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## GLOSSARY

**Caress** A gentle touch or gesture of fondness. To touch or stroke in an affectionate or loving manner.

**Client** One for whom professional services are rendered. In therapeutic language it is stated persons with a particular disorder.

**Coach** A person who trains, one who gives private instruction, a personal tutor.

**Countertransference** When strong affection, attachment, anger, jealousy, any emotion, is experienced by the therapist towards the client during the process of therapy.

**Erectile Dysfunction** The inability of a male to achieve penile erection, or erection achieved, but insufficient rigidity/duration. The cause may be physical or psychic. Erectile dysfunction is also known as erection problems, abbreviated: E.P.

**International Professional Surrogates Association** Abbreviated form: IPSA, organization founded in 1973 by a group of surrogates who created it as a support group for themselves. By 1978 it had expanded to become a professional body, with a code of ethics, conducting training 'sessions and setting standards for this profession

**Orgasmic Dysfunction** A male sexual dysfunction in which ejaculation is unable to be attained, or is attained after a frustrating period of time.

**Premature Ejaculation** Male sexual dysfunction in which ejaculation consistently occurs before penetration and before the partner has had a chance to reach orgasm. Such methods as the ueeze and stop-start techniques are frequently effective in treating this condition.

**Prostitution** Writers on the subject in the past have differed widely in their attempts at definition. The illicit intercourse of the sexes. On the other hand, the popular conception of a prostitute as a woman who temporarily loans the use of her body to miscellaneous men in return for Money is obviously too narrow and restricted; also, to give up to lewdness for hire. In most cases essential factors to come within the meaning of prostitution are held to be immoral relations with at least two men contemporaneously, and for gain in each case.

**Sensate Focus Socialization Techniques** Special stroking exercises that help to relax and educate the client about his own body. The emphasis is on permitting him to fully experience sensual pleasure, to let go. The goal is to gain relaxation and to achieve comfort with sensual

experiences that are primarily non-genital.

**Spectatoring** A term introduced by Masters and Johnson, to describe the behavior of an individual who likes to observe his own sexual performance as if he were a spectator.

**Squeeze Technique** A method for delaying premature ejaculation, preferably under the guidance of a sex therapist The partner stimulates erection, then squeezes or pinches the head, or shaft of the man's penis, or pressing the perineum, with her fingers as soon as he signals that ejaculation is about to take place. This technique can also be done during masturbation. Repetition of this maneuver conditions him to achieve a normal delay in ejaculation.

**Stop-Start Technique** A two-step sex-therapy method used in overcoming premature ejaculation. In the first step, the male stops all stimulation, whether himself or by his partner, just as he approaches the moment of ejaculating inevitably. When that moment has passed, he starts again, and by repeating this process will gradually gain control over the timing of his ejaculate.

**Surrogate** The word surrogate is defined as one that takes the place of another, a substitute. Houghton Mifflin Company.

**Surrogate Coach** A surrogate partner, sex surrogate, sexual rehabilitation technician and bodywork therapist, intimate trainer.

**Transference** A Freudian term for feelings of strong affection, attachment or other emotions, experienced by the patient towards the analyst during the process of therapy.

**Triadic Therapy** Involves three people: client, therapist, and surrogate.

**Verbal Therapist** A specialist in conducting (talk) therapy. Someone who helps a client understands the source of their problems. For the purposes of this study, the term verbal therapist refers to social workers, psychologists, psychiatrists, sex therapists or sex educator, offering psycho-sexual therapy to facilitate the growth and development of persons with mental/emotional sexual issues and disorders.

**Virgin** An individual, male or female, who has not engaged in partnered genital intercourse.

# CHAPTER 1: Introduction

# AN EXPLORATION OF SURROGATE TREATMENT

## 1.1 Surrogacy

*I was a therapist before I became a surrogate. I realized that you couldn't teach* ***someone to swim if he was sitting on the beach You can't coach someone without getting in there with him.***

***Barbara Reed Play Girl, 1985***

The word "surrogate" means a "substitute." Just as a surrogate mother takes the place of a biological mother, in this work surrogates are substitute partners for intimacy training. Surrogates can be either males or females working with either male or female clients. There are male surrogates who work just with females. There are male surrogates who work with males and females, and there are males who work just with males. There are also females who work with both males and females and those who work only with females. For the purpose of this study, the focus will be on female surrogates working with single, Caucasian males.

The female surrogate is an alternate to a relationship where there is lack of an available sexual partner. Surrogate partners have also been called sex surrogate, coitus trainer, rehearsal partner, co-therapist, relationship therapist, intimate teacher, rehabilitation technician and surrogate coach. A coach is defined as "one who trains, one who gives private instruction, a personal tutor." (American Heritage Dictionary 1982)

Surrogacy is the action component of a therapeutic triad that consists of a verbal therapist, surrogate coach and client The client will put into practice what he learns from both the surrogate and the therapist. He will learn, and be expected, to take responsibility for his sexuality. He will then apply his newly acquired skills with a partner of choice.

In the past, surrogates have been compared to a "bicycle." The therapist provides the manual, but a client can read about riding a bike for 20 years and still not know how to actually ride a bike. Surrogates provide the actual experience of getting on the bike. Carol Cobb-Nettleton makes the above analogy more clear when she states: "The surrogate is not the bicycle, sex is the bicycle, the surrogate provides support while the client learns to ride" (Personal Communication, 2000). A professional surrogate coach is someone who becomes an intimate partner for clients with a variety of concerns. These concerns include persons with:

**sexual dysfunctions;**

**fear or shyness around females;**

**aversion to sex and sexual body parts and/or body fluids;**

**a history of sexual abuse;**

**mental or physical challenges;**

**spinal cord or head injured;**

**debilitating, degenerative diseases that create feelings of isolation and inability to explore their own sexuality.**

Surrogate partners provide a service known as surrogate treatment for persons suffering from difficulties, which prevent him from experiencing a healthy, sensual/sexual relationship. While learning how to create relationships, individuals

receive from the surrogate treatment: pleasure, companionship, support, understanding, tools and techniques for social as well as sexual interaction. Clients can receive this training in one of three ways; 1) weekly or bi-weekly two-hour session, 2) a three-day weekend intensive, or 3) a two week clinical intensive.

Surrogate partners engage with clients in emotionally and physically intimate experiences that are simultaneously diagnostic, skill building and transformational. Theoretically this therapy integrates a cognitive, behavioral, dynamic, humanistic, existential approach and serves as a unique diagnostic tool (Blanchard, 1999).

Surrogates are there to coach the client into developing specific behaviors that will provide them with skills that they did not possess before entering therapy. "Sexual competence and well-being cannot be taught by books; above all else, sexuality is an experience and it is from an intimate relationship with another that we learn" (Matusow, 1984).

One of the controversies of surrogate treatment is the question of legality. Even though surrogacy has not been declared illegal, it is, in most states, considered a "gray area." Professional surrogates do not advertise their services. This would be solicitation, considered illegal in most states. Surrogates obtain their clients by verbal referrals from clinical therapists. The therapist does not receive any money for the referral. Any money exchanged for the service of the surrogate is strictly between surrogate and client The possibility of sexual contact during sessions between surrogate and client and the exchange of money is the "gray area" that judges this service as **controversial.**

From the east coast, Victoria Shannon writes in *The Courier-News* (1984), "Neither the American Psychological Association nor its New Jersey chapter has a formal position on the use of surrogates... there's a legitimate need for surrogates when the surrogate is sophisticated, trained, paid, and in touch with the psychologist."

The national American Psychological Association (hereinafter APA) has not taken a definitive position on the use of sexual surrogates. Ethics committee staff informed members of the APA (who had been calling the Washington office for clarification of their position) that the use of surrogates is 'iffy' (*Sexuality Today*, 1982).

