- How do you feel about the changes that have been occurring in your relationship during this program?
- Do you enjoy foreplay before intercourse? Is there anything you and/or your partner can do to make foreplay more enjoyable?
- How do you feel about starting to have intercourse with your partner in sensate focus sessions?
- How do you feel about planning in time for sex together (as opposed to relying on spontaneous sex)?
- How do you feel about communicating during intercourse (e.g., if you want to change positions or slow things down)?
- How do you feel about the way your partner communicates during intercourse?
- Are there certain things you really do not like during intercourse? Are there certain things you would really like to try during intercourse (e.g., clitoral stimulation, breast touching, looking into each other’s eyes)?
- What kinds of things could you and/or your partner do to make sexual intercourse more enjoyable?
- How has the program changed the way you think about sex and intimacy in your relationship?
- How do you feel about your progress in the program so far? Have you achieved any of your goals?
- What are your current concerns about your sex-life together?
Sensate Focus - Intro to Intercourse
These sensate focus sessions begin like the sessions in Module 4 with general body touching and genital stimulation, and then introduce penetration.

Now that you two are starting to incorporate intercourse, it is especially important to be patient and take things slow. These sessions should be a positive and enjoyable experience, not a rush or a hassle. You should use these sessions to experiment with how you and your partner like intercourse to play out.

You will need to complete at least 3 sessions per week. Each session will take approximately 1 hour so it is important to schedule in time with your partner so that you can complete these sessions without being rushed or interrupted.

Remember:

- **Always** share a discussion letter before doing sensate focus;
- There is no pressure for either of you to become or remain aroused;
- Orgasm and ejaculation is still discouraged at this point, just explore, experiment and have fun.

Sensate Focus Instructions

- Begin each session by sharing a discussion letter.
- Make sure you are feeling relaxed and open to the experience.
- Prepare the room together.
- Start the session as you have in other modules with general body touching and then genital touching once you and your partner are ready. There will be no designated toucher or receiver this time, so feel free to experiment with taking turns as well as touching each other at the same time. Also feel free to experiment with new types of touches and caresses.
- Neither of you should feel any pressure to become aroused. All you need to do is enjoy the sensations and communicate with your partner. Orgasm/ ejaculation should be avoided at this stage.
- When she is ready, your partner will indicate that she would like to start penetration. Some positions that can enhance the sexual experience are discussed below. This is a good time to apply lubricant and put on a condom if necessary.
- You and your partner can work together to insert your penis into her vagina. If she feels any pain or discomfort, be especially careful and
patient. There is a tendency for people to **go silent** upon penetration but it is vital that you and your partner **keep communicating** throughout this whole experience.

- Remember you are taking this **nice and slow**. For the first few sessions, once your penis is inside her vagina just sit still for a little while (no rocking or thrusting) and just feel each other in this position. This is called the "quiet vagina" technique and gives her a chance to relax into intercourse. Repeat the quiet vagina technique whenever you want to. You may also go back to massage, and manual or oral stimulation at any time.

- When you and your partner are feeling comfortable to move on (and this may be after several sessions) you may like to try some of these techniques:
  - Let her squeeze and relax her kegel muscles around your penis;
  - Gently thrust together or rock your pelvises back and forth;
  - Use your hands to touch her breasts or clitoris;
  - Ask your partner to touch your scrotum or buttocks;
  - Use the waxing and waning technique by having intercourse for brief periods, then return to body and genital caressing for a few minutes, and then return back to intercourse again.

- Do this session over about an hour. Remember you are **not** aiming to end the session with ejaculation or orgasm. When you and your partner decide to finish, you might like to share a kiss and a cuddle and take a moment to talk about the experience. Many women really enjoy intimacy and affection after sex and can feel unsatisfied or rejected if there is no cuddling.

**Below are some sexual positions that many couples find useful in these sessions.**

**Female on top**
This position allows your partner to have more control over how fast and how deep the penetration occurs. **How to do this:** While lying on your back, your partner gets on top and bends her knees so that she is sitting above your pelvis. Either you or your partner can then guide your penis inside her. From this position you can easily make eye contact with your partner and share some passionate kissing!

**Coital alignment technique**
This position is similar to the standard missionary position, but allows for more clitoral stimulation. **How to do this:** You go on top, as in the standard missionary position. Then move your body upward a little, so that the base of your penis, or pubic bone, applies pressure to her clitoris. Then you both rock back and forth keeping pressure on the clitoris.
**Clitoral stimulation**
In any position you try, your partner may want you to touch her clitoris or breasts, or she may like to touch them herself.

