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EROTOLOGY AND THE STUDY OF DESIRE AND AROUSAL

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This dissertation submitted by John. F. Wirth and Melissa Vinson has been read and approved by three faculty members of the American Academy of Clinical Sexologists.

The final copies have been examined by the Dissertation Committee and the signatures that appear here verify the fact that any necessary changes have been incorporated and that the dissertation is now given the final approval with reference to content, form and mechanical accuracy.

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Erotology and the Study of Desire and Arousal

It is the responsibility of the field of sexology to more clearly define what we mean by erotology, ecotherapy, and ecospirituality and its use in therapy regarding desire and arousal. As an agent of change in society, sexology must educate society about new thoughts in the field and the possibility of new ways to enhance understanding and ease with sexual topics. Archaic thought and definition can no longer be used if society is to move forward in intelligent, humanitarian, and non-bigoted ideas about the sexual rights and actions of others. If sexology is a mirror of the society we live in, then the study of sex and the education taught from that study must keep up with the vast amount of information available to the human race in the 21st century. Sexology must share its unique and far reaching understanding and ideas on a level equal to the advanced therapist in sex therapy practices, the medical community and society at large. The intelligent, information seeking public will accept no less from those who are in this helping field, and it is a duty to society at large to share learned truths.

Philosophically speaking, a look at the definitions of erotology and desire reminds us of the uniqueness of society. Erotology has several different definitions that can be found with a similar theme. It has been described as the study of erotic expression in any form of representation which seeks to sexually arouse its audience (Erotic Media Experts LLC 2005) the scholarly study of sexual love, including erotica and pornography (Farlex 2004) and as the study and description of sexual love and love making (Merriam-Webster Incorporated 2007). Parts of these different interpretations or definitions acknowledge that the study of erotology is similar to the study of arousal and desire. The various definitions suggest that erotology focuses on erotic expressions in different forms, which has the ultimate goal of evoking a response. An online sex dictionary presents an

alternative definition calling erotology a euphemism for pornography. This shows that the definition of erotology varies depending on your source of reference (Farlex 2008).

In the relationship between erotology and desire, the question remains, how does a person begin to have desire, how does that person become aroused, is there a way of defining what make desire happen, and are there tools to help increase, promote, encourage and/or enhance desire? If there are tools, what are they, and what techniques and skills are required? The study of Eros has always strived to answer these questions with varying degrees of success. Attempts to address arousal and desire, increasing it, or the lack of it in individuals and couples has lead to professional diagnostic labels and criteria that sometimes lead to help, but often limit improvement in sexual functioning for the individual. These attempts have also lead to a plethora of medical advice, surgeries, devices, pharmacology, alternative supplements, techniques, media, toys and aids, and multiple theories on what will work, but ultimately may not. Certainly, labels and diagnostic criteria, medicines and vitamins, plus teaching behavioral skills and techniques for problems, while attempting to give information to society, may lead to more confusion for specific individuals looking for answers. And individuals are aggressively seeking solutions in many arenas.

There have been numerous theories on phases of arousal in humans. Masters and Johnson's theory and extensive research is well known to experienced clinicians in the field. In her book *The Nature and Evolution of Female Sexuality,* Mary Jane Sherfey, M.D. writes extensively about differences in female response and her theories regarding arousal, vaginal insensitivity, and potential for multiple orgasms. She includes numerous

diagrams of anatomy to educate the reader. According to her the four phases of arousal in women are presented as:

> Phase I, Excitement. Duration: several minutes to hours.
> Phase II, Plateau. Duration: 30 seconds to 3 minutes.
> Phase III, Orgasm. Duration: 3-15 seconds.
> Phase IV, Resolution. Duration: with orgasm, 10-25 minutes; with no orgasm, several hours. (Sherfey 1972)

Her chart, presented over four pages, shows these four stages along with nine parts of the female anatomy and how they progress through the phases of arousal. The body parts include the skin, breasts, clitoris, labia majora, labia minora, greater vestibular glands, the vagina in the upper 2/3rd and lower 1/3rd, the uterus and perineal body, rectum and others. While not being presented in a chart, comparisons and similarities are listed between the sexual response cycles of women and men. According to the Sherfey, the response cycle in men may be divided into the same four phases as in women, although they are less well defined. The fact that women do not have a refractory period is introduced, as well as a woman's ability to have multiple orgasms. The refractory period is mentioned but apparently is not considered a phase in the sexual response cycle of men. She includes information that a man may delay ejaculation purposefully, and that many young men are capable of repetitive ejaculations. However, for men, after the initial ejaculation, the erectile chambers return to plateau level refractory period. Sadly, there is no mention of desire, cathexsis, eroticism or what happens first in the phase-one-desire that leads to acts and interest in sexual contact. Historically, no researchers have adequately defined this preemptive what-happens-first phase: desire.

Patients, when asking for help clearly state, "I have low libido, no interest in sex." Problems with desire have been diagnosable, according to the medical community, as a

consequence of sexual dysfunction. There are twenty three diagnostic labels for sexually based disorders in the Diagnostic and Statistical Manual of Mental Disorders. (DSM IV 2000) Sexual desire disorders head the list. An online article entitled "Sexual Dysfunction; Treatment" reports that treatment for sexual dysfunction depends on the cause of the problem. If the cause is determined to be physical then medical treatment may be the focus for correcting the underlying disorder that is contributing to or producing the sexual disorder. If the cause is determined to be psychological, treatment consists of counseling and therapy. If necessary, treatment can also include a combination of medical, behavioral, and psychological approaches. The experienced sex therapist knows that society has been bombarded with new drugs that can enhance erection, or reduce premature ejaculation for males, and hormone replacement or addition that may help to increase desire in males or females. Pharmaceutical companies with an eye on gigantic sales are aware that there is a component of interest that they have not captured, and there is a rush to develop an inhaler, a pill or a cream that will magically make phase-one-interest happen. As the experienced sexologist is aware, and society is beginning to learn, drug therapy does not always fix the problem. Hormone levels can be adjusted, vasocongestion ability in place, yet interest or success in sexual interaction remains disappointingly low.

Sometimes, treatment may need to be behavioral techniques that will help retrain the mind and thought process, or help shift the focus to problems that exist in the relationship and ultimately deter successful and passionate surrender in sexual interaction. For example, if there is loss of desire due to relationship issues, introducing changes in the environment, timing, lovemaking techniques or changes in foreplay may

help induce desire. With arousal disorder, the use of toys and vibrators may aid circulation. A warm bath and a massage from a partner may promote circulation and relaxation, and a more intimate emotional connection. (NWHRC Health Center 2005) Techniques of sensate focus exercises have been known to work with some patients because of education attained regarding a partner's needs, and also the promotion of intimacy without pressure to perform. However, these same behavioral and sensate focus exercises, aimed to reduce stress and sexual performance anxiety, and sexually educate couples, instead can often focus couples on existing and more serious relationship problems of which they were unaware. This can result in less sexual success for troubled patients, even in the most experienced sex therapist offices.

Experienced sexologists understand the impact of conflicts, boredom, or unhappiness with partners and that these and other types of sexual dysfunction can contribute to desire disorders. Poor communication between partners is often present with all sexual dysfunction, desire and arousal problems. Members of society seeking information, education, and sex therapy may be limited in understanding that learning to communicate, resolving conflict, and dealing with negative emotions are positive points that can enhance sexual relationships. Although they may be aware that there are problems, that they no longer desire sexual interaction enough to have it, and that they feel unhappy in their relationships sexually, they may be completely unaware of how to remedy those difficulties.

Desire, the phase prior to any sexual action or interaction, is the area that needs more research specifically due to its depth and variety of definitions. To place it in the arena of diagnostic mental disorders when there is lack of it is confusing. A singular

definition of that first phase is needed to enlighten society so that a better understanding can lead to better solutions. A noted psychologist and clinical sexologist in the field, discussing the origins of desire stated,

> "Your biggest sex organ is the one between your ears. What is desire, after all, other than the hope that you can fulfill your sexual fantasies? And that's all in your mind." (Granzig 2006).

What makes the mind engender fantasies of sexual fulfillment? How can sex therapists use knowledge of fantasy and phase-one-desire to help patients reach their goals? A look at the basis of human sexual interest leads the way toward a new definition and begins the development of theories for more successful therapy.

The biological and genetic factors affecting desire are deeply rooted in us and universal. Originally biological desire was based on procreation, as humans, like other animals, were uncivilized and probably had sexual contact to simply increase the population. It was later in our evolution that pleasure became the primary reason for sexual contact. As experienced clinicians, our interest must turn to answers about what began the pleasure phase of desire to have sexual contact in the first place. Where does the interest start, what is its nexus? Desire starts in the thinking mind and may come from what we know and describe as our sexual template and/or what we find attractive as individuals, or as previously stated our cathexsis to express the affectional, emotional and sexual energy in determining a sexual object choice. The question is where does this necessity for a template originate and what does it entail?

Experienced sexologists understand that desire or lack of it may have simultaneous causes as previously discussed. Society generally acknowledges that desire is probably caused by certain cues, and that lack of it may be due to feelings of boredom, anger, apathy, or any number of negative emotions and health related issues. Generally

speaking members of society agree that when feelings are positive, desire for sexual contact may be increased. Some people agree that sexual desire is markedly increased, as a possible means to reduce stress or redirect attention, when circumstances of life are especially difficult as well. Cues that foster desire differ for each person.

Sexological research in general shows that development of our sexual template is a process that takes place and indelibly imprints on each human mind during early stages of development and continues to refine as we age. If this is true that the sexual template may have to do with biology, then other theories about phase-one-desire can be researched and developed from that premise. The chemical changes in our brains, which determine our gender and sexual orientation, also may affect our individual view of what is desirable. The sexual template for the typical female brain probably would be to find masculine qualities desirable in a partner or the male gender in general as a starting point for desire. The typical male it would seem then will find feminine qualities desirable or the female gender in general as a starting point. All embryos begin as female. There has been a theory postulated, yet unproven, that if there are only partial changes in the brain chemistry from the original female fetus to male, the resulting male may have the sexual template for same sex partners, defined as homosexuality. If the chemical changes in their bodies during in-utero development did not fully alter the brain from the original female model, males might view males and masculine features as desirable in their sexual template. The same might be true of the female embryo whose hormonal shift only began to be triggered to produce a male; would the resulting female child with this partial shift prefer female qualities as sexual interest and result in lesbianism? Use of the term *starting point* represents the basis of what a person may find desirable from one point in

time and why. From this starting point of finding which gender is desirable the individual can become more selective of various traits as biological maturity, development and interest continue. The sexual human will eventually prefer a fully developed template from which sexual interest, fantasies, and desire can be nurtured and fulfilled.