The Massachusetts Psychological Association was the first state psychological association to prohibit the use of sexual surrogates by its members. Thus far, the Massachusetts State Psychological Association is the only professional organization that prohibits the use of sex surrogates. Massachusetts' position is in sharp contrast with the APA. In the state of California, the legal status of surrogate partners is undefined. This means that there are no laws regulating the profession at this time (IPSA 1973).

The American Association of Sex Educators, Counselors and Therapists (hereinafter AASECT) does not take an official stand on the issue of the use of Sexual Surrogates, except to say that if sex therapists use surrogates they should do so in an 'ethical' manner" (Dauw, 1988). For the most part, surrogate work is not considered illegal as long as they uphold specific professional standards such as working with a licensed therapist, refrain from advertising, and generally follow the International Professional Surrogates Association (hereinafter IPSA) Code of Ethics (Appendix A).

The following are statements from clients defining for themselves what a surrogate is. Robert, a 43 year old virgin, defined a surrogate as someone who helps people to

become whole again, guiding them to a more fulfilling life, allowing them to discover themselves. A surrogate is a person to practice healing and growth with, someone who helps to find and build confidence in a safe environment. Mark, who has spinal cord injury, described a surrogate *as* someone who did not look like the stereotypical hookers. She did not wear heavy make-up and was well dressed. The female surrogate, who worked with Mark, was a registered nurse with a Master's in social work. She emphasized that in their treatment, they work mostly with a client's poor self-image and lack of self-esteem, not just the act of sex itself. Mark shared that as he learned more about surrogates, he began to think that perhaps a surrogate could really help persons with physical challenges and their social and sexual problems (The **Sun, 1990).**

In surrogate coaching, clients are taught how to ask for what they desire, how to communicate to a woman who is neither therapist nor a lover, but rather one who represents facets of both these relationships and brings to the healing process honest reactions from a female perspective. A former client, who completed the surrogate treatment course in 1990, wrote a letter to his surrogate coach. Joe wrote about his experience as a surrogate client and reflects on his relationship with his surrogate coach. According to Joe, his surrogate coached him through the treatment process with "loving care" (Appendix B).

## 1.2 The Surrogate

*"I've never met a client I couldn't work with, I've worked with a lot of badly disfigured men and looked for the beautiful part of them — like the elephant man with the lovely hand."*
***Anonymous Surrogate***

A surrogate coach is a sex educator providing information that our schools and society fail to provide. She dispels sexual myths and fallacies obtained from misinformed friends and family. Because she teaches sex education, there is a misconception about surrogates that they perform the same work as prostitutes. Media focus, as in talk shows, newspaper stories, magazine articles, and documentary films, only focus on the sensationalizing of a teacher of sex. A graduate student in human sexuality, writing a paper on the subject of sexual surrogacy was watching a late-night cable television talk show about sexual issues. The show, hosted by a man, had a beautiful female guest who looked like a model and was a sex surrogate. The topic of the show was her 'erotic' career. The host seemed to accentuate the sexiness about the work rather than the clinical aspect of helping clients (Silvestri, 1999, p. 1).

This account of a TV talk show is an example of the media's sensationalizing the image of an attractive female who uses her body to awaken men's erotic fantasies. A surrogate's role is different than that of a prostitute. Her job is to teach clients skills needed to be more effective socially and sexually. The surrogate's goal is not "getting the man off' or giving him a good time; rather, it is a therapeutic, process which helps to diagnose and treat a (sexual) problem or concern (Zilbergeld, 1999).

It is important to understand the differences between a prostitute and a surrogate coach. The main difference between the two is in motivation. The prostitute's motivation is, generally speaking, monetary, while a surrogate's motivation is to help clients have healthy, fulfilled relationships.

Another difference between a prostitute and surrogate is that prostitutes' fees are relative to the sexual acts performed in a short span of time. A surrogate coach teaches a. socialization process in conjunction with sensate focus exercises which educate clients and help them develop intimate relationships. This process may take several months, even a year, to complete.

The verbal therapist, surrogate and client decide how much time is required for the client to achieve his relationship, social and sexual goals, and what elements are needed to achieve them. Sexual acts may or may not be a part of the surrogate process. Indeed, if there is sexual intercourse, it is usually at the end of the treatment process.

In a paper written by Raymond J. Noonan entitled, *Sex Surrogates: A Clarification of Their Functions,* he addresses the question of the difference between the roles of the surrogate and the prostitute. Noonan surveyed 54 sex surrogates and asked them to estimate the percentage of time they spent in seven key activities with their clients (Appendix C).

Noonan's data strongly supported the author's hypothesis that sex surrogates provide more than sexual service for clients, spending almost 90% of their professional time performing non-sexual activities. In addition, the surrogate functions *as* educator, counselor, and co-therapist within the professional therapeutic context. Clearly, the sex **surrogate functions far beyond the realm of the prostitute** (Noonan, 1984, p. 4).

There are no specific academic degrees required to qualify as a surrogate coach. There are, however, certain qualities, which appear to provide valuable background to the surrogate's ability to coach. These qualities include comfort and ease with one's own body and sexuality, warmth, concern, empathy and trust. Non-judgmental attitudes towards choice of lifestyle, sexual activity and sexual partners are also important (IPSA, 1973).

A surrogate must also be able to mentally, emotionally and physically handle multiple relationships. These requirements alone make her a rare individual. In his graduate course on sex therapy, William Stayton states: "Surrogates are highly unusual people, exceptionally intelligent, who can synchronize two roles as a professional and as a partner. I have seen them perform miracles. They, indeed, are saints in the world" (Stayton, 1995).

Surrogates are women who are very comfortable with their bodies and their sexuality because they need to bring to their clients a sense of security around sex. Many clients state that they need to gain confidence with their bodies and their sexuality. In addition to having a strong desire to help others, the surrogate is compassionate, bright and independent The surrogate is placing herself in a highly controversial situation and must be able and willing to defend her choice of profession.

The surrogate is a trained professional and should belong to the organization known as the International Professional Surrogates Association (IPSA). Based in Los Angeles, IPSA provides a 12-week training program. The program teaches surrogates sensate focus exercises, which include socialization skills, clinical training around sexual dysfunctions, information about sexually transmitted diseases and safe sex practices. Part

of the training incorporates how to work with therapists in this triadic therapeutic modality and how to handle situations with clients who are scared, frustrated, embarrassed and for those in crisis-like circumstances. A surrogate needs to love sex and care deeply for her clients who she also wants to teach how to love sex.

IPSA maintains a Code of Ethics that outlines surrogate behavior and the responsibility of upholding the highest standards of a helping professional. There is no required licensing for surrogates, but in becoming a member, a surrogate must uphold the guidelines of this organization. 1PSA has assumed the responsibility of assuring the therapeutic community and the general public that its members have received adequate training, achieved professional competency and have adhered to standards of ethical behavior (IPSA, 1973) (Appendix A).

Lynn A. Dannacher performed a study to determine the "self concept and sexual adjustment of female partner surrogates." Dannacher interviewed 36 women, 18 were professional surrogates and 18 were employed in other occupations outside the home. The groups were homogenous on socio-economic and demographic levels. The women ranged in age from 23 to 60 years of age. The comparison group subjects never had been trained or employed as surrogates and were employed in their chosen profession for at least one-year.

The study results indicated that there were no overall significant differences between the groups on self-concept. However, surrogates had a significantly greater level of sex knowledge, participated in more varied sex activities, and attached more pleasure to sexual activities (Dannacher, 1985).

Even though surrogates have special qualities, they come from many simple lifestyles and are wives, mothers and even grandmothers. For the most part, they do not fit the stereotypic Hollywood hype of sex teacher, temptress, or even prostitute. “Women who serve as sex surrogates are professionals. Few observers will guess the nature of their work at the mall, the grocery store, or at home” (1PSA, 1973, p. 8). Konik (1991) writing for Playgirl Magazine has this to say about the appearance of the average surrogate: "If anything, surrogate partners are resolutely average-looking, far from the idealized Venus and Adonis of many client's fantasies."

