CHAPTER 5;
CASE STUDY ANALYSIS

5.1 Introduction

In this study, 68% of 151 subjects studied completed the sensate focus exercises and corrected their problem. This chapter, Case Study Analysis, is the qualitative results of this research. Qualitative research, as defined by Denzin and Lincoln (1994) "...involves the studied use and collection of a variety of empirical materials — case study, personal experience, introspective, life story, interview, observational, historical, interactional, and visual texts that describe routine and problematic moments and meanings in individual's lives."

The goal of this chapter is to present data collected from the interviews conducted by this researcher of the three surrogate coaches. The information gathered from these interviews and the recording of the surrogates' personal experiences provides insight and deeper evaluation into the surrogate treatment program. The interviews are reported by the surrogate in a narrative style with a beginning, middle and ending which includes the surrogates' feelings and her observations of the client's experience.

A secondary goal of this chapter is to disclose material gathered from the interactional interviews between the surrogate and client. This material extracted from the surrogates' historical files, revealed eight emergent themes. These themes, or patterns, depict essential characteristics regarding the client's personal view of his problem, the way he was experiencing it and what effects it had on his social and sexual life.

The emergent themes that became clearly evident are as follows: 1) fear of women, 2) lack of social/sexual confidence and experience, 3) shyness and anxieties around social

and sexual situations, 4) inability to develop intimate relationships, 5) need for social/sexual education, 6) freedom from emotional and mental pain of childhood abuse, 7) lack of desire, and 8) fear of performance. These themes or patterns were found in each of the nine diagnosed problem categories. These categories, as previously stated, are: 1) late-life virginity, 2) Erectile Dysfunction, 3) Premature Dysfunction, 4) Sexual Orientation, 5) Person's with mental and/or physical Disabilities, 6) Social Phobia, 7) Avoidant Personality, 8) Orgasmic Disorder and 9) Aversion.

This qualitative chapter provides a sampling of stories and exemplary cases, as reported by the surrogates. These stories are representational of all of the 151 participants of this study. Included in this sampling are the accounts of the most successful and the most difficult cases from each of the eight emergent themes.

5. 2 EMERGENT THEMES

Theme — Fear of Women

There were thirty-two of the 151 subjects who expressed being afraid, nervous and anxious around women. Issues with women was reported by other subjects who recognized that their fear of women was a significant factor in their inability to pursue se nal relationships with women. The men who fell into this category struggled with the ability to feel comfortable in the presence of women's genitalia. They may have grown up with domineering mothers, been put down by female family members or peers, or possessed fears of depending on women to fulfill their needs. As Zilbergeld (1999) says, "Since the boy had to break away from his mother and feminine ways to establish his masculinity, there's a fear of once again coming under the domination of women."

A story of one client who expresses fear of women, particularly female genitalia, is B. B's diagnosed problem is late-life virginity. He has carried through his life the scars of emotional abuse inflicted by his mother. B came to surrogate treatment because he could "see the years slipping away from him and his dream to have a wife and family was feeling further and further from his reach." B's Surrogate coach, C, discloses the background details which led him into treatment

> B is a 43-year-old Catholic attorney who describes his problem as, 'virginity, extreme fear, and anxiety around women and sex.' His stated goal is 'to have intercourse, feel comfortable with female genitalia' B started masturbating at

> 14 years of age, with, as he says, 'a lot of guilt and shame.' His masturbation practices when he began therapy were 'infrequent' Also at age 14, his mother began telling him stories about how horrible and painful sex is for women. She told him stories of her visits to the gynecologist and that she needed a drink, a whiskey sour, when she got home from one of these appointments. She also told him that sex was causing her permanent harm and she wanted her doctor to verify that fact so she could justify not having anymore sex. B's first sexual experience was during his college years. He was in a relationship with a girl he cared for very much. They had been dating for quite some time and the petting sessions were 'heating up.' He said that he was 'very nervous and scared,' but during one of these 'heated dates,' he reached down and touched her genitalia. Her response, to his touch was 'ouch, that hurt.' From this point on, B has been afraid to go far enough with women to 'hurt them.'

I asked Surrogate C how B came to be in surrogate treatment. She told me:

> He had been in verbal therapy for five years when he entered the surrogate treatment program. His verbal therapist told him about the surrogate process. B and I met over the phone a few times, and I spoke with his therapist before we agreed on proceeding with treatment. B and I met at a mutually agreed upon hotel for a 3-day weekend intensive. He was successful in performing the sensate focus techniques and was able to engage in oral sex and intercourse with me. He and his therapist were very pleased at his ability to accomplish so much in this short period of time.

I questioned Surrogate C on whether she had any follow up information on B's ability to incorporate his learning experience into his everyday life. She said:

> B felt that the weekend had impacted him in several ways. He had experienced more erections in the past two weeks (since the program) than he had in the past five years. He said 'my sexual imagination is more active than ever before, it is like the sexual switch has been turned on. There's a change in the way I fantasize. Now, fantasies are about having explosive, wild sex on the office floor. I would not have gone there in fantasies before. I now feel I can expand myself socially now that virginity is behind me. This has opened social as well as sexual doors for me. Having been able to view the female genitalia helped immensely in allaying the fears of the female anatomy.' Sexual positioning was a concern for B. He could not perceive how it would happen naturally. He felt that our experience together had taught him that the sexual act is very natural and normal. He expressed that he, 'now understands that the only sexual restriction should be 9hat of consent. I guess I now believe "free love." B was glad to find that the experience helped him differentiate from his parents and the mistakes they made. After our experience, he was able to express his anger that he had for his parents for telling him lies about sex. B commented that he, 'felt more comfortable with his body and about the possibility of other people seeing it It's just remarkable to me. It (the weekend) has been a life shaping, life-changing event.'

I asked the Surrogate C *if* she thought B would transfer his new skills to a partner of choice. Her reply, "He has a good chance of succeeding in changing his social and sexual life. B has a very positive attitude and a five-year relationship with a verbal therapist with whom he will continue in therapy."