It is possible that the genes making up DNA in each of us from generation to generation also influence desire. In modern society, men and women are not living as their ancestors did long ago by struggling to keep warm, engaging in daily hunting and gathering or being on guard for wild animals. If our ancestors were to select mates who failed to deliver the resources promised, who had affairs, who were lazy, who lacked hunting skills, or who were abusive, their survival, and specific DNA reproduction would have been at risk. In contrast, a mate who provided abundant resources, who protected their mates and their children, and who devoted time, energy, and effort to the continuation of the genetically sound family would be a great asset. Because of the choices made by our ancestors, who chose well and thrived, a clear evolutionary desire in a mate evolved. As descendants of those people, we carry their evolutionary based interest with us today. Because of different times and demands of location and society, we still possess some of the selection based traits of our ancestors but to varying degrees. Society still shows a clear interest in survival of the fittest, according to research quoted on BBC News.

> Women are attracted to more masculine-looking men at the most fertile time of their menstrual cycle, psychologists have shown. During the less fertile times, they choose men with more feminine-looking faces. These are seen as kinder and more co-operative, but less strong and healthy genetically. A controversial implication of the new research is that, in evolutionary terms, it is natural for a woman to be unfaithful in order to

> secure both the best genes and the best caregiver for her children. This is because a less masculine-looking man may be a better long-term partner, but the strongest, healthiest children would be produced by a quick fling with a more masculine-looking man. (BBC News 1999).

An international study on choosing a mate was conducted by David Buss and his colleagues for over five years from 1984 to 1989, in thirty-seven cultures. They investigated populations that varied on many demographic and cultural characteristics. The participants came from nations that practice polygamy, such as Nigeria and Zambia, as well as nations that are monogamous, such as Spain and Canada. In all, the study sampled 10,047 individuals. The results were:

> Male and female participants in the study rated the importance of eighteen characteristics in a potential mate or marriage partner, on a scale from unimportant to indispensable. Women across all continents, all political systems (including socialism and communism), all racial groups, all religious groups, and all systems of mating (from intense polygamy to presumptive monogamy) place more value than men on good financial prospects. Overall, women value financial resources about 100 percent more than men do, or roughly twice as much. There are some cultural variations. Women from Nigeria, Zambia, India, Indonesia, Iran, Japan, Taiwan, Colombia, and Venezuela value good financial prospects a bit more than women from South Africa (Zulus), the Netherlands, and Finland. In Japan, for example, women value good financial prospects roughly 150 percent more than men do, whereas women from the Netherlands deem financial prospects only 36 percent more important than their male counterparts do, or less than women from any other country. Nonetheless, the sex difference remained invariant--women worldwide desire financial resources in a marriage partner more than men. (Buss 1994. pg 24).

The outcome of this study shows that from our ancestors up until the present day, the idea of security or having adequate means is still important for a woman's interest in a sexual mate. A sense of security, as well as the potential for healthy offspring, will increase the interest or desire for sexual contact of females.

Men usually desire different traits in a mate and this too comes from our ancestors. Mechanisms evolved to allow men to sense cues to a woman's underlying reproductive value. These cues involve observable features that can be seen and ultimately influence desire, arousal and mate choices. Our ancestors had access to two types of observable evidence of a woman's health and youth: features that can be easily seen are physical appearance, such as full lips, clear, smooth skin, clear eyes, lustrous hair, and good muscle tone. Women are at their peak health and fertility in their late teens and twenties. A study was conducted over the course of several decades to see which traits men find most desirable in a mate using college students as a sample group. The findings showed that men placed the highest value on physical beauty and this was consistent through out the progress of the study.

> A cross-generational mating study, spanning a fifty-year period within the United States from 1939 to 1989, gauged the value men and women place on different characteristics in a mate. The same eighteen characteristics were measured at roughly one-decade intervals to determine how mating preferences have changed over time within the United States. In all cases, men rate physical attractiveness and good looks as more important and desirable in a potential mate than do women. Men tend to see attractiveness as important, whereas women tend to see it as desirable but not very important. The sex difference in the importance of attractiveness remains constant from one generation to the next. Its size does not vary throughout the entire fifty years. Men's greater preference for physically attractive mates is among the most consistently documented psychological sex differences. This does not mean that our genes forever fix the importance people place on attractiveness. On the contrary, the importance of attractiveness has increased dramatically within the United States in this century alone. For nearly every decade since 1930, physical appearance has gone up in importance for men and women about equally, corresponding with the rise in television, fashion magazines, advertising, and other media depictions of attractive models. (Buss 1994, 58).

Culture will further influence the development of a person’s sexual template. For example, what is thought to be attractive in one part of the world could actually cause a

lack of desire in another. Things as simple as daily wardrobe, size and shape of the body, a slim versus plump body build are viewed as sexual enhancements in every culture and across time. In a book entitled *Erotica 17th-18th Century* by Gilles Neret., two hundred pages of various erotic artworks from that period, in the 17th and 18th centuries, can be found by unknown, anonymous, and also famous painters including Rembrandt. The images were considered desirable and erotic for the time-period. The women portrayed are plain and sometimes muscular with a much higher percentage of body fat. Today the sexual template of society is consistently manipulated through vast media outlets as we, as a world society, are shown what is arbitrarily desirable. The trend is toward females with larger breasts, slimmer body type, a small midriff and long legs. Heavy, or full figured females is not the media image of what females should strive for, not what men are supposed to find desirable. Both sexes are encouraged through all media pressure to find this female body type as the most desirable, and sexually attractive. Males, who are promoted as sexually desirable are shown in media advertisements and video footage as muscular and slim. Often men who are older, with graying hair, and who appear to be successful and prosperous are depicted as sexually desirable, matching the image previously identified in research. Today men of this type are shown in hormone and/or erectile dysfunction pharmaceutical advertisements.

Modern media in this era show significant shifts in how society's view of desirable body image has been manipulated and changed. An example of this shift can also be seen in a more current erotic magazine that has changed the types of women they show as desirable to society over the years. Looking at various magazines and cover models from Playboy magazine in the 1960's reveals the desirable look of women in that

era as having more body fat percentages, less make up and less need for use of photo-shopping. (Peterson 2008) Photo-shopping refers to modern techniques of using a computer and programs for photo enhancement and change to edit skin blemishes, freckles, moles, and other perceived body imperfections. Searching the internet for Playboy cover models from the 1970's until the year 2000, shows a constant focus on image perfection, a decrease in body fat percentage of the models, and an increase in their breast size.

Throughout the years, men who have bought this magazine and others and women who have seen them have probably slowly accepted this manipulation and changed their perceptions in what is sexually desirable. Men have been consistent, as the study by David Buss suggests, in their search for youth, health and beauty in women partners. Beauty has changed its look. Women have adopted these ideas for themselves as well, not necessarily in what they find desirable in how women look, although research shows they agree as well, but what they feel a mate would find desirable in women. Surgery on women, by choice, for female breast augmentation and fat reduction through liposuction, lap-band, and intestinal bypass has increased exponentially. However, women still look for a man who is giving, financially stable and of high status. (Peterson 2008)

Despite the influence from the media and society through the ages, sexual interest is still rooted in our genetic make up and even our five senses. Because of this deep rooted sense of attraction, desire may be aroused on a subconscious level as well as consciously. Sexual desire, linked to our sexual templates, does not always initiate with our full awareness. Perhaps subconsciously we are always aware on some level of the need to procreate, and whether we are creating human life or not, we are programmed to

react as if we are. Does this then create desire and arousal for sexual contact? The author of *The Nature of Sexual Desire* suggests that sexual desire is what always fuels our sexual awareness by stating:

> There may be other desires, intentions, and concerns that blend themselves with sexual awareness, but this does not change the fact that what ultimately lies at the core of such instances of awareness is sexual desire. (Giles 2004, 2)

Linked with our sight-sexual-awareness are our other senses. Previously mentioned are some of the sight related issues of desire and arousal. Out of touch, taste, smell, hearing and sight, smell is the most basic and powerful sense we have. A variety of smells affects men and women in a variety of ways. Studies in 1998 and 2006 by Alan Hirsch of *The Smell & Taste Treatment Research Foundation* showed that:

- Men were most aroused (40% more blood flow to the genitals) by the smells of lavender and pumpkin pie; and by doughnuts and licorice (31.5%)
- traditional perfume or "floral fragrances" give only a 3% increase in blood flow
- women found some aromas stimulating, while others actually shut down blood flow to genitalia
- Women showed the most sexual response to the fragrances of licorice candy, cucumber, baby powder (each 13%); pumpkin pie and lavender (11%)
- women were actually turned off by the smells of men's cologne, barbequed meat and cherries (Hirsch 2006)

The connection between sex and aromas may be as simple as a correlation with happiness and learned behaviors. However, it is clear in research that pheromones are significant to reproductive, therefore sexual, interaction in more creatures than just the human being. Humans have a sense of smell that does not match that of other mammals that have many more olfactory cells, for example dogs have approximately 200 million to our 10 or so million. It is generally known that animals are drawn to copulate by sense of smell during

estrus. Our vision, it has been postulated, tends to be better than our sense of smell, however could it be that our sense of smell may trigger fantasy and desire? In fact, research shows that olfactory response plays a large part in our human reproductive process and that in turn affects human behavior. In recent research there are clear indications that rats when given an arbitrary odor will learn to associate that with female rats that are absent the odor normally associated, and that the new odor will cause a rise in luteinizing hormones associated with sexual contact. This may be Pavolian behavior. (Kohl 2001) The same happens in human males in the presence of females and also when there are only estrogen pheromone compounds present alone. There is an arousal response in the hypothalamic regions of the brain that can be seen in straight males according to a study in 2005. It may be that the brains of the participants acquired a sexual response to these hormonal chemicals as a result of previous sexual experience. In other word, the response to estrogen pheromones described in this study could be a learned response associated with smell. Gay males in this same study also showed hypothalamic response to estrogen pheromones, but much more to testosterone pheromone compound. Straight females in the study also showed hypothalamic arousal patterns to the smell of testosterone pheromone compound. (Throckmorton 2005).