After a surrogate came to visit a graduate class in human sexuality, a student wrote about her experience in meeting a surrogate coach. She described that she caught a glimpse of the surrogate as she peered through the small window in the door, looking for a familiar face.

As the surrogate quietly opened the door and entered the room, the student noticed she was carrying a small child in her arms. The student believed that the woman must have been lost and said, "I remember thinking to myself as she positioned the child gently on the table, she's going to feel a little awkward when she discovers what we're talking about in the human sexuality class." When the professor turned to warmly greet the surrogate, the student watched even more curiously. The surrogate was about to share her experience with the class. "Wow, was my first reaction", recalls the student (Florio, 1993 p. 1).

Surrogates should possess the gift of valuing anotherts life and the ability to share With those persons who are unable to advance beyond their fears, insecurities, mental and/or physical limitations and disabilities. The files of the three professional surrogates

in this study are filled with cards, letters and notes of gratitude for the life changing service they provided for their clients.

## 1.3 The Therapist

For the purpose of this study, the term "verbal therapist" refers to a social worker, psychologist, psychiatrist, marriage and family counselor, sex therapist or sex educator who refer clients to surrogate coaches. Verbal Therapists are the referral sources for professional surrogates. When a professional therapist works in conjunction with a surrogate, the treatment program is considered effective and ethical. This type of therapeutic modality is known as a triadic form of therapy (See Appendix D).

The verbal therapist has a responsibility to both the surrogate and the client. She/he should properly screen the client for reasonable certainty that he is a viable candidate for surrogate treatment and that the surrogate would be safe working with him The therapist needs to look at his/her own values and comfort with sexuality on personal and professional levels, and needs to have clear ethical standards that are communicated to the client Because of the legal "gray area" of surrogate treatment, there must be willingness on the part of the therapist to discuss with the client the ethical, moral and legal issues, which underlie this type of therapy.

A significant role of the therapist is to handle both the positive and negative transference and counter-transference between therapist and client, and between client and surrogate. The client needs to be reminded that the relationship between him and the surrogate is a professional one. If the client, at any time is becoming romantically attached to the surrogate, it is the therapist's role to keep the relationship in perspective.

People who have need of surrogate coaching may be introduced to the process in one of three ways: 1) the client may contact the therapist requesting the services of a surrogate, 2) the

therapist may suggest to a client issues that may benefit a client from surrogate coaching, and 3) one of the professional sexology associations may refer a client through IPSA to a surrogate and she would then refer him to a verbal therapist.

Why a therapist refers a person with particular problems to a surrogate depends on both the client's needs and the evaluation of the therapist. A primary factor for referral is whether or not the therapist is willing to risk the legal ramifications in order to best serve the client. According to Malamuth, Wanderer, Sayner & Durrell:

> A survey conducted among 111 health professionals (72% of whom were practicing clinical psychologists) indicated that while the majority did not refer clients to sexual surrogates, most would do so if such referral were clarified as legal. Youthfulness and previous referral experience were found to be associated with willingness to employ a surrogate partner (1976, p. 149450).

Another survey conducted in *Sexuality Today* (1982) entitled: "Majority Support Use of Surrogates, But Do Not Use Them," reported:

> The overwhelming majority of respondents to our most recent survey — 70% stated their belief that surrogates have a legitimate place in sex therapy. However, of these same respondents, only 14% said they themselves are currently using surrogates. Twenty-eight percent specifically opposed their use; the rest did not answer the question.

Therapists familiar with the use of surrogates agree that surrogate treatment is beneficial to persons with certain sexual concerns. Because of legal fears, however, many therapists do not want to take the chance of lawsuits. In the *Philadelphia Inquirer* (1984), Sommers has this to say:

> It's a new profession and a powerful and effective way of helping people... provided that we have proper ethical safeguards. I don't think we have the right to withhold treatment that works.

Therapists also need to understand that when they refer a client to a surrogate, they are not abandoning the client. The therapist needs to actively counsel the client for the duration of sessions between client and surrogate and he/she needs to participate as the third component of this triadic team.

Blanchard (1999), President of IPSA, has this to say about the therapists and their role in working with surrogates:

> One of the misconceptions that therapists have is that the surrogate is a tool for them to use, when in fact the surrogate is a para-professional with a clinical judgment of her own, and is a human being with feelings. Mother misconception is that the point of being with a surrogate partner is for the client to have a one-shot learning experience.

Surrogate treatment is a process that consists of the triadic team effort of surrogate coach, client and verbal therapist. It may take as many as 15 to 20 sessions for the client to achieve his goals. The therapist who recommends surrogate treatment to a client must be committed for the duration and to the team approach that is necessary for moral, ethical and legal surrogate treatment.

## 1.4 The Client

> *We are born to be curious and to discover — sexuality is a vital part of this experience —yet many of us stop experiencing, maybe due to a bad experience, possibly due to fear or embarrassment, our lack of knowledge or skill. Maybe in our way, the inability to communicate, rigidity in religious or ethical self codes, physical or emotional handicaps, building on past failures to create more (sexual) failures.*
>
> *Paul, Surrogate Client, 1989*

A social worker who used surrogates in her private practice for many years said the following about her clients: "With most of the clients I see that either religion or their parents were rather rough on them., repressive of their sexuality" (Roberts, 1999). In agreement with this statement, Masters and Johnson (1970) state that religious orthodoxy was found to be a factor in every dysfunction that they treated at their clinic in St. Louis.

The clients of surrogate treatment are persons with intimacy, relationship, and sexual concerns which can stem from underlying fears acquired from childhood and which are negatively affecting healthy sexual pleasure. Many clients are dealing with lifelong anger, particularly at women, and feelings of self-contempt. Regarding these underlying fears, Masters and Johnson (1970, p. 74) had this to say about their clients and sexual dysfunction:

> Sexual dysfunction is marked by specific levels of sensory deprivation that have origin in fear and apprehension of sexual situations, denial of personal sexual identity, rejection of partner, negative circumstances of sexual encounter, or lack of sexual awareness. Even if previously established,

> appreciation of sensate focus can be lost through lack of opportunity for expression or subjection to personally disagreeable experience.

The range of reasons a client seeks surrogate treatment is extensive. Some seek help to rescue them from the isolation that stems from severe shyness, some have sexual fears, inhibitions, phobias, or self-esteem issues. Vena Blanchard, President of IPSA speaks about the type of clients seeking surrogate therapy.

> Sexual concerns for male clients involve dissatisfaction with orgasm, ejaculation, and/or erection difficulties. They may seek therapy to address problems relating to lack of experience, fear of intimacy, shame or anxiety regarding sex, low-level of arousal, lack of sexual desire. The causes for sexual concerns might result from medical conditions, negative body image or physical disfigurement, physical disabilities, issues of sexual, physical, or emotional abuse and/or trauma (rape or incest, for instance), sexual aversions, confusion about sexual orientation, lack of sexual or social self- confidence (Blanchard, 1999).

Modem society is lacking in positive sex education. Schools have extensive programs to teach about the dangers of drugs, alcohol and suicide, and they teach the importance of talking to someone about problems and concerns. Yet, it is believed that if one talks about sex, one is teaching sexual permissiveness. Education of human sexuality is taboo in American society and the lack of it has made it difficult for people to receive training in dating, social skills and obtain valid information about sexuality.

Even though we have come through what was called the "Sexual Revolution" of the 1960's, we still have a thread which weaves through our society that attaches sex with

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guilt and shame. Although women have "come a long way, baby", men are still expected to take the lead in sexual matters and to be the aggressor. In an interview which appeared in *Glamour Magazine* (Murphy, 2000), Howard Ruppel had this to say "Men are taught to feel like they have to not only conduct the orchestra during sex, but play all the instruments *as* well." The lack of social/sexual education puts undue pressures on males that can create problems which can lead to late life virginity. When asked what percentage of her clients are late-life male virgins, practicing surrogate coach Vena Blanchard answers, "50%" (Blanchard, 1998).