A second story about the fear of women is that of a middle-aged man who was afraid of intimacy and of allowing women to feel too close to him. He was unable to relax and give himself permission to enjoy the closeness of sexual encounters and was thus unable to ejaculate when sexually with a women. Surrogate coach B tells the story:

> R is *a* 36-year-old Agnostic business executive with a diagnosis of orgasmic disorder. R is college educated with an additional two years of law school. He had a happy childhood and felt loved by his parents. During therapy he disclosed to me that the reason he could not ejaculate with women was that he, 'was afraid to let them know his pleasure depended on them.' R began to masturbate at age 12. He did not experience any guilt then or now when he masturbates. His fantasies are of heterosexual sex activities. R began to date when he was 18 years old and was 19 when he had intercourse for the first time. During his first intercourse experience, he had delayed dysfunction. Since then, he has always had delayed dysfunction. When R began surrogate treatment he had been depressed for the last six years and in verbal therapy for the past three and one-half years. During our first session, R wore sunglasses. He avoided all eye contact with me and at one point took my cigarettes and ashtray and moved them down to his end of the table without asking permission. Also in this first session, we completed the mirror exercise and

> when I asked him to rate his body image on a scale from 1 — 10. He arrogantly replied, 'I give myself an 81-2.' When I was performing the head caress exercise on him, he said, 'You don't do this very well It wasn't hard enough, I could hardly feel it'

I questioned the Surrogate B on how she handled a client such as this with a condescending attitude. Her reply: I need to stay focused on the task of helping him to gain some level of mist with me. After a few sessions I will share with him how his comments and attitude are not conducive to creating a positive relationship.

She continues with her story:

> I also discussed with his therapist this negative side of R that I was experiencing in the sessions. The verbal therapist shared that he believes R is hiding insecurities behind his arrogant behavior. The verbal therapist asked me to point these behaviors out to R in the next session.
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> During the third session, R wore clear glasses, but was very passive. I gave him a foot-bath which he enjoyed, but he would not reciprocate. In our fourth session, R enjoyed receiving the back body caress, but was not ready to give to me. I feel he needs to know me better and like me more. We snuggled on the sofa and touched for a half-hour, but he is still not ready to give. He shared that he feels that I am in charge, and that this makes him uncomfortable because he wants to be the one who is in charge. In Session five, R tells me he was with a woman this past week,- and that he was able to orgasm. He did not know why he was able to be with her. He thinks maybe out sessions are helping his confidence. He does admit he likes it when

the sex is focused on him and he has allowed himself to be pleasured. We were relaxing in the tub while we talked about this. I called the verbal therapist, and he is pleased with our progress. In the next session we did the front body caress. R was able to receive and then also to reciprocate. He touched my genitals and we had a good time laughing. He teased me for talking too much. We are trying to work on the eye contact. Afterwards we took a shower, he shut off the light kidding around, and we washed each other. In session six we did genital pleasuring, but while exploring me, he looked away. He didn't like it if I looked into his eyes, because as he said, 'that was too intimate.' We did some kissing, and as always he held me with hands clenched. When he left I asked him for a hug, which he did and surprisingly with his hands unclenched. By session 10 I got new music, as he had complained about my taste in music. He complimented me on choosing music that he liked. He even felt close enough and laid his head in my lap. I feel we are progressing. We are more comfortable with each other. We took a shower, he performed the front body caress on me, then mutual touch, then genital pleasuring for him. He was very responsive. He reached out to me, I felt he wanted to pleasure me, but he didn't. His orgasm took long to achieve and I could feel his disappointment. In session II, R was very distant. Although, he did touch me first, then mutual touches on genitals. After playing, he pulled me up and we danced for about half-hour. He still avoids looking at me. He reached out to me, touched my breasts and wanted to give me genital pleasuring. We had intercourse, without orgasm. He claims he

> knew that as soon as we became sexual, he would no longer orgasm. The verbal therapist told me that there was something in his history, where mother was distant and he did not get enough attention from her, but that he couldn't let her know that he missed it.

This client did not return for any further treatment sessions. The therapist phoned to tell Surrogate B that R was terminating. I asked her how it felt to have a client leave before completing. She said it was sad, especially since he had gone this far in the program.

,These two examples represent the thirty-two males who considered fear of women as their stated secondary problem. B had early childhood messages that infiltrated his teenage years and his adult *life.* R had built a wall to protect himself from allowing women to get too close to him. Fear of intimacy and trusting a woman with their vulnerability was stated by many of the studied subjects.

Theme — Fear of Performance

Thirty of the 151 subjects had specifically expressed the fear of not being able to sexually perform. Performance anxieties derive from high sexual expectations which males either learn from society or are self-induced. Zilbergeld (1999) writes about the myths of male sexual performance. He calls these myths the "fantasyland model of sex." Men believe they need a penis that is, "two feet long, and hard as steel." They think that their sexual ability must be able to, "knock the socks off of a woman." He credits these myths to the messages males receive from sexual jokes, romance novels and porn movies that portray "positive references to large penises and denigrate small ones." Zilbergeld agrees that these

perfect people, fantasyland performances are fun to view and read about, but then because we do not have, "realistic models or standards in sex, little idea of what is customary or even possible in the real world, we tend to measure ourselves against these fantasies."