Remember:

- There is no pressure to feel aroused during these sessions - just enjoy the sensations and try to relax;
- Use lubrication if you like;
- Be open-minded and playful!
- Be emotionally supportive and patient
Secret Men's Business: Module 6

Your partner has now made it to Module 6 - the last module of PursuingPleasure.

This module will focus on options to further enhance your sex life together as well as consolidating what your partner has learnt over the program and planning for any problems that may arise in the future. This module also includes regular communication exercises and sensate focus sessions which continue to explore the style of sexual intercourse you and your partner enjoy.

The order of this info sheet is a little different from previous modules.

Communication Exercises
During this module, you can either:

- Write and swap letters or;
- Discuss the question without using letter.

The list of questions in this module is shorter than usual. This is to allow you and your partner to decide on the topics of the questions. You may like to discuss things brought up in this module or any other topics that you think are important to discuss.

Remember to:

- Choose one question at a time;
- Do at least 3 questions per week;
- Always do a communication exercise before a sensate focus session.

Discussion Questions:

- How do you feel about coming to the end of the program?
- What has changed in your relationship over the course of the program?
- Do you have any concerns about ending the program?
- What have been the most important aspects of the program?
- What difficulties might emerge after the program has finished? What could you and your partner do to address these difficulties?
- How do you feel about experimenting with some of the sexual extras described below (fantasy, erotica, vibrators, dress-up, etc.)?
• How do you feel about continuing to make couple dates after the program has finished?

Sensate Focus - Continuing Intercourse
These sensate focus sessions will continue on from Module 5, but now you can incorporate orgasm and ejaculation into intercourse. It is important not to put pressure on her to orgasm though, as this can inhibit a woman’s enjoyment and create performance anxiety. And remember that most women do not orgasm in every sexual encounter, and many women still feel sexually satisfied without orgasm.

These sessions should be a positive and enjoyable experience to share with your partner, so try not to rush. Use these sessions to be sensual and intimate and develop the type of sexual relationship you want to continue into the future.

You will need to complete at least 3 sessions per week. Spend at least 1 hour in each session (although you may want to spend much longer!). Make sure you choose times when you won’t be rushed or interrupted.

Remember:
• Always share do a communication exercise before sensate focus;
• Don’t focus on arousal or orgasm, just relax and enjoy the pleasurable sensations;
• Don’t pressure your partner to orgasm.

Sensate Focus Instructions
• Begin each session by doing a communication exercise.
• Make sure you are feeling relaxed and open to the experience.
• Prepare the room together.
• Start the session with general body touching and then genital touching. There will be no designated toucher or receiver.
• Neither of you should feel any pressure to become aroused. All you need to do is enjoy the sensations and communicate.
• After some pleasurable body and genital touching, and perhaps a bit of teasing, begin penetration. This is a good time to apply lubricant if you wish, and/or put on a condom. You may like to try the positions suggested in Module 5, or any others you enjoy.
• If your partner feels any pain or discomfort when inserting your penis,
take this step **very slowly** and keep communicating.

- You may like to begin with the "quiet vagina" technique to give your partner a chance to **relax into intercourse**.

- When you and your partner are feeling comfortable, start moving, rocking and thrusting in the ways that you **both enjoy**. Gradually increase the speed and intensity of intercourse as you get more into it (make sure you don’t thrust **too fast or hard** for your partner though). You may also like to try some different positions or any of these techniques:
  - Squeeze and relax your kegel muscles;
  - Touch your partner’s clitoris or let her touch it herself - this is a very good way of increasing enjoyment and arousal;
  - Use the waxing and waning technique.

- Don’t focus on arousal or orgasm/ejaculation, but if you or your partner feel that orgasm/ejaculation is imminent, let it happen and **enjoy the sensations**.

- If you ejaculate before your partner is sexually satisfied, ask her what you can do to satisfy her (e.g., oral/manual stimulation, using a vibrator on her clitoris, body massage).

- Afterwards you might like to share a kiss and a cuddle, a massage, take a moment to talk about the experience, or have a glass of wine together. Many women really enjoy **intimacy and affection after sex** and can feel unsatisfied or rejected if there is no cuddling.

**Looking to the Future**

As your partner nears the end of the program, it is time to look to the future and decide how to continue this positive journey. While there will be no more formal exercises to complete, it is important that you both keep practicing what you have learnt about sex and each other throughout the program. To do so, I suggest the following:

- **Keep scheduling in couple time** - Couples who continue to plan in regular date-time together are more likely to maintain a happy and healthy sex life. Make sure you plan in both **sexual and nonsexual** couple dates to ensure that emotional **and** sexual needs are being met.