The first session with the surrogate and client is for sexual history taking. At that time, the client is asked to describe the problem in his own words and the therapist assigns a diagnosis code. Following are the DSM IV diagnostic code descriptions for clients who seek surrogate treatment. They are listed in the order in which they appear in the DSM IV Manual.

DSM IV 300.23 Social Phobia of (Social Anxiety Disorder): In this category of clients we find those who are afraid to be in, social settings and who are extremely self-conscious and feel that they are being judged and criticized at all times. This is particularly the case when they are in a sexual situation. There is fear that they will not do everything "right", that their partner is scrutinizing every move, every word.

Diagnostic Features:

The essential feature of Social Phobia is a marked and persistent fear of social or performance situations in which embarrassment may occur. The diagnosis is appropriate only if the avoidance, fear, or anxious anticipation of encountering

> the social or performance situation interferes significantly with the person's daily routine, occupational functioning, or social life.

Many therapists believe that this social anxiety group of clients would be most helped by pharmacology. Repressing anxieties and phobias with drugs may allay anxiety symptoms, but medical treatment does not heal the underlying emotional wounds that prevent a person from feeling socially and sexually inept. Verbal therapy and surrogate treatment educates such a person about himself, about how to create a sense of security in the world and how to achieve personal goals.

DSM IV 302.79 Sexual Aversion Disorder. In this category are those who have deep fears and anxieties surrounding sex and, more than likely, the female anatomy. Such people are listed under the category of aversion.

Diagnostic Features:

> The essential feature of Sexual Aversion Disorder is the aversion to and active avoidance of genital sexual contact with a sexual partner. The disturbance must cause marked distress or interpersonal difficulty. The individual reports anxiety, fear, or disgust when confronted by a sexual opportunity with a partner. The aversion to genital contact may be focused on a particular aspect of sexual experience (e.g., genital secretions or vaginal penetration). Some individuals experience generalized revulsion to all sexual stimuli, including kissing and touching.

DSM IV 302.72 Male Erectile Disorder. This is the category is for persons with erection difficulties. There are four types of erectile disorders: 1) primary dysfunction is

the inability to obtain and maintain an erection for intercourse, 2) secondary dysfunction is one time in hundreds of times they are successful, 3) situational dysfunction is ability to gain and maintain erections in some situations, but not others. For instance, they may not be able to perform at home, but can when away on vacation, 4) global dysfunction is an inability to obtain an erection at all, including during masturbation. Such people seek surrogates who will be patient and understanding as they coach the client through the use of educational tools and techniques to gain satisfactory erectile function. Those persons who profile this type of client are listed under the category Erectile Dysfunction.

Diagnostic Features:

The essential feature of Male Erectile Disorder is a persistent or recurrent inability to attain or to maintain an adequate erection until completion of the sexual activity, and may cause marked distress or interpersonal difficulty. Persons with erectile disorder may have experienced inadequate erections since adolescence. Others have feelings of nervousness and/or anxiety when one may be divorced after 30 years of marriage and are now faced with dating and meeting new women.

DSM IV 302.74 Male Orgasmic Disorder *(formerly* Inhibited Male Orgasm): This group of clients has also been called retarded ejaculators. This dysfunction is an inability to experience orgasm without prolonged time and effort either through masturbation or with a partner. Because of the extensive time and effort requirement, this disorder can be very frustrating and exhausting for both partners. Such people seek a surrogate coach as

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a partner who can be patient, understanding and will educate them regarding their own sexual response and how to work with it to achieve their orgasmic goal.

Diagnostic Feature:

> The essential feature of Male Orgasmic Disorder is a persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase. He cannot reach orgasm during intercourse, although he can ejaculate from a partner's manual or oral stimulation. Some males with Male Orgasmic Disorder can reach coital orgasm, but only after very prolonged and intense non-coital stimulation. Some can ejaculate only from masturbation and only after a very long period of time.

DSM 302.75 Premature Ejaculation. Persons with premature ejaculation are unable to control their orgasm when in a sexual situation with a partner. They may last only a few minutes after penetration or could even have an orgasm at the beginning of penetration. These persons seek surrogate coaching for the patience, understanding and educational training regarding their own bodies' sexual response cycle. They can dialog with the surrogate regarding sensations and receive feedback and coaching from her on how to control the building and release of their orgasm.

Diagnostic Features:

The essential feature of Premature Ejaculation is the persistent or recurrent onset of orgasm and ejaculation with minimal sexual stimulation before, during, or shortly after penetration and before the person wishes it. The clinician must take into account factors that affect duration of the excitement phase, such as age, novelty of the sexual partner or situation, and recent frequency of sexual

activity. The majority of males with this disorder can delay orgasm during masturbation for a considerably longer time than during coitus.

DSM IV 301.82 Avoidant Personality Disorder. Individuals with Avoidant Personality Disorder suffer from extreme shyness and are unable to approach women or to speak to someone they might find attractive. Feelings of inadequacy and low self- esteem pervade their social and sexual lives. Such people seek surrogate coaches for socialization skills training which can build confidence in being with a woman both socially and sexually.

Diagnostic Features:

> The essential feature of Avoidant Personality Disorder is a pervasive pattern of inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation. Individuals areunwilling to get involved with people unless certain of being liked and restrain themselves in intimate relationships because of fear of being shamed or ridiculed. He or she is preoccupied with being criticized or rejected in social situations and is inhibited in new interpersonal situations because of feelings of inadequacy.

The mentally and physically challenged are candidates for surrogate treatment Many are born with debilitating disorders such as mental retardation, those who are damaged with spinal cord or head injuries, and those who are born with degenerative diseases which can impair opportunities for a "normal" sex life. Generally speaking, the disabled population is not looked upon as having any sexual needs or desires.

Regarding sex and the physically challenged, Mooney, Cole and Children say:

> Virtually nobody is too disabled to derive some satisfaction and personal reinforcement from sex — with a partner if possible, alone if necessary. When a disabled person is unable to enjoy sex, the greatest obstacle to enjoyment usually isn't the difficulty or impossibility of making particular movements, but the social convention that sex consists of putting the penis in the vagina and that all the rest of the rich range of human and mammalian sexual responses — oral, manual, and skin stimulation — are abnormal. Human sex is widely versatile and not limited to the genitalia (1975 p. viii).

Patricia, a surrogate coach, specializing in working with the mentally or physically challenged, and who treats paraplegics, quadriplegics and victims of multiple sclerosis and cerebral palsy, was quoted in *The Courier News:*

> This area has my heart. There's a need for it. It's so rewarding. In addition to enduring other types of discrimination, the disabled are perceived by the public as asexual. I envision a time when surrogates can work with the disabled in a clinic setting with a support staff of psychologists and physical therapists (1984).

Sexuality consultants working for the mentally challenged population report that the repression of sexuality causes some clients to act out aggressively in negative behaviors. Because society sees this group as lacking sexual desires, there is little concern for their sexual well-being. David Strauss has this to say about sex and the physically challenged:

> No matter how uncomfortable, solutions must be found if individuals with mental retardation and developmental disabilities are to progress sexually. Often, such individuals develop undesirable and frustrating behavior as a

> substitute for appropriate and satisfying sexual behavior because they just do not know how to do what with whom (1991).

Persons with issues pertaining to sexual orientation also seek surrogate therapy. This group struggles with the desire to fit in to "normal" dating relationships. They struggle with what turns them on and their fantasies. They want to be attracted to women, to feel comfortable with them and find if they can maintain sexual relationships with them. A surrogate provides a safe, nonjudgmental female with whom they can explore sexual possibilities. What the surrogate also provides for the client is opportunity for him to gain information so that he can determine his orientation and what steps to take to live his life honestly, whether gay or straight.