The origins of desire discussed here have one thing in common. They are associated with and stem from the mind, and/or areas of the brain. No matter what our genes and five senses, our families, our cultures, our era, our society and our never ending barrage of advertising tells us, our desire starts in thought and physiology, learned fantasy and is rooted in our sexual template. The mental and physical aspects of desire and arousal are entangled, even if society seems to focus on treating only the physical

aspect of arousal with a goal of the quick fix. Close attention to the popularity and large volume of sales of Viagra, Levitra, and Cialis as well as other erectile dysfunction medications are a clear example of this focus. Due to a lack of understanding of desire, many individuals are looking for pharmaceutical and easier remedies for boosting sexual desire. Most of western society seems to be looking for a magic pill, an aphrodisiac as the answer, while eastern and ancient civilizations utilize herbal and spiritual approaches. Society, often neglecting the many and varied areas available to enhance desire continues its frantic search for the goal of making people more interested in sex for pleasure, and in perfecting sexual body responses. Experienced sex therapists, taking this cue can include cosmopolitan ideas to help patients reach their goals. The new green movement toward ecologically sound practices can incorporate the five senses as well as cognitive and behavioral techniques to help patients discover and accomplish their goals of more satisfying sexuality.

ECOTHERAPY IN PRACTICE

Experienced sex therapists will want to keep up with main stream thought and theory in regard to the renewed focus on ecology, natural environment and the green movement. The word Eco actually historically has its etymological root in French, Latin (oeco) and Greek (oikos) origins. The meaning at the time had to do with house or household, habitat. It is currently thought of as a prefix, a quality or attribute of something. More recently it is associated with habitat, environment, ecological, natural, and original or saved environments. The word Ecology is the scientific study of the distribution and abundance of life and the interactions between organisms and their environment. A popular term in today's society, ecologic or ecological may be connected with the sense of being environmentally friendly. A search for the word eco combined with other areas of study leads to a great deal of information forming new thought and theory. The term eco-psychology, for example, is often used interchangeably with many other terms such as environmental psychology, environmental sociology, and environment-behavior studies (Wikipedia 2008). This theory has a place in considering sexual goals.

Roger Barker was a researcher in the field of environmental psychology. From his observations in the field, he developed the theory that there is an influencing factor in social settings that affect behavior and he believed that man in his natural environment should be a focus of study and research. Anthropologist E. T. Hall wrote *Hidden Dimensions* and defined four interpersonal zones that measure the amount of personal space man is comfortable with in specific situations. These included intimate zone,

personal zone, social zone and public zone, each growing larger in distance and determined culturally (Wikipedia 2008).

Eco-psychology has been around since the early 1990's and was probably brought into mainstream society by Theodore Roszak who coined the term in his book *The Voice of the Earth.* Eco-psychology theory regarding mental health is that mental health is affected by our relationships with our environment or the ecosystems in which we live. Humans are dependent on healthy natural environments, personally and culturally, not only for their physical sustenance, but for mental health too. The damage to ecosystems may mean that we cause damage to ourselves mentally as well. (Wikipedia 2008)

Ecotherapy is based on the emerging field of ecopsychology, which looks at the relationship between our mental/emotional/spiritual health and our culture's increasing disconnection from the natural world. Ecotherapy,

> "is a way to improve mental health by being active outdoors and in a green environment" (*What on Earth is Ecotherapy?* n.d.).

Studies have shown that 'green exercise' has helped decrease depression for people with mental health problems. Ecotherapy may help people find balance, connection, guidance, and healing in their personal lives through deepening their relationship with the natural world. The practice redirects us to see our personal needs and wants within the web of life and to discover new ways to honor the world and people around us. (Mackey, n.d.) Ecopsychology, ecotherapy and ecospirituality all seem to be part of the same theory and that theory is presented at times with the exact same wording in definitions found. The common theme between the three is one of acceptance. Eco, and which ever follow up word you choose to use, seems to be part of the green movement, or the minimal environmental impact movement. The focus of these therapies

are on removing the negative feelings that go with being unbalanced physically, mentally and spiritually with emphasis on holistic approaches for remedies. Many universally used websites generally agree that we as human beings are a part of the whole of nature and our world, that we are all one with every component of life. Ecotherapy then, addresses these issues by helping us form a connection with each other, our partners and our world. Incorporating these ideas into healthy sexuality can only improve movement toward sexual interest goals.

Many bird and animal species decorate and tend their courting and mating areas with great care before they are able to make love or begin the process to procreate. In the same way, if a human believes they have helped create a healthy, thriving and vital planet, or environment for self and partner, sexual interaction may be improved. Unfortunately, some mental health facilities have become very modern and the use of the outdoors as a therapy tool has virtually vanished (*Health & Fitness Magazine* 2007). The renewed societal focus on ecology may be a significant area of interest for therapy patients who seek guidance and healing and attain it through deepening their relationship with each other and with everything in the natural world. Although appearing to be unrelated to sex therapy, examples of techniques in ecotherapy, ecospirituality and ecopsychology would include encouraging a simple daily walk, paying close attention to seasonal changes, or joining with a partner to clean up a local stream. The parallel process of thought, interest, and commitment to these activities can match those of the individual's or partner related sexual activities. Attention to feelings associated with this technique can be addressed in therapy as patients are encouraged to process the new awareness in dealing with their sexual partner and relationship.

Use of the common theme of acceptance in this environmentally sound and currently popular process in sex therapy should include the patient's positive regard for increasing natural and holistic sexual interaction between partners or for the individual self. These same eco-positive techniques described could encourage renewed natural intimacy when done with a partner. The techniques and skills learned can be related to sex therapy through a patient's development of patience, understanding, connectivity and acceptance of their own unique sexuality and that of others, more specifically to their partner. Personal respect for space/environment and creating a more personal sexual space in their home and lives can help increase comfort, acceptance for, and phase-one-desire for sexual interaction, of partners.

Although directly in line with most religious tenets, eco therapy, psychotherapy and spirituality in this format could also be beneficial for those that don't follow or practice any mainstream religions. As a holistic process for sex therapy it could give an outward focus that may feel less personally threatening. For those without a personal religious dogma to bring taboos and rules to sexuality, the new eco-sexual, natural process of sexual interaction may be a refreshing change. Even if this is a placebo effect at work, this new area, thought, and theory in therapy could lead to a greater sense of wellbeing that would affect emotional as well as physical health. These are the two main parts of human beings that are involved in the sexual response cycle and possibly phase-one-desire itself. For clinicians, are there more additions to include with these eco-ideas for finding the evasive phase-one desire enhancement goal, the key before arousal occurs? There are other interesting options now available to experienced sex therapists

that will also improve their therapy practice, educate society and actually make a difference in the sexual lives of their patients.

The Perfect Sex Therapy Office: Safety

It is generally agreed, after researching the topic , that there are indeed ideas among colleagues and patients about what makes a mental health office setting perfect. There is no current literature on the perfect setting that focuses on all aspects of safety, furnishing, paperwork, and extras. This chapter will focus on all those issues as they relate to new and especially the experienced therapist who hopes to build and develop a successful practice. The perfect setting for a sex therapy office is unique, however, all agree that any therapy office must be in a good and safe location. This means pointedly safe for the therapist as well as the patient. Recently, on February 12 of this year, Dr. Kathryn Faughey, a clinical psychologist in New York City was murdered in her office by a patient of her colleague. Apparently he came to the offices to rob Dr. Kent Shinbach, MD, a psychiatrist who had treated the man. (Munsey 2008)

Due to the death of Dr. Faughey, Mr. Munsey, noted that research shows low levels of awareness to danger by many experienced therapists, and especially those new in the field. Indeed research by Laura Gately and Sally Stabb, who interviewed 200 doctoral students, shows that they agreed the training they received regarding violent patients and episodes was virtually nonexistent and they admitted being ill prepared to handle patient violence. (Gately and Stabb 2005) Munsey compiled a list of suggestions, from a number of psychologists, for improving therapists' offices with an eye on safety. Some of those ideas are presented here with addition by the author of this paper.

In larger cities where it is possible, therapists should lock the door to the office system and make it possible for patients to be allowed entry after pressing an entry button. Therapists in private practice typically always have patients who have scheduled

appointments and never accept walk in patients. Security cameras in common areas should be considered, and used, by any therapist who sees patients with a violent potential or history. Screening potential patients for violence with common assessment instruments like the MMPI-2 and other tools could be helpful in discerning who to keep and who to refer to more qualified agencies. Remembering that a therapist does not have to take every patient is a good practice. If you feel uneasy, trust your instincts.

Every office should have a rehearsed evacuation drill that has been practiced and refined more than once. This facilitates the egress of staff on the premises and ability to contact law enforcement immediately should it be required. It is a good idea to let patients know that this plan is in place in case of emergencies. Doing so affords them the hope of safety and assures them that the therapist plans to be safe as well. A secure area of the building or office suite, immediately accessible, can be designated as an area where staff can be safe and locked away from any intruder or threat.