- **Keep communicating** - If you don’t want to slip into old patterns then keep discussing your thoughts and feelings together. You can do this by sharing letters or just set aside time to have a good chat. Also, keep communicating **in bed** like you have been in the sensate focus sessions.

- **Have realistic expectations** - All couples have periods of time when their sex life is less satisfying than other times. When these periods
occur, the aim is not to stress-out and to keep communicating.

- **After a bad experience** - If you have a bad sexual experience with your partner, it is important not to overreact. See it for what it is - just one bad experience. Try talking about it and approaching the situation with light-heartedness and humour. It is also useful to reconnect sexually within 3 days.

- **Have a flexible definition of sex** - Couples who define sex as more than just intercourse are more likely to experience a satisfying sex life. A flexible definition of sex means understanding that sex is more than just penetration (it is also kissing, fondling, stroking, licking and caressing); understanding the importance of sensuality and intimacy; acknowledging that sex does not always have to end with intercourse; and acknowledging that orgasm/ejaculation does not have to be a part of sex every time.

**Anticipating Difficulties**

One of the best ways to prevent problems re-occurring is by anticipating what difficulties may arise. Below are some common difficulties that may arise after the program (and in the years to come):

**She feels too tired/stressed/grumpy to prioritise couple time and sex**
If tiredness and stress seem to be getting in the way, you and your partner might need to think about ways to address her stress level and time management. Planning couple time on less stressful days may help, and offering to help her out with certain responsibilities so as to make more time for love-making and couple dates is an option.

**Her negative thoughts are getting in the way**
Negative thoughts can make sex a negative experience. It is important to make sex as relaxing as possible and talk about any negativity that may be emerging.

**She is avoiding sexual time with you**
This might occur if she feels her emotional and non-sexual intimacy needs are not being met within the relationship. Therefore, it is important to have both sexual and non-sexual couple time to make sure her non-sexual needs are being met. It is also useful to discuss what factors may be inhibiting her interest in sex, and problem-solve ways to deal with this together.

**You don't like the changes in her and want to go back to how things were**
It is possible that you will feel uncomfortable by the new sexual patterns that have emerged from this program, and want to go back to the way things were. It is important to discuss this and work out what it is about the changes that make you uncomfortable. It is also important to acknowledge that change can be difficult and new patterns can take a while to settle in, but the benefits of change often outweigh the negatives in the long run.

**You may have sexual difficulties that impact the relationship**
If you have difficulties with erections, ejaculating too fast, or low sexual desire, this can impact your partner’s sexuality. There is plenty of medical and psychological help for these kinds of sexual concerns that you may like to seek out. In the mean time, it is important to communicate about these issues and there are lots of self-help resources for men’s sexual difficulties.

Lastly, if you or your partner ever feel like things really aren’t going so well anymore, I suggest that you seek out some professional couples therapy. This does not mean you or your partner have failed - many couples need some booster-sessions to help them get back on track again.

**What Else - Sexy Extras**

Here are a few ideas that may help to further enhance your sex life together. It is entirely up to you and your partner as to what you want to try. But remember, it won’t hurt to try!

**Fantasy**

The use of sexual fantasy can help get your partner’s mind in the mood! A fantasy is any sexy daydream that is enjoyable and arousing. You can have fantasies on your own or share them with each other, but remember, your fantasies may be very different and that is okay.

It is important to remember that fantasising about something or someone is very different from actually acting out these things. Therefore, nobody needs to feel guilty about the content of their fantasies.

**Erotica**

Erotica can take many forms such as books, websites, films and art works with sexual content. Erotica can help to ignite sexual feelings and research has shown that women respond physically to erotica just as much as men! One note of caution: Most pornography is made for men and may not be sexually appealing to your partner. Look for erotica made for women or couples.

**Vibrators**

Vibrators can be very helpful in boosting sexual arousal!! By applying the vibrator to the clitoris during foreplay or intercourse, your partner can enjoy a lovely buzzing sensation that really enhances sexual enjoyment. Some women also enjoy a vibrator being inserted inside their vagina during foreplay.

Some couples are uncomfortable with the idea of vibrators because they consider them to be artificial or cheating somehow. But why not think of a vibrator as a helpful and enjoyable addition to your partner’s sexual pleasure?

**Other possibilities...**
**Sexy Talk** - It can be **fun and sexy** to introduce sexy talking into the bedroom (or before you get to the bedroom). Different couples have different preferences, but some common themes of sexy talking include describing a **fantasy**, saying what you like in **sexy words**, repeating certain **phrases** or just saying whatever turns you on at the time.

**Dress-up** - Some couples like to dress up during sex in order to **increase arousal** or **act out a fantasy**. This may involve a full-blown doctor-and-nurse costume set, or could simply involve some sexy lingerie and a business tie!