Fear of sexual performance is the second largest theme category for this group studied. The clients' stories tell of negative first time experiences. They may have been in situations where they climaxed too quickly or were not been able to orgasm at all. Possibly, they were unable to achieve an erection or to retain one long enough to penetrate their partner. Others speak of just needing an understanding and patient partner. Surrogate C shares about one client with the fear of performance as his stated goal:

> T is a 43-year-old Jewish virgin. He is a professional gambler with two college degrees_His stated problem, 'fear of erection problems, I need to be able to relax.' He began to masturbate at age 13. He currently masturbates daily, with no guilt. T did not go on dates in high school, and had only one date in his senior year of college. He has paid for sex intermittently throughout the years, but he was unable to experience orgasms. His first serious relationship was at age 34. His girlfriend performed fellatio and he could not hold an erection. He was in this relationship for one year with no success at either intercourse or orgasm. I would drive to meet with T in his home. Because of the distance, we would do extended sessions of several hours at a time. In the first of the sensate focus exercises, the mirror image, T rated himself as a nine. While he was experiencing the head cams exercise, he achieved an erection. In fact, he had erections most of the day. He seemed vent comfortable with me except for his lack of eye contact. T 's touch was

very sensual and he told me that he liked me. At the end of this session we took a shower together and had a picnic on his bed. In talking with his therapist, we decided to work on T receiving small doses of touch at a time. We also decide that T and I should not attempt to engage in coitus until we have several more sessions. The next session began with me giving T the foot- bath. He enjoyed this exercise and was able to relax. He hared with me that Tie has fantasies about feet and shoes. I encouraged him to use his fantasy during our sessions, but he says he is, 'uncomfortable and embarrassed.' During the next session, I performed the back body caress on him. He was able to relax. We then traded places and he reciprocated very beautifully, he has a good touch. We experimented with genital pleasuring to me and he did really well, hi fact, he had erections all evening. Session three, I administer the front body caress to T. He asks me to masturbate him. He likes it when I 'talk dirty'. While talking sexy to him for 10 minutes, he was able to orgasm. He told me that his verbal therapist has instructed him to think of me in his fantasies. He said that he pictures me in fantasies, but not in having intercourse. The following session begins with mutual back body and front body caressing. We also share oral sex both ways. He has erections and is very nurturing to me. He said he enjoyed the oral more than ever. We discuss trying coitus, but he says, 'no matter what you say, I am not comfortable with it' The therapist would like us to try intercourse. T is hesitant and fears his performance ability. We use a condom and at first he has slight erection problems. I helped him to relax and he was able to allow himself to get into

> it. It was a good session, T said, 'intercourse with you was the best experience I've had thus far.' T had agreed to four more sessions, however, he terminated treatment. The racetrack closed here (in the north) and he moved to Florida to follow the races. At the time of closure his fantasies were becoming more sexual, but only with him as the giver and not as the receiver.

T represents many of the men in this study who had a fear of performance. When they feel that the success or failure of a sexual encounter is their responsibility, they tend to withdraw from sexual situations. Masters and Johnson (1970) has this to say about male sexual performance:

> Over the centuries the single constant etiological source of all forms of male sexual dysfunction has been the level of cultural demand for effectiveness of male sexual performance. The cultural concept that the male, partner must accept full responsibility for establishing successful coital connection has placed upon every man the psychological burden for the coital process... and the responsibility for its success.

According to the updates that Surrogate C has received, T is still unable to just receive, he is only comfortable as the giver which has him more in the control seat His termination reflects his fear to continue treatment because of the possibility of being able to be sexually successful. To continue with progress in fulfilling his goals, he would then have to find a partner of choice and again be in sexual situations where he was responsible for the success or failure of that encounter. This is a very threatening position for males with fear of performance.

Theme- Shyness and Anxieties

In this category, 12 clients had expressed their desire to overcome shyness, anxiety, as well as social and sexual inadequacies. "For some men, the problem is that they are very shy and find it extremely difficult to meet women or to ask them out. (Zilbergeld, 1999). Persons who are shy will avoid situations where they may experience embarrassment or anxiety. Public places where they could meet females are for this group, feared situations. They tend to isolate themselves by becoming overachievers at school or at work. They avoid circumstances that would require them to interact with others.

L's story is an interesting perspective that was repeated by other subjects of this study who were able to recognize and label their own fears and inhibitions. L is the client of Surrogate A.

> At the time of the coaching, L was 30 years old. He is a Jewish, college graduate who lived alone. L worked as an Actuary. His diagnosed problem is premature ejaculation. His sees his problem as, 'being shy and anxious around sex and women. I have erection problems around women, even though I do experience some thickening of my penis, I loose it quickly.' L believed that his parents were happy and he felt loved as a child. Although, the therapist tells me that the client's parents were 'odd.' L began practicing masturbation at age 11. He currently masturbates regularly, one to three times a week. The longest relationship he had been in was for only two months. The verbal therapist that L is working with has never worked with a surrogate before. He previously had been in therapy with this therapist, for 25 sessions. I saw him

> for a total of 20 sessions. At our first session, he rated his body image as a seven. But in my opinion, he is a very attractive man. When we did the head caress, second session, I sat in against him, and I remember him saying, 'I think it's going to work.' L expressed to me that he is anxious and worried about dating women. I reassure him by telling him that these sessions will teach him what he needs to know to create conditions for good sex. In session three he tells me that he knows that the distance he puts between us is a problem. He shared that I am too much the teacher with him, that he would like more spontaneity. Session four, I decided to forego the foot-bath as L thought it was 'corny.' I remember him not liking to do the sensate focus exercises. I shared with him that he is an attractive man and he shared that I was attractive to him. We closed the session lying together hugging on the floor.

I questioned Surrogate A regarding what she does if clients refuse to do the sensate focus exercises. She said, "the exercises will get Completed in one form or another. The . client's resistance is most definitely a part of his problem that needs to be worked through. I just get more creative and re-introduce the techniques as we continue to work together." She continues her story:

> After the back body caress, L seemed more comfortable. During the following sessions we petted frequently, and after the front body caress, he had erections and became more emotionally aroused. We talked about dating organizations. He said that he first wanted to see pictures of the girls before he would meet them. He says he is, 'very particular about what they looked like.' I shared

this with his therapist. She told L he should not judge women by looking at them in pictures. She told him women are much more than just a body and that he needs to not look at women just as sex objects. Session six, I shared that he would need to be more vulnerable to be in a healthy relationship. I told him I felt there is no emotion from him, that he is like a wall. I spoke with his therapist about the distancing and she said to tell him that I missed the lack of warmth. She said it was up to me to help him learn to be close. So, I explain to him that he needs to share his feelings with me *as* I represent the women he will come in contact with in the real world. Session seven, L placed an ad in the personals of *a* local magazine. He admited that he is afraid to risk by reaching out. He gives to me a back body massage. I give him oral sex, but with no penis hardening response. The verbal therapist and I discuss that there is a lack of warmth and presence and that he has been a tough client. I told

the therapist that L said to me once, 'I know what the rules are, but I will be in charge.' The therapist said, 'being in charge means security for him.' For me to continue working with this client, I needed numerous consultations and supervision from a senior surrogate.

