Therapist Training for Psychosexual Issues

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THESIS

A dissertation on the creation and implementation of a short professional training course in providing effective therapy for psychosexual dysfunction.

NB: To avoid expressions such as he/she, him/her, or alternating between gender references, I have used the grammatically inaccurate but politically correct 'they' throughout.

Summary

Sexuality is a highly sensitive issue and needs intelligent and highly empathetic therapy to achieve a positive outcome for the client who presents with a problem in this area. There must be an ability to work safely and competently with both males and females, along with a sound knowledge of the psychological sexual processes of both genders; there must also be a thorough understanding of physiology, the sexual personality and the dynamics of sexual interaction. Not least, it is of paramount importance to create an environment, both psychological and physical, where the client may feel assured of total confidentiality.

Many therapists, even those of great experience, will confess to varying levels of discomfort and uncertainty when working with psychosexual issues and it is for this reason that the training course to which this summary refers was devised and written. It seeks to provide the professional therapist with an effective knowledge base and an at least adequate understanding of all aspects of sexuality, as well as to provide enough desensitisation that the methodology taught can be confidently employed.

The written work of the course is based mostly upon the tried-and-tested methods employed by the author of this thesis over many years. It is client-centred and focussed more on practicalities than theory, covering every important aspect from the moment of first contact with the prospective client through to the end of a successful therapy.

Contents

NB – All of the unique elements of the course have been developed by the course author

Acknowledgements and Appreciation

I want to extend my appreciation to the following individuals who have all been of inestimable help throughout my research and who have also sustained my confidence that I could produce a worthwhile training instrument in a sensitive subject.

My wife, Julie, who has tolerated with good humour images of particular body parts appearing suddenly on my computer screen in her presence, and my endless muttering to myself as I sought to make sense of some piece of research. She has also provided unwavering reassurance that although a non-academic, I could produce this thesis.

I must also thank the past students of my dance school, so helpful with my early research; the students and members of my hypnotherapy school who showed such an intensity of interest when I spoke on this subject that I was motivated to develop the course; my friends Tanya and Peter, who have provided insights into the world of homosexuality; certain clients, whose anonymity I promised to maintain, for their feedback on some of the methodologies that I have developed; my many supportive friends in the profession, too numerous to mention but including especially *Rita Stanley, David Uri, Josephine Teague, Nick Cooke and David Newton;* and last but most definitely not least, the individuals who were instrumental in providing my early training: *David Landau, Neil French, John Hudson, Peter Millin, Michael Mallows, Stephen Brooks and others.*

Thank you one and all.

Chapter One

Introduction, Aims and Objectives, Research Findings

1.1 Introduction

There are those individuals who believe that far too much emphasis is placed on sexuality and sexual activity, yet sexual unhappiness is one of the most common causes of depression and anxiety.

Sigmund Freud said, in 1905**:**

> *If the vitae sexualis of an individual is as he wants it to be, there can be no neurosis; however, this an almost impossible circumstance, since in most cases the sexual requirements of that individual would be socially unacceptable.*

The above statement is paraphrased, since various translations from the original work contain subtly different wordings. It may even be apocryphal in part, but in any interpretation it clearly conveys the understanding that sexual difficulty creates anxiety. So often that anxiety, emanating from the sexual belief system as it does, culminates in a psychosexual dysfunction; it befalls the professional therapist to alleviate that dysfunction as effectively as possible and so restore good emotional health to the client.

This thesis will illustrate the reasons for the inception of the training course to which it refers and the origin of the perceived need. It will also give a clear insight into the knowledge-base and research that underpins the tutorials.

In April 2003, the author of this dissertation presented a brief talk to around one hundred and fifty professional therapists on the differences between the psychosexual processes of males and females. Following the talk it became evident that many of those present had scant knowledge of the subject and the predominating questions during the ensuing 'Q&A' session were:

- *"Where can I get proper training at a reasonable price?"*
- *"Isn't it embarrassing to talk about such things in the consulting room?"*
- *"Is it safe to work with members of the opposite sex?"*
- *"What style of therapy would you usually employ?"*
- *"How do I know if the problem is psychological and not physiological?"*

Research (detailed later) immediately indicated that there was a need for a training course designed for the professional therapist and which was readily accessible, both financially and as far as study time is concerned. There are a few other courses available but they are usually expensive and also not particularly suitable for the professional therapist wishing to extend their skill set.

Notably, the 'Relate' course is conducted over a two year period; this is comprised of five modules of residential training, three of 48 hours and two of 72 hours; the course covers a great deal of detail, including couple counselling and "gender and sexual identity confusion, and work with issues of sexual orientation cultural difference."

The training fee is £5000.00 and as excellent as it undoubtedly is, both this fee and the training time places the course beyond the reach of the majority of private sector professional therapists.

Another course is offered by The Tavistock Centre in London, which is of three years duration and carries an excellent accreditation; the cost of this one is uncertain though the timescale once again renders it unsuitable for many working therapists. A similar problem exists with the various university courses, including that of the University of Central Lancashire, which offers a part-time course lasting from 1 – 5 years.

Other than the above, trainings in this area are typically of a weekend duration and are necessarily scanty, as far as the amount of information that can be delivered.

What was required was a ‘plug in’ to the existing knowledge base and one which would seek to take account of, rather than duplicate, the skills and expertise that had been acquired during training and subsequent practice. Many of the issues that are covered on the longer courses are not frequently required by the ‘average’ therapist (for instance, working with sex offenders or those individuals with gender confusion) and from the outset it was not intended that the course would purport to be as complete as the longer trainings that are available. It is, essentially, as complete as the ‘average’ therapist could need it to be.

The author has many years of experience of working with psychosexual issues in both males and females, and has also produced a considerable amount of training materials in other therapy subjects for both the neophyte and the experienced professional. The

collation of information for this course, much of which was in purely cerebral form and therefore had to be transcribed into documentation, began in 2004 and the written material was completed in September of 2006, totalling eighty-six thousand words.

The author's own training was extremely eclectic and his early research into psychosexual behaviour patterns was via **Human Sexual Response,** by **Drs. W.H. Masters & V.E. Johnson (1966)** and, to a lesser extent, **Sexual Behavior in the Human Male (1948)** and **Sexual Behavior in the Human Female (1953)** both by **Dr. Alfred Kinsey** and colleagues**.** Although these works are now dated, they are seminal; little new relevant information has been published (although that is not to say that there have been no new volumes on the subject) and it is partly for this reason, though mainly that the course is based on the author's experience and direct research, that there are few annotations in this document.

1.2 Aims, Objectives and Scope

The primary aim of this course is to provide the professional therapist with the opportunity to study an accurate and readily accessible training in psychosexual disorders. Successful completion of the associated exam confers a diploma which will help to create confidence for the client as well as for doctors and consultants who may wish to refer their patients to a specialist in this field.

A secondary objective is to create an extra teaching resource for the training school of which the author is Principal, as well as for other teaching professionals – it is to be hoped that the course will be deployed within other training organisations in the UK. As indicated earlier, there are a large number of therapists who lack the specialised

knowledge that is an integral part of success in this field and who are therefore possibly providing ineffective therapy. It is envisaged that over a period of time, many of these individuals will take the opportunity to improve their expertise.

The scope of the training is limited to those situations which are most likely to be presented to the professional psychosexual therapist for resolution, rather than making any attempt to cover all psychosexual problems. For instance, highly specialised issues such as paedophilia and violent rape are discussed, but only to remind the student that these behaviours are outside the current range of study. Physiological issues are addressed but only in so far as educating the therapist into working solely with the associated psychological issues and/or with the consent of a conventional medical consultant or GP. Ageing and sexuality is also discussed and recommended reading indicated where necessary.

The course is unique in that it takes into account relevant aspects of client personality, based on the author's own research (detailed below) carried out between 1997 and 1999. The understanding that this confers enables the therapist to rapidly build a high degree of rapport and trust – both essential elements of the therapeutic encounter and especially so when working with sensitive issues such as sexuality. There are many other elements of the course which are both original and important and this will become clear later.

The written resource of the course is in excess of 150,000 words and provides a reference work for the therapist, should such be needed. It includes 'hyperlinks' to internet sites to allow further research or specialised study to be conducted.

1.3 Research Findings

The preparatory research is shown in reverse order, for reasons which should become obvious.

The last research segment before beginning to design this course was among therapists who confessed uncertainty and difficulty when seeking to work with clients who had presented with psychosexual difficulties. Some refused to take such cases; some admitted to varying degrees of embarrassment even when working with a member of their own sex and few were completely at ease. They were also uncertain about their ability to always recognise psychology as distinct from physiology as far as sexual problems were concerned.

Just prior to that, investigation of respected internet sites (including *NHS Direct* and *BBC Health*) indicated that 50% of the population of the UK will suffer prolonged sexual dysfunction at some point in their lifetime. It was this statistic that confirmed the decision by the author to develop a professional course based on the success of his consulting room experience with psychosexual issues.

Other relevant research was conducted some years earlier, among the students of a school of dancing; this gave access to a cross-section of individuals who were happy to help with research projects. As a result, it was possible to establish that while females seem to be fairly relaxed about talking to an individual of either gender concerning a sexual difficulty, the same was not at all true of males. Later research showed that they were more at ease with the idea of talking to a female therapist, no matter what their presenting sexual problem. Additionally, although females are at

ease with a therapist of either gender, there is some empirical evidence that therapy proceeds more readily with a male therapist. Subsequent work with clients has shown how both genders may be put more at ease by taking personality type into account.

1.4 Relevant concepts

The earliest research work of which the course makes extensive and specific use was carried out in 1997. It was designed to test a hypothesis developed as a result of observations made when working with clients; it concerned the possibility of fundamental behaviour patterns being handed down as a genetic inheritance, thus being 'hard-wired' into the psyche.

That research was not, at the time, associated directly with sexual matters, though was intended to test various associated ideas which included:

- The probability that some psychological illness is personality-related.
- There are three main definable personality types.
- Nurture will always be answerable to nature.
- Suppression of a natural instinctive drive causes specific problems.

These are the concepts that are relevant to this paper, though there were many other areas that were explored. The test sample was in excess of 3,500 individuals and was conducted using multi-level marketing techniques for distribution via friends, colleagues and the internet with the offer of an *'in-depth assessment of personality and hidden talents'* as an incentive to participate. The responses from those to whom reports had been indicated a high degree of accuracy in the order of 75%-80% which subsequent tests confirmed.

The original questionnaire comprised forty-nine questions, compiled specifically to test the stated hypothesis; it transpired that one block of twelve produced much the same result as the entire paper and a shorter block of three produced a slightly less accurate but easy-to-use 'conversational' assessment. The research was first published in 1999 in the book **Rapid Cognitive Therapy;** with an updated test in 2000 in **Warriors, Settlers & Nomads;** and later in a more comprehensive form in 2005 in **HYPNOSIS: Advanced Techniques in Hypnotherapy and Hypnoanalysis,** which includes a chapter on the basics of working with sexually-related issues.

In his work with clients suffering psychosexual problems the author found that the four concepts listed earlier were particularly relevant in the following manner:

- Many psychosexual problems are clearly personality-related.
- The personality of the client is pertinent to the problem.
- The teachings received about sexuality during the formative years will distort the 'secret' desires of the individual and effect neurosis.
- Sexual inhibition is often the cause of specific types of problem for different personality types.

The personality test used on the current course produces a clear 'snapshot' of the way that the client functions. Combined with a recently-developed, interview-style and psychosexually-specific questionnaire of forty-one questions, it can instantly reveal the primary issue at the heart of the presenting problem, allowing for a swift resolution. Research is ongoing and adjustments will be made as necessary, possibly allowing increasing accuracy to evolve.