**Tantric Sex** - This is the spiritual art of love-making passed down from ancient Indian tradition. Many couples find that reading about Tantric Sex, or attending workshops, helps to refresh and revitalise their love-life together.

Once you and your partner have finished off this module, there is just one last requirement. Could you please fill out the online **POST-PROGRAM SURVEY** to help me gather information about **PursuingPleasure**. This information is really important for helping more couples in the future! There will also be a **follow-up survey in 3 months time**.

Thanks!

Well done on supporting your partner throughout this challenging program. She couldn’t have done it without you!
Female Questionnaire (as Word Document)

Ladies Questionnaire

General Information

1. What is your age? ___Years ___Months

2. What is your partner's age? ___Years ___Months

3. What is your relationship status?
   Married
   De facto/Partnered/Co-habitating

4. What is the approximate length of you and your partner's relationship in years and/or months? ___Years ___Months

5. Please indicate if you have experienced any of the following sexual difficulties:

<table>
<thead>
<tr>
<th>TICK ONE OR MORE BOXES</th>
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</thead>
<tbody>
<tr>
<td>Have not experienced sexual difficulties</td>
</tr>
<tr>
<td>(skip questions 9 and 10)</td>
</tr>
<tr>
<td>Painful intercourse</td>
</tr>
<tr>
<td>Failure to become aroused/lubricated</td>
</tr>
<tr>
<td>Lack of sexual interest</td>
</tr>
<tr>
<td>Reduced satisfaction</td>
</tr>
<tr>
<td>Inability to orgasm</td>
</tr>
<tr>
<td>Delayed orgasm</td>
</tr>
<tr>
<td>Other (please specify):</td>
</tr>
</tbody>
</table>

6. Please indicate approximately how many years and/or months it has been since you started experiencing sexual difficulties? ___Years ___Months
7. What percentage of the time do you have problems with your sexual functioning?
   - About 10% of the time
   - About 25% of the time
   - About 50% of the time
   - About 75% of the time
   - All the time

**Sexual Functioning**

These questions ask about your sexual feelings and responses during the **past 4 weeks**. Please answer the following questions as honestly and clearly as possible. Your responses will be kept completely confidential. In answering these questions the following definitions apply:

*Sexual activity* can include caressing, foreplay, masturbation and vaginal intercourse.

*Sexual intercourse* is defined as penile penetration (entry) of the vagina.

*Sexual stimulation* includes situations like foreplay with a partner, self-stimulation (masturbation), or sexual fantasy.

*Sexual desire or interest* is a feeling that includes wanting to have a sexual experience, feeling receptive to a partner’s sexual initiation, and thinking or fantasizing about having sex.

1. Over the past 4 weeks, how satisfied have you been with your overall sexual life?
   - Very satisfied
   - Moderately satisfied
   - About equally satisfied and dissatisfied
   - Moderately dissatisfied
   - Very dissatisfied

2. Over the past 4 weeks, how often did you feel sexual desire or interest?
   - Almost always or always
   - Most times (more than half the time)
   - Sometimes (about half the time)
   - A few times (less than half the time)
   - Almost never or never
3. Over the past 4 weeks, how would you rate your level (degree) of sexual desire or interest?
Very high
High
Moderate
Low
Very low or none at all

Over the past four weeks, have you experienced any sexual activity or intercourse (no sexual caressing, foreplay, masturbation or vaginal intercourse)?
Yes
No (please skip questions 4-19)

Sexual arousal is a feeling that includes both physical and mental aspects of sexual excitement. It may include feelings of warmth or tingling in the genitals, lubrication (wetness) or muscle contractions.

4. Over the past 4 weeks, how often did you feel sexually aroused ("turned on") during sexual activity or intercourse?
Almost always or always
Most times (more than half the time)
Sometimes (about half the time)
A few times (less than half the time)
Almost never or never

5. Over the past 4 weeks, how would you rate your level of sexual arousal ("turn on") during sexual activity or intercourse?
Very high
High
Moderate
Low
Very low or none at all

6. Over the past 4 weeks, how confident were you about becoming sexually aroused during sexual activity or intercourse?
Very high confidence
High confidence
Moderate confidence
Low confidence
Very low or no confidence
7. Over the past 4 weeks, **how often** have you been **satisfied with your arousal** (excitement) during sexual activity or intercourse?
- Almost always or always
- Most times (more than half the time)
- Sometimes (about half the time)
- A few times (less than half the time)
- Almost never or never

8. Over the past 4 weeks, **how often** did you **become lubricated** ("wet") during sexual activity or intercourse?
- Almost always or always
- Most times (more than half the time)
- Sometimes (about half the time)
- A few times (less than half the time)
- Almost never or never