I questioned Surrogate A regarding how common it was to consult with a supervisor or senior surrogate. She told me there is tremendous support in the surrogate community. They call upon one another frequently to discuss cases or obtain direct supervision on a particularly difficult client

At the ninth session, L shares with me that he got drunk at a party and took a girl home. They were naked in his bed and he felt his erection, but didn't feel

it was hard enough for intercourse, so he ended the date. Session 13, L has received some responses from his personal ad, and he is in a good mood. The session went well. I found that he really likes kissing. He admits that he is not being honest with the therapist and me. He confessed that he holds back from sharing with both of us regarding his feelings and fears. Session 16, we have intercourse. He says, "it was not as good as he had expected.' He lies on the floor looking at the ceiling and I ask him what he is doing. He says, 'nothing just looking at the ceiling.' Session 18, is a good session. We sat on the sofa and talked about things he needs to work on, and he is able to look at me more often. We looked at *Penthouse* together, and he told me what is attractive to him in women. We talked about how to set up the atmosphere for a date. I spoke with the therapist and we decided that he should stop surrogate treatment for a month, but he will continue to work in verbal therapy about distancing, vulnerability and communication. On July 24th L and I have our final session. He tells me that he has a new girlfriend. They have had sex three times and his erections are, 'okay, but could be better.' He also expressed that he was still somewhat nervous and anxious, but growing more confident with each encounter. I told him to remember the conditions that worked when he *was* with me. We suspended our visits indefinitely, but! suggested that he continue working with the therapist. I also told him that he can call me anytime with questions. At this closure session, we had intercourse. He had a bit of erection problems, because, as he said, he was 'thinking of his girlfriend.'

I asked Surrogate A if she had any updated information on L's progress. She said she had heard from him about six months after their final session and that things were going well between he and the girlfriend. They are communicating easily with each other. I encouraged him to continue with his therapist and he said that he would.

Persons that suffer from extreme shyness are affected in many areas of their lives. Their work situation, daily routine and their social life all incorporate stress from fear of being in circumstances that they will feel anxious or embarrassed. Thus, this particular concern is an overall personality problem, which also includes their sexuality. To overcome shyness around sexuality and to find an understanding and supportive partner could spill over into these other areas which cause this type of client anxiety and embarrassment. Thus, successful surrogate treatment could be life changing and life altering in several areas for persons with the stated theme of shyness.

Theme- Gain Confidence and Experience

This theme was listed as the reason for seeking surrogate treatment by 26 of the 151 men studied. Their expressed concerns were about gaining confidence and experience with women and sex. One virgin says, "I need to gain confidence so I can date girls." Another client with social phobia says, "I lack confidence and experience. I need correction of this problem." One other client with premature ejaculation says, "Sex has always been difficult I get involved with the wrong women. I need to have a complete experience and learn how to use *a* condom." Surrogate B tells the story of a client expressing the need to gain confidence and sexual experience:

C was 52 years old when he began the surrogate treatment process. He is a Protestant and works as a Pharmacist. His diagnosed problem is erectile dysfunction and his stated goal is that he wants to gain confidence with women. C had been married two times but he was currently divorced and living alone. He started masturbating at age 12 and as he says, 'with guilt.' Currently, he masturbates about once a year with only, 'some guilt.' His first wife would not agree to oral sex either giving or receiving, but they did have intercourse for the first few years of marriage. His second wife never touched his genitals or performed oral sex. One time when they were having sex, he climaxed on the sheets. His wife jumped up and ripped the sheets off the bed disgusted at him for the mess. Prior to starting the surrogate treatment program, C did not have intercourse for 25 years. I worked with him for 28 sessions. The the first session I realize that C and I have a good rapport. He talks a lot, and he is a sweet guy. He also loves women despite his negative sex history. His body image rating (as he sees himself) is a six. In session two, I give him the sensate focus foot-bath, he really enjoys this treatment. I find it surprising how sensuous he is with his touching. As he was leaving, he kissed me like a little boy, very soft and shy. Session four, it is obvious that C is not interested in the session tonight, he talked a lot. He shared with me that he masturbated this past week We did the head caress again because he really likes it I administered the back body and he reciprocated, but he was not as sensuous as I expected. After the back body exercise, he covered his genitals as he was getting up. By the end of the session, C was very distant. Session

> five: We performed the front body caress today. C liked it and this time he did not cover his genitals. He found the sexological (genital exploring) interesting. He said that he liked seeing the vagina. We tried some breathing exercises, but he does not like doing them. I suspect it is an intimacy issue, although, he was vary much a giver during the exercises. At session eight, the first thing he told me was that he had been thinking of me all week and that he wanted to have sex right away. He was aroused very quickly. We performed mutual touching and he was able to orgasm manually, but with a partial erection. On the 10th session we use the 'stuffing' technique (inserting a semi- erect penis into the vagina). He shows great affection towards me and the feeling is one of closeness. He orgasms very quickly but without full erection. After his climax, he needs to wash up right away. He said he has concerns about when he leaves the treatment program, who will he have to replace these feelings of closeness. I talked with C's verbal therapist, he said that he believed that the treatment was going well. We discussed the use of papaverine (erection injection) to help C maintain an erection and gain some confidence. In session 12, C claimed the injection did not work, although he had 1-1/2 hour control and a semi-erection with his manual orgasm. We both felt it was a good session. We had better communication than in most sessions. It was a very sexy visit.