Persons with a sexual abuse history have experienced sex as pleasure and sex as pain, emotionally, mentally and physically. They report that when experiencing sexual abuse they know that much of the sex they are enduring is not normal, but that it can also feel good. As adults, it becomes increasingly hard for them to separate the confusion of guilt and shame attached to pleasure and/or pain and the sex act. According to Leiblum & Rosen (1989, p. 299);

> Studies of child molestation indicate that between...3% to 31% of males have been sexually abused as children. Long and short-term responses to child sexual abuse and rape may.include fear and anxiety, depression, impaired social functioning, sleep disturbance, somatic disturbance, and sexual dysfunction…

The clients of surrogate treatment come from a range of economic backgrounds, education levels, religious affiliations, ages, professions and problems. The comparisons

of client demographics in relation to their success or failure in the surrogate treatment program will be presented in Chapter 3 and Chapter 4.

## 1.5 Sensate Focus Socialization Techniques
## Course of Treatment

*"Our experience indicates that the use of action methods along*
*With specific steps and techniques accomplish*
*Goals and produce the best positive results."*
*Fithian and Hartman, 1972, p. 140*

The specific process followed by surrogates is known as sensate focus socialization techniques. Sensate focus exercises were devised by Masters and Johnson during their 1960's work with couples. Sensate focus techniques are still utilized today to help people appreciate their physical bodies and trains a person's mind to pay very close attention to a particular body part that is being touched. These exercises are designed to put sensuality into sexuality. Masters and Johnson wrote about the sensate focus technique:

> The largest sex organ, the skin, is the place to begin to awaken a person's' ability to live more from the neck down and not just in their head, from the neck up. The exercises are designed to free sexually dysfunctional individuals from inhibitions that deprive them of an opportunity to respond naturally to sensory experience.

The sensate focus process takes the client on a slow, thorough touch and exploration of body parts and various sensations. Through this exploration, men are able to learn what it is that does and does not turn them on. These sensate focus sessions are free from the pressure of having to perform sexually and intercourse is not allowed during these sessions.

With intense focus on the body, new awareness may surface. Buried childhood traumas, memories and negative associations around sex may emerge, and bring to the surface hidden sexual feelings or experiences. The information gathered during this process is then relayed to the therapist. This is information the surrogate needs to know in order to coach the client through painful memories that impede his sexuality.

The sensate focus exercises are generally done in the nude. This is requested in order to help desensitize the client to his own nudity and to that of a female. A client has the option to keep clothes on until he reaches a level of comfort and trust, but he is encouraged to give himself and the surrogate permission to enjoy the exercises with clothes off.

Generally, a surrogate is not chosen for a particular client or for a particular case. There are surrogates who may chose to specialize in certain populations, such as the mentally or physically challenged, but mostly they are trained to work with all types of people, problems, issues and concerns. However, the "matching" of client with a particular surrogate was the practice in one clinical setting in California in the late 1980's.

Two types of surrogate coaching have been reported by Savage (1983) in an article in which she states that surrogates play either an objective or subjective role with their clients. The objective role tends to be less emotionally intimate. The surrogate

teaching is focused on the sex education of the client and the verbal therapist closely monitors the process.

In subjective surrogate coaching, there is more of a relationship developed between client and surrogate. She uses skill to balance the emotional experience with the reality that this is a working student/teacher therapeutic relationship. In subjective surrogate coaching, there is more of a risk that the client could fall in love with the surrogate. Vena Blanchard answers the question, "Do clients ever fall in love with you? ...Yes, but not often. When it happens, we address the issue and put it into perspective. Genuine caring between client and surrogate helps the therapy. I'm not an unfeeling technician who comes in to do a job. I'm there for the client with all my heart. But I try to help him understand the boundaries of the relationship." (Stone, 1983).

Blanchard also addresses the possibility that she could have feelings of infatuation for the client. If this should happen, she would first share her feelings with the client and then the therapist. The decision could then be made to ask another surrogate coach to take the case.

The course of the treatment begins when therapist and client establish a relationship. Either the client has come to a therapist because he has heard about surrogate coaching or during the course of therapy sessions, the therapist informs the client about surrogate treatment. When the client and the therapist are ready, a surrogate is contacted.

The therapist then presents the case to the surrogate who is informed of the client's sex history, problem and the therapy he has completed thus far. The surrogate decides if this is a client with whom she is willing to work. The next step is for client, surrogate and

therapist to meet. At that time there is discussion about the surrogate process. The client may ask questions of the surrogate to determine *if* she is someone with whom he is willing to work. He then becomes familiar regarding the course to be followed during the treatment sessions.

The client is given an overview of the treatment process. He is infotmed that the weekly sessions will be approximately 2 hours in length. The cost of each session and the approximate number of sessions are discussed. Today, in 2000, the average cost of a two-hour session is $150 to $200. If the course is conducted in a three-thy intensive weekend the average cost is $1,800, plus surrogate expenses such as travel, lodging and meals.

Fifteen years ago when one of the surrogates for this research started practicing, the cost was very different (Hart, 1984). "An average course of treatment runs about 12 to

20 weeks and the surrogate's fee for each two-hour session ranges between $35 and $50." The cost of a three- day intensive was around $800, plus expenses.

After agreement that the client and surrogate can become a team, it is the client's responsibility to take the next step and contact the surrogate. The therapist, surrogate and especially the client, need to see that he can take the initiative and the necessary steps to develop a sexual life.

The first two- hour session consists of the surrogate taking a sexual history of the client. She needs to have him define problems and to set goals. This particular interview is not as extensive as the one the one taken by the therapist. The surrogate is mainly interested in family background, religion, education, profession and sexual experiences with males or females. Recorded also are what other therapies were utilized, general

health history, medications taken and the use of drugs or alcohol. She is particularly interested in masturbation habits, the age he began masturbating and whether he felt guilt or shame? Does he masturbate now? If so, what is the frequency and the method?

The format of the sensate focus exercises is *as* follows: hand dance, head and face caress, foot bath, back body caress, front body caress and full body sculpting. Instructions are given for specific caresses *as* caresses denote a softer, gentler, more sensitive touch. Unless the clients prefer otherwise, a romantic atmosphere is created by soft music, lighted candles and the like.

The course to be followed will include socialization, communication, and assertiveness skills training. The client will be given homework assignments that may include books to read, videos to watch, erotic material to read and/or view and visits to erotic dance clubs. The client will be encouraged to notice women, talk to them, or ask them for phone numbers or a date. Any and all assignments are designed to help the client perceive themselves as sexual, sensual beings and to remove barriers that may be in the way of creating a life which includes sensuality, sexuality and relationships. Persons with shyness, anxiety, and fears regarding women will learn to overcome the mystery surrounding them and fears regarding their sexuality.

Clients need to understand they are required to participate fully in the surrogate program. It is the action part of their therapeutic process. The surrogate may teach them to dance, may request them to go to a lingerie store and buy her something he would like to see her wear. There will be role playing in areas that may be difficult for the client If he is too anxious to attend a party, they could role-play how to greet people, how to get into a conversation or how to get out of a conversation. He will also learn how to ask for

a date and will role-play how to handle acceptance or rejection. The client will learn to be social before he becomes sexual.

The client will learn communication skills. He will learn to say what he likes and does not like sexually. He will also practice asking his partner what her sexual desires are as well as what she does not like. He will experience that he cannot give someone pleasure unless there is agreement in giving sexual pleasure. In learning to take responsibility, initiative and action in reaching his relationship goals, the client will gain confidence and learn what it is he can do, instead of worrying about what he cannot do. All of this is incorporated within the program of "sensate focus,"

The client also knows that the surrogate will be confiding the therapist to inform him/her of the content of each session. It is customary for the surrogate to phone the therapist to discuss both the physical as well as the emotional content of each session. From this information, the surrogate and the therapist together decide what is best for the client's next session. The therapist will then incorporate what he learns from the surrogate into the next verbal session with the client Also, the therapist will report to the surrogate any relevant information gathered in his/her verbal therapy session that the surrogate may need to assist her in her work.