9. Over the past 4 weeks, **how difficult** was it to **become lubricated** ("wet") during sexual activity or intercourse?
- Extremely difficult or impossible
- Very difficult
- Difficult
- Slightly difficult
- Not difficult

10. Over the past 4 weeks, **how often** did you **maintain your lubrication** ("wetness") until completion of sexual activity or intercourse?
- Almost always or always
- Most times (more than half the time)
- Sometimes (about half the time)
- A few times (less than half the time)
- Almost never or never

11. Over the past 4 weeks, **how difficult** was it to **maintain your lubrication** ("wetness") until completion of sexual activity or intercourse?
- Extremely difficult or impossible
- Very difficult
- Difficult
- Slightly difficult
- Not difficult

12. Over the past 4 weeks, when you had sexual stimulation or intercourse, **how often** did you **reach orgasm** (climax)?
- Almost always or always
- Most times (more than half the time)
- Sometimes (about half the time)
- A few times (less than half the time)
- Almost never or never
13. Over the past 4 weeks, when you had sexual stimulation or intercourse, **how difficult** was it for you to **reach orgasm** (climax)?
- Extremely difficult or impossible
- Very difficult
- Difficult
- Slightly difficult
- Not difficult

14. Over the past 4 weeks, **how satisfied** were you with **your ability to reach orgasm** (climax) during sexual activity or intercourse?
- Very satisfied
- Moderately satisfied
- About equally satisfied and dissatisfied
- Moderately dissatisfied
- Very dissatisfied

15. Over the past 4 weeks, **how satisfied** have you been with the amount of **emotional closeness** during sexual activity between you and your partner?
- Very satisfied
- Moderately satisfied
- About equally satisfied and dissatisfied
- Moderately dissatisfied
- Very dissatisfied

16. Over the past 4 weeks, **how satisfied** have you been with your **sexual relationship** with your partner?
- Very satisfied
- Moderately satisfied
- About equally satisfied and dissatisfied
- Moderately dissatisfied
- Very dissatisfied

17. Over the past 4 weeks, **how often** did you experience **discomfort or pain during** vaginal penetration?
- Did not attempt intercourse
- Almost always or always
- Most times (more than half the time)
- Sometimes (about half the time)
- A few times (less than half the time)
- Almost never or never

18. Over the past 4 weeks, **how often** did you experience **discomfort or pain following** vaginal penetration?
- Did not attempt intercourse
- Almost always or always
- Most times (more than half the time)
- Sometimes (about half the time)
- A few times (less than half the time)
- Almost never or never
19. Over the past 4 weeks, how would you rate your level (degree) of discomfort or pain during or following vaginal penetration?
   Did not attempt intercourse
   Very high
   High
   Moderate
   Low
   Very low or none at all

**Partner’s Sexual Functioning**

1. Please indicate if, in your view, your male partner has experienced any of the following sexual difficulties:

<table>
<thead>
<tr>
<th>TICK ONE OR MORE BOXES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has not experienced sexual difficulties (skip questions 2 and 3)</td>
</tr>
<tr>
<td>Painful intercourse</td>
</tr>
<tr>
<td>Failure to get/maintain an erection</td>
</tr>
<tr>
<td>Lack of sexual interest</td>
</tr>
<tr>
<td>Reduced sexual satisfaction</td>
</tr>
<tr>
<td>Premature ejaculation</td>
</tr>
<tr>
<td>Delayed ejaculation</td>
</tr>
<tr>
<td>Other (please specify):</td>
</tr>
</tbody>
</table>

2. Please indicate approximately how many years and/or months it has been since you think that your partner started experiencing sexual problems? ___ Years ___ Months

3. What percentage of the time do you think that your partner has problems with his sexual functioning?
   About 10% of the time
   About 25% of the time
   About 50% of the time
   About 75% of the time
   All the time

**Concern about Sexual Difficulties**

Below is a list of feelings and problems that women sometimes have concerning their sex life. Please read each item carefully, and check the box that best describes how often that difficulty has bothered you or caused distress over
the last 4 weeks. Please check only one box for each item, and take care not to skip ANY items. Please check one box per question.