I asked Surrogate B why C was reluctant to give the papaverine injection the credit for his erectile functioning. She said that it is common with clients to discredit the use of this drug. They want to be able to perform without a sex aid. They will usually agree to try it just

as a confidence booster, but do not want to take the injection process into sexual situations with other partners. She continues her story:

> Session 15: C maintained erections the whole session, mostly really good ones (without the papaverine). He stated that he 'has not seen erections like this since he was 20 years old', and that he is feeling more sexual. He said that since his youth he thought that if he was distracted, and lost the erection, it would not come back. He has learned with me that the erection will come back. On the 22nd session, we had very successful intercourse. He then wanted to try another surrogate just to practice transferring what he has learned from me to another woman. His therapist agreed and C met with another surrogate for two sessions. They both felt that the sessions went well. He was able to perform coitus with her and last long enough to feel that he had control. Closure: C wants to keep our friendship alive, and does not understand why we can't keep in touch, even if he is dating or married. He says, 'I've never had such an experience.' He said that he 'wanted to marry me.' He told me, 'you'll never have to work again, I'll take care of you.' I told him that's not a reason I would get married.

In the beginning of C's sessions, Surrogate B says that he, "talks a lot." This was C's way of covering up his nervousness and lack of confidence. That he did not want to depend on the papaverine injections indicates his desire to attain his own ability to perform, which would give him the self-confidence, he wanted. C asked to try his newly acquired skills with another safe partner, a surrogate, before a sexual encounter with a partner of choice. This

helped him to gain even more confidence and experience before leaving the surrogate treatment program.

Theme-Social and Sexual Education

Social and sexual education is a very important aspect of surrogate treatment. The sensate focus socialization skills are designed to teach the client social skills and sexual information he needs to attain his social and sexual ability. Twenty-six of the subjects in this study said they needed instructions on how to conduct themselves in social settings particularly when with women. They also admit that they needed their sexual questions answered to distinguish between sexual myths and misinformation from fact.

A group that is in need of social and sexual education is the mentally and physically challenged. In this study, six out of the nine physically challenged clients stated their need for this training. Deutsch & Fralish (1993) describe what is accepted sex therapy in rehabilitation centers for the head injured:

1. Education about basic anatomy and physiology, pregnancy, contraceptives sexually -transmitted diseases;
2. Social skills training focused on dating skills;
3. Counseling to encourage emotional expression; and
4. Community social experiences that have a high probability of success.

These guidelines do not incorporate any hands-on sex help. There is a need for sexuality training that is not being addressed. Specifically, persons who could enjoy or benefit from sexual activities are not able to obtain this type of training. Surrogate treatment

offers the hands-on sexual training that the physically challenged are unable to procure from basic clinical services.

Surrogate A tells the story of N, a physically challenged client who is wheelchair bound. This client's mother contacted a therapist because her son was constantly having erections and he was also inappropriate with women in public. N stated in his interview with the surrogate that he, "wanted to learn more about his potential for sensuality and sex."

> N was 25 years of age when he started surrogate treatment. He was disabled in a car accident when he was a teenager. His mother contacted a sex therapist because she felt that N should have social and sexual training. I first met N when I went out to speak with his parents. It was discovered that N had spent a lot of time in the hospital where I was employed as a nurse. When I agreed to work with their son, the parents hugged me and with tears in their eyes said, 'Thank God for good people like you.' In our first session, it was clear that N had very limited knowledge of his body and that he needed to learn where his sensitive areas were located. N is a quadriplegic, but he had limited use of his hands. We did the head caress, and it was hard for him to give to me because of his physical limitations, but he did have a lovely touch. We found that N was able to use the sensuality tools. He enjoyed the discovery of different sensations from the feathers, massage oil, and fur mitt. Because we would not be incorporating the socialization homework, by session three we were exploring genital pleasuring. We were able to find a technique for N to masturbate to orgasm. He was very excited about this and so were his parents. In session five N wanted me to get dressed up in sexy clothing. I wore garters

> and high heels and his mother thought this was great. I tried to educate N to go more slowly and not grab at me when I walk in the door. I wanted him to show respect to me, learn to be respectful of other women and to consider their feelings. We practiced role playing on appropriate behavior when in the presence of a woman, particularly one that he finds attractive.

I asked Surrogate A about the possibilities of client N finding a partner or even an appropriate love interest. She replied, "Social isolation is a major problem for this population. I have experienced many disabled clients who suffer from isolation, loneliness and a longing for both social and sexual contact. So much of the outside world is closed off to them. This is one of the reasons that surrogate treatment is an important service for this special population. Together we can explore their bodies and find their sensitive, erotic zones. If they can learn how to pleasure themselves, they then at least can obtain some relief and possible release from their sexual frustration. Surrogate A continues with her narrative:

> I saw N once a month for two years. He suffered from depression because of his situation and sometimes our sessions were not pleasant. He would cry a lot from the frustration of wanting a girlfriend. He would get crushes on women he would see at the mall when he and his parents went shopping and would become even more depressed because he was unnoticed by the women. Our sessions ended when N and his family moved to Florida They made this move for N's health and also so he would be able to venture outdoors all through the year and not be even more isolated during the winter season.

At this writing, Surrogate A is still in contact with N and his parents. They often send Christmas cards and family pictures. The parents have shared with her that the sessions

helped their son. They have told her they are, "grateful for your blend of both love and professionalism."

The idea of surrogate treatment for this population raises two issues. One concern is the legal, moral and ethical use of surrogate coaches and the second issue is whether physically challenged people should be sexual. For a lot of physically challenged people, family and/or caretakers do not want to deal with the sexual needs or desires of someone they feel should be asexual (Strauss, 1991). N was fortunate that his family was willing to acknowledge that he had sexual needs and frustrations and that they agreed to acquire for him the services of a surrogate coach.