The client is first asked to perform what is called the body image exercise, or mirror work. The media does a disservice in leading people to believe that there is an ideal body image modeled after heroes and "perfect" people. The body image exercise is designed for the client can then begin to see his or her own unique beauty.

In this exercise, the client will stand before a full-length mirror, preferably nude, and talk about his body parts. He is instructed to start with his hair and end with his toes and

to say what he likes and what he doesn't like. At the end of the exercise, he will give himself a rating from 1 to 10 so both he and the surrogate can learn the level of his self-image. It is information that is the basis the surrogate uses to help him improve his self-esteem.

The first sensate focus exercise is called the hand dance. Hands are special because we experience a great deal of touch communication with and through them.

We are touched or touch with them more than any other part of the body. The hands are a safe body part to start the exercises. The hand dance begins with both partners facing one another and are seated closely enough to comfortably access one another's hands. The surrogate takes the lead by placing oil in the palm of one hand of the client and gently caressing it paying particular attention to the fingers. The process is then repeated on the other hand. After both hands have been worked individually and are coated with oil, both of them are caressed together. The client is encouraged to feel the sensations and relax with the movements of the surrogate.

The roles of giver and receiver are then reversed. The client now applies oil to the hands of the surrogate. Following the same procedure, each hand is caressed individually, then both hands together. The next step is for both people to do one another's hands simultaneously.

After each exercise the client is asked to discuss his sensations. It is his opportunity to discuss his awareness of the texture, temperature and pressure of touch. He is to verbalize his feelings toward both giving and receiving. Hartman and Fithian (1972 p.190) comment about sensate focus; "We can tell a lot about feelings by the way the

client deals with their hands. The surrogate will notice if they are overpowering or withdrawing and how he responds in a give and take situation."

The second exercise is the head and face caress, which is an exercise to learn how to feel comfortable and safe in the hands of another person. The surrogate initially gives to the client. She sits on the floor with her back against the wall. The client then leans his back in against her, between her legs, resting his head and shoulders on her chest. The client, as the receiver, should feel comfortable and safe enough to allow himself to go limp and rest against the surrogate as the giver.

The focus of this exercise is on the neck, face and head. There is to be no touching anywhere other than specified areas. The surrogate should allow the client to rest his head in the crook of her arm and she will cradle, nurture and explore the client's head one side at a time. Gently letting her hands flow over the head, neck and face of the receiving client, she takes time to explore. Next, she shifts the receiver's head to the center of her body. Then starting at the top of the head and working down the hair and scalp, over the forehead, eyes, cheekbones, nose and mouth, the surrogate totally explores the client's facial structure. Movements with this exercise must be spontaneous, and often music is used. When the surrogate has completed about 15 minutes of giving, they then switch and the client becomes the giver.

The third sensate focus technique is called the footbath. It is important to set the atmosphere. The room temperature needs to be comfortable, the water for the foot-bath must be warm to the touch, with music, candles or low lighting as part of the atmosphere. Then, there is an environment for relaxation and fun.

The client (also known as the receiver) is seated in a chair with his feet flat on the floor as the surrogate attends to one foot and leg at a time. Needed for this exercise is a tub of warm water, shaving cream, cornstarch that is applied with a powder puff, and massage oil.

To begin this exercise, the surrogate (known as the giver) gently picks up one foot and slowly places it in the tub of water. After the foot and leg are bathed slowly with the water, the foot and lower leg are lathered with a thick shaving cream, which is slowly and evenly spread over the foot and leg and worked between the toes. Then she will use a washrag or sponge to rinse the off the shaving cream. It is best to support the receiver's leg on the giver's leg, using it as a footrest. The leg is then towel dried and cornstarch is applied with soft caresses from the powder puff. By lightly applying cornstarch, dusting it on, the palms and fingers are used to caress the leg toes. Cornstarch is used because there are no perfumes or chemicals, which could cause allergic reactions. Lastly, the cornstarch is removed gently with a towel.

The final step in this exercise is to gently apply massage oil. The surrogate slowly massages oil onto the leg, foot and toes and works it in for a few minutes. This leg is left wrapped in a towel before proceeding to the other leg. Again, the giver and receiver switch roles. At the end of the exercise there is discussion and feedback. The client is asked, "Which do you like better, giving or receiving?" He is also asked," Why do you think that is?" It is important for the client to be able to receive and to give while staying focused on what he is feeling, as well as to express feelings when he is asked. This gives both him and the surrogate information about how he relates to others, which is information she will report to the therapist.

The next sensate focus exercise is called the back body caress. It is done with client lying face down, in the nude, on the floor or on a bed. The surrogate will pay attention to the back of the body, which includes his arms, legs, head, neck, torso, hands and feet. She can use a variety of sensuality tools to elicit different feelings from the client. She usually uses a powder puff with cornstarch, feathers, a fur mitt and oil. The idea is to experiment with different sensations. Silk or other materials may be used. Usually, the surrogate will brush her hair completely over the body and finish off lying with her entire body on his. They can also lie side by side, and breathe together.

When asked to switch, the client may be hesitant to try to elicit sensual pleasure. If he is unsure of his ability, he needs to be reassured that he is here to learn and that his awkwardness will subside with practice. He is learning to touch and caress warmly, enjoyably, and sensually.

The next exercise is the front body caress that is the same process as the back body caress. As in the other exercises, genitals are not involved. This exercise is for the client to learn to experience and appreciate other erotic sensations and body parts. The front body includes: head, face, neck, torso, arms, legs and feet. The same sensuality tools are used as in the back body caress. The exercise ends when the giver lies on top of the receiver touching face to face. If this is too uncomfortable (either physically or emotionally), they may lie side by side, either facing one another or his front facing her back in a "spooning" position.

The final sensate focus exercise is body sculpting or total body workup. The best place to do this is in the shower. It is very similar to the hand dance. The client should focus on feelings and sensations and use all techniques learned up to this point. Both

bodies are explored from head to toe, although genital exploration is still not incorporated into the treatment process. Exploring genitals could bring on pressure that would interfere with the process of learning about and adjusting to the client's own body and the sharing of sensations. After showering and sudsing one another with soap, they play with a washcloth and Water. Afterward, they towel dry one another. The shower can now be used in subsequent sessions as an exercise for reconnecting between appointments and also for hygiene purposes.

After the client has experienced sensual training, he is ready to receive sex education. Exercises to this point are called non-demand, which means that genital touching was not involved. The sensate focus exercises are designed to help the client gain confidence and self-esteem, to learn to communicate feelings, and to allow the client to explore new feelings and sensations.

The first part of sex education is called a "sexological." Generally, surrogate clients lack knowledge about the functioning of their own sex organs, or those of a female and the sexological addresses this problem. The surrogate and the client will explore the genitalia of first the client and then the surrogate. They will refer to an anatomy book and with the use of a hand held mirror compare and discuss the functions and sexual responses of males and females. The surrogate may also insert a speculum into her vagina so that the client may explore the vagina. An anonymous surrogate says: "The purpose (of the sexological) is to eliminate the feelings of mystery, awe, alarm and the sense of dirtiness which many men associate with the female genitals." This helps him to demystify the sex act and to experience normal functions of the human body. The

client's feedback, upsets, or enjoyment regarding this exercise is valuable information shared with the therapist.

An important part of sex education is the knowledge of sexually transmitted diseases (STD's) and how to protect oneself with safe sex practices. Condoms are used for intercourse and the client is taught how to incorporate fun and play when using a condom prior to intercourse.

The client is then expected to either masturbate himself or allow the surrogate to masturbate him to the point of orgasm and ejaculation. When the client is able to let go in masturbation, then oral sex is explored. They each perform on the other, cunnilingus on the surrogate, and fellatio on the client. The final step of the surrogate treatment process is intercourse. When the client is able to perform intercourse without premature ejaculation, is able to maintain a suitable erection without erection problems, and is able to ejaculate without retarded ejaculation, then completion of the program is just a session or two away. It is a decision made between surrogate, client and therapist whether the client is able to put into practice the skills and tools he has learned and is if he is ready to transition from the surrogate to a suitable partner. When all three agree, the client will continue to work with the verbal therapist, but sessions with the surrogate coach are terminated.

Built within the sensate focus course are homework assignments to encourage him to date. Role-playing is used to illustrate several common scenarios which may cause anxiety, fear and confusion. In the role-playing, client and surrogate have practiced how to approach someone he may be attracted to and get a phone number. He is coached on how to make that first phone call and ask for that first date. They practice how to handle

rejection of his advances and how to handle acceptance. It is an ideal closure when the client has an interest in a partner of choice and the relationship coaching had been incorporated into his process with that particular partner.

Closure between surrogate and client may be emotional. The client has felt extraordinary physical and emotional sensations he has never before experienced. Risking more than he ever believed possible, his accomplishments portray how far he has come in his sexual growth and development. One client made a list of all the "firsts" he experienced on one weekend intensive (Appendix E).

The surrogate has been the catalyst for a potential new lifestyle for this client. Blanchard (1999) speaks on closure:

> Clients grow to trust and care for their surrogate partners. She is someone with whom they can share honestly, perhaps for the first time in their lives. Through the relationship they discover that they can be valued for who and what they are in this intimate, interpersonal relationship. They learn that the same potential exists with future partners of choice and they learn how to develop more honest and satisfying relationships.

Professional surrogate coaches do not continue with any form of sexual relationship with the client after termination of treatment. However, he is given permission to call with a question, or ask for advice, but he needs to clearly sever their previous connection and seek partners with whom to share his new skills and abilities. "I've had some people call me from their bedrooms and ask, 'What do I do next?' I become their 'big sister', says Patricia, surrogate coach.

Surrogates report meeting with former clients for a cup of coffee or dinner. It is interesting for them to learn how the client is doing. It is rewarding for the surrogate if the exercises, homework, social and sexual training has been transferred to a partner of choice. "It is really why I do the work," says Janice, a surrogate coach. "It's the difference I can make in someone's life. What could be more rewarding than that?"

## 1.6 Evolution of Professional Touch Therapy

*"In the ancient temples, where sex was a sacrament and ecstasy a divinely inspired state, the priestesses often were sacred prostitutes .... She being guide, teacher, healer, transformer, catalyst"* .

(Stubbs, 1994, p. 15)

The History of hands-on sex help from a historical perspective depicts women as the givers of life and as possessing the qualities of healers. These images have been revealed in writings and works of art in ancient Egypt and in the myths of the Greek and Roman' gods and goddesses. The power and beauty of nature has been humanized by terms such as "mother nature" and the correlation of women to humanity's life-sustaining dependency on "mother earth." As human beings we share a need for the mother, the healer, the giver and sustainer of life.

> What we find everywhere — in shrines and houses, on wall paintings, in the decorative motifs on vases, in sculptures in the round, clay figurines, and bas reliefs — is a rich array of symbols from nature. Associated with the worship of the Goddess, these attest to awe and wonder at the beauty and mystery of life (Eisler, 1987, p. 18).

The ancient spiritual system, Tantra, is related to both Hinduism and Buddhism. The basic belief is that spiritual enlightenment is attained through sexual energy. The practices of this philosophy are designed to bring forth the feminine qualities of both men and women. This quality, or energy, is the key to higher ecstasy that leads to integration of sex and spirit. "...it acknowledges the existence of both inner and outer realities, and that the primary path to integration is through sexual energy" (Mann and Lyle, 1995, p. 63). Whether they are called sacred whores, temple prostitutes, goddesses, witches or, as

Stubbs writes in his book entitled *Women of the Light* (1994), women identified as sexual healers have been around a very long time.

Irving Wallace's novel, *The Celestial Bed*, (1987) tells the story of a surrogate working in a sex clinic in Arizona. He begins with this introduction:

> In 1783 one of the most popular attractions in London was the Temple of Health, promoted by an amiable Scot named Dr. James Graham. The main feature of the Temple was the canopied Celestial Bed, supported by twenty-eight pillars and attended by a live nude Goddess of Health. Male visitors were invited to recline on the Celestial Bed for fifty pounds a night with the promise that this treatment would lead to a cure for impotence.

The hands-on sex help of today began with the 1950's and 1960's work of Masters and Johnson in their sex clinic in St. Louis. Because of this work, they are called the grandparents of surrogate treatment. Blanchard (1999) speaks about the beginnings of hands-on sex help known today as surrogate coaching:

> They (Masters and Johnson) had great success in working with hands-on sex therapy for couples. In order to work with single people who were experiencing sexual dysfunction, they trained and hired women to "substitute for" the wife of a client in a program that was identical (or very similar) to their couples treatment program.

Masters and Johnson (1970) spoke about the need for partners to work with their single male patients. One of the most prominent concerns of their developing therapy approach to sexual dysfunction was the demand for treatment from the unmarried men

and women. Their book *Human Sexual Inadequacy,* appeared on bookstore shelves in 1970 and marked the beginning of sex therapists and sex clinics investigating the use of surrogate partners. Vena Blanchard (1999) suggests there was no proposed surrogate partnering before this date.

Many people, however, suggest it (surrogacy) has precedents: specifically, in temple prostitutes or certain tribal cultures where an experienced person trains or helps an inexperienced or unwell person.

Masters-and Johnson's book was the catalyst for therapists exploring the possibility of surrogate treatment. Women were trained and surrogate treatment was used in conjunction with sex clinics and also as a third component for private, independent therapists. In 1973, the International Professional Surrogate Association (IPSA) was founded. Just three years after Masters and Johnson first proposed the idea of surrogate partner therapy, a group of surrogates created IPSA as a support group for themselves. Within 5 years it expanded to become a professional body with a code of ethics, training sessions and standards for the developing profession (Blanchard 1999).

Regarding Masters and Johnson's use of surrogates, Lo Piccolo (1978 p. 319) writes:

> Masters and Johnson (1970) report that in their use of surrogate partners, female surrogates with sexually inadequate males achieved approximately equal success in the reversal of the sexual dysfunction as was true in those cases in which the sexually dysfunctional males were treated in conjunction with their wives. There clearly is a need for a female partner who can share the patient's concern for success, cooperate in the physical

> application of suggestions presented in therapy, and exemplify different levels of female response.

In 1970, after the release of their book, Masters and Johnson were forced to reverse their statistical comment regarding the success of their use of surrogate partners because of a lawsuit against the clinic. Following is a quotation from an article that appeared in the June 17, 1974 Time Magazine, which addressed the issue of surrogate partners:

> In that 11 year period (of using surrogate partners) they, Masters and Johnson, provided surrogates for about 50 men; the treatment overcame impotency problems for at least 75% of the cases. A lawsuit against Masters brought about by the irate husband of an alleged surrogate, forced them to cease the use of surrogates. Masters regretted having had to give up the surrogate therapy stating: "The success statistics with single impotent males have completely reversed. We now have a failure rate of 70% to 75%."

At this juncture, Masters and Johnson were forced to close the doors on further treatment of sexual dysfunction which included the use of surrogates. However, the concept *was* already in the journals and in the minds of the therapists who saw potential for a substantial part of their client population. Professional surrogates had been trained. Masters and Johnson had introduced a program and coined a phrase that had gained interest in the field of sex therapy.

## 1.7 Touch Therapy to Surrogate Coaching

*"Reflecting on the omnipresent specter of AIDS, we are struck by the magnitude of its impact on all aspect of sex therapy and sexuality generally."*

*Leiblum and Rosen, 1989, p. 275*

Masters and Johnson are known as the "grandparents" of surrogacy. They began their practice of surrogate treatment in a clinic setting. Client and surrogate would come to the location in St. Louis and reside together in an apartment provided for them. They would meet with their therapists (a male and female team) each morning. At that time, the client and the surrogate were given their assignments for the day.

The assignments would include one or two sensate focus exercises, free time to explore the city, to have lunch, then they would practice one or two more sensate focus exercises. They would meet again in the evening with the therapists to report the results of performing the assignments. In this clinical model, the surrogate was under strict supervision by the verbal therapists. She was expected to follow the assignments for each day and was not to deviate from the therapist's requests. After the Masters and Johnson legal case, surrogates began to work independently.

Referrals and networking with therapists became the only professional way to obtain clients. Surrogates would contact therapists to tell them of her training and availability. She would work with the clients outside of the therapist's office, either in her residence, the client's residence or a location agreed upon by surrogate and client. Such an arrangement is a change from the restricted clinical setting of the Masters and Johnson treatment approach.

Today, the surrogate coach has freedom to determine, along with feedback from the therapist and the client, what homework assignments are appropriate for the client outside of the sessions and the training of the sensate focus socialization techniques. These independent surrogates have also been called "spontaneous" surrogates. They are no longer under strict supervision by the therapist but are part of a triad team in which she has the freedom to spontaneously introduce assignments and exercises within the sensate focus process. This is known as an open-ended process, rather than a rigidly structured program practiced at the Masters and Johnson clinic.

In 1972, Hartman and Fithian opened a clinic, Center for Marital and Sexual Studies, near Los Angeles. Their approach combined both the clinically supervised and the independent surrogate models. They called their approach the "Bio-Psycho-Social Approach." Their work incorporated supervision by the male/female therapist team as well as the social skills and psychological needs of the client:

> We have a bio-psycho-social approach to the treatment of human sexual dysfunction. We believe the physical background and current physical status should be examined; someone with a physical problem should be referred for medical cam. This is the biological aspect of our ideal program. We agree with Freud that the image one has about one's self stems from their basic biological image; therefore, it is important that their basic biology be dealt with before the program moves on to consideration of feelings concerning one's self. Self- concept, along with psychological testing, forms the psychological portion of the program. It is important this be done before one is put in touch with someone else. This is the sociological step in the piogram. This process is an

> interdisciplinary approach to the resolution of sexual dysfunction
>
> (Hartman and Fithian, 1972 p. 2).

In March 1978, at the Fourth Annual Meeting of The Eastern Association for Sex Therapy, a workshop entitled "The Question of Surrogates" was presented by Bernard Apfelbaum of the Berkeley Sex Therapy Group. He states:

> Our approach to individual body-work sex therapy was not independently developed, but is the result of our efforts to remedy what we found, in our practice, to be unworkable in the other approaches. We moved from an independent, 'spontaneous' surrogate model to a behavioral-analytic model using a co- therapy structure, the only one of its kind in use with individuals.

In the behavioral model, the focus is on changing unwanted, negative behavior to the desired behavior that attains a certain goal. The primary interest of behavioral therapy is the client's behavior and how it affects his present situation. The belief is that only those present sexual behaviors need to be changed and, subsequently, personal sexuality goals will be reached. This model is mostly focused on sex education and overcoming sexual barriers to obtaining goals. Objective surrogates work with this modality. It does not recognize the importance of socialization, communication or relationship skills. These skills are more the concern of the subjective surrogate coach.

Apfelbaum goes on to say, "What, then, is meant by 'relationship therapy?' One thing it clearly means is a rejection of the tacky role-playing ... of the 'spontaneous' surrogate." He is clearly in disagreement with the Masters and Johnson model, the Hartman and Fithian model and the independent model for surrogate treatment.

In the late 1970's, the topics of conversations and conferences were which surrogate treatment model works the best and the legal concerns of this therapeutic modality. An article was written about a weekend conference held at UCLA, entitled "Professional and Legal Issues in the Use of Surrogate Partners in Sex Therapy." A gathering of surrogates, therapists and attorneys to discuss the future of this controversial issue: "After the Masters and Johnson experience, a threatening legal shadow fell over the field of sexual surrogate therapy" (Elias, 1977).

Harold Lief, noted sex educator, has this to say:

> As we approach the mid-point of the eighties, it can be argued that the presence of sexual surrogates in our midst is a social and cultural phenomenon as well as one which reflects a lot of changing values about sexuality. We live in a society that demands sexual performance, so that shame over inadequacy rather than guilt over sinfulness are becoming the more important of the two emotions in sexual behavior (Matusow, 1984).

Concerns, in the sex communities, about sexually transmitted diseases skyrocketed after what is now called the AIDS epidemic. This, naturally, affected surrogate treatment Zilbergeld (1999) writes: "An important question has to do with sexually transmitted diseases. After all, surrogates have sex with many partners and they seem like prime candidates for contracting one or more of the many common diseases. The fear of spreading or getting AIDS, or of being sued for transmitting it, has caused some therapists who work with surrogates to stop doing surrogate therapy."

Surrogates also report being aware of their responsibilities in safeguarding themselves and their clients from sexually transmitted diseases (STD's). "Surrogates are

very concerned and conscientious about not only their own personal health and well-being, but the health and well-being of their clients as well. Surrogates claim that 50% of their clients are virgins or near-virgins. These people have not been with many, if any, partners and are a low risk from the surrogate's perspective" (Blanchard, 1999).

The possibility of women spreading the HIV virus to the population was discussed in Sex in America (Michael, Gagnon, Laumaim, Kolata, 1994, pp.212 & 213):

> The first necessary condition for the virus to spread is regular and frequent sexual contacts between infected and uninfected groups. The largest infected group is gay men. To spread the virus to the heterosexual population, the gay men would either have to have frequent sex with bisexual men, who would then have frequent sex with many women, or the gay men themselves have to have frequent sex with many female partners. But then those women who are infected would have to have frequent sex with many other men to take the epidemic one more step into the general population.

Surrogates are expected to be responsible in their private lives in protecting themselves and their clients from STD's. They need to procure periodic AIDS testing, gynecological exams and particularly engage in the practice of utilizing condoms both personally and professionally.

> I cannot speak for all surrogates, but the ones I have worked with are extremely careful about disease and were this way before the advent of AIDS. As far as I know, no one has ever had any sexually transmitted disease. The surrogate I now work with gets an HIV antibody test every six months and demands two negative test results from every new client Safe sex is the name of the game,

> and it is played compulsively (B.Zilbergeld, personal communication, December 4, 1999).

Another factor affecting surrogate treatment, since the Masters and Johnson era, is the use of medical and pharmacological treatments particularly for erectile dysfunctions. Viagra is the most widely publicized and advertisements for better sex potential is seen daily in the media.

> With Viagra removing the need for sex therapists to help persons with dysfunctions to overcome their psycholgocial blocks to erectile functions, therapists began focusing more attention on interpersonal dynamics in the couple's relationship (B. Stayton, personal communication, April 15, 2000).

Pharmacological treatments may be of benefit to those persons who suffer from shyness, aversions, abuse and fears. When working in conjunction with the surrogate treatment program, the use of pharmacological treatments could give the client the extra confidence to help him reach his sexual and social goals.

There is a basic human need for physical touch. Touch therapy has evolved beyond only the tactile functioning of this need. In our English language of today we use 'touching words' when we are moved emotionally by an event. In referring to someone who may be mentally unstable, we say he is 'touched in the head'. Even the telephone company uses touch in their marketing slogan of 'reach out and touch someone.' When someone is upset we say they were, 'rubbed the wrong way,' or for achievements, people get 'stroked' (Weinstein, 1984).

The surrogate treatment program has evolved from the physical aspect of 'touching' a person's life to include 'touching' them mentally and emotionally. The practices of the

sensation focus socialization skills offer surrogate clients opportunity for growth and development for their mental, physical and emotional wellbeing.