0 - Never
1 - Rarely
2 - Occasionally
3 - Frequently
4 - Always

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<tr>
<td>How often did you feel distressed about your sex life?</td>
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<td>How often did you feel unhappy about your sexual relationship?</td>
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<td>How often did you feel guilty about your sexual difficulties?</td>
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<td>How often did you feel frustrated by your sexual difficulties?</td>
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<td>How often did you feel stressed about sex?</td>
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<td>How often did you feel inferior because of sexual difficulties?</td>
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<td>How often did you feel worried about sex?</td>
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<td>How often did you feel sexually inadequate?</td>
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<td>How often did you feel regrets about your sexuality?</td>
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<td>How often did you feel embarrassed about sexual difficulties?</td>
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<tr>
<td>How often did you feel dissatisfied with your sex life?</td>
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<td>How often did you feel bothered by low desire?</td>
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**Relationship Satisfaction**

1. Read each statement carefully and decide which response best describes how you currently feel about the relationship you have with your partner. Please respond to every statement.

(a) Please indicate how you feel about your relationship.
   Very dissatisfied
   Dissatisfied
   Neutral
   Satisfied
   Very satisfied

(b) Please indicate how often you get the things you want from your relationship.
   Never
   Rarely
   Sometimes
   Frequently
   Always
(c) Which of the following do you see as good aspects of your current relationship?

**TICK ONE OR MORE BOXES**

1. Sexual activity
2. Communication
3. Companionship
4. Support
5. Other (please specify):

2. In the following everyday matters, how often...?

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Almost always</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) is your partner considerate and caring towards you?</td>
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<td>b) do you get on each other's nerves around the house?</td>
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<tr>
<td>c) in the evenings do you spend time together talking about the day's activities?</td>
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<td>d) when you have a disagreement, do you talk it through fairly amicably?</td>
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<td>e) do you sometimes feel your partner is critical of you?</td>
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<tr>
<td>f) on an ordinary day, do you say good-bye or greet each other with a hug or a kiss?</td>
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</tbody>
</table>

3. What happens when you argue?
Conflict is resolved amicably
Conflict is resolved with one partner bearing a grudge
Conflicts are not satisfactorily resolved
Other (please specify) ____________
4. Which of the following do you argue about?

<table>
<thead>
<tr>
<th>TICK ONE OR MORE BOXES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sex</td>
</tr>
<tr>
<td>2. Religion</td>
</tr>
<tr>
<td>3. Money matters</td>
</tr>
<tr>
<td>4. Division of household labour</td>
</tr>
<tr>
<td>5. Children’s upbringing</td>
</tr>
<tr>
<td>6. Other (please specify):</td>
</tr>
</tbody>
</table>

5. Please indicate how seriously you see your sexual difficulties affecting other aspects of your relationship.

- Very seriously
- Some influence
- Unsure
- Little influence
- No influence

**Communication**

1. (a) Are you and your partner able to talk about most things?

- Never
- Rarely
- Sometimes
- Frequently
- Always

(b) Which subjects do you avoid or find difficult to discuss?

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<thead>
<tr>
<th>TICK ONE OR MORE BOXES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sex</td>
</tr>
<tr>
<td>2. Religion</td>
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<tr>
<td>3. Money matters</td>
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<td>4. Division of household labour</td>
</tr>
<tr>
<td>5. Children’s upbringing</td>
</tr>
<tr>
<td>6. Other (please specify):</td>
</tr>
</tbody>
</table>

2. (a) Would you like to change the ways in which you and your partner communicate?

- Yes
- No *(go to Question 3)*
(b) If YES, in what way would you like to see your communication patterns change?

<table>
<thead>
<tr>
<th>TICK ONE OR MORE BOXES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Be more open and direct</td>
</tr>
<tr>
<td>2. Be less dominating</td>
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<tr>
<td>3. Be less passive/submissive</td>
</tr>
<tr>
<td>4. Be more rational/practical and less emotional</td>
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</tbody>
</table>

3. Is it difficult to tell your partner:
   (a) What you like about him/her?
       Always
       Frequently
       Sometimes
       Rarely
       Never

   (b) What you don’t like about him/her?
       Always
       Frequently
       Sometimes
       Rarely
       Never

4. (a) Do you tell your partner what you do and do not like during sex?
       Always
       Frequently
       Sometimes
       Rarely
       Never

   (b) Do you feel comfortable sometimes being the initiator of sexual activity?
       Always
       Frequently
       Sometimes
       Rarely
       Never

   (c) How do you feel when your partner initiates sexual activity?
       Very negative
       Negative
       Unsure
       Positive
       Very positive
(d) How do you feel when your partner refuses a sexual advance that you make?
Very negative
Negative
Unsure
Positive
Very positive

**Intimacy**

Please indicate the extent in which you agree with the following items:

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>Almost always</th>
<th>Always</th>
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<tbody>
<tr>
<td>1. My partner listens to me when I need someone to talk to</td>
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<td>2. I am satisfied with our sex life</td>
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<td>3. I can state my feelings without my partner getting defensive</td>
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<td>4. I feel our sexual activity is just routine</td>
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<td>5. I often feel distant from my partner</td>
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<td>6. I am able to tell my partner when I want sexual intercourse</td>
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<td>7. My partner can really understand my hurts and joys</td>
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<td>8. I “hold back” my sexual interest because my partner makes me feel uncomfortable</td>
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<td>9. I feel neglected at times by my partner</td>
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<td>10. Sexual expression is an essential part of our relationship</td>
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<td>11. I sometimes feel lonely when we’re together</td>
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<td>12. My partner seems disinterested in sex</td>
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</table>
Your comments

There are many different reasons why women experience sexual difficulties. To gain a better understanding of these reasons, would you like to comment on why you think your sexual difficulties have come about?