Theme — Inability for Intimate Relationship

During their sex history interview with their surrogate, eleven of the 151 subjects studied talked about the desire to be in a relationship. One client, a virgin, said, "I want to be a great husband and good lover." Another client, with social phobia diagnosis, stated, "I would like to have a girlfriend." Kaplan (1979) writes about the need to understand a client's concerns and fears around intimacy before treating the diagnosed disorder. She goes on to say that the importance of a client's pleasure and intimacy fears has not been, "sufficiently appreciated."

It is recorded in the history data from the surrogate files that clients expressed their need to experience resolution of their intimacy concerns before they would be able to

correct their diagnosed problem. Following is the story of S, as told by his surrogate coach, Surrogate C:

> When S talked about why he felt he needed surrogate coaching, he expressed his desire to 'be in a relationship.' He was 22 when we started our sessions. S worked as a body mechanic. His religious upbringing was as a Protestant. S remembers receiving sex education in high school, 'which was minimal,' and he also obtained information from friends, but as S says, 'mostly misinformation.' He began masturbating at age 13 with guilt, but he does not have guilt about masturbating now. At 18 years of age he attempted intercourse and experienced erection dysfunction. Since that first encounter, he has never had erections around women. I saw S for a total of 14 sessions. S claims he is not nervous to be here,.but he taps his foot a lot He says that I remind him of his aunt. In the beginning sessions, S loved receiving the head caress. He even experienced a slight erection. During the hand dance exercise, he took the lead_ I was very pleased at this assertive move. In session three he allowed himself to enjoy the foot-bath. He told me, 'I got lost in space.' Session five is the back body caress and he achieves another slight erection. He could have been more sensual, but his hair brushing movements over my body was great I called the verbal therapist and told her things were going well, but that I would like to see more feelings from the client I told her that he doesn't share his thoughts and feelings. During session eight, the front body caress S said, 'this gives me the chills.' I remember, at this moment, • hoping that he is able to complete his goals, he is a very tender man. I do feel

our relationship is getting closer, but I still would like him to share more of his thoughts and feelings. According to S, 'everything is great!' In session nine he told me he *feels* he is making progress with relationships. He was able to get the phone number of a girl he likes. We took a shower together and performed the sexological. He asked if we could try intercourse, but he was unable to maintain an erection and he prematurely ejaculated. In session ten we experience mutual oral sex. He is able to hold back his orgasm and I remember this made him very happy. I spoke with his therapist and told her things were going well. I do, however, worry that he wears a 'macho man' mask to hide his insecurities. I am concerned that he will attract insensitive women with this attitude. The therapist says she will work with him regarding this concern. In session 12 we had good coitus, he was able to prolong his orgasm., but he still lacks ability to express his feelings. He would only say, 'it was good.' In speaking with his therapist we agree on two more sessions. He will continue to work with her regarding his lack of self-expression and the 'macho mask.'

I asked Surrogate C if she felt like she was "cutting the apron strings" and forcing him out into the world. She agreed that S was a fragile client "What I mean by that (fragile client) is that he is very sensitive and, thus, vulnerable to hurtful relationships. It was hard to put him out in the world. Although, I did receive calls from S in the months that followed our work together. He told me he is reading women's magazines to learn more about what women want in relationships. He is also attending night school to study photography. S

made the remark, "1 feel like a stud." He phoned me one year later to tell me that he is married to an older woman, she is pregnant and they both are very happy.

S is the type of client from whom surrogates receive the greatest reward. 'This is the reason I do the work", says C. "To know I have affected the life of someone who may have struggled for years with issues that could prevent him from feeling loved and giving love in return is, in my experience, the most rewarding gift I can contribute to my fellow human beings."

Theme- Abuse

Abuse can appear in many forms, sexual, physical, emotional or verbal. Regardless of the type of abuse, the goal of therapy is to allow the client to speak about buried past traumas and to get in touch with feelings that cause him to be emotionally and physically numb. The most effective form of therapy for abuse survivors is physical and verbal integrative approaches. "In our work we have found that long term talk therapy by itself is not effective in helping individuals move beyond the early pain (of childhood abuse)" (Lafair, 1994). Surrogate coaching offers both physical and verbal integrative treatment.

In this study seven subjects said they wanted to be free of abuse issues which they felt were blocking their ability to be sexual with women. Five out of the seven subjects completed their therapeutic goals. In researching the files of the three professional surrogate coaches, it was interesting to note the differences in the number of clients and the time period of those clients who spoke of an abusive childhood.

SURROGATE	YEAR	N=CASES	ABUSED CLIENT
A	1977 – 1987	97	1
B	1985 – 1990	26	2
C	1986-1992	31	4

Surrogate A has this to say about the statistics, "Sexual abuse or any type of abuse was not discussed in the 1970's or 1980's time period. It became a more 'popular' therapeutic concern in the 1990's. It was not part of our surrogate training to pay particular attention if a client talked about abuse in the home." Surrogate C tells the story of M, a survivor of both sexual and emotional abuse:

> When M came to work with me, he was 67 years of age. He is a Quaker, who works as an International Program Director for his church. His diagnosed problem is erectile dysfunction. M feels his erectile failure is, 'largely due to the early bad experiences.' M entered verbal therapy two years prior to surrogate treatment. The reason for seeking therapy was because his wife left him for another man. She at one point during their breakup said to M, 'sex is everything.' This had come as a blow to him, because he never realized his sexual inadequacies had any effect on her or their relationship. M comes from a wealthy, but dysfunctional family. Mostly, he was raised by a succession of governesses. M remembers that at age five, his French governess, Mme. Kechlan, made him cross his arms over his chest during nap time. 'Obviously to keep us (he and his twin brother) from touching our genitals.' Also at five years old, M was circumcised. He recalls, 'I remember being very scared, nightmares, not knowing what was going on, or why.' M was sent away to