Chapter Two

Treatable conditions; teaching structure; gender preference

2.1 Treatable Conditions

The course teaches skills necessary to provide effective direct help with all commonly presented psychosexual problems, including: *Hypoactive Desire Disorder (Frigidity); Anorgasmia; Vaginismus; Dyspareunia; Persistent Arousal Syndrome; Erectile Failure; Premature Ejaculation; Exhibitionism; Sexual Addiction; Penetration Anxiety* and others that are less easily definable, including relationship difficulties.

To obviate the likelihood that a therapist will inadvertently work with a symptom that has its origins in physiology rather than psychology, the training insists that all clients should have received a medical consultation before embarking upon any form of therapy. There are several physiological conditions that can create problems with sexual function, including, but not exclusively:

- Diabetes type 2
- Hypertension
- Parkinson's Disease
- Artherosclerosis
- Prostatectomy
- Hysterectomy

The reason that these particular circumstances are listed here is that appropriate therapy can make a noticeable and lasting improvement to the sex life of those who sufferer them. It is important that the employed methodology is designed to work at

the reduction of impairment by addressing the relevant psychological aspects of the condition. In many cases these will be some or all of: **stress, depression, anger, embarrassment, guilt.**

Therapy is not necessarily aimed at restoring full sexual function when physiological problems exist, for there are times when this is simply not an available option. In these circumstances we can work towards acceptance of:

- What can be achieved in the way of increased affection, emotional closeness and sexual activity.
- The continued existence of the physiological restrictions.

Although it may not be possible to achieve a situation in which the client is able to enjoy full sexual intercourse, there are only a few occasions where valuable improvements to the sexual life cannot be established. These can include the acceptance of masturbation without guilt or shame and learning how to enjoy giving pleasure to a partner when it is no longer available to self.

From the foregoing it can be seen that the work of the specialist in psychosexual dysfunction is not always to restore 'normal' sexual functioning – though this will invariably be the prime objective, where it is possible – but rather to ensure the best circumstance for the client under the prevailing circumstances. This must always include addressing the emotional needs of the individual as well as the physical, and the course therefore provides adequate tuition and information for the student to understand this necessity.

2.2 The Teaching Structure

Defining the teaching structure was a difficult part of the development of the course and it was eventually decided to employ a modular system which would allow a degree of 'chunking up' of important information. This approach provides the student with an outline structure, within which more detailed material could be accessed. It was also considered necessary for a degree of desensitisation to be conducted, since many of the attendees, whilst being professional therapists, would not be so confident that they would be immune from embarrassment which might inhibit the learning process as well as create specific difficulties during clinical practice. The manner in which this particular concept is fully addressed is illustrated later in this document.

Since the course is designed to be conducted over a five-day period, it was decided that four individual modules would provide the best base, leaving the fifth day for revision and questions. Although every module is a complete entity in itself, each would integrate into a complete resource for future reference by the student. The whole would 'dovetail' comfortably into the previously existent skills of the individual and also to the manual on analytical therapy that is included as part of the training materials.

The four modules are presented as follows:

- **Module One:** *Introduction; Fundamental Processes; Anatomy; Analysis of Male and Female Sexual Attitudes; 'The Lovers Guide' instructional DVD Video.*
- **Module Two**: *Commonly Presented Problems; Understanding the Mechanics of Sex; Fact Sheet Handouts for Clients; List of Paraphilias.*

- **Module Three:** *Therapeutic Methodologies; Client Assessment; the 'STAX' Therapeutic Technique. **
- **Module Four:** *Providing Answers; Solutions; Positions for Sexual Activity; Hypnosis Scripts for Sexual Repair or Enhancement.*

Material of particular relevance to this report is contained within the first module and accordingly, some of it is presented here. The text that follows will give a clear view of the quality of the written material. The style is intended to be accessible to a wide range of intellectual abilities, rather than directed toward the academic mindset.

The excerpt commences on the next page.

** The 'STAX' technique is a unique methodology and has never before been published.*

2.3 Course Excerpt

Fundamental Processes

The whole process of sexual reproduction is odd – not just because of the sheer power of its instinctive drive but also because it is something of a puzzle as to why it exists at all. Many animal species are what is sometimes referred to as 'intersex' – that is, they are both sexes at the same time – and there are around 4000 species which are all female and reproduce without any form of sexual activity. Some species change sex apparently voluntarily, not just once but several times, and if you add to this the fact that homosexual behaviour occurs in more than 450 different species, you can begin to appreciate that our 'style' of sexual coupling is actually far from 'normal'. Not only that, life on earth existed for three billion years before the advent of sexual reproduction, some three hundred million years ago, so it is hard to explain why and how sexuality came into being.

Given the manner in which a new human animal arrives in the world, and the fact that males have nipples and a modified clitoris, it is likely that humankind have evolved from a one-sex species with mainly 'female' characteristics. Many people believe that the clitoris is an 'atrophied penis' but this is probably an idea originally mooted by a male; it is known to be a similar organ and even functions in a similar erectile manner. The fact is, though, that the male has no organs which could ever have produced offspring and therefore it is far more likely that the clitoris developed into the penis.

Of course, this idea depends heavily upon the notion that a clitoris ever existed in those early pre-human ancestors; it is entirely possible, though, that neither penis nor clitoris existed in those early creatures and both have evolved separately, though they both originate from the same foetal tissue. Some strength is given to this argument if you consider the fact that since the clitoris appears to exist solely to contribute to sexual pleasure it would not have been needed when reproduction was asexual. As yet, no clearly defined purpose has been defined, as far as procreation is concerned, for the existence of the organ.

We are not unique in the enjoyment of sexual activity – there are many animals that appear to copulate purely for pleasure and many that masturbate. What sets the human animal apart, however, is a highly developed emotional centre; three of those emotions, equal second in power only to **fear**, give rise to most human neuroses and especially so within the areas of relationships and sexuality. Those three 'villains' are **Shame, Guilt** and **Embarrassment** and you will be reading more about them later on. They are more often the subject of psychosexual therapy than any other emotional response.

An Important Concept

All therapy is about change and when we work with a client's sexuality we are seeking to make changes to one of the most fundamental parts of an individual's psyche. The following concept of change work is of immense importance:

1. **The change being sought must be desired above all other changes.**
2. **The change being sought must be desired without constraint.**
3. **It must be *totally believed* that the required change is achievable.**

4. **The reward for the change being achieved must be greater than other available rewards.**

Part of this course covers a work method that will let the therapist see clearly where any of the above criteria are not being met; subsequent therapy sometimes may not even be necessary once we have ensured that our client is able to fulfil each of those criteria. Where it remains necessary – which it will, most of the time – we have ensured a far greater opportunity for a lasting and beneficial outcome. We will examine those concepts individually:

The change must be desired above all others: If there are other things that the client would like to change in their life, then we have to make sure that those things are of secondary importance, at least for the duration of therapy. It might be, for example, that a client places money above sexual activity in order of importance in life; in that case, if there are money difficulties, they will severely hinder the therapy we are seeking to provide. There is more about this subject discussed later, in the section on **Relative Sex Drive**

The change being sought must be *totally* desired: It is easy to imagine that this would definitely be the case with sexuality but it is not necessarily so. There are many reasons for resistance, just one being a belief that what the client wants to achieve would be in some way unacceptable to others, or that it is in some way 'wrong'.

It must be *totally believed* that change can be achieved: The belief system is all important in areas of sexuality – sometimes the entire problem stems from an

erroneous belief of how an individual's sex life 'should' be or about the sex lives of others. This easily leads to the client belief that they do not have the resources to achieve change and therefore is extremely limiting. At other times, a client might just be trapped in the idea that they simply cannot achieve what others do in any area of life.

The reward must be greater than other available rewards: The psyche tends to move towards behaviours that need the least effort. Essentially, the mind will seek to solve simple problems before addressing difficult ones such as sexuality, unless the reward is high enough. Consider these two scenarios:

- An individual can earn £50.00 by standing in ice water for ten minutes, or £45.00 by walking ten meters.
- An individual can earn £5000.00 by standing in ice water for ten minutes or £50.00 by walking ten meters.

By far the majority of people would make a choice far more easily in the second scenario than in the first. The same result might arise if the second scenario was the same as the first except that the ten meters became five miles. In both cases, the value of the reward against the level of discomfort is being assessed and available energy will be directed accordingly.

All of this is enormously relevant to the therapist; if the client is also seeking to resolve problems in other areas of life, then the energy being expended in those areas will diminish our own efforts. So our duty of care is to help the client to temporarily 'shelve' all unnecessary problem solving activities, or to suspend therapy for their sexual difficulty until such time that they can focus entirely on what we are doing.

To put it into the context within which we work, let's look at the following hypothetical situation:

- An individual presents with Vaginismus and is also having her house renovated. She still has to make decisions about furnishings, lighting and decoration and so on.
- The same individual presents with Vaginismus; her house renovation is complete and everything in her life should be wonderful – and it would be, were it not for the fact that her sex life is so poor.

It should not take too much imagination to recognise that the second scenario offers a far greater likelihood of success than does the first. To recap an important point: we need our clients to focus all their available energy on to resolving the presenting difficulty, and we need that energy to be as high as possible for the duration of the therapy.

Embarrassed and Embarrassing

We will now consider one of the important practicalities of working as a psychosexual therapist. It is a fact that many people, even the apparently most well-adjusted, are prone to feelings of embarrassment or anxiety when discussing sexual matters. This can be particularly noticeable when talking to somebody with whom they are not familiar; these feelings can be greatly exacerbated when the conversation is with somebody of the opposite sex or with somebody whose sexual preference is different from their own.

Many therapists have the same difficulty, even though they may be in denial about it. The fact is, though, that unless you are totally at ease and relaxed with the subject,

whoever you are talking to, you will give myriad signs and signals to your client that this is the case – which will do nothing to enhance the chances of therapeutic success. It's no good believing that you will keep it under control. If you are not *genuinely* at ease to the point where it is no different from talking about somebody's hairstyle or the colour of the coat they are wearing, then you *will* give the game away and the therapy will be compromised.

If you are embarrassed, you will be embarrassing.

You will reveal discomfort in two main ways and though your clients will not necessarily notice these consciously, they will feel uncomfortable themselves and probably not continue with the therapy. It might be that they will even decide that they are 'not ready' or that therapy is simply not for them. The two ways in which you will subconsciously reveal discomfort are:

- Speech patterns
- Body signals

It is the **speech patterns** which are the most difficult to control; you will speed up or slow down, speak more clearly or less clearly, mumble, quaver, laugh for no real reason, become lascivious, and possibly even get quite the wrong – and usually unfortunate – word into the conversation.

The **body signals** can include foot shuffling, crossing the legs, folding the arms, face-pulling (which is completely unconscious **OR** completely uncontrollable), blink-rate increase or decrease, tear reaction, shoulder hunching, finger interlocking/gripping, or symbolic masturbation. All of these, and more besides, are far more likely when discussing intimate matters with a member of the opposite sex and it is male therapists who are worse affected (we will shortly consider why that should be).

It is absolutely vital that you are able to discuss any topic of sexuality, with either sex, with homosexuals or with heterosexuals, without *feeling* in any way uncomfortable, before you begin to work in this area.

Consider the following:

- You may well need to work with penetrative difficulties with a homosexual male.
- You will need to discuss the use of a dildo with either male or female.
- You will need to discuss how to properly masturbate somebody of both your own gender and the opposite.
- You will need to discuss vibrators and vaginal expanders.
- You will probably be expected to provide graphic information about the 'normal' shape, size and construction of genitalia, both male and female.
- You will need to discuss the use of pornography.
- It is inevitable that you will encounter fetish work.
- It is likely that some client, sometime, will start discussing something that you did not even know existed.

There are many more situations like these that will arise when working with client sexuality and the above gives you the merest inkling of the areas in which you will be having conversation. If you are already completely certain that none of the above will cause you any disquiet, then you have a head start on most students and a very high chance of being an outrageous success in this field… unless you are simply in denial that you have a problem.

Honesty with self is vital. If one or two or more of the above concepts gave you pause for thought, there is no point in denying this, even to yourself. To do so would inhibit you from utilising the desensitising opportunity that this course presents, both in the written material and in classroom discussion – if you claim that you are already 'ok', your subconscious will accept that you do not wish to make any changes. Recognising and accepting your own inhibitions is vital if you are to conduct yourself as a **'Specialist in Psychosexual Disorders'** or a **'Sexual Fulfilment Consultant'** in a truly professional manner. If you are simply not able to do this then it is possible that you need to attend therapy sessions for some work on your own psyche before you can properly implement what you are learning here.

Problems for the Male

Most people feel that the male is more sexually-orientated than the female, and this most definitely the case, generally. There are exceptions among men with certain medical problems, and women with psychological conditions which include 'Persistent Sexual Arousal Syndrome' which is perhaps better known by the more familiar term 'Nymphomania'.

So why should it be the male who is most likely to experience profound psychosexual difficulties? And why should it be the male therapist who is most likely to encounter difficulties when working in the area of sexuality?

This question does not have a simple answer, unfortunately, and it may even be the case that females and males both encounter the same amount of difficulty, with the male simply finding it more distressing and reporting it more. It is bound up with

evolution and understandings and misunderstandings acquired during the formative years, and is an acutely uncomfortable consequence of a conflict between nature and nurture. Put simply, the human male has to contend with a constant conflict between how he is truly 'designed' to be, and the relatively socially acceptable individual that he has become – purely by stint of the conditioning to which he has been subjected via his upbringing and early adulthood. This conflict is constant and relentless and it is little wonder that it is the cause of difficulty, not just in the sexual areas of life but in life generally.

Here are the possible origins of this situation: for the best part of four million years, since the first humans (hominids, really, and not at all like us, but considered to be our earliest ancestors) appeared on the planet, the male has been the pursuer and expected that the female would copulate without much objection. This expectation survived millennia and was considered totally normal; most of the time, the male's physical advantages of size and strength meant there was nothing that a female could do about it... later, it was even supported in law, as long as he was married, for until 1991, he could insist on it and just 'take her' since the crime of 'Marital Rape' did not appear on the statute books until then.

No Moral Judgement

Let us recognise, at this point, that this course is not concerning itself with moral judgement, women's rights, political correctness or any of those arguments. It is simply looking (at this point in the material) at one of the prime reasons for sexual difficulties in our current times. If you are now wishing to argue the cause of women's rights and millions of years of male domination, please re-read and

understand the first part of this paragraph. Notice that the text says ‘sexual difficulties’ and not ‘male sexual difficulties’. We are simply looking at the way things are – or *were,* until relatively recently.

In 1991, the Marital Rape act was introduced and men can now be jailed for insisting on having sex with an unconsenting partner. Again, we are not looking at moral issues here, but the problems that can arise when four million years of evolved instincts have to be ‘blocked’ in some way. Once again, if you are female and bristling at this point, you will shortly see that women *also* suffer from this sudden change. This course is not biased in either direction, though if you *are* finding irritation or some sort of ‘snort’ reaction, you are exhibiting the conditioned response to which these writings have just referred.

Obviously, it was a morally correct decision to introduce the Marital Rape act – it is inconceivable to any ‘decent’ individual that women should be coerced or forced into sexual activity. The problem is, the human subconscious knows nothing of such moral correctness and although it may well seem uncomfortable to do so, there is a need to recognise that exercising control over the fundamental urge for sexual activity causes great problems for the male. It is this situation with which we have to work professionally and with objectivity.

Sexual Instinct in the Male

It is fair to say that males do not handle restricted access to sexual activity very well, certainly not as comfortably as do women; it is also fair to say that most males have

an unceasing drive over which there is little, if any, control. It is only the *response* to that drive which can be controlled and this is a modern thing, certainly not instinctive.

The healthy human male will seek sexual activity on a daily basis. This is not a matter of choice but of the way that he is designed – the human male is sexually prolific and does not need to wait for the female to be in season before sexual coupling. According to some schools of thought, just about everything that a male does is subconsciously associated in some way with either sexual activity or survival – or both. So it is fair to say that the human male has to suppress or control a totally natural instinct many times during the course of a day. We will study this in more detail shortly.

Of course, a male's existence is not centred *purely* on sexual activity. From the very beginning, he has had the ability to suspend that drive for at least long enough to hunt and kill in order to survive. Things are not much different today; the modern male will suspend – or sometimes redirect – his instinctive drives long enough to earn a living. Nevertheless, it remains probably the most important part of the sexually active male's life. So important, in fact, that if the ability for any form of sexual activity, including masturbation, is completely and permanently removed, he can suffer deep depression and may even become suicidal. This is sometimes observed in the case of those individuals who have had the prostate gland and associated nerve bundle removed as a result of cancer, with resultant impotence.

The possible reason for this particular depression is the subconscious belief that he is now of no further use to his tribe and is therefore 'surplus' to requirements. We will

examine methods of dealing with this situation later, in the **solutions** module of this course.

With advancing years there is usually a gradual lessening of the sexual drive, along with some reduction in the ability to achieve rapid erection and ejaculation. For some, there is eventually a total cessation, whilst others will retain some activity, mostly masturbatory, into advanced old age.

Sexual Instinct in the Female

Whilst it may be true that females do not actually *like* an absence of sexual activity, they are definitely more adaptable than males; they seem more able to cope with the situation and less likely to suffer neurosis and depression as a result of such restriction. Some researchers (Masters and Johnson, Kinsey, *et. al.)* have suggested that whereas in the male, the frequency of masturbatory activity increases during prolonged lack of sexual contact, in the female, the opposite is the case – masturbatory activity declines.

This might be because for those four million years of evolution, women were probably not the sexual hunters; they did not need to be and the success of the human race depended solely on their ability to give birth to a healthy child once a year for as long as their body was able to conceive. The male would find ***them*** *and it is likely that they had little choice in the matter.*

Supporting evidence for this view comes from the fact that within a relationship, males, especially when young, will wonder whether they will be able to have sexual

intercourse that day. Females, on the other hand, seldom need to wonder about this – it is often, if not usually, instantly available, thanks to that incessant male quest. Perhaps more importantly, females, much of the time, are not even in a psychological 'state' where they would even be considering sexual activity. Males are seldom, if ever, out of that state – as you have already read, this is not a matter of choice. Females, on the other hand, can often decide whether to be sexually aroused or not.

Women, then, far from having to suppress an instinct in the way that males do – an instinct which is responsible for the very existence of our species – are actually complying with one. They are waiting for the male to come to them. This is not to say that a female's sex life is easy, though, as we shall see later on. In the next module of the course, though, we will closely examine the 'sexual way' of both males and females.

Finally, it is worthy of note that if you were to ask the question: *"Would you prefer a million pounds or a wonderful sex life?"* most men would eventually plump for the sex life, while most women would opt for the money. There is no mystery about this nor is there any criticism; they are both opting for what their genetic inheritance has prepared them – sexual activity for the male, security for the female. It is what their ancestors have been doing for millions of years…

End of course excerpt

2.4 Gender preference

Although this course is predominantly based around heterosexual difficulties, it would be incomplete if homosexual issues were not at least considered or discussed. Some of the early research carried out by the author suggested that many heterosexual therapists have little genuine understanding of the mechanics of the sex-life of same sex relationships, or, indeed, of the psychological and emotional forces involved. There are not unusually erroneous beliefs such as:

- Homosexuality is a matter of choice.
- It is a psychological illness.
- It can never be 'reversed'.
- It should always be 'corrected'.

To this end, one of the afternoon tutorials will be conducted by two homosexual individuals (one male, one female) who will ensure that the students receive sufficient knowledge about the most important aspects of homosexuality and homosexual relationships. Although only one afternoon is given over to this subject, it should be remembered that many difficulties and methodologies covered in this course generally are applicable to both genders and to individuals of either gender preference.

Chapter Three

Therapist discomfort; a safe environment

3.1 Euphemism, innuendo and body parts

The issue of therapist discomfort within conversations appertaining to sexual activity is a matter of considerable importance. This will be clearly illustrated later on but first it is necessary to consider the origins and causes of such disquiet.

For the majority of individuals during their formative years, sex is an unfathomable mystery. In some instances, a child might be reared in a 'nice' home where any discussion about sexuality or sexual issues is conducted amid euphemism, innuendo and covert glances. In other families, often (though not exclusively) those from lower social strata, there may be less in the way of polite euphemism and far more reference to 'filth', less innuendo and more direct reference to body parts. Add to this the misinformation and youthful lore that is disseminated in such areas of learning as the school playground, and it is easy to see how almost all adults have at least some degree of unease surrounding the entire process of procreation from start to finish. More importantly, the resultant embarrassment about discussing such matters serves to deepen inhibition to the point where inhibition feels 'normal', even 'right'.

With few exceptions, therapists come from an ordinary background, often choosing a career in therapy as a result of the rigours of their own particular upbringing. They are, therefore, prone to the very same forces within the psyche that create the psychosexual difficulties with which their clients present. They will suffer similar

inhibitions, similar embarrassment, and even a similar lack of accurate knowledge; few, if any, general therapy training courses address this situation in even the most summary manner and as a result, many therapists find themselves ill-equipped to provide professional assistance in this area when it is required.

3.2 The effective therapist

To be effective, the psychosexual therapist must be able to:

- Be confidently relaxed when discussing the client's presenting difficulty, whether the client is male or female.
- Create an environment within which the client feels at ease.
- Discuss heterosexual and homosexual matters with equal objectivity.
- Remain objective at all times and not allow personal preferences or beliefs to compromise the therapeutic alliance.
- Present a professionally calm exterior irrespective of the behaviour or symptom under discussion.
- Know when and how to refer on to a more experienced practitioner.

Competence within each of these six concepts is likely to achieve a successful therapy where it is possible to do so, while the individual who is incompetent within even only one or two of them will almost inevitably demonstrate their discomfort via body movement and speech patterns. These indicators – universally understood as symbols of 'awkwardness' and embarrassment – are completely involuntary and impossible to control at a conscious level. Such display will necessarily have a deleterious effect upon the client's comfort and well-being and it is even likely that the eventual outcome will be a spontaneous decision to abandon therapy.

It is therefore paramount that this course approaches the problem of therapist discomfort on a practical level, since it is impossible to simply 'lecture away' such conditioned responses from the psyche.

3.3 Suitable desensitisation techniques

It was decided that, in a short course such as this is designed to be, a 'flood' desensitisation would carry the greatest likelihood of success. This technique, also sometimes referred to as 'exposure therapy', is commonly employed to allay fears and panic attacks. Essentially, it is a relentless application of the stimulus that creates a particular undesired reaction; the object of the exercise is that after some time (which tends to vary between different individuals) it ceases to provoke any greater reaction than would be considered usual. It cannot work for all situations but where we are dealing mostly with matters of thought process it can provide a rapid resolution of the presenting difficulty.

Hence the written work of the first module of the course includes anatomical images, both graphical and photographic; there is also a 'Lovers Guide' DVD, a respected 'sex education' video, which is explicit without being overtly pornographic. Partly because of the content and partly because of being presented with an air of 'normality' in a professional classroom, these resources will go at least part of the way to the creation of the level of ease and confidence that is required.

Group discussion about the content of the 'Lovers Guide' film and also about the differing sexual attitudes of males and females will provide further desensitisation, as well as education. In addition, the module associated with day two concerns 'the

mechanics of sex' and also includes detailed fact sheets concerning different sexual behaviours and attitudes of both males and females; these will also be topics for group discussion.

Thus the first two days of the course will have achieved much desensitisation while also increasing detailed knowledge and understanding. With the presentation and practice of the various therapeutic methodologies that follow over the next two days and the revision and 'Q&A' session on the final day, it is anticipated that all issues associated with therapist discomfort will have been resolved. Where this appears not to be the case, the student will be advised to seek therapeutic help to resolve the matter.

3.4 A safe environment

For therapy to have the best chance of a successful outcome in an area as sensitive as sexuality, it is essential to create a safe environment for both client and therapist. To the uninformed, it might seem that the whole area of working with sexual issues is fraught with the danger of accusation and subsequent litigation.

There is no reason why this should be the case, however, when the therapist has been properly trained as a specialist in psychosexual dysfunction and presents themselves appropriately. The client is aware that they are consulting a professional therapist and equally aware of what is to be the subject of such consultation. The properly trained therapist, in turn, will suffer no more discomfort than if they were working with, say, motivational difficulties or panic attacks and will therefore engender confidence within the client.

3.4.1 Environment for the client

At a basic level, there are several facets of what might be termed 'professionalism' that can allay the majority, if not all, of client uncertainty:

- **Professional manner:** finding the balance between welcoming and reserved.
- **Professional dress:** 'normal' business attire is suitable.
- **Professional premises:** premises should look like a consultation room rather than resemble a domestic setting. Working 'from home' is not recommended unless it is not evident that it is a domestic address.
- **Professional advertising:** advertising and promotion should be clearly clinical without seeking to appear medical.
- **Allow a 'chaperone':** a third person present during at least the initial consultation can be helpful. It might be a contra-indicator to allow this in the main body of therapy, though, given the intimate nature of the work. At the end of the initial consultation the client should feel confident to attend sessions on their own where this is considered advantageous.

3.4.2 Environment for the therapist

For the therapist to be certain of being protected from false accusations can be more difficult, though the above criteria for the client's confidence will certainly be of some help. It might seem that filming the session is a suitable proposition but any electronic recording of the sessions, audio or visual, must only be carried out with the client's permission. In the event, this can be an enormously inhibiting concept; an individual might well think twice about allowing intimate details to be preserved in this manner and will possibly instead choose to not speak of them – which can negatively affect the outcome of therapy. A suggested alternative is a security camera outside the

consulting room which can be set up to record clients arriving and leaving; it would be difficult for a client to make any false claim when the filmed record shows a 'normal' demeanour.

3.5 Miscellaneous

In addition to the above suggestions, it would also be advisable for the therapist to ensure that their professional liability insurance would cover the legal costs of defending any claim of sexual impropriety; it is likely that it would be covered within the 'professional misconduct' heading but it is possible that there might be exclusions with some companies.

Legal advice suggests that any 'disclaimer' or 'therapeutic contract' forms would probably not provide protection from prosecution, if a client was so-minded; it is even possible that they could claim that a degree of coercion had been exercised, thus exacerbating the situation. They might also have the effect of creating client concern which would be inhibiting to the progress of therapy.

At the time of writing, the author (who has always worked in the manner that this paper indicates) has not at any time been subject to any formal complaint, nor have there been any occasions where he has felt any need for concern.

Chapter Four

The unique elements of the course

4.1 Inherited Personality Traits

The research into the notion of inherited fundamental aspects of behaviour has been previously indicated **(1.4)** and here there is a need to clarify it so that certain elements of this thesis can be clearly understood.

The three personality groups defined were **Resolute Organisational, Intuitive Adaptable** and **Charismatic Evidential** often abbreviated to: **RO, IA** and **CE** respectively. Their popular and descriptive names of (again respectively) **Warrior, Settler** and **Nomad** seem to be favoured, even by therapists, over the 'professional' designations given above. These names are based on their probable tribal origins.

The research showed that while the behaviour of most individuals indicates the influence of all three types, it is usually the case that one type is dominant. Moreover, this is quite evident, though without knowledge the ramifications as far as a personal relationship is concerned will not usually be observed. Hence many people not only form a partnership with somebody who is not truly a suitable 'match' but also compound the situation by being devoid of understanding of the dynamics of that partnership. Thus it is possible to provide effective relationship assistance for couples, once the relevant part of the training has been assimilated.

A guide to the demeanour and behaviour of each defined type is essential here.

4.1.1 Resolute Organisational/Warrior

Positive attributes: Determined, perceptive, tenacious, self-sufficient, pragmatic, stable and cautious. Planning and organisational abilities are exceptional.

Negative attributes: Controlling, sarcastic, dogmatic, critical, manipulative, ruthless, selfish, possessive. Hate being wrong and being seen to be wrong.

Physical demeanour: Tendency to dress in sober colours, undemonstrative, little body language, few facial expressions, socially aloof.

They are based upon fear, particularly the fear of change and the fear of vulnerability. This is a deep-rooted response from the subconscious, possibly inherited from their earliest tribal ancestors, the Warriors of old. For these people, change could be dangerous (that which was known could be evaluated and dealt with appropriately) and being seen to be vulnerable was tantamount to death at the hands of an enemy or even a member of their own tribe where there was internal conflict. The great need not be seen to be wrong is a modern illustration of that facet of personality.

Within a relationship, they take more than they give and will typically be unwilling to concede fault. Usually eschewing romance, they are selfish where sexual matters are concerned yet will expect their partner to be available and ‘ready’ when it suits them. Patience and understanding is usually absent and there is an apparent inability to learn those facets of human behaviour, even when it can be shown that their life would be improved as a result. Almost always sexually jealous, they will often be fiercely protective of their partner though it is entirely possible that this is based on a controlling territorial response – their partner is their property.

4.1.2 Intuitive adaptable/Settler

Positive attributes: Adaptable, sociable, intuitive, forgiving, helpful and supportive, caring. Communication skills, insight and understanding of others are outstanding.

Negative attributes: Moody, naïve, anxious, worry what others think, gullible, easily swayed. Can 'cut off their nose to spite their face' and assume the role of martyr.

Physical demeanour: Conservative in manner and tend to dress quietly in mid-tones. Socially welcoming though sometimes shy, their body language is responsive.

A deep-rooted psychological drive for love and security is typical of the Settler. Their early ancestors formed the first civilisations and would have worked as a unified whole, rather than the despotic chieftain-led Warrior tribes. Their strength was in shared resources and community effort; they are givers rather than takers and can find some difficulty in asking for what they want or in stating their personal rules. Normally easy-going, if they are pushed beyond their own personal limit they can abruptly become ridiculously stubborn and unyielding.

Within a relationship, they are nurturing, sharing and unselfish. Though usually affectionate and responsive, they are sometimes also inhibited and can have great difficulty in telling their partner what they do and do not want to happen – as far as they are concerned, this would be selfish. Problems arise when their partner does not guess correctly or fails to perceive the almost invisible signals; the Settler can then irrationally believe they are unloved and will withdraw their participation in the relationship. Although this is usually a temporary situation, it can lead to arguments which exacerbate the problem; once the Settler has taken a negative stance, they find that 'getting out of it' is extremely difficult.

4.1.3 Charismatic Evidential/Nomad

Positive attributes: Outgoing, enlivening, 'sharp', extrovert, persuasive, charismatic, personable. The CE personality excels in promotion, presentation and showmanship.

Negative attributes: Scruffy, irresponsible, introverted, shallow, cowardly, self-centred. Thoughtlessness concerning others can be little short of astounding.

Physical demeanour: Individuality is important to the CE and presentation may be 'showy' or determinedly drab or scruffy. They often like to be the centre of attention.

Change and excitement is what drives the Nomad. Not for them fighting or security; the former is too dangerous, the latter engenders stupor-inducing boredom. All of humanity was nomadic originally but it seems probable that the attitude of the modern CE has developed as a result of the lifestyle adopted after the advent of civilisation. Devoid of 'roots' they wandered the land ensuring that they were different enough to be interesting to others, thus to earn their keep as actors, prophets, magicians, itinerant minstrels and similar. There is often an attraction to the extreme or outrageous.

The Nomad personality has difficulty with almost everything associated with relationships; fidelity, responsibility, sharing and caring particularly. All of these are anathema to this freedom-loving and self-orientated individual. They will compensate by creating excitement through the instigation of outrageous behaviour, or stimulate change via the incidence of the monumental problems which they seem to encounter with remarkable ease. Creatures of extreme in most areas of life, they can be sexually voracious and selfishly demanding or 'all show and no go' (the latter appears to be especially true of females). The love of physical stimulation often leads to philandering and sometimes a fascination with enhancement drugs.

4.1.4 Why this is important

For the therapist, being able to easily assess the personality of the client and therefore assess their probable sexual attitudes can provide a rapid start to therapy. It is important to understand, though, that these are only *indicators*, albeit indicators that can readily be confirmed or refuted via further assessment. In practice, the accuracy of the test employed in this course appears to be enough that we can gain useful insight into the origins of misunderstandings and lack of communication that underpins most sexual difficulties. This is especially true where we are able to work with both the partners in the relationship.

For instance, the RO personality may fear loss of dominance and discover just that, in the form of Erectile Dysfunction or Anorgasmia; the IA might become anxious that they are no longer loved and find a reason for it which might, again, be Erectile Dysfunction or Anorgasmia; the CE will become bored and establish a need to leave the relationship and move on and again, it could be either Erectile Dysfunction or Anorgasmia. Here, the symptom is the same in all three cases but the origins are markedly different, hence the course teaches a client-centred therapy, rather than a methodology which focuses predominantly on any one symptom. Obviously, there are very many symptoms and even more causes, and the foregoing personality/symptom pattern definition is purely for illustration.

The personality dynamics within a relationship are easy for the student to grasp, since there are only six combinations to consider. These are:

- Warrior/Settler
- Warrior/Nomad

- Settler/Nomad
- Warrior/Warrior
- Settler/Settler
- Nomad/Nomad

Although there are certain other aspects to take into account, the basic 'rules' for each of the above combinations hold true in the vast majority of cases. For instance, within the Nomad/Nomad relationship, problems can arise from the deep subconscious need within both individuals to be the centre of attention. This can easily lead to separation; yet there is often a strong physical/sexual attraction that will draw them back together, only for the process to be repeated. One of the most notable examples of this type of relationship was between the actors Elizabeth Taylor and the late Richard Burton, both of whom had extraordinarily colourful lives and relationships – with each other and with many others.

There are, of course, other facets to most sexual difficulties than solely those related to personality but it is also the case that understanding the psychological functioning of an individual provides a key to a suitable therapeutic methodology.

4.2 The 'STAX' technique

The 'STAX' technique allows access to the major sexual discomforts of what the course refers to as the 'three cousins' – **Shame, Guilt** and **Embarrassment.** It is unusual in that although it is an analytically-based method, it does not necessarily require the client to tell the therapist what memories or events have been accessed. This methodology can be used in conjunction with other well-known therapeutic

models such as EFT, TFT, EMDR and NLP and systematic desensitisation. It also provides a starting point for regression to cause or other investigative styles.

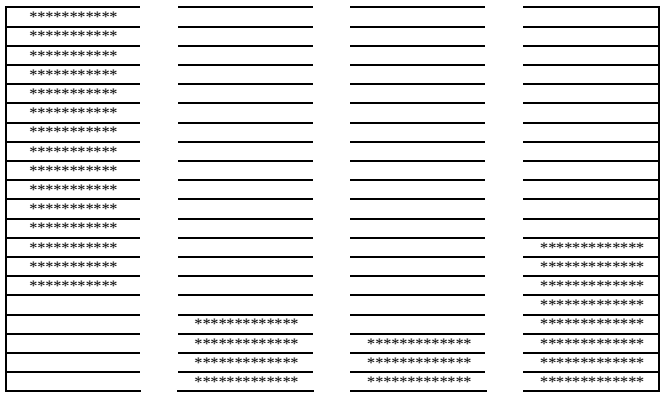
Essentially, we introduce the client to the idea that originally, their confidence concerning sexual matters would have been just as it should be, at 100%, even if they are not able to recall such a situation – which may indeed have been even before they knew what sexuality truly was. A four-column graphic represents **Confidence, Shame, Guilt, Embarrassment** (the last three can be renamed as 'Awkwardness', 'Discomfort', 'Shyness', 'Anxiety' or whatever the client feels is most appropriate).

The easiest way to illustrate the process here is to reproduce a section of the course notes, which is given on the following page:

Excerpt from course notes

Having gained the client's understanding of what we are seeking to achieve, we can now give them the graphic to look at with the instruction that for every bit of sexual discomfort, another sliver is removed from the sexual confidence stack to be stored as an offset to sexual confidence in one of the other stacks. Now we invite our client to fill in the appropriate number of levels in each stack.

A good way to handle this is to have your client start at the **top** of the **confidence** column, shading in one box for every box they shade from the bottom on the other three stacks. So you might end up with something like:



Confidence Guilt Shame Embarrassment

Your client does not have to be aware, at this stage, of what has actually caused these feelings or why, because they only have to show how much of each they actually believe they can feel. If they hesitate, you can ask them to think about anything that they keep secret – and assure them that they don't have to tell you what it is – and then ask which if the three seems most relevant to that thought.

End of course excerpt

4.3 Cognitive questioning

Although not a truly unique methodology, the first part of the questionnaire that has been devised for the course quickly lays bare erroneous beliefs, misunderstandings, suppositions, ideas acquired via hearsay, media-created fantasy, and other destructive elements within the client's psyche. It is not at all unusual for this questioning technique to rapidly provide the basis for reparative therapy; on these occasions, it is not usually necessary to pursue questioning any further. The cognitive questionnaire is shown in Appendix 1.

When it is needed, however, the second section is concerned with the client's sexual personality and incorporates the classifications discussed at **4.1,** though it goes further in that there is a detailed study of the expected sexual characteristics and behaviour of each type. In addition, it investigates the conflict that all too often exists between the **Existent Sexual Behaviour** and **Ideal Sexual Behaviour,** and also looks for congruence between the **Primary Activity** (the behaviour during the initial approach when seeking sexual activity) and **Consummatory Activity** (the behaviour patterns *during* sexual activity). This is important because incongruence generates confusing 'mixed signals' which can easily lead to sexual communication problems.

There can also be incongruence between what might be called the individual's general personality type and their sexual personality. Where this is profound, it is usually indicative of a deep-rooted psychological difficulty and a regressive or analytical style of therapy is indicated. It is the single biggest cause of the situation wherein there is a constant failing of relationships and without the revelation provided by the answers to the questionnaire can easily be mistaken for an 'urge to repeat'.

The course provides the therapist with a simple system for assessment, based upon a questioning technique and the table which is reproduced here:

Primary	Consummatory
Passive	Passive
Secretive	Secretive
Humorous	Dismissive
Romantic	Affectionate
Flirtatious	Exploratory
Direct	Controlling

The elements of the table, in both **Primary** and **Consummatory** columns are graded numerically from 1 – 6 in ascending order to indicate their energy. The pairings shown are the most compatible; the greater the separation between choices of **Primary** and **Consummatory** behaviours, the more incongruence is indicated. This system has been empirically tested and appears to be more than adequately accurate. The assessment is conducted via questions, a sample of which follows, in which we are assessing the **Existent Sexual Behaviour.**

Sample questions from the course.

We are going to examine the client's **Existent Primary** behaviour to begin with: Say to the client: *"I'm going to ask you a couple of questions about the way that you deal with sexual things. Now, the important thing is to tell me exactly how you truly behave, not how you believe you should be. Is that ok?"*

Wait for your client to affirm agreement before continuing. If your client is in a relationship, make sure you have the partner's name and use **question A;** if not, use **question B.**

Question A: *"Good. Ok, imagine that you really want to have sex with* [Name] – *tell me which of these is* ***most likely*** *even if they are not exactly how you would be."*

Question B: *"Good. Ok, imagine that you really want to have sex with a partner – tell me which of these is* ***most likely*** *even if they are not exactly how you would be."*

1. *Drop a small hint and wait to see if* [partner] *makes a move*
2. *Talk about it and hope that* [partner] *suggests it*
3. *Make sexy jokes that cannot be misunderstood*
4. *Make a romantic statement or show of some sort*
5. *Flirt heavily and make obviously sexy conversation*
6. *Come straight to the point to save wasting time*

It can be easier to have these typed on a form and allow your client to tick the relevant answer. It is always a good idea to encourage your client to take time to think and to discuss each option; you can then be reasonably certain that you are getting an accurate response. It is perfectly acceptable to clarify the question as much as your client needs – for instance, statement 4, *make a romantic statement or show of some sort*, could be clarified with, for example:

- Saying that [Partner] looks really lovely/handsome/fanciable
- Buying tickets for a show that the partner wants to see
- Suggesting a candle-light dinner at a romantic restaurant
- Writing a poem or song

End of sample questions.

4.4 Relative Sex Drive (RSD)

This is a unique concept based upon the idea that we have only a limited amount of libidic (not *necessarily* sexual) energy available to the psyche and that it is 'allocated' by the subconscious according to perceived need. Thus the sex drive, rather than having a finite value of 'high' or 'average', for example, may be defined relative to other important aspects of life and living.

To establish the **RSD**, we ask our client first to decide upon the four most important attributes of their life besides **Sex Life**. For the purposes of illustration here, we will assume: **Health, Career, Love and Affection, Social Acceptance.** Now we request that the client place the five (including **Sex Life**) in order of importance, so that we might end up with:

- Love and Affection
- Career
- Sex Life
- Health
- Social Acceptance

In the above instance, the **RSD** can be said to have a factor of **3,** reflecting its importance relative to the other elements**.** What this means, from a practical point of view, is that if there is a problem or difficulty associated with **Love and Affection** or **Career** they will take priority for available libidic drive and the Sex Drive will subsequently suffer. Conversely, where the **RSD** has a factor of **1,** then its importance to the individual is such that it is likely that the 'trials of life' will seem of little importance as long as the Sex Life is at least satisfactory.

In addition to establishing the **RSD,** we can assess the current state of satisfaction of the higher elements of the list (those above **Sex Life**) on a scale of 1 – 10, with 10 being least. For instance, if **Love and Affection** were ascribed a value of **4** and **Career** was graded as being at **7** the total value is **11,** which can be classified as **Negative** in that it will have that effect upon the client's sexual performance**.** Finding a way to either resolve or accept the issues surrounding **Career** would make more energy available for expression of the sex drive – which would possibly improve the value for **Love and Affection** in the process.

Finally, in sexual relationship work with couples, assisting them to gain an understanding of the **RSD**, especially where they differ in value and where the elements on their lists differ, can provide a basis for an effective reparatory therapy.

4.5 Shorthand for the therapist

The aspects of personality that are revealed by the work discussed at **4.1,** the second section of the questionnaire referred to at **4.3,** and the **RSD** can be expressed via an 'equation' which allows the therapist to see at a glance the likely source(s) of conflict. For clarity, the **Existent Behaviour** is designated simply as **E;** the **Ideal Behaviour** becomes **I,** while the **Primary** and **Consummatory** activities in both instances are illustrated by **P**x and **C**x, where 'x' indicates the element from the table shown in section **4.3.**

Here is an example profile that might be derived from the questionnaires:

Type: Resolute Organisational

Existent Behaviour: Primary Passive; Consummatory Passive

Ideal Behaviour: Primary Direct; Consummatory Secretive

Relative Sex Drive: 2

1 Attribute above RSD, negative 8

Using the abbreviated notation, this can be expressed by the single line:

RO: EP1C1/IP6C2; RSD 2, Negative 8

This expression would enable the therapist to see that the conflict between **Existent** and **Ideal** behaviours (**EP1C1/IP6C2)** along with the considerable incongruence shown in the **Ideal Behaviour** (**IP6C2)** indicates that the problem probably has its roots in neurosis within the client. This diagnosis is strengthened by the **RO** personality type since passivity (shown at **EP1C1**) would not usually be part of that persona. The high negative (**8)** after the **RSD** suggests that there is a problem which is possibly purely transient.

In this particular instance, an investigative or analytical intervention would be indicated, though it would be desirable to first help the client to resolve or accept the single issue creating the **Negative 8.**

This concludes the section on the unique elements of the course; there are others, though they are considerably less substantial than those shown here.

Chapter Five

The examination structure; student suitability

5.1 The need for a diploma examination

There are many one-day and two-day seminars in existence in the UK, including some on psychosexual difficulties. Participants do not usually have to do anything other than attend to receive the associated certification and it therefore says nothing about the skill level or otherwise of the attendee. It was intended from the outset that this was to be a 'bona fide' training course offering the opportunity to acquire a sound knowledge in a highly specialised subject. To maintain integrity, it was considered essential to avoid the situation wherein a student might claim skills which they simply were not able to deliver, hence the instigation of an examination which has the added benefit of conferring a diploma rather than simple certification.

There is a further important consideration, in that the field of hypnotherapy is not yet regulated in even a voluntary fashion (though the author is involved in efforts to bring about such a situation), a fact that is quite well known in the conventional medical profession. This being the case, the possession of a diploma that has been acquired via examination might help to instil confidence in a doctor who is considering referring a client for psychological therapy. To support this, there will be, on the website of the Essex Institute, a register of therapists who have successfully completed this course; it will be quite clear that the students listed there are genuine specialists in their field who have completed a written examination to confirm their skills and suitability in the methodology.

5.2 The examination structure

If the diploma examination were to completed in the classroom it would make serious inroads into the time available for teaching, if it was to be of sufficient difficulty to make the exercise valid. Therefore a 'take home' document of thirty multiple choice questions was created, each question having between four and six possible answers. 80% accuracy is required as a pass mark and it would not be possible to attain this without having absorbed the taught material. It is likely that most students will need to refer to the notes to complete the exam successfully but it is considered that this may be viewed as research and is a useful addition to the classroom training.

The above situation could be considered as an Industry Standard, in that almost all examinations within the field of hypnotherapy are completed by the student at home. In any event, many of the questions are structured in such a way that only if the student has fully grasped the concept of what they have been taught would they be able to answer the question correctly.

The examination is shown at Appendix 3.

5.3 Student suitability

The question of suitability for this type of training, given the explicit nature of some of the course content, was taken very seriously. Some of the considerations to be taken into account include:

- Personal integrity.
- Ability to inspire trust and confidence.
- A 'sensible' attitude towards sexual matters.

- Ability to address sexual issues without evident embarrassment.
- Sensitivity to and awareness of clients' feelings of 'awkwardness'.

A questionnaire or interview appeared to be viable options but after consultation with several colleagues, it was decided that any selection process based on either situation would necessarily be subjective and, in any case, it is likely that the aspiring student would present themselves in a positive light that might not have real substance.

The problem was exacerbated by the fact that the training itself is designed to address many of the issues under consideration and it was eventually determined that, given the amount of interactive work that is contained in the course material, peer review at the completion of the course would be the best method of determining the suitability of any student for this particular field of work. Every student will therefore be invited to pass comment, in confidence, on any class member about whom they feel uncomfortable, giving their reasons for their comments. When similar concerns are expressed by 20% or more of the class, these will be considered worthy of further investigation; where it is considered that such concerns are valid, one of two eventualities will apply:

1. The diploma examination will be withheld and a refund of fees will be made.
2. The individual will have the opportunity to achieve a limited diploma which qualifies them to work only with a specific gender/gender preference.

In addition to this, each student will complete a questionnaire (shown in appendix 2) before the commencement of the training that will serve two purposes: (a) it will provide an ongoing research into sexual attitudes and beliefs; and (b) in the event of

complaint, it can provide confirmation of potential difficulty. It is to be hoped that in the manner outlined here, it will possible to accurately assess any individual who is unsuited for work in this field.

Chapter Six

Validation and promotion of the course

6.1 The importance of validation

For a diploma training to carry credibility, it is desirable that it be accredited with a professional body qualified to provide such endorsement. There are many accrediting bodies; unfortunately, few are involved with any form of specialist training such as that offered in this course.

The author is Founder/Chairman of **The Association for Professional Hypnosis and Psychotherapy (APHP)** but it was not felt appropriate that the course should be, effectively, self-accredited. Consequently, the **National Council of Psychotherapists** (NCP) was approached and given sight of the course materials and they agreed to endorse it at a level where, on successful completion of the course, the student will be eligible for registration with them at Licentiate level. This organisation is sufficiently established to be known to the vast majority of professional therapists as an impartial body and therefore this accreditation is an aid to the successful marketing of the course. Later, the training material was examined by the head of the **National Register of Advanced Hypnotherapists** who offered further accreditation, which was accepted.

6.2 Promotion of the course

The publicity for the school generally is generated by an effective internet presence and it was therefore logical to place the details of the new course prominently on the

website at the earliest opportunity. The author has sufficient expertise in website design and building to add a specialised section to the existing site, giving details of the course structure and duration and this task was completed by mid August 2006. It was also announced that there would be an 'Essex Institute' register of specialist practitioners and that all successful participants would receive an entry here at no charge.

This, in itself, maybe insufficient to achieve the desired class numbers without further promotion; it is widely recognised that some of the best advertising is by word of mouth. To this end, advance details of the course were released to students who were known to have a high interest in learning more in this area of work. This ensured a good deal of enthusiastic early publicity, to the point where there were several requests for a commencement date. It was decided that the course would be complete by late September 2006 and in order to allow time for proof-reading, a 'first run' date of November 20th-24th 2006 was decided upon.

Shortly afterwards, details of the course were published in the journal of the **APHP,** after which a descriptive brochure was prepared and mailed to a list of professional therapists which was purchased especially for the purpose. This activity resulted in the enrolment of eighteen students; the school classroom has a maximum comfortable capacity of twenty-two, therefore this student intake was considered satisfactory.

The foregoing chapters illustrate how and why the course was conceived, researched and brought into existence. The rest of this thesis looks at the first implementation, the teachability, the response from students, and the conclusions which may be drawn.

Chapter Seven

Implementation – the first presentation

7.1 The attendees

Three of the enrolled students had to withdraw at short notice because of unforeseen circumstances and so it was that fifteen individuals, six males and nine females, ages ranging from twenty-four to fifty-three, attended this first implementation. Their skills and experience level was varied, one individual having completed sixteen years in private practice, while two others had only just completed their basic training. All were capable of understanding and assimilating the presented work.

Not all of the students were from this country; there were five for who English is a second language, three of those currently resident in the United Kingdom and two having arrived from Germany especially for the course. These were the only two who already knew each other well.

The possibility of students arriving from abroad had occurred to the author whilst designing the course (this is not unusual on the basic training at the school) and it is partly for this reason that the written material is extensive. Where speech can sometimes be misheard or forgotten, the written word can be translated later on, thus clarifying any part of the work that had not been completely understood. In any event, the author is known as a provider of extensive support text for lectures and seminars and many students would expect this to be the case in this instance.

It was decided that an overview of each day of the tuition be given here, since in this way a clear picture of the progress of the students can be gained. It also allows easier observation of a few salient details and events.

7.2 Day one

The day began with an outline of the aims of the training, description of the various elements and the scope and the type of presenting difficulties with which the training would equip the student to deal effectively. The students were all aware that this was the first time the course had been presented and had paid a lower fee than it is anticipated will be charged once the material is 'polished'. It was clearly stated that there might be areas which would prove to be in need of adjustment and all present were instructed that constructive comment would be welcome.

The morning session progressed as planned, the material being well-received and few questions asked. As had been anticipated, there was some minor embarrassment apparent when attention was drawn to some of the photographic illustrations but this was short-lived except in the case of one of the males present. After a brief conversation during the lunchtime break, however, he professed himself to be now at ease with the material. Most of those present later stated that they had at first felt some minor embarrassment, though had sought not to reveal it, a fact which highlighted one of the important aspects of the course overall – that of desensitisation.

The afternoon was given over to group discussion, mostly about the differences between males and females that had been highlighted during the morning talk. The purpose of this was as much for desensitisation as it was for education. The class was

divided into two groups, one of eight students, one of seven, each having three males present. Subjects given for discussion were:

- **Male and Female 'pros and cons'.** Here, the groups were asked to discuss what they perceived to be 'typical' aspects, both positive and negative, of male and female behaviour, which need not be sexual. The intent was to explore the validity or otherwise of the beliefs expressed and their likely effect upon relationships. The positive beliefs may show an expectation which could prove to be unrealistic.
- **Stereotypical sexual concepts.** This subject was selected to reveal the erroneous assumptions that men and women sometimes make about each other. It proved to be very successful, provoking some surprise.
- **The 'Bit of Rough'.** The exercise here was to attempt to come to a conclusion as to the psychological processes of those men and women who become irresistibly drawn towards an individual of a much lower social stratum.

The discussions started quietly and it was evident that some students were reticent about voicing an opinion. By the time they had moved on to the 'Stereotypical sexual concepts', however, this was becoming less noticeable and the third discussion, the 'Bit of Rough' was decidedly animated in both groups, with humour being apparent.

The day finished on time and the general consensus of those present was that it had been an excellent start to the training and had provided several surprising insights. It was unanimously decided that the discussion groups were a good idea and had done much to create confidence about discussing sexual matters.

Before they left the premises, all students were reminded to view the 'Lovers Guide' DVD during the evening so that any observations or comments could be discussed the next day. As previously stated (**3.3** paragraph 2), the film is one of a series of 'respectable' sex education videos.

7.3 Day Two

The second day opened with a full classroom discussion (as opposed to groups) about the film they had watched the previous evening. Three had not been able to view it, since there was no DVD player available in their hotel; they guaranteed they would watch it at the earliest possible opportunity.

The general opinion was that it had been well-chosen for the course. Whilst it was explicit in many places it was not in any sense pornographic and it was felt that it could be confidently recommended to clients when necessary. The therapist who works with psychosexual disorders would find the content of the film to be invaluable when working with a client who needs help with any of the following:

- Education about foreplay
- Education about masturbation
- Education about sexual intercourse
- Understanding how the sexual self 'works'
- Achieving orgasm
- Premature ejaculation (control techniques and exercises)
- Alleviating Vaginismus

An interesting observation from several students was that they had felt that the presenter of the film was uncomfortable in some way. Several said that they would not feel comfortable consulting him as a therapist and subsequent discussion revealed that they had reacted to precisely the embarrassment signals that had been spoken of on day one. (These are defined in the **course excerpt** at **2.3**, page 17, paragraph 2.)

The morning tuition concerned common difficulties that might be presented to the professional psychosexual dysfunction specialist and with some of the practical issues surrounding sexual relationships. Included in this module are several information sheets that can be photocopied and given to clients to reinforce work that is conducted during the therapy session. As with day one, this was well-received and many intelligent questions were asked this time.

The afternoon was again given over to, in the beginning, group discussion, followed by the first of the questionnaire exercises. The discussion element concerned 'Antisexual behaviour' and concerned those behaviour patterns that a sexual partner might unwittingly do that would be a 'turn off'. As in the previous day, this was conducted in two groups and the development of confidence was immediately evident; as the discussion progressed there was a dynamic shift to conversation about sexual pleasure generally, even the most shy individual appearing to be confident and at ease.

The second part of the afternoon session was initially less successful. It concerned the assessment of **Relative Sex Drive,** one of the unique elements of the course as illustrated at **4.4.**

This time, they were working in groups of three, in the standard training format of Therapist, Client, Observer. It was soon evident to the author that they had not gained the understanding that it had been intended to convey, and further evident that, since everybody was experiencing the same uncertainty, it was the teaching rather than the learning which was at fault. The author was able to recognise immediately that the origin of the problem lay in that fact that there had not been enough explanation of the *reason* for the process and also in the accidental reversal of the polarity of the 'scale of 1 -10' exercise, which was taught as '10 being most' while the notes stated '10 being least'. These situations addressed, the confusion dissolved, the exercise was completed successfully by all students, and the class came to a close on schedule.

7.4 Day three

This third day of the course has no designated practical or group exercises for the afternoon session; instead, two homosexual individuals, one male, one female, speak on the sex lives and relationship issues of homosexuals. An accurate understanding of these concepts is of considerable importance to the heterosexual therapist.

The morning session began with an investigation of the course questionnaires. This included the empirical origins of each, the fact that the second of them is a powerful cognitive therapy model as well as a means of gathering information about the belief system, and how the third provides great depth of information concerning the client's inner thought processes. The last one allows the construction of the single line 'equation' shown at **4.5**. The three questionnaires used in succession convey enough information that the therapist has a valuable 'signpost' from which to work.

Also covered in this module are the following important concepts:

- Conducting the initial consultation.
- Defining the true nature of the presenting problem.
- The 'Core of Privacy'.
- The 'Acceptable Client Profile'.

Of the four elements listed, it is probable that the last is the most important, since where psychosexual therapy 'fails' it almost always does so because of (a) a problem with the therapist/client rapport and communication; or (b) the presenting difficulty is beyond the scope of either psychologically-based therapy *per se* or the skill and expertise of the therapist. Accordingly, the Acceptable Client Profile is defined in the course as one in which:

- The responses to the initial consultation questions indicate that the presenting problem is one with which the therapist is able to provide effective help.
- A conventional medical consultation/examination has been conducted.
- The effects of any medication have been taken into account (most commonly Benzodiazepines, Lithium, Beta Blockers, SSRIs and other antidepressants, though the contraceptive pill can have a deleterious effect)
- The client's expectations are within the bounds of what might be considered 'normal' (maybe only after conversation with the therapist).
- The client's request does not create noticeable conflict with the therapist's own moral and sexual belief system.
- The therapist has no sexual attraction towards the client.
- The client is psychologically 'normal'.
- There is a comfortable rapport between therapist and the client.

Also covered are the client preparation procedures, which include clarification about the style of therapeutic methodology that is being proposed, and the importance of ensuring congruence throughout therapy. Although it was included in the course notes for this module, there was very little time to discuss the 'STAX' technique, one of the unique elements of the course. Accordingly, the author decided to postpone this until the next day; the class were content with this prospect.

At the end of the morning session, the students were advised to study the written material of the module during the evening in order that they might be conversant with the practical work of conducting the questionnaires during mock client sessions the following afternoon.

7.5 Day four

The day commenced with questions and comments concerning the previous module's homosexual content during the afternoon session; the entire class were confident that they had understood the talk but recognised that there could be a benefit in further investigation of the concept. All but two of them had read the written work of module three and all were certain they would cope easily with the mock client session scheduled for the second part of the day.

Module four is concerned with solutions and practicalities, and deals with:

- The therapist's professional image.
- A technical analysis of the indicators discovered via the answers found in response to the preliminary questionnaire.
- The selection of a work methodology.

- Positions for sexual intercourse (photographic images).

This module also contains several hypnotherapy scripts; while these will certainly not be used in every case, it is essential that they are of high quality when they are needed and not all therapists are capable of creating them for themselves. All those present were skilled at delivering a script and these were discussed only briefly.

The mock client sessions were commenced almost immediately after the students returned to the classroom in the afternoon, working in the 'standard' format of Therapist, Client, Observer. This progressed extremely well from the outset, with everybody recognising the validity of the concepts being investigated and the manner in which that investigation was conducted.

The preliminary questionnaire produced enlightenment of their own personal issues in a few cases; others discovered the origins of problems in their relationships and everybody felt that this part of the work methodology would provide a firm basis for subsequent therapeutic endeavour. As the afternoon progressed it became evident that from a teaching perspective, more time was needed for the intended amount of practical work; although everybody was able to complete the task satisfactorily, the general consensus was that more time would have been desirable. As a result, the STAX methodology again had to be postponed for the next day.

7.6 Day five – the final session

The STAX method of working was finally investigated during the first part of the final session. It is outlined at **4.2** of this document; the written material of this section

of the course is comprehensively detailed and many possible origins of the inhibiting concepts of **Shame, Guilt** and **Embarrassment** are discussed, in order that the student has a base of understanding. These include:

- Uncomfortable experiences during early sexual development.
- 'Inappropriate' or involuntary sexual climax(es).
- Experiences perceived as humiliating in early sexual encounters.
- Events perceived as in some way worthy of guilt.
- Embarrassment through lack of knowledge or control.
- Fear-inducing events.
- Unadmitted sexual fantasy/fetish perceived as shameful.

Each of those headings is explored in detail, with examples of the type of event that might be encountered, thus providing a complete working methodology. Conducting this part of the therapy in a 'contentless' manner was fully explained and the class were also shown a method where it was possible to work with a strong physical element, using coins to represent the emotional stacks.

The rest of this final session was taken up with questions, observations and comments. The questions were, for the most part, concerned with how a therapist would work with a specific type of problem; the observations and comments were favourable and there were no serious criticisms made, although the issue of the time allowed for the practical work with mock client sessions was raised once more.

At the course end, they were given their exam to take home and urged to send any feedback, negative or positive, in order that the course can be improved where

necessary, and also to inform the author if they had become aware of any fellow student about whom they felt uncomfortable. It was evident that they had formed a close-knit peer group, since there was much hugging and plans to meet after their exam had been completed.

The overall impression gained by the author after completion of the tuition was that the course had been extraordinarily well-received and was certainly suitable for the purpose for which it had been designed – namely, educating therapists to a level where they could work confidently and skilfully with psychosexual issues.

Chapter Eight

Observations and preliminary conclusions

8.1 The need for reorganisation of material

Detailed review of how the existing course structure had served throughout the week illustrated that some reorganisation would be advantageous, as far as 'teachability' was concerned. The author was unhappy about having to twice postpone the tuition of the STAX technique (**4.2**); in addition, there was the fact that the afternoon practical work of day four, where the students had conducted mock client sessions, had felt somewhat rushed, even though the designated exercises had been properly completed.

The fact that each module contained information that was relevant to at least one of the questionnaires meant that there was considerable flexibility as to when those questionnaires were introduced as a practical exercise. The group exercises, important for the desensitisation process, had also to be considered and it was eventually decided that one of these could be omitted, being, in any case, not entirely dissimilar from one of the others. This would allow the RSD exercise (**4.4**) to be implemented on the afternoon of day one and would achieve the same objectives as the original exercise as well as implementing practice at a necessary questionnaire.

The 'Sexual Belief System' questionnaire (**4.3, Appendix 1**) that had originally been practiced on the afternoon of day four could now be part of the day 2 practical work (instead of the RSD exercise) leaving the 'Sexual Personality' exercise (**4.1, 4.3**) to be carried out on the afternoon of day four. Finally, it was decided to place the analysis

of the STAX methodology on day five, where it had finally been introduced and had helped to create a sense of completion of training.

Although it is not possible to be entirely certain, before the course is taught for a second time, that this reorganisation will result in a smoother and more efficient presentation, it is felt probable that this will be the case. In any event, the overall effect is that the tuition appears more evenly balanced and this is obviously advantageous as far as student confidence is concerned.

8.2 Preliminary conclusions

The overall conclusions, at course end, were as follows:

- The course material provides all of the necessary information for students to ethically promote themselves as a 'Specialist in Psychosexual Dysfunction'.
- It is readily holds the students' interest and concentration.
- The methodologies taught are easy to learn and implement.
- There is no superfluous information – everything is relevant to the training.
- The students quickly gain confidence from the material.
- The methodologies involved encourage at least adequate client care.
- Any competent teacher should be able to present it easily and efficiently.
- It fully achieves every objective envisaged at the outset.

Although the above is purely the assessment of the author, it was decided that if the students' examination papers revealed no contra-indicators, no further adjustment to the course material is necessary.

Chapter Nine

Students' comments and examination results

9.1 Negative observations

There were only two negative observations received after the course was completed, one of which was incorporated into two of the answers on the examination paper. The questions concerned 'average size' and the multiple-choices offered in both cases were stated in fractions of an inch. One student commented that she had found the questions confusing as she does not *"…work in feet and inches – so they don't really mean anything."* Notwithstanding the fact that conversion should not be beyond a student of this course, the remark was accepted as a valid comment and the examination paper amended accordingly in two places (the paper shown in this document in Appendix 3 is the revised version).

Another remark – again from one student only – was that there were a few typographical errors which detracted from the otherwise high quality of the work. The course had already been voluntarily proof-read by an experienced reader but has since been presented for professional reading and all noted errors corrected.

One member of the class stated that she thought the course would be improved if there was some reference to, or advice on, Tantric sex. The author considered this point at some length but eventually decided that since the training is primarily concerned with sexual dysfunction, rather than enhancement, the addition of this particular aspect of sexuality was contra-indicated.

Although it had been made clear to all students that they could confidentially report any unease about the suitability of a class member for working in the sphere of psychosexual difficulties, no such comment was forthcoming.

Many of those present made a point of stating that the course material appeared to be already at a professionally polished level and that there was no overt indication that this had been the first implementation of the training.

9.2 Written Comments

A précis of some of the written comments is shown here. The first is taken verbatim from an internet forum, posted by a university-educated young woman who had been extremely uncomfortable when addressing any type of sexual issue with her clients and had tended to refer them on to other therapists.

Comment 1: *"If you want to increase your understanding and confidence with psychosexual matters, I can highly recommend Terence Watts' 'bootcamp' Diploma course. It lasts a week and it's amazing how much more I know now - and no more coyly 'pussy-footing' around the terminology for the urm, cough, genital area ;-) It's made a huge difference to the way I now work!"*

Comment 2: *"The course benefited greatly from the wealth of material and the educational DVD. The written work, although plentiful, was simple to understand and work with. It called for lots of study but this served to enhance knowledge… It was inevitable that there would be a few giggles at the beginning of the week but by the end of day three we were all totally at ease discussing all sorts of sexual matters… the*

course was informational, immensely interesting and enjoyable and I was sorry to reach the end of a fun week."

Comment 3: *"This workshop … was intensive yet enjoyable, and probably as helpful indirectly (in terms of personal development) as it was overtly (for its imparting of detailed research, expert experience, and likely areas of sexual therapy)… I felt the progression of the week was extremely well balanced. A day or so to desensitise explicit topics and, to some extent, our sexual neuroses – while developing a workable understanding and acceptance of those personal issues – was shared effectively with evolutionary psychology and sexual biology… I finished the week feeling able to tackle many potential psycho-sexual problems – and, perhaps more importantly, with both eyes wide open to more of my necessary areas of improvement and personal growth …I also thought the exam was extremely shrewd in the way it pretty much forced students to review, revise and reflect on important points of the course."*

9.3 Examination results

Every student who submitted an examination paper – one declined, for personal reasons – achieved the required pass-mark of 80%. This was the lowest mark and was achieved by two students; the highest was 90%, achieved by just one candidate. There was one question, concerning age and sexuality, which 50% of candidates answered incorrectly, possibly indicates a weakness in the training material.

The results indicated that all students had gained enough knowledge to work effectively and safely within the area of psychosexual dysfunction.

Chapter Ten

The final summing up

10.1 Observations

At the time of preparation of this report, some three months have elapsed since the completion of the training and a considerable amount of review has been carried out. In retrospect, it is felt that:

- The main area that needs improvement is in the balance and order of the group exercises as detailed at **8.1** and the inclusion of more material concerning age and sexuality, as observed at **9.3**. Other than these aspects, it is felt that no revision is needed for the foreseeable future.
- The written material provided for the students is at least adequate in volume and provides a reference work should it be needed later on; it is also provided on a CD Rom to facilitate ease of research if necessary.
- The 'Sex Education' DVD that was incorporated complemented the rest of the material extremely well, in that it placed emphasis on some of the important concepts taught, whilst providing enlightenment in other areas.

10.2 Conclusions

The completed course appears to have properly fulfilled the objectives of creating a specialised training that is readily accessible for the professional therapist, whilst at the same time providing a valuable teaching resource for the training school of which the author is Principal. It is hoped that in the future other teachers may adopt the training into their own schools as an adjunct to their existing curriculum.

Appendix 1

Cognitive Questioning

The Sexual Belief System

Own Sex Life

If the client is totally sexually inactive, go to **Q5**

1. On a scale of 1-10, where 1 is low, how fulfilling is your sex life?
2. What number on that same scale would be at least acceptable?
3. What would have to happen to make it that good?
4. How did you discover that it was only at [stated value]?
5. Has it ever been better? *If the answer here is "No" go to* **Q7**
6. Why was that?
7. Is there anything you would like to do sexually that you've never told anybody? *On "No" go to* **Q10**
8. What do you think would happen if you told a partner? *On "Don't know" go to* **Q10**
9. How did you find that out?
10. Have you tried to make changes before? *On "No" go to* **Q13**
11. What did you do?
12. What happened when you did that?
13. Is there anything else you want to tell me about your sex life?

If your client is not in a relationship, go to **Reality Check**

Partner's Sex Life

14. On a scale of 1-10, where 1 is lowest, how fulfilling is your partner's sex life?
15. How did you find that out?
16. Does your partner want to change anything in [his/her] sex life? *On "Don't know", go to* **Q20**
17. How did you find out about that?
18. What does [she/he] want you to do that you don't already do?
    a. How did you find out about that?
    b. Would you be able to do that?
    c. What would your own sex life be like then?
19. What does [she/he] want you to stop doing?
    a. How did you find out about that?
    b. Would you stop doing that?
    c. What would your own sex life be like if you did stop?
    d. How would that seem to you?
20. Is there anything else you want to tell me about your partner's sex life?

Reality Check

21. On a scale of 1-10, where 1 is lowest, what do you think might be the quality of the average person's sex life?
22. How did you find out about that?
23. How did they get it to be like that?
    a: Conversation; b: Taking control; c: Just lucky; d: Other (what?)
24. What is the average person like, sexually?
    a: Relaxed/confident; b: Tense/awkward; c: Take it or leave it

25. How often do they do it?
26. In what sort of places do they do it and in what sort of positions?
27. What are the men like?

    a: Confident; b: Selfish; c: Sharing; d: Affectionate; e: None of those

28. What are the women like?

    a: Willing; b: Selfish; c: Eager; d: Adventurous; e: None of those

29. What do the (men/women) do that you wish your partner(s) would do?
30. What do the (men/women) do that you wish *you* could do?
31. What do the (men/women) do that you know your partner(s) would not?
32. What do the (men/women) do that you know you would not?
33. How did you find out about those things?

Embarrassment and Fear

34. Does it embarrass or frighten you to talk about sex, especially to a partner? *If "No" go to* **Q40**
35. On a scale of 1-10 where 1 is lowest, how much?
36. Will you tell me what you think causes that?
37. What embarrasses you more than that?
38. What do you fear will happen when you talk about it?
39. What makes you think that? *Now go to* **Q41**
40. What *does* or *would* embarrass you?
41. Is there anything else you want to tell me?

Appendix 2

Student Questionnaire

Your Gender: [ ] Male [ ] Female

Answer the following questions to show what you currently believe to be the most likely scenario for "most people."

On a scale of 1 – 10, (with '10' being highest) in general and assuming an established relationship and an 'average' personality type,

	Male	**Female**
How important is sexual activity?.....		
How irritated when refused?.....		
How important to feel loved?.....		
How easily tempted to 'stray'?.....		
How likely is a spontaneous affair?.....		
How much anxiety after illicit sex?.....		

Multiple choice questions (answer as 'most people')

Is good sex dependent on an emotional connection?

Male: [ ] Sometimes [ ] Most of the time [ ] Always [ ] Never

Female: [ ] Sometimes [ ] Most of the time [ ] Always [ ] Never

Is self-masturbation better than intercourse?

Male: [ ] Sometimes [ ] Most of the time [ ] Always [ ] Never

Female: [ ] Sometimes [ ] Most of the time [ ] Always [ ] Never

How important is it that the partner enjoys sexual activity on any one occasion?

Male: [ ] Very [ ] Moderately so [ ] Not really relevant

Female: [ ] Very [ ] Moderately so [ ] Not really relevant

How important is orgasm/ejaculation?

Male: [ ] Very [ ] Moderately so [ ] Not really relevant

Female: [ ] Very [ ] Moderately so [ ] Not really relevant

Can sex be rewarding *without* orgasm/ejaculation?

Male: [ ] Sometimes [ ] Most of the time [ ] Always [ ] Never

Female: [ ] Sometimes [ ] Most of the time [ ] Always [ ] Never

Place in order of importance (with '5' being least):

For male enjoyment of sexual intercourse:

[ ] Full Breasts [ ] Firm buttocks [ ] Supple and active body

[ ] Active female participation [ ] Female's evident pleasure

For female enjoyment of sexual intercourse:

[ ] Big penis [ ] Hard penis [ ] Athletic masculine build

[ ] Pre-coital foreplay [ ] Post-coital affection

Place in order of sexual importance (with '4' being least important):

Male wants: [ ] Beautiful face [ ] 'Sexy' body [ ] Loving manner [ ] Sexually eager

Female wants: [ ] Handsome [ ] Good build [ ] Emotionally aware [ ] Loving

Who is most likely to *truly* enjoy pornography? [ ] Male [ ] Female [ ] Both

Who is most confident with the opposite sex? [ ] Male [ ] Female [ ] Neither

Grade each of the following on a 1-10 scale of importance (with '10' high)

	Male	**Female**
Sex life.……..……..		
Love & affection…….....		
Money……..……..……..		
Health…….…….....		
Social approval……..……..		

Some sexual disorders are physiological, some psychological. How confident are you currently that you can tell one from the other?

[ ] Very confident [ ] Fairly confident [ ] Uncertain [ ] Not at all confident

OPTIONAL: Is there anywhere particularly where you think **you** differ greatly to the answers given above? (state where if so, though there is no need to state how you differ)

Did you seek help to complete this questionnaire? (**Please** be honest here!) Yes/No

Who would be most likely to seek help to complete it? [ ] Male [ ] Female

OPTIONAL: State which you would prefer to consult if you were seeking help with a sexual difficulty: [ ] Male therapist [ ] Female therapist

OPTIONAL:

Name:…… Signed:……

Appendix 3

Final Examination

Please take care with the completion of this exam – all the questions are in a multiple choice style and you should indicate the answer that you believe is closest to the facts. You should never use your own attitudes/responses as a guide unless you are 100% certain that they are the same for the majority of clients.

If you are not certain of an answer, research it via the course notes or the internet until you are sure that you have the correct facts to hand. Everything you need is available to you via the course material.

Remember – you cannot ever afford to use guess-work with your clients

The pass mark required is 80% accuracy

Last date for submission is 30 days after completing the course

YOUR NAME: ……

DATE COURSE COMPLETED: ……..

The Physical Body

1. Which of the following is <u>not</u> part of female genitalia?

- Prepuce
- Frenulum
- Vas Deferens
- Glans
- Fourchette

Answer: …….

2. The usual size of the visible part of the clitoris is:

- Between .1" and .2" in length and about .25" wide (2.5 – 5mm x 6.5mm)
- Between .1" and .2" in length but wider than .25" (2.5 – 5mm & wider than 6.5mm)
- About .25" wide and longer than .2" (6.5mm wide and longer than 5mm)
- There is no usual size

Answer: …….

3. Males fear that their penis is too small:

- Always
- Frequently
- Sometimes
- Rarely

Answer: …….

4. During masturbation, a female will be most likely to:

- Think about her favourite fantasy male
- Think about a hard penis
- Concentrate on the sensations in her body
- Think about sexual intercourse

Answer: …….

5. Masturbation produces a more intense climax than sexual intercourse:

- Usually
- Sometimes
- Only for males
- Only for females

Answer: …….

6. What percentage of heterosexual individuals indulge in anal sex?

- 15%-30%
- 30%-50%
- 50%-70%
- Fewer than 15%
- More than 70%

Answer: …….

7. The correct name for the 'G-spot' is:

- Para urethral glands
- Clitoris
- Fourchette
- Prepuce

Answer: …….

8. Which two of the following are essential for a male to achieve erection?

- Testosterone
- Nitric Oxide
- DHT
- Amino acids
- Arginine

Answer: …….

9. The size of an erect penis on the 'average' male is:

- 5 – 7 inches long and 4 – 6 inches in circumference (approx 13 – 18cm x 10-15cm)
- 7.5 inches long and 6.5 inches in circumference (approx 19cm x 16.5cm)
- 5 inches long and 5 inches in circumference (approx 13cm x 13cm)
- It varies according to his height and build
- It varies according to his race

Answer: …….

10. Female ejaculation is:

- Extremely rare
- Common
- Comprised mostly of salts
- Usually clear/watery
- Mostly urine

Answer: …….

11. Cowper's gland is the equivalent of:

- Bartholin's gland
- Skene's gland
- Ovaries
- Clitoris

Answer: …….

12. The skin of the penis shaft is formed from the same foetal tissue as:

- Labia Majora
- Labia Minora
- Fourchette
- Vaginal canal
- Prepuce

Answer: …….

13. The following is essential for physical sexual arousal <u>in both males and females</u>:

- Physical stimuli
- Increased blood flow
- Psychological stimuli
- Erotic thoughts

Answer: …….

14. The frenulum is found in female genitalia:

- Never
- Sometimes
- On the underside of the clitoris
- Joining the Labia Majora and Labia Minora

Answer: …….

15. How much ejaculate does the 'average' male produce?

- 1.5ml – 6ml
- Less then 1.5ml
- More than 6ml
- 3ml – 4.5ml

Answer: …….

16. The clitoris has:

- The same number of pleasure receptor nerve endings as the penis
- Twice as many pleasure receptor nerve endings as the penis
- Seven times as many pleasure receptor nerve endings as the penis
- Fewer pleasure receptor nerve endings as the penis

Answer: …….

17. The Refractory period is:

- Longer in the male
- Longer in the female
- The same length of time for each
- Variable according to the individual

Answer: …….

Symptoms and Therapy (In all cases assume a clean 'bill of health')

18. Which of the following is most likely to respond to psychosexual therapy alone?

- Vaginal dryness
- Secondary Erectile Dysfunction
- Hypoactive Sexual Desire Syndrome
- Premature Ejaculation

Answer: …….

19. A fetish or paraphelia can be released using only psychosexual therapy:

- More often than not
- Sometimes
- Rarely
- Never
- If the client wants it to be

Answer: …….

20. A male will readily accept that he has an active Masturbatory Guilt Complex:

- Always
- Frequently
- Sometimes
- Never

Answer: …….

21. Which of the following is <u>most likely</u> to have a physiological origin?

- Erectile Dysfunction
- Dyspareunia
- Vaginal Dryness
- Dry Ejaculation

Answer: …….

22. A widower of 70 years old wants to know if you can help him sexually in a new relationship with a female who is 60 years old. What do you tell him?

- A very high chance
- Only if he had a good sexual relationship when he was younger
- It depends on the female
- You can probably help if they see you as a couple

Answer: …….

23. A senior couple ceased all sexual activity because it created arguments. Now they want to rekindle their sex life. What do you tell them?

- They must resolve the cause of their previous arguments first
- Open and intimate discussion about their bodies and needs is essential
- They will each need individual therapy
- They should watch a sex education video and let nature take its course

Answer: …….

24. Which of the following illnesses would be likely to cause most sexual difficulty?

- Parkinson's disease
- Diabetes
- Renal disease
- COPD

Answer: …….

25. A post-menopausal female presents with diminished sex-drive. You tell her:

- It's normal – sex-drive diminishes with age
- Talk to her about masturbation and recommend a personal lubricant
- Suggest she watches a soft-porn video
- Suggest she visits a surrogate sexual partner

Answer: …….

26. A female of 24 years presents with Vaginismus. You will tell her:

- A vaginal dilator and a soft-porn film is an essential part of therapy
- Hypnotherapy and/or regression will resolve the difficulty
- You will use relaxation therapy with her
- She needs to learn how to masturbate properly

Answer: …….

27. A 27 year old male presents with penetration-linked Erectile Failure. His *Sexual Personality Profile is*: IA:EP2C2/IP4C5; RSD1 with his partner being: **EP6/C6; RSD 3 Negative 10. What is the most likely source of his problem?**

- Fear of upsetting partner
- Genital embarrassment
- Performance anxiety
- Partner's lower level of interest
- Rejection anxiety

Answer: …….

Miscellaneous

28. Sexual reproduction evolved:

- 300 Million years ago
- 30 Million years ago
- When hominids first appeared
- When mammals first appeared

Answer: …….

29. Tick which of the following statements are <u>true.</u> In general:

- Females can become sexually aroused in 2 minutes or less
- Males can usually inhibit ejaculation indefinitely
- Females can achieve orgasm faster than a male can achieve ejaculation
- Females don't like porn
- Males are only interested in a female while she will have sex with them
- Most males are more interested in sex than romance

30. Tick which of the following statements are <u>untrue.</u> In general:

- 'Normal' males can live without sexual activity just as easily as females can
- Females seem to get greater pleasure from intact males than from circumcised males
- Females enjoy short very hard penises more than long semi-hard ones
- Males are anxious about their genitalia
- Most relationships are sexually satisfactory
- Most people harbour secret sexual wishes

Your name: ……..

Examination submission date: ……

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http://www.bbc.co.uk/health

NHS Direct

http://www.nhsdirect.nhs.uk

Ageing and sexuality (1):

http://www.apa.org/pi/aging/sexuality.html

Ageing and sexuality (2):

http://www.wooster.edu/psychology/moreinfo.html

Health and sexuality (1):

http://www.mja.com.au/public/issues

Health and sexuality (2):

http://www.sexualhealth.com/channel.php?Action=view&channel=3

Sexual Problems in Women:

http://www.medicinenet.com/sexual_sex_problems_in_women/article.htm

Sexual Problems in Men:

http://www.malehealth.co.uk/userpage1.cfm?item_id=129

Sex Tips and Dating Advice:

http://www.sexinfo101.com

About Sexuality:

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http://www.webs.uidaho.edu/wisui/Polan%20Article%202.pdf

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