If you would like to make any additional comments about your sexuality, sexual functioning, relationship or the questionnaire, please feel free to comment below.

To submit your responses, please enter your email address and then click the submit button below. Remember your email address is only being used for a record of who has completed the questionnaire and will not be used to inspect or track your individual responses.

Extra questions on the female post-treatment and follow-up treatment questionnaire

Treatment Satisfaction

Which part/s of the program did you find the most helpful?

Which part/s of the program did you find the least helpful?

Do you have any suggestions for how the program could be improved?

Is there anything else you would like to comment on regarding your experience of the program, your sexual functioning, or this questionnaire?
Partner Questionnaire (as Word Document)

Partner Post-Program Questionnaire

General Information

1. What is your age? ___Years ___Months

2. What is the approximate length of you and your partner's relationship in years and/or months? ___Years ___Months

Sexual Functioning

Please complete the following questions even if you have never experienced sexual difficulties.

1. Over the last month, how often were you able to get an erection during sexual activity?
   - No sexual activity
   - Almost never or never
   - A few times (much less than half the time)
   - Sometimes (about half the time)
   - Most times (much more than half the time)
   - Almost always or always

   Q2. Over the last month, when you had erections with sexual stimulation, how often were your erections hard enough for penetration?
   - No sexual activity
   - Almost never or never
   - A few times (much less than half the time)
   - Sometimes (about half the time)
   - Most times (much more than half the time)
   - Almost always or always

   Q3. Over the last month, when you attempted intercourse, how often were you able to penetrate your partner?
   - No sexual activity
   - Almost never or never
   - A few times (much less than half the time)
   - Sometimes (about half the time)
   - Most times (much more than half the time)
   - Almost always or always
Q4. Over the last month, during sexual intercourse, how often were you able to maintain your erection after you had penetrated your partner?
No sexual activity
Almost never or never
A few times (much less than half the time)
Sometimes (about half the time)
Most times (much more than half the time)
Almost always or always

Q5. Over the last month, during sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?
No sexual activity
Extremely difficult
Very difficult
Difficult
Slightly difficult
Not difficult

**The next three questions refer to satisfaction with intercourse. Remember all answers are strictly confidential.**

Q6. Over the last month, how many times have you attempted sexual intercourse?
No attempts
1-2 times
3-4 times
5-6 times
7-10 times
11-20 times

Q7. Over the last month, when you attempted sexual intercourse how often was it satisfactory for you?
Did not attempt intercourse
Almost never or never
A few times (much less than half the time)
Sometimes (about half the time)
Most times (much more than half the time)
Almost always or always

Q8. Over the last month, how much have you enjoyed sexual intercourse?
No intercourse
No enjoyment
Not very enjoyable
Fairly enjoyable
Highly enjoyable
Very highly enjoyable
The next two questions refer to your orgasms.

Q9. Over the last month, when you had sexual stimulation or intercourse, how often did you ejaculate?
No sexual stimulation/intercourse
Almost never or never
A few times (much less than half the time)
Sometimes (about half the time)
Most times (much more than half the time)
Almost always or always

Q10. Over the last month, when you had sexual stimulation or intercourse, how often did you have the feeling of orgasm (with or without ejaculation)?
No sexual stimulation/intercourse
Almost never or never
A few times (much less than half the time)
Sometimes (about half the time)
Most times (much more than half the time)
Almost always or always

The next two questions ask about sexual desire. In this context, sexual desire is defined as a feeling that may include wanting to have a sexual experience (for example masturbation or sexual intercourse), thinking about having sex, or feeling frustrated due to lack of sex.

Q11. Over the last month, how often have you felt sexual desire?
Almost never or never
A few times (much less than half the time)
Sometimes (about half the time)
Most times (much more than half the time)
Almost always or always

Q12. Over the last month, how would you rate your level of sexual desire?
Very low or not at all
Low
Moderate
High
Very high

The next two questions refer to overall sexual satisfaction.

Q13. Over the last month, how satisfied have you been with your overall sex life?
Very dissatisfied
Moderately dissatisfied
About equally satisfied and dissatisfied
Moderately satisfied
Very satisfied
Q14. Over the last month, how satisfied have you been with your sexual relationship with your partner?
Very dissatisfied
Moderately dissatisfied
About equally satisfied and dissatisfied
Moderately satisfied
Very satisfied

This question refers to erectile function.

Q15. Over the last month, how do you rate your confidence that you can get and keep your erection?
Very low
Low
Moderate
High
Very high

The next five questions refer to ejaculation. Remember that all answers will be kept confidential and will not be discussed with your partner.

Q16. How difficult is it for you to delay ejaculation?
Not at all difficult
Somewhat difficult
Moderately difficult
Very difficult
Extremely difficult

Q17. Do you ejaculate before you want?
0%  Almost never or never
25%  Less than half the time
50%  About half the time
75%  More than half the time
100% Almost always or always

Q18. Do you ejaculate with very little stimulation?
0%  Almost never or never
25%  Less than half the time
50%  About half the time
75%  More than half the time
100% Almost always or always

Q19. Do you feel frustrated because of ejaculating before you want?
Not at all
Slightly
Moderately
Very
Extremely
Q20. How concerned are you that your time to ejaculate leaves your partner sexual unfulfilled?
Not at all
Slightly
Moderately
Very
Extremely

Extra questions on the partner post-treatment and follow-up treatment questionnaire

**Treatment satisfaction**

Please give an overall summary of how helpful you have found the treatment program?

Which part/s of the program did you find the most helpful?

Which part/s of the program did you find the least helpful?

Do you have any suggestions for how the program could be improved?

Is there anything else you would like to comment on regarding your experience of the program, your sexual functioning or this questionnaire?

Thank you for taking the time to fill out this questionnaire.
Details of email therapy provided during *Pursuing Pleasure (PP)*

From the beginning of the treatment, women in the *PP* treatment groups were advised that unlimited email therapy was available throughout the entire program. Within the content of the online modules, women were repeatedly encouraged to email the therapist so as to address their individual needs, discuss challenges and obstacles, or to ask questions and clarify online content and the required exercises.

In order to align the email therapy with the framework of the *PP* program, all email correspondence from the therapist utilised a mindfulness and CBT framework, as well as general counselling skills, to address challenges that arose for participants and to reinforce the concepts from the *PP* program. To do so, a range of techniques were used over email such as psychoeducation, thought challenging, mindfulness training, expressed empathy, and relaxation techniques.

The exact manner in which the email communication was conducted differed for different women. Some women engaged in a more conversational style of correspondence with many back-and-forth replies, whereas others wrote longer emails with more details about their concerns that did not require so many back-and-forth replies. All email exchanges were followed-up with further email contact, although follow-ups were not always replied to.

As well as replying to emails sent by participants, and in order to enhance engagement and motivation, a certain amount of email contact was initiated by the therapist in the form of reminders, “check-ins” and motivational messages to the women. The therapist utilised particular time points to send reminders and check-in
emails to participants - at the beginning of a new module, in the middle of a module, and at the end of a module. Also, when a participant had not engaged in email contact for over two weeks, the therapist initiated email contact to check-in and assess how the woman was managing the program exercises.

**Details of chat-groups facilitated during Pursuing Pleasure**

From the beginning of the treatment, women in the treatment groups were advised that they were required to attend a one-hour online chat-group every two weeks with other women in the program. Via email, it was explained to women that the chat-groups would give them an opportunity to share their experiences throughout the program and discuss challenges that arose over the treatment. Each group contained 4-8 women.

Further details about the aims and format of the chat-groups, technical issues, and confidentiality were provided in the first chat-group for each woman. Women were also given the opportunity to ask any questions they may have had about the groups. All groups took on a loose structure that included greetings, review of module exercises over the past two weeks, experiences of the program, discussion of challenges and barriers to change, specific intervention suggestions (if necessary), and the closing of the session. In addition, the concluding sessions focussed on relapse prevention after finishing treatment, and women had the opportunity to reflect on their progress over treatment and celebrate their achievements.

In order to mimic face-to-face cognitive therapy, rather than simply acting as a support group, the facilitator used a variety of CBT and mindfulness-based interventions, as well as general counselling skills and group therapy techniques.
These interventions included activities to develop therapeutic relationships and group cohesion, validating experiences, offering psychoeducation, thought monitoring, exploring and challenging cognitive distortions, addressing barriers to change, instructions for mindfulness meditation, suggesting specific behavioural interventions, Socratic questioning, solution-focussed questioning and reinforcing concepts from the PP program content.
Appendix 11

Picture of Chat-Room