boarding school when he was just 5-112 years old. He began stammering at this time and he remembers that no one attempted to find out why. From ages 10 to 12, M had another governess, Petit M recalls her sexual overtures, 'She would invite me into her bed, but with strict instructions never to tell mother. I always felt shameful and dirty after these interludes.' M started masturbating at age 13. He wrote about his first experiences with girls, 'I was from the outset afraid of girls in the sense of somehow being controlled by them.' M was married at age 26. He recalls his wedding night, 'The very first time we tried intercourse, I went limp and failed. I then sought psychiatric help at the Institute of psychoanalysis.' M was able to have successful intercourse during an eleven-year period, which produced five children. During these productive years, M was in and out of hospitals for depression and nervous breakdowns. When he came to surrogate treatment, M had been seeing a sex therapist for two years. His motivation for seeking therapy, 'If my marriage is over, my life is not over.' He had a very strong determination to succeed with me. In fact, it was his idea to find a surrogate coach. He said, 'I enjoy being with women and I know they enjoy being with me.' I saw M for 25 sessions. He was able to accomplish all sensate focus exercises. I participated in his socialization training. We went dancing, out for dinner, to exotic dance clubs and spent weekends at his county home. Through the use of the sex aid papaverine, M was able to maintain erections and experience successful intercourse. During our work together, M met C through his church work. They eventually married and I was invited to the

> wedding. All of M's children were present and they knew who I was and the role that I played in their father's life. All of the family, including M's new wife, treated me like I was the guest of honor. A very rewarding and happy ending to a story that began with loneliness, despair and a childhood that was emotionally and verbally abusive.

M's abuse was more emotional and verbal than it was physical. Other clients in this theme had similar circumstances. One client was forced to watch his parents have sex, another was set up by his .father to have sex with his stepmother. A 22-year-old virgin had to sleep in his mother's bed until he left home to attend college. Physical abuse was also present in this client population. At the age of 12, three teenagers who forced him to perform sexual acts on them and the farm animals held P against his will for eight hours in a barn. J was molested as a child and his continuing sexual fantasies were masochistic.

Whether the abuse is mental, emotional or physical the results of low self-esteem, guilt, sexual inhibitions, frustrations and confusion about pleasure and pain are the same.

> Hitting children turns the skin into an organ of pain instead of pleasure. The buttocks became the preferred location for spanking because it is a region close to the sex organs and provides a type of sexual stimulation. This association of pain with sexual pleasure can lead to a pathological disorder called alagolagnia which can be sadistic or masochistic (Montague, 1971).

Victims of sexual abuse have additional concerns and confusion to overcome regarding sexuality. The prospect of sexual encounters is equated with a mix of pain and pleasure. Sexual intimacy causes them to retreat in fear believing that pain will somehow be attached to feelings of trust and closeness. Persons with this concern need to learn that their

body can be a source of pleasure and give themselves permission to be a sexual being and safely enjoy themselves sexually.

Theme — Lack of Desire

The loss of desire, also known as inhibited sexual desire (1SD) was a concern for seven of the 151 men in this study. The question of whether desire is biological or psychological is discussed by Helen Kaplan Singer in her book *Disorders ofSexual Desire* (1979). It is the hormone testosterone also called "libido hormone" that is responsible for the level of sexual desire in not only male and female humans, but in all animal species that have been studied. They also report more recent evidence of a "small peptide molecule called LH-RF which may enhance sexual desire even in the absence of testosterone."

Other biologic factors play a role in affecting both positively and negatively the centers of the brain that control sexual desire. Affecting these biologic factors is attraction and love mechanisms that stimulate sexual centers in both humans and animals "In physiologic terms, (these mechanisms) may exert a direct physical effect on the neurophysiologic system in the brain which regulates sexual desire." (Kaplan, 1979)

The affects of biological and psychological inherent sexual circuitry do not guarantee that every person has a high or even "normal" sex drive. "...there is no sexual stimulant so powerful, even love, that it cannot be inhibited by fear and pain" (Kaplan, 1979). The clients with this concern either struggled all of their sexual lives with low sexual desire, or they loss desire because of circumstances, which affected their sexual lives. Follows is the story of J as told by his surrogate, A:

J was thirty-four years of age at the time he entered treatment He had no religious upbringing, lives alone, and works as a private construction contractor. He said there was no sex education, or sex messages, either negative or positive, from his parents. He began masturbating around age 12 and with no of guilt. He obtained most of his sex education from a friend and mostly he just 'practiced regularly with the girls with no problems or guilt.' I was previously married and *as* result of that marriage has two grown sons. During his marriage he had been drinking heavily. Prior to therapy, he entered himself into Alcoholics Anonymous. J's stated problem to me was, 'anxiety, wild misconceptions about sex, dissatisfied with *a* lot of things and loss of desire for sex is included.' In our first session I felt that I was very sweet although I could see that he was not always that way. As a drunk he says that he was very nasty and I sense a lot of hidden anger and probably at one time, a lot of rage. We did the body image and he gave himself an eight I spoke with his therapist regarding his diagnosed problem of losing his erection just before ejaculation, even during masturbation. His therapist agrees there could be physical problems on board, but he still wants I to go through the treatment process, he feels it will be 'good for him.' If he is not successful, the therapist will then look into urological treatment As the sessions progress, J enjoys all the sensate focus exercises. He likes to talk, asks me a lot of questions. He wants to know, what I like sexually, and do other women like the same. J is afraid he won't be able to find a woman who enjoys sex and playing. Someone who can help bring back his desire for a

sexual relationship. During our sessions he was always curious *as* to whether or not I was turned on. By the fifth session he was able to have an ejaculation with a partial erection. The sixth session was a disappointment for 3 as he was unable to obtain an erection. He talked about his drinking problem. He started drinking when he was 16 and he would have erection problems when he would drink too much. After the army he found that he would get hard enough to penetrate, but he was not completely firm. I noticed that he would not get even a partial erection until there was genital contact. J talks a lot about penis size. He is concerned that his penis size is able to satisfy a woman. His wife would say things to, 'totally destroy and frustrate me, including sexual slanders.' She would make comparisons between him and other lovers and put him down. I recommended he read Zilbergeld's book, *Male Sexuality* and 3 tells me he already has a copy. After the seventh session Ps therapist called to tell me S has decided to, 'cool it with surrogate treatment and therapy.' He told the therapist that there is financial pressure and that he needs to, 'give himself a break from everything.' He also told the therapist that he does not plan to meet or date any women. I heard from 3 about one year later. He was dating and wanted me to meet his girlfriend. He had told her about his experience with surrogate treatment and she wanted to know from me what else she could do to help him. We met on several occasions. J and N were married and he still continued to have problems maintaining an erection. I had recommended he see a urologist to get an opinion on his physical capabilities to hold an erection. When I spoke with him after his

> examination and test results, his comment was, 'it's broke, the doctor says it's (his penis) is broke.' J, his wife and I still get together for dinner. The sex aid, Viagra, has changed his sexual ability. With Viagra, J is able to attain and maintain an erection and prolong his ejaculation to both he and his wife's satisfaction. They have a lovely home, travel a lot and seem very happy.