Establishing a system where patients can securely lock away their personal belongings while in the common and main office area, will help insure that no weapons are carried into the therapist's office in a purse, valise, or backpack. Patients given the privilege of use of a locked drawer are given the key while in session and may retrieve personal belongings prior to departure.(Munsey 2008)

The experienced therapist knows that placement of a desk in the office is of utmost importance. It establishes a boundary between the patient and the therapist if such a boundary is needed by either person. It also signals that the therapist is open and available if the desk is not used as a boundary. However, with this in mind, no boundaries-of-protection also leaves both the patient and the therapist open to assault. To

counter the potential for assault on a therapist, placing the desk and a rotating chair against the wall closest to an exit door is a must. This position allows seating for the patient away from the exit door and facing the therapist. An experienced therapist will practice getting up and down many times a day and leaving the office by that door. If any action or overt anger is expressed by the patient or sensed by the experienced therapist, they must be prepared to give themselves an out and immediately exit the room. Excuses for this exit often suffice if distraction is needed. Having an alarm system, panic button, or code words used between staff, colleagues, and therapist will help to protect therapists and others from potentially violent episodes.

In an office setting where other colleagues share space, it may be a good idea to reduce the sacrosanct idea of sessions and periodically allow very brief interruptions from a colleague. (Munsey 2008) This type of behavior introduces reality into the world of therapy sessions and sets a precedent for openness and limited privacy where situations may hold a potential for danger. Experienced therapists with colleagues should be able to call for immediate help that is reciprocal to them as well. In an office setting where a therapist is alone, in private practice with no staff, therapists can consider a safety monitoring system with a remote key alarm, or panic button audited by a local police or security agency. Therapists in private practice must never work alone at night when others are not around. Clinicians can ask police to patrol the area and inform them of the time that the office will be closing so that they can be present and aware of discrepancies in schedule. Female clinicians should consider never having appointments with male patients after dark, and males could consider the same with female patients' appointments, both for safety and potential threats of stated impropriety.

Experienced clinicians would never, and should never use their private homes as a therapy office. The potential for danger, and stalking behaviors, goes up exponentially when patients are allowed this intrusion into therapists' private lives. And the therapeutic boundaries facilitated by singular definitions of therapist-patient roles is forever broken and redefined. All of these thoughts are even more pertinent for the safety of clinical sex therapists.

Even experienced therapists often miss potential weapons in their own office because they are seen daily and look like simple letter openers, statuary, paperweights and chairs. Removing potential weapons, or keeping them out of reach or site of patients is a good idea. (Munsey 2008) Clothing chosen and worn to the office can also be considered here. Something as simple as a necktie or decorative scarf can be dangerous in the hands of a patient who is angry. A patient instantly grabbed a necktie worn by this writer , many years ago. when the patient reacted angrily due to transference issues. It is an experience in potential danger that this writer will not forget and can warn against.

Therapists can consider enlisting local experts willing to teach self defense , and can consider taking classes to learn to protect and defend oneself from attack. Often simply stepping out of the way of a lunging patient is enough, but when it is not, there are techniques that can be easily learned to stop physical harm to the clinician and allow the therapist to break free from a patient's grasp. Nothing helps more than awareness of violence potential and making the office setting perfect to thwart and decreases such threats.

The Perfect Sex Therapy Office Setting:

Location and Furnishing

The location, appearance, layout of, and everything found in an office has an effect on the therapeutic process and on the patient. Many therapists do not fully understand the significance between office setting and the therapeutic relationship. Simply the location of the office alone will have a great deal of influence in the patients overall comfort, and willingness to return for future sessions. Katherine Morris, in writing about the focus of a literature review states,

> A review of the psychological literature shows that the office has been virtually ignored and the therapeutic relationship emphasized, and so therapists are not taught about the 'office' per se. The office is an extension of the therapist and is therefore part of the therapeutic relationship. Meeting in a posh private office has a different effect on a patient than a session held in a bare-bones agency setting. Likewise, meeting in the patient's home, a quiet outdoor place, or any area other than the therapist's office can effect what is expressed, felt or imagined by the patient and the therapist. (Morris 2007).

After considering safety of the location and inside the office for therapist and patient, other important influences come into play. An experienced therapist is also a business person who plans to make a living doing therapy. Attention must be paid to the setting and furnishings. The best office should have curb appeal that invites the patient in. It must also be secluded enough that patients do not think that they are on display to the public as they enter for therapy. Seeking mental health or behavioral therapy in itself still

carries a stigma of taboo or embarrassment for some, and seeing a sex therapist is not something that many will ever admit they are doing or have previously done.

There should be adequate legal parking for the therapist and patients. Thought should be given to the type of patients to be seen and a safe parking area to accommodate those patients is a requirement. Handicapped patients must have the best spaces.

The office chosen and furnished by an experienced sex therapist is an investment in future success. The exterior of the building needs to look aesthetically and ecologically pleasing, for example, a well-kept lawn, fresh paint, area free of dirt, cobwebs, or other debris. All lighting on the outside of the building should be maintained and working to ensure a safe, well lit entrance and exit. The building address numbers should be easy to read so new patients are not searching unnecessarily for the building. A clean receptacle for trash and cigarette debris could be placed outside by the exterior door. The office should not have any strong odors, including room sprays or deodorizers, to accommodate the physical health of patients who may be allergic to chemicals and those aware of the eco-green movement.

The building, or office when possible, should be equipped with separate entrance and exit doors in an attempt to preserve patient confidentiality. Once inside, attention to many details will help ensure a positive response from patients.

According to Georgia Dullea, in her article on the subject, if a therapist has plants in the office, they had better be healthy,

> "A healthy plant is a metaphor that growth goes on here. But if the plants are dying, the therapist is giving the message that he or she isn't capable of nurturing real, live patients.
> There is symbolism in chairs, too." (Dullea 1983).

Therapists may consider contracting with a local greenhouse or florist for regular maintenance and rotation of live plants. Too little attention to esthetics as well as a sudden shift in décor can also send an unsettling message cites Joan Oliver who interviewed a therapy patient stating that she,

> "went so far as to confront her therapist on the issue. A ripped, falling-apart sofa was a bone of contention. "She's a wonderful therapist," Ms. Paul said, "but I told her, 'In order for people to trust you and feel they can come to you and talk about their deepest, darkest problems, you have to create an environment of professionalism and comfort.' No one would suggest selecting a therapist on the basis of decor. But the right design can be an attraction." (Oliver 1996).

As professionals, we need to remember that we are not treating a diagnosis. We are treating the individual who is suffering from bi-polar disorder, schizophrenia, depression and other symptom anomalies. Although they are patients who need attention, many will immediately make note of any discrepancies in the office that also require the same..

A good rule of thumb then when considering a perfect office is that it should reflect the status or quality of the clientele the therapist hopes to attracts. Furnishings are an investment in success and must be of high quality, comfortable and easy care, while pleasant in appearance. An experienced therapist's office will be one that encourages patients to relax as much as possible and that engenders a feeling of safety for disclosure. Furniture that appears garish, formal, ultra modern, cheaply made, or fragile in design will put patients off and probably make them ill at ease. Couches and chairs, though of high quality, should be casual enough to be inviting and comfortable enough to be used with confidence.

Chairs, shelves, tables and the therapist's desk should never be made of metal or plastic, but of a good quality wood and fabrics where applicable. Leather is excellent for

couches and chairs as long as it is of good quality, and comfortable. If a file cabinet is a requirement and absolutely essential to the interior office, it should be a low two drawer model, made of a good quality wood, not veneer, and be able to be securely locked. It is far better, and should be common practice, to have all file cabinets in another area out of sight since they are rarely used during sessions. Hardware on all pieces of furniture must be of high quality, or none at all. Bulletin boards, due to their messy, agency/dorm room appearance, are not appropriate in any areas where they will be seen by patients. Bookshelves filled with current or classic text regarding the therapist's specialties, and those of acclaimed authors in mental health is a good idea. These books must be in good condition, well organized and without dust. Gently handled, well read books add to the idea that the clinician has done reading and research.

Many new therapists and some who are experienced do not recognize the need for a clock that can be seen by the patient so the patient can monitor the time left in the session. Patients will normally be careful of the time left and gage their disclosures accordingly. This clock must be of high quality material, with prominent numbers that can be easily seen from across the room if necessary, and must face the patient. This allows the clinician to keep his or her attention on the patient and not on the clock, encouraging security, safety and bonding in the relationship. Plastic, dollar store models are unacceptable in perfect sex therapy or mental health business office settings.

Like the clock, placement of furniture in the session office, apart from safety issues, is equally important for process related issues. The therapist's chair and desk, kept neat and uncluttered, should be placed by the door as stated earlier. This allows the experienced clinician to place other furnishing like a firm, comfortable couch, and a chair

or two about the room. Patients will be asked to choose the place they will be most comfortable and an experienced therapist will be watchful about where a patient chooses to sit. Will a patient choose to sit closest to the therapist or farther away, will a couple sit together on a couch or separately? Will children sit between their parents or align with one or the other? Placement of furniture should be deliberately placed to answer important process questions for the clinician. This allows the therapist to separate partners who can then face each other and talk. The therapist's chair, being mobile, can be moved to take advantage of proximity issues, allowing easy moving into and out of the action.

Carpet or flooring in the inner office must be of good quality, in good repair, and clean. It is imperative for safety of the patients and because patients notice discrepancies of this kind. They expect good quality when they are paying for services from a therapist, even if it is only a floor. Lighting of the office space should be incandescent and good enough to read by in all areas, yet low enough to cast a glow of warmth and hominess, and never harsh fluorescent or overhead.

Window treatment must be of high quality fabric, wood or other materials that the clinician's patients would be expected to have in their own home. Consider the idea that if a therapist covers office windows with cheap plastic mini blinds, that therapist may draw patients who can afford to cover their windows at home with cheap plastic mini-blinds. This writer knows a colleague who uses plastic lawn furniture for her patients in her office opposite her desk. Her practice is not thriving.

In the best offices there is a waiting area that is not immediately adjacent to the therapist's office and is large enough to accommodate the clinician's largest single group

or family. Patients can wait there without the thought that they will meet the next patient as they exit their session. An experienced clinician will be aware of noise in the waiting area and offices and use a white noise or sound device that masks voices and sounds that could be overheard. A sound machine inside the therapist's session office masks exterior waiting room noise as well. Many offices also use ambient sound from radios or stereo systems, playing quiet soothing music to mask noise and relax patients. When the clinician's office is adjacent to the waiting area a well designed, good quality, and obvious sign should be available to signal any incoming patients that the therapist is still in session when applicable. These can be purchased with a slide in frame that fits on the therapist's office door, in either colored plastic, or brass finish from any place that does engraving. Normally the reverse side is blank, but can be engraved to suit. It may say 'Therapist in Session' or 'Please Wait' as appropriate.

Waiting room furniture must be of good quality and comfortable whether it is separate chairs or sofa seating. If acceptable, some clinicians include a coffee pot with brewed coffee, and hot water for tea plus tea bags and accouterments. When possible, china or glass mugs are best for quality, but disposable, good quality hot cups are acceptable. A water cooler or filtered water at the tap is an excellent idea.

A coffee table and end tables by chairs are a good idea so that patients can place items off the floor. Both must be of good quality, closely matching the quality of the inner office furnishings. Lamps may be floor or table lamps, but must caste an ambient glow suitable to read by without glare. Either style must be heavy enough that they are not easily tipped over or seem fragile when turned on. Overhead lighting and/or harsh fluorescent is not appropriate in this setting. Reading material in the form of magazines

or books is appropriate for the waiting area with the restriction that the magazines be current and in good shape. Torn, old or abused books and magazines show inability to care for surroundings, lack of investment, and commitment. Some clinicians serve foods like cookies or small wrapped candies in a closed container. These are choices made based on the clientele a clinician hopes to draw.

Artwork throughout the waiting area and inner session office can be designed to evoke thought and emotion from patients. Serious consideration should be given the patient population of the therapist prior to permanent purchase of artwork. Low class, low cost, cheaply framed art from local discount stores is not acceptable for a successful office. If purchase cost is a problem, consider rental of good pieces. Abstract art can be disconcerting to some patrons and evoke anxiety and discomfort. Landscape scenes may sooth patients who are stressed, while pictures of people interacting, the ocean, or animals, may evoke varying emotional responses. Personal family photos placed where patients can see them may not be appropriate although many therapists choose to display them. Thought should be given to the natural transference stories that patients make up that are a rich part of the therapeutic process. Personal family photos belonging to the therapist and seen by the patient, will undoubtedly and significantly change what a patient thinks and feels.

It should go without saying that boxes of tissue, coasters, and napkins if there is food or drink, should be easily available to patients in any therapy office setting. Small simple receptacles fitted with liners for trash are a must. If needed, pens, pencils, paper and a white board may be stored and available for visual aids, education, or group sessions. A small TV with DVD/VCR capability can be useful for educational films. Data

equipment for the office takes thought and research for pricing and good quality. The perfect sex therapy , mental health office will have a printer/copier, laptop computer with DVD/CD capability, portable telephone with enough range to walk outside if needed, a personal data assistant (PDA) that synchronizes with a computer based calendar system in the form of a singular system or combined with a cellular phone, and an office telephone with message machine as a backup for patients' calls.

In the successful office of today, an experienced therapist is using computerized forms and has an essentially paperless office except for the initial intake paperwork filled out by the new patient and kept in locked storage. Computerized forms of this kind can be purchased by the clinician or developed personally, following all the requirement rules of that clinician's license. It is essential that sex therapists follow these requirements to deter legal issues. Storage of data in incredible amounts can easily be done on discs for the purpose. It is imperative to note here that no data about any patient should ever be stored on a therapist's computer hard drive due to the possibility of ever breaching HIPPA laws of confidentiality. Consider theft or eventual sale or discarding of a computer tower or laptop. Data kept on hard drives IS retrievable even if deleted. If you have already made that mistake, a word to the wise; when purchasing a new one and ridding yourself of that old hard drive, remove it and completely destroy it. Use a hammer.

Two final pieces of furniture that need extra attention are a locking trunk or cabinet and the therapist's chair briefly mentioned earlier. Special consideration should be given to the chair that a clinician sits in all day long. It must be exceptionally comfortable, of excellent quality material and designed to support the body and back for

years without breaking down. This singular piece of furniture should fit better than the most comfortable pair of shoes. It needs careful consideration prior to purchase. It is not only where a therapist spend the entire day, but is seen by the patient as *the master's chair.* Imagine sitting in a chair that is frayed, soiled, or breaking down in the back and seat cushion area, or in one in which the legs are wobbly. Imagine patients noticing that. The therapist's chair is and should be a major purchase and will be a good investment in years to come, no matter what the initial cost. It should be easily mobile, normally on wheels or casters so that it rolls easily and quietly across flooring or carpet. There is a company called Relax-the-Back selling very high end office chairs that are exquisitely comfortable and very expensive. Other companies that might be considered are Broyhill, Lane, La-Z-Boy and any fine furniture dealer. Chairs that are advertised as and appear comfortable for 20 minutes on Monday may be a terrible disappointment by Friday. Therapists should sit in every chair more than once prior to purchase and ask about the ability of returns after the chair has been tested for a week.

A locked cabinet or lockable trunk is the next purchase that requires specific attention. This piece of furniture is used to house educational items, objects and materials that the experienced sex therapist removes during sessions at the request of the patients. Articles of this nature may be sexual aids, lubricant samples, condoms, catalogs, videos, diagrams and charts of the human body, and sculpted forms that depict internal and external organs or body parts. The successful sex therapist will have these and other items available to show to and teach patients, allowing patients to ask questions and become more comfortable with topics concerning their use. The experienced and successful sex therapist will have discerning knowledge about each item and comfort in

freely imparting it to patients. Discreet ability to purchase some of the items in the office setting may make patients more comfortable with their willingness to use and try new things in their home environments to enhance desire and find success in sex therapy.

The Perfect Sex Therapy Office :

What Sex Toys to Have on Hand and Why

More than fifty sex therapists were interviewed around the United States regarding having sex toys/erotic equipment in their offices and all of those interviewed stated that they did not have sex toys on hand nor did they consider it a good idea. However, the sex toy and sexual aid industry is one of the fastest growing and most successful industries in the marketplace. New and innovative ideas about building a sex therapy practice require an experienced clinician to think outside the box, to move forward into the world of the future of sex therapy and be willing to become an educator, joining with patients to explore improving and enhancing phase-one-desire in new ways. It is possible, with these thoughts in mind, that patients looking at new toys, and/or even being able to discuss and touch these items may be aware of the potential for arousal and ultimate success in therapy. Open discussion of this awareness of a natural state of arousal may be an impetus to and help create a desire for sexual intimacy and interaction with a partner that patients were unaware of prior to open education about availability of toys and aids.

A cabinet in the therapy office with sex toys, sexual aids and sexual art objects, and/or sample items for educational purposes indicates to the patient that the items contained herein are special, there is something new to learn and experience, and it allows them to believe they are in a safe environment to do so. Sex toys, aids and masturbation are taboo and shameful topics for many people. Even those who consider themselves liberal and well informed have great difficulty discussing sexuality. Some women hide their vibrators from any public view and the fact that they use them is a

secret from everyone, often even their partners. Men, too, may hide masturbatory devices, explicitly sexual magazines, and movies designed to increase arousal and desire. Experienced therapists are aware of and sensitive to these facts. An experienced sex therapist that wants to increase business and success in sex therapy must be able to explain the numerous options available listed in this paper and be able to discuss openly the uses of each of these aids and art objects, and the educational information patients want and need about them. (See Appendix A) Although clinicians must use discretion when working with significantly shy patients, the clinician must also work through their own embarrassment, reticence, and bias issues on the topics of sexual aids and discussion, just like any other topics sensitive to them.

It is imperative that sex therapists know the laws of their state regarding sexual art, toys, and educational materials of this kind and that observation of legal issues be meticulous regarding purchase and sale of items and/or advising patients about usage options. There are specific legal issues associated with sex toys in certain states. Some US Southern states discourage the sale of, even outlaw, obscene devices such as sex toys (Wikipedia 2008). The National Association for Sexual Awareness and Empowerment (NASAE) is an organization that professionals can join for support in the field of sexuality. This organization provides this type of information, education, resources and support to professionals and to the public to help people become more aware and feel more empowered (NASAE 2008). It may be advisable for clinicians to have patients sign an informed consent document prior to discussing and handling sexual aids, toys, art objects, and information in the office setting. This document might state the patient understands they are being given information only and never being advised to use or

purchase any object they see, handle, discuss, or purchase. It might also state that the patient if doing so is purchasing any item as necessary for a medical reason only or as an object of art and not for use other than that stated.

According to Wikipedia, the definition of sex toy is any object or device that facilitates human sexual pleasure (Wikipedia 2008). This source describes a marital aid as a euphemism for sex toys, although marital aid is a broader term, as it also refers to drugs and herbs that allegedly enhance or prolong sex. (Wikipedia 2008) Sex toys go by a variety of names, including adult toys, marital aides, medical aids, and due to various state laws, art or novelty items.

There is a large variety of sex toys for in office education from which to choose. Many sex toy stores and websites are set up by category, gender, and life style of the buyer, focusing on straight, gay or lesbian and aimed at helping a customer wade through the sea of options on their own. The lists for categories provided usually include vibrators, dildos, anal toys, masturbators, lubricants, dildo harnesses, bondage and fetish items, condoms, aids for erection enhancement, a sale of erotic books, clothing in different fabrics and leather, lingerie, shoes, toy accessories, party favors and gags, adult DVD's, dolls, simulated body parts, similar toys made from various materials, sex toy reviews and guides and tips (Web Merchants Inc 2008). Most WebPages have descriptions regarding what the toy is but there is only vague information about how each is to be used. Most are packaged in brightly colored, somewhat artistic boxes with clear plastic covering for easy viewing. High end items are beautifully packages and some are often colored and shaped discreetly enough to leave out on a bedroom side table. Although most sex therapists do not have room in their office for every item listed, some

should be considered an in office necessity. All items should be able to be discussed knowledgably. Specifics regarding options and use are discussed further in this chapter.

Along with anatomical charts and sculpted medical models, an item of specific interest to the clinician should be a pillow-type simulations of the vulva, that a therapist can use to educate a person about what vulvas look like, and how the area can be stimulated, focusing on anatomical instruction (House O'Chicks 2008). These pillows come in varying vibrant colors and materials that range from exotic silks to synthetics and velvet.

Two of the most well known sex toys or aids are the dildo and the vibrator. They are also purchased more than other toys or aids. Dildos specifically by definition are usually a non-vibrating device, resembling the penis in shape, size, and overall appearance. These items are used typically for insertion into the mouth, vagina, and/or rectum for stimulation, pleasure, and simulating the feel of a finger or penis depending on the size and texture of the dildo. Dildos of varying sizes and materials are also often used for dilating the vagina when a female is experiencing difficulty with insertion and also after cancer related tendencies of vaginal atrophy caused by hormone cessation, chemotherapy and/or radiation.

Dildos come in a variety of textures due to the materials used to produce them and what is most popular for marketing to specific audiences. Some are made of hard plastic while others are made of various softer materials in an attempt to simulate the feel of skin. These may include rubber, silicone and a mixture of latex and silicone called Cyberskin. While Cyberskin may feel more realistic, it may be prone to small tears due to its soft material. There are even varieties of dildos that are manufactured from glass.

They are often made of crystal clear glass, and many are made in vibrant and beautiful colors.

Glass sex toys can be found at many sex retailers and appear to look more like an *objet d'art* decoration than a toy. They are usually made of hard glass, a common name brand of this glass is Pyrex, and they are normally completely safe to use. The user can heat it up or make it cold, and the glass can withstand both temperatures. They are non-porous and washable in sterile solutions to help prevent infection with reuse (Wikipedia 2008). Glass dildos come in many different colors and sizes and actually look like works of art. These toys are longer lasting than other toys of silicone, plastics and rubber, found on the market (Wikipedia 2008). Glass dildos are one of the common glass objects of high quality and price. They do not have seams or sharp edges like some plastic models may. Also, in terms of germs and disease it is the safest material to use for this type of adult toys. Most glass dildos have been rigorously tested and proven durable. Despite being durable users must be careful, if dropped it may break or chip. Use after damage or failure to inspect a glass dildo for cracks or abrasions could lead to serious injury. The safety of glass dildos is up for debate and there are varying opinions depending on which therapist is consulted. One drawback may be limited realism due to excessive hardness. All dildos can be used with forms of lubricants specific to manufactured materials. Dildos without a flange or wide base must never be inserted into body orifices where difficulty in retrieving them would be a problem. A double-ended dildo is a longer, more flexible dildo with both ends designed for penetration. This can allow for mutual penetration between two partners or double penetration for a female, simultaneous vaginal and anal.

Anal toys are toys used to stimulate the anus for sexual pleasure. Butt plugs are short dildos used for anal insertion, which have larger bases, or a wide flange, so they cannot become lost in the rectum. Retrieval of items inserted and lost in the anal orifice is a serious concern and one that sex therapists should always address with patients. Anal beads are balls on a safe string or bumps on a flexible wand for insertion into the rectum and are removable at various speeds for added stimulation. Anal stimulators can be used by both males and females. Prostate massage toys are specially curved dildos used to insert into the anus and massage the prostrate (Wikipedia 2008). It may be the equivalent to a G-spot vibrator/stimulator for a woman.

Nipple toys and aids to stimulate the area around the areola can be used by both sexes. These stimulators are designed like a clamp or clothes pin type device that causes varying degrees of pressure to the nipple when used. Some cause more pressure/pain than others depending on the choice of the user. Other nipple toys are designed to create suction around the nipple area and some also vibrate.

Vibrators in general are devices intended to vibrate against all areas of the body and stimulate the nerves for a relaxing and pleasurable feeling. Like the dildo, some vibrators can be inserted in a body cavity, and are intended to cause erotic stimulation. Some are the simulated shape of a penis, while others that are used for stimulation are not designed for internal use. Some vibrators are larger hand held devices that fit over the hand, or over a fingertip. There are glove and fingertip vibrators that are made of washable materials that slip over the hand or finger and are used for stimulation of a point on the body or whole body foreplay. Other vibrators resemble eggs or bullets in shape and are aptly named due to their discreet size and shape. They can be easily concealed

and/or carried in a purse, pocket or case. Bullet vibrators are small and bullet-shaped, and are for external stimulation, alone, or for insertion into other toys, such as a cock ring, to increase stimulation of the clitoris and penis during cock ring use. Many of the bullet shaped variety come with a control wand that looks like a small television remote control, with only a limited number of operating buttons, and have a wire going to the egg or bullet for activation. Penetrative vibrators are usually 5-7 inches in length and 1-2 inches wide, the approximate size of a real penis. Anal vibrators are usually shorter and are wider at the base so that the vibrator cannot remain stuck inside the body when inserted in the rectum. Vibrators without a wider base or flange must never be inserted into the anal orifice.

G-spot vibrators have a curved shape at the end adding to the ease of fit for women who want to stimulate the G-spot reportedly located on the front wall of the vagina. Vibrator wands are usually large vibrators that plug into the wall. Wands are for external body and clitoral stimulation and many popular retail stores use descriptive packaging, identifying these wands as back massagers. Many vibrators are electric and some vibrators described are battery operated. There are luxury vibrators and vibrators named Rabbit. Rabbit vibrators are large, have a penis-sized shaft for vaginal insertion, and two small ear-like appendages on the lower front part of the shaft designed for more focal stimulation to the clitoris during penetration use. The shaft of the vibrator may contain beads that swirl around in a variety of directions and speeds, all somewhat controlled by the user (Wikipedia 2008). As the Rabbit vibrator is the most well-known in this category, there are also others of similar type in a variety of other animal shapes and objects, such as the Silicone Beaded Butterfly, the Love Bird, The 7th Heaven

Bangin' Beaver (EdenFantasys 2008), The Purple Titan, and the Thumbs Up Vibrator (Xandria 2008). Luxury vibrators are made of precious materials for the upscale market and high-end retailers, such as Fred Segal, who sells them to those who have this preference (Wikipedia 2008). Luxury vibrators could be considered artistic quality. All vibrators may increase the intensity and speed of orgasm and may be helpful for inorgasmic disorders.

Other general toys for penetration are Ben Wa balls and Kegel exercisers. Ben Wa balls are hollow metal balls that are insertable inside the vagina to help increase vaginal strength, which may lead to stronger orgasms, or help women who have trouble achieving orgasm. The Ben Wa balls are for use inside of the vagina for stimulation and can be held internally while standing or moving for varying time periods. Kegel exercisers are to improve muscle tone in the pelvic floor. Specifically as a sexual aid, they are for improving arousal, enhancing sexual pleasure, as well as enhancing vaginal response. (Wikipedia 2008) Both may increase muscle tone for females who have bladder leakage problems.

Some of the non-phallic shaped vibrators come with leg straps so a woman can wear the vibrator against her labia and depending on the shape have stimulation of the glans clitoris and the vaginal opening. This allows the woman to keep both of her hands free if she desires to stimulate her breasts, body, or touch a partner while using this type vibrator. Some vibrators are shaped with a gentle curve and are small enough, yet powerful enough, to stimulate the entire vulva while sitting upright with the vibrator slightly underneath the body. A gentle rocking motion can produce variances in pressure and afford some control. Glove and fingertip vibrators are worn on the hand by either a

person using them auto-erotically, or may be used by a partner who is manipulating them for massage and stimulation of areas of the body to enhance desire, arousal, foreplay and orgasm. All of these vibrators, not intended for internal stimulation and in varying shapes and sizes, are a good alternative for a woman or man who does not desire the sensation of penetration during masturbation but desires more intensity.

The Fleshlight, originally developed by former police officer, Steve Shubin, who was going through a period of abstinence while his wife was in a high-risk pregnancy, is a sex toy that men might enjoy using to simulate penetration. Shubin was granted a patent in 1998 for his invention, as a 'device for discreet sperm collection'. This is the definition given by the patent office for the U.S. Patent number 5,782,818. The Fleshlight, is named for the flesh-like material used in its inner sleeve, as well as the plastic case that houses the sleeve, which generally looks like an oversized flashlight. The inner sleeve, shaped like a long soft tube, fills the inside of the flashlight-looking outer housing. It is hollow with only one opening at one end of the device. A sense of suction is created after penis insertion and with partial or full withdrawal of the penis in a thrust or pumping motion. The interior of the tube is made of a soft material known as Real Feel Superskin. This skin of this device is not made of rubber, latex, or silicone. Instead, a mixture of plasticized oil and polymers is the base product. Use of this type of material could be beneficial for those who may be allergic to latex. The polymer used can stretch to many times its normal size to accommodate the male penis and then return to its normal size afterwards, much like the openings/orifices of the human body. The sensation created, by insertion of the penis into the Fleshlight, is intended to simulate that of feelings of the inside of body orifices. One design option, for the outward appearance

of the Fleshlight is a simulation of the labia majora, labia minora, the vaginal opening, and the glans clitoris. Two other design options, the oral and anal Fleshlights, imitate the look of the openings of a mouth and/or rectum respectively. This aid is designed for male auto-erotic play as well as use by a partner on a male lover.

Penile toys also include a plethora of other objects made for the pleasure or use of a male. The design of Pocket Pussies, for men to use when masturbating, has the various appearances of a vagina, anus, or other body orifice for penile penetration. Cock rings, also known as C-rings, are rings that fit around the erect penis, keeping blood engorgement in the penis to help maintain erection. Some cock rings also have a protruding stimulator to stimulate the clitoris, anus, scrotum, or perineum. Some models have an opening in the stimulator area to insert a bullet-vibrator, as described previously. Cock rings also come in a variety of colors, materials, animal shapes, etc. The best ones would be the ones made with the softest material, which stretch the most, in order to fit the majority of penises and for ease of application or removal This could also provide more comfort than a more restrictive, tighter cock ring. A triple crown is another type of cock ring that has additional rings to hold the testicles. Because the testicles tend to pull towards the body before ejaculation, this restrains them and may intensify an orgasm (Wikipedia 2008). A ball lock is a padlock that fastens around the scrotum, separating the testicles from the penis (Wikipedia 2008). Other common terms are cock and ball cages and cock and ball harnesses (EdenFantasys 2008). Cock rings and ball locks may help men who have erectile dysfunction.

A penis sleeve is a device that goes over the shaft of the penis which is then inserted into someone else, to increase the other person's stimulation during sexual

penetration. Most penis sleeves have beads on the outside to aid in stimulation. There are some penis sleeves, like those found at edenfantasys.com, that vibrate, increasing stimulation for those who enjoy both. A penis extension is a short dildo with a hole in one end for placement over the penis to extend its length and/or girth. This extension may be more for the pleasure of the other partner, by sight or feel of penetration, as it simulates a longer or larger penis. It may also enhance ego concerns in the male who may be worried about prowess and size. (Wikipedia 2008). This aid should not be used for penetration of the anal orifice.

Patients who are shy, developmentally disabled, socially thwarted or who are interested in sexual experience with a copy of a human body can experience that with a large variety of sex dolls. Although probably too large for therapy office storage, accurate knowledge of these dolls, where to get them and their usage is imperative. Sex dolls are human shaped free standing or inflatable dolls. Although the shape of a human female is the most popular, they also come in the shape of men and animals. Sex dolls range from cheaper model sex dolls that are inflatable using air, in lower price ranges of less than $50. Dolls like these are usually very limited and simple in their shape and have no distinguishing features. The heads resemble a balloon with a face, in shape, and their bodies look like the material used for an inflatable pool or beach toy with two halves of plastic or vinyl welded together. Due to their cheap manufacturing, they may burst at the seams after only a few uses.

Sex dolls in price ranges between approximately one hundred to two hundred dollars are dolls made of heavy latex without welded seams. They may have plastic mannequin-style heads and styled wigs, plastic or glass eyes, and properly molded hands

and feet. Some in this price range also have inflatable bodies manufactured in the same way the cheaper dolls are, however, their heads are closer to that of mannequins and may be made of rubber or latex. The more realistic looking heads and faces are used to encourage fantasy and interest and can be used for oral sexual gratification. Other orifices may be usable as well. While more realistic, these dolls may pose a problem for the percentage of users who have a latex allergy. They are also more rigid and less or not at all flexible with the ability to be posed.

Finally, the most expensive sex dolls range in cost from six hundred to above seven thousand dollars. They are made from silicone and the same material used to construct the Fleshlight to look and feel more natural and almost human. The top of the line sex dolls and the most expensive can be very lifelike, with a face and body modeled after real women or men. These male and female dolls have both a mouth and anus opening. While the female dolls have a vaginal opening, the male dolls have an area that accepts several attachments of varying penis sizes. They even have an attachment for a flaccid penis if a woman or man chooses to dress their doll in clothes or enjoy a male figure without an erection. Pubic hair is an additional option feature to these dolls if the owner desires this. The head of the dolls come in a variety of types from large facial features to slim facial features. Asian, Black, Caucasian and Latino skin tones and facial features are options as well. The heads of these dolls also include realistic synthetic ,or sometimes even real, hair. The sculpted skin and hair stretch over a plastic or metal skeleton with flexible joints that allows them to be positioned in a variety of poses for display and for sexual acts (Real Doll 2008).

Real Dolls were created by Matt McMullen, a struggling sculptor, in the 1990s due to demands for his small posable softer sculptures to be made larger, human sized softer and penetrable. Each human size doll takes 80 hours to make and McMullen's company sold over two million dollars in dolls in one year. (Laslocky 2005). The Real Doll company is working on creating dolls that offer the same life like qualities in a slightly smaller size and lighter weight version. This would allow an individual to lift, move, and position a doll in any way they choose with less physical effort. The Real Dolls also come in a more limited anatomy version, a torso from the neck to the groin, and a doll that is only a waist/hip section including genitals and the buttocks muscles. The Honey Doll, another doll created by the Japanese, has sensors placed on each of its various orifices and will moan as different sensor/areas are touched. If the motion sensors are activated repeatedly, after a certain period of time, the doll will sound as if it is having an orgasm (Gizmodo 2008). As technology catches up with fantasy there may be even more changes in sex dolls. There are companies developing biped robots that are capable of human movement as well as walking and standing on their own. This robotic development combined with life like skin, further advances in artificial intelligence, and sensory locations could have a serious impact on the sex doll industry (Humanoid Research Group 2001-2008). Sex dolls could be valuable for specifically physical sexual release used by those unable for whatever reason to interact with a live human partner.

For those interested in various intensities and alternatives of sex play, numerous toys are available to the public. Different types of wrist and ankle restraints, blindfolds, gags and whips are found at most adult toyshops and internet sites. Wrist and ankle restraints are made out of various materials, including soft foam, metal and nylon.

Products found around a house can also be used such as scarves, ties, ribbon and rope. A blindfold is made out of almost any material as well. Mouth gags are usually made of a strap with a ball attached that inserts into the mouth to eliminate the ability to speak. Whips are made with an assortment of material depending on the purpose of the whip. Some are made of feathers to be used to tickle the skin while others are made of leather that can be grazed over the skin or used to hit the skin at varying levels of force. Metal beads are also a design of a whip type device that can be used, cold or warmed, gently to stimulate the skin. All types of interaction with bondage, dominance, and sadomasochistic sexuality have significantly important rules regarding serious safety practices that should be discussed with patients. Use of bondage toys and aids requires patients' understanding of ties, ropes, and devices that will release easily. Toys that are used to increase stimulation by pain must be used with caution so that participating partners are not unnecessarily harmed. Experienced and wise sex therapists will educate and warn patients of the potential for harm and danger during pain related or bondage type sexual play, will encourage the patients to seek out full education in this area prior to participating and will document said warnings.

For those that are not satisfied with the sex toys already mentioned, there are unique machines and furniture created to enhance pleasure. The Monkey Rocker Sex Machine, found at www.blowfish.com, is a penetration device that allows thrusts and glides while the user rocks. This device is used for vaginal and anal penetration and operates quietly. Sex swings, also known as love swings, are common products found at adult stores. In general, a sex swing is a harness where one person suspends his/herself in the harness, usually with a back support, buttock support and stirrups for the legs. The

sex swing helps when trying new or more difficult sexual positions and it provides more comfort by reducing weight and gravity. This can be extremely helpful for couples if one or both people are overweight or disabled. (www.blowfish.com, n.d.)

For individuals with disabilities or who are simply interested there are also sex toys in the form of Sex Chairs. These chairs may be called sex chairs or love chairs but their purpose is the same. That purpose is to allow men and women to engage in a variety of sexual positions and utilize handles, footrests, sliding tracks, adjustable chairs and pieces that vibrate, all to help with penetration, friction and enhancement of desire and erotic pleasure. A sex chair made by the Sex Chair Company in the United Kingdom is made from leather in the buyer's preference of colors in red, black and tan. When pushed together the Sex Chair looks like an average chair or recliner. The chair has a roll out section, which is located under the main seat and behind the individual's calves when seated, that becomes an extra seat when pulled out, allowing the user to slide back and forth toward the individual sitting in the main seat. This may allow penetration with a penis into a vagina or orifice, regardless of who is sitting where, and with the useful motion of thrusting. This particular chair also has a back massager built into it as well as a vibration function for both seats (Sex Chair 2008).

Another chair of this type is made and specifically advertised for those who have spinal cord injury, stroke, arthritis, back pain, other physical challenges, and for seniors. It is aptly named the IntimateRider™ and its advertisements state it gives intimate mobility to those who need it. This chair was designed by a person who is a C6-7 quadriplegic who encountered sexual interaction problems in daily life and was dissatisfied with other solutions. Ability to move the arms was limited and there was no

mobility at all in trunk or legs of the body. The information and video seen on line encourage the user that satisfying sexual interaction can be found in fluidity of motion and many sexual positions with use of this chair. There are natural positions options for sexual intercourse. The folding chair design appears to be a light weight sling type of carefree fabric and has good back support. The seating area is short from front to back and lower to the ground than normal chairs, allowing a partner to kneel or be in a hands and knees position. The chair moves as easily as a rocking chair, on ball bearings, but the motion is forward and back, enhancing thrusting, and it is described as being very difficult to turn over once seated. Legs of the chair are enhanced with non-skid tips for all surfaces. It can be adjusted for height requirements. There are optional accessories that can be purchased along with the chair. For example, a penile vibrator, from Ferticare is suggested to enhance ejaculation for spinal cord injured patients. A RiderMate™ that looks like a short camping cot is also available for a partner and also has a washable cover, non-skid legs and folds flat for storage. Several cushions are also available for position changes, added support, and protection of skin and joints.

Arousal and desire can be topics of discussion in counseling however, suggestions regarding the use of and reason for sex toys has lacked explanation in detail. Therapists may have suggested patients shop at stores in local areas for sex toys that interest them, may have even given several addresses for stores known to the therapist, but often the therapist does not explore the patient's feelings about shopping there. Therapists may suggest patients shop on the Internet, now that there is so much availability, but, again, do not explore patient's feelings about doing so. An example of this lack of detail regarding use of or how to find specific sex toys is obvious to the consumer who searches

the internet. The phrase “sex toys” will produce a large number of “hits”, which are links to WebPages with that exact phrase or a variation of it. The hits that come up with this search are a majority of the time, advertisements, or links to sex shops or erotic stores. If the search phrase is changed to “sex toys and therapy” you receive far less resources and usually several court case sites related to sex toys and local laws. Discovery Health has a wide variety of articles related to sexual health, STD’s, definitions of sex terms, relationship advice and even advice on how to speak to your children about sex. Yet there is only one article on the subject of sex toys and it does not provide information on how these can be useful for women other than achieving orgasm, which is not stated specifically, but with innuendo instead. Nor is there any information on this site on how sex toys are to help with desire or intimacy in a relationship.

Certainly sex therapists can suggest that patients have alternatives regarding where to find and purchase toys and aids. Looking online for sex toys can be a private way to make purchases for therapist or patient. Some internet sites for purchasing sex toys are goodvibrations.com, adameve.com, thegoodiesack.net, discreet-romance.com, edenfantasys.com, blowfish.com, theadulttoyshoppe.com, adultemart.com, xandria.com, xxx-sextoys.net, cybernooky.com and cantender.com. If a person prefers to order from a catalog, there are online stores that will send a catalog free in the mail and it will arrive in discreet packaging so mail carriers and neighbors will not know what it is. Goodvibrations.com, adameve.com, blowfish.com and xandria.com are just a few sites that offer free catalogs. Purchasing on line and from catalogs does not allow the patient or consumer to touch the object of interest, nor ask questions about its use that can be trusted, and discuss its pros and cons with an experienced clinical sex therapist. Patients

purchasing sex toys and erotica over the Internet may believe it is anonymous and simple, but when using the Internet they may also fear that the information requested is forever retrievable electronic data as is all Internet use.

If sex therapists suggest that an individual or a couple go to a sex toy store, the patients may be uncomfortable doing so for a variety of reasons. For example, patients may be concerned that some adult sex toy stores are not discreet enough in their location, entrance, and exit, as well as their internal setup and layout. Most stores of this type have security cameras and video surveillance that records the presence of shoppers. Patients also might not feel comfortable asking questions of shop employees. While there may be on the job training and familiarity with the merchandise the employees usually, do not have a clinical background. Often patients feel embarrassed about talking to a sex therapist about sexual issues and may be even more uncomfortable, and therefore unlikely, to discuss questions about erotic toys with a young, teenage, or opposite sex employee. Patients often reject homework that is important because it is either too easy or too difficult. If going to a store that sells erotic toys and adult sexually oriented enhancements of desire is too difficult for any reason, patients will not follow through.

If a therapist wants to be completely educated in the topic of sex toys, he or she might try the toy prior to educating patients about it. There are websites, such as edenfantasys.com, that will send out new toys free of charge to interested people for them to try at home and write a review for the website. This is a way to become familiar with the toys that are available to the public, and an excellent way to stay informed about all of the new products that may be useful to enhance desire for patients in the office. Part of research, description, and education of patients must be tempered with the uniqueness of

each person's experience, however. Not all persons will have the same experience with the same sex toy or aid, and an experienced sex therapist will absolutely not divulge his or her own experience of use of any toy or aid.

Appendix A

Vibrators

- Natural Contours Superbe Vibrator
- Natural Contours Magnifique Vibrator
- Natural Contours Liberte Vibrator
- Natural Contours Jolie Vibrator
- Natural Contours Ultime Vibrator
- Form 6 Silicone Rechargeable Vibrator
- Little Chroma Metal Vibrator
- Waterproof Clitoral Hummer
- Waterproof Teardrop Vibrator
- Slender Tulip Vibrator
- Internal Sensation Waterproof Vibrator
- Clit Exciter
- Flex-O-Pleaser
- I Rub My Duckie
- Water Dancer
- Octopussy Splash-Proof Mini-Vibe
- Galaxy G-Kit
- Petal Pleaser
- Smart Vibes G2 Galan
- Little Darlins Turtle
- Playful Pets Vibe
- Swinging Pendulum
- Sweet Dreams McKenzie
- Gigolo II
- Sinnflut Intensity
- Black Stallion
- Da Bomb
- Wascally Rabbit
- LAYAspot
- Cliterrific Complete
- Bronze Giant
- My Secret Velvet Touch
- Insatiable G Vibrator
- Rabbit Habit
- Rabbit Habit Elastomer
- Beyond 2000 Rhino Vibe
- 7th Heaven Platinum G Spot
- Blue Dolphin
- Jungle Elephant
- Cyberskin Vibrating Cock
- The Tongue II
- Beaver Teaser
- Waterproof Marble Jelly Vibe
- Power Rabbit Pearl
- The Original Rabbit
- Aerotech
- Throbbing Cock Vibe
- Climax Critter
- Slender Sensations
- Hide A Vibe
- Pearl Diver
- Little Pearl
- Nubby Satisfier
- Little Bunny
- Love Rockets
- Clit-Oral Pleasures
- Remote Control Butterfly
- Light it up Wabbit
- Venus Penis
- Velvet Touch Clit Licker
- Waterproof Finger Fun
- Just Right
- Rabbit Tech 5000
- The Purple Titan
- Chocolate Jelly Vibe
- Thumbs Up
- Jelly Thruster
- The Stimulator
- Pink Passion
- Ultimate Beaver
- Foreskin Vibe

Cock Rings

- One-Touch Vibrating Cock-Ring
- Silicone Cock & Ball Rings
- Dryad Wooden Cock-Ring
- Striped Leather Velcro Cock-Ring
- Chrome Donut Cock-Ring
- Beyond 2000 GX4 Cock-Ring
- Clitoral Kiss Me Ring
- Ring of Xtasy
- Love Ring
- Magna Erectus Rings
- Jelly Teaser
- Figure 8 Stimulator
- The Power House
- Super Stretchy Vibrating Cock Ring
- Li'l Rabbit Stimulator
- Super Jelly Beaver
- Lover Tapper Cock Ring
- Clit-A-Saurus
- Vibrating Leather Cock Ring

Dildos

- Dryad Wooden Ergonomic G-Spot Dildo
- High Flyer Aluminum Dildo
- Mister Right Silicone Packer
- Boi Next Door Silicone Dildo
- Loverboi Silicone Dildo
- Boitoy Incognito Silicone Dildo
- Boitoy Silicone Dildo
- Boifriend Silicone Dildo
- Goodboi Silicone Dildo
- Bigboi Silicone Dildo
- Celtic Cross Silicone Dildo
- Smoothie Vibrating Silicone Dildo
- Mistress Silicone Dildo
- Selkie Silicone Dildo
- UR3 Color Cocks
- Leo Silicone Dildo
- Realistic Silicone Dildo
- Champ
- Johnny Silicone Dildo
- Titanic
- Nexus Silicone Double Dildos
- Share Silicone Double Dildo
- Jelly Dong with Suction Cup
- Flexible Dildo
- Gelatin Bendable
- Dildo
- Ecstasy
- Red Rider
- Ultra Realistic Dong
- Huge Cock and Balls
- Dreamlover
- Slik Willy
- Vac-U Lock This Natural 7 Inch
- Cyberskin Dildo
- The Softee
- Jelly Double Dong
- Jelly Kong

Glass

- Iridescent Ribbon Glass
- Elizabethan Glass Dildo
- Rose-Colored Glass Dildo
- Yellow Rose Tipped Glass Wand
- River Glass Dildo
- Double Delight Glass Dildo
- Clear Bumps Glass Dildo
- Glass Twister Dildo
- Air Twist Glass Dildo
- Fire & Ice Glass Dildo
- Blaze Glass Dildo
- Eggplant Glass Dildo
- Strawberry Glass Butt Plug
- The Pawn Glass Butt-Plug
- Dewdrop Glass Butt-Plug
- Stubbies

Penile Toys

- Senso Masturbation Sleeves
- Head Honcho Sleeve
- Silicone Lovers Arousal
- Jelly Extender Sleeve
- Senso Pocket Gal
- Naughty Nymphette
- Ultimate Extender
- Sweet Cheri
- Mr. Majestic
- Realistic Penis Sleeve
- Magnificent Eleven
- EZ Pleaser
- Dayton Rains Cock Sucker
- Excutive Oro Stimulator
- Cyberskin Extension
- Vibrating Port A Pussy
- The Animal Masturbator

Plugs

- Dryad Wooden Butt-Plug
- Stainless Anal Plug
- Tristan Silicone Butt-Plug
- Tristan 2 Silicone Butt-Plug
- Jester Silicone Butt-Plug
- Buddy
- Silverado Silicone Butt-Plug
- Fever Silicone Butt-Plug
- Little Zinger
- Anal T-gel Vibrating Plug
- Hot Pinks
- Blazing Anal Plug

Anal/Prostrate

- Glide Prostrate Massager
- Excel Prostrate Massager
- Vibro Prostrate Massager
- Aneros M.G.X.
- Aneros Maximus
- Aneros Eupho
- Aneros Helix
- Colt Anal-T
- Anal Fantasy
- Red Ringer Anal Wand
- Jelly Joystick
- Pleasure Wand
- Dr. Kaplan Prostrate Massager
- Strap On Anal Pleasure
- Anal Rocket
- Jelly Love Beads
- Anal Invader
- Jelly Delight
- Anal Pleasure Pearls
- The Bandit

Strap-On

- Strap On Anal Pleaser
- Beginners Hollow Strap-on
- Private Harness
- Jack Rabbit Harness
- Heart Shaped G-Spot Strap-on
- Ultra Harness 2 Vac-U Lock
- Super Penetrix

Bullets

- Silicone Sims Self-Satisfier
- Colt Waterproof Bullet
- Beyond 2000 GX4 Dolphin Delight
- Dreamboat
- Micro Orb
- Pussy Pleaser
- Clit Kisser
- 5x Space Explorer Vibe
- Double Play
- Little Beaver Finger
- Single Ben-Wa Egg
- Double Ben-Wa Eggs
- Xandria Silver Bullet

Nipple

- Square Nipple Clamps
- Nipple Bulb
- Nipple Suckers
- Traditional Nipple Pleasure
- Crystal Nipple Clamps

Whips/Paddles

- Josephine Paddle
- Dryad Flogger with Wooden Butt-Plug Handle
- Rubber Bessie
- Tickle and Whip

Massagers

- Hitachi Magic Wand
- Octo-Pleaser Massager
- Pleasure Dot
- Silent Vibrations

Miscellaneous

- Police Handcuffs
- Pinwheel Pricker
- Nitrile Black Dragon Gloves
- Twisted Hemp Rope Kit
- Amazing Hot Heart
- Firm Rubber Ball Gag
- Bondage Tape
- Sports Cuffs
- Soft Lover's Blindfold
- No Peeking
- Deluxe Tethers of Trust
- Fireman's Pump
- Blue Fun and Colorful Penis Pump
- Tease Me Ties
- G-Spot Jelly Finger Stimulators
- Magic Flesh Doggie-Style Girl

Machines/Furniture

- Monkey Rocker Sex Machine
- Inflatable Pillow
- Love Swing

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