In session five J was able to perform sexually with his surrogate coach. In session six J was unable to obtain an erection. This type of behavior is common for clients who are fearful of success. If they find that they are capable of accomplishing their stated goals, they get scared of this accomplishment because now they will have to except the responsibilities that follow success and the reaching of a goal. probably terminated therapy because he was learning too much about himself and possibly the extent of his erection problem. As his therapist had said in the beginning, "I want J to go through this treatment, it will be good for him, even if he is not successful."

J was one of the subjects who completed the sensate focus socialization skills, but did not correct his problem through the treatment process. He did, however, use the skills he learned in treatment, transferred them to a partner of choice and was able to complete one of his goals, as stated by him, "I would like to have a successful relationship."

5.3 Case Study Conclusion

Through the process of the sensate focus exercises, many clients in this study were able to overcome, if not completely, but in varying degrees, their concerns and problems that inhibited their sexual lives. Under the guidance of their surrogate coach, they gained trustworthy, reliable, factual and actual social and sexual education. The virgins were able to face their fears and embarrassments of being with a woman more sexually experienced than they were sexually experienced.

All clients were given the opportunity to explore a woman's body, ask questions and be vulnerable. In a safe environment, provided by their surrogate coach, they were able to practice their own bodies' physical capabilities. They learned to focus more on what they could do, sexually, and to focus less on what they could not do sexually. Gaining confidence and experience enabled them to overcome fears of not being able to perform sexually.

The surrogate coach, using the sensate focus socialization skills taught these clients how to dance, how to take a woman out on a date, how to be appropriate in social settings such as a restaurant, cocktail party or singles clubs. They learned how to make that first phone call and ask for a date and then how to create a romantic setting using candles, soft music, fragrances and intimate conversation.

Surrogate coaching opened social and sexual doors for these clients, which provided for the majority, a freedom and happiness that they had possibly never known before. They gained experience and were given opportunity to further their potential to obtain their life goals that had been inhibited by social and sexual fears and problems. The completion of

the sensate focus socialization process had given them training that is otherwise not available to clients in any other field of treatment. The integration of professional physical, hands-on sex work and reputable verbal therapy is unique to the surrogate treatment - process.

The final results of this study showed that 86% of the clients completed the socialization process and 62% completed the entire treatment and resolved their diagnosed problem. These statistics indicate that surrogate coaching is a valuable treatment process that combines social therapeutic modalities as well as sexual therapeutic modalities to provide a very unique experience for those persons who seek resolution of both perceived and real social and sexual limitations and problems.

CHAPTER 6:

CONCLUSION

The implications of this study are that socio-economics, education, age, religious backgrounds, living arrangement or masturbation practices, do not limit the success of the sensate focus socialization techniques in surrogate treatment. The statistical data demonstrates that clients, who complete sensate focus exercises, will also achieve resolution of their diagnosed problem. Out of 151 subjects, 129 completed the sensate focus techniques, 102 of them went on to resolve or correct their diagnosed problem.

The results did not show a significant difference between the effects of the independent variables upon the completion of the sensate focus dependent variable. This is of great importance to the field of sexology. This finding indicates that the surrogate treatment program is effective for persons in various age ranges, occupations, religious upbringing, education level, living arrangements or masturbation practices.

Surrogate treatment is of value to clients in every diagnosed disorder that was studied in this research project, indicating that surrogate treatment is a therapeutic modality available to a significant number of persons in need of social and sexual training. Also of importance to note, is that the clients' desire to obtain social and sexual relationships surpassed any possible negative affects of any of the independent variables analyzed in this study. One's religion, level of education, their physical or mental challenges were not significant factors to inhibit their determination to accomplish desired sexual and social needs.

Presented in the clients' personal stories are indication that they received benefit from the socialization process, even if they did not obtain resolution of their diagnosed disorder. Some of

these clients took the skills training out on their own and completed the resolution of their problem with a partner of choice. Even if they do not complete with them, the surrogates who give body, mind and spirit to guide their clients through their fears, want them to obtain a life that includes love, relationship and even family.

Suggestions for future research are a focus on data analysis from the files of the verbal therapists. The therapists' records would contain further information on a client's ability to transfer his newly acquired skills to a partner of choice. Interviews could be conducted of clients immediately after participating in surrogate treatment How did they find the experience? Did they feel they have gained new social/sexual skills from the process? Research of clients who had completed the process several years ago would produce data on the long-term effects of obtaining this knowledge and experience.

The records used in this study did not contain data regarding the intensity of religious training in the home and whether the client was still practicing the religion of the family at the time of treatment. Therefore, further research on the effects of religion and sexual repression regarding inhibitions and dysfunctions is also suggested.

This study only focused on mate clients working with female surrogates. Other studies could be replicated for female clients working with male surrogates, males working with males, or females working with females. This research was limited to Caucasian males residing on the East Coast. A future study could include people of color and a broader geographic area.

A future research regarding the usefulness of surrogate treatment, would be to compare similar control groups treated by: a) medication alone, b) standard verbal sex therapy, c) standard verbal sex therapy and surrogate treatment, and d) no treatment. This comparison could distinguish groups of those needing either simple or complex sexuality